Board of Directors in Common - Part 1

Wed 17 June 2026, 09:30 - 14:45

Boardroom (The Quay) - 2 Nuffield Road, Poole

Agenda

09:30 - 09:50
20 min

1. Patient Story

- 01.1 Board Report STRIVE Final.pdf (5 pages)

09:50 - 10:00
10 min

2. Formalities

- 01a Agenda BoD in Common - Part 1 - June 2026.pdf (4 pages)
- 02b BoDiC Minutes Part 1 08 04 2026.pdf (28 pages)
- 02c BoDiC Action Tracker - Part 1 Jun 2026.pdf (1 pages)
- 02d Board in Common Annual Work Plan 2026-27.pdf (2 pages)
- Declarations of Interest Joint (2026-27).pdf (1 pages)

10:00 - 10:05
5 min

3. Chair's Comments

10:05 - 10:15
10 min

4. CEO Report

- 4.1 CEO Report June 2026_FINAL.pdf (12 pages)
- 4.2 Letter of Representation - DHC AFT application 20 April 2026 Final.pdf (3 pages)

10:15 - 10:25
10 min

5. Board Assurance Framework & Strategic Review

- 5.1 DHC DCH Board Assurance Framework Q4 and Risk Review Board June 26 030626.pdf (4 pages)
- 5.2 Appendix 1 DHC BAF Q4 Review Final Board June 2026.pdf (13 pages)
- 5.3 Appendix 2 DCH BAF Q4 Review Final Board June 2026.pdf (13 pages)
- 5.4 Appendix 3 BAF - DCH DHC Refreshed Risks Board June 2026 030626.pdf (4 pages)

10:25 - 10:35
10 min

6. Corporate Risk Register

- 6.1 DHC - Corporate Risk Register FINAL.pdf (5 pages)
- 6.2 DHC Corporate Risk Register - Appendix 1.pdf (1 pages)
- 6.3 DCH - Corporate Risk Register FINAL.pdf (5 pages)
- 6.4 DCH Risk Report - Trust Board May 2026.pdf (33 pages)

10:35 - 10:45
10 min

7. Quality Committee Assurance Report

- 7.1 Assurance Report QCIC May 2026.pdf (6 pages)

10:45 - 10:55
10 min

8. Learning from Deaths Q4 Report

- 7.2.1 Learning from Deaths Report - Q4 2025-26_Board.pdf (16 pages)
- 7.2.2 DHC Annual Learning from Deaths Report - 2025-26 Board June 2026.pdf (7 pages)
- 7.2.3 DCH 25-26 Q4 Learning from Deaths Report_.pdf (12 pages)

Ellis,Kara
10/06/2026 16:30:45

10:55 - 11:05
10 min

9. Maternity Report

- 7.3.1 MatNeonatal Report Front Sheet FINAL.pdf (2 pages)
- 7.3.2 Maternity Neonatal Quality Safety Rep MarApr FINAL.pdf (19 pages)

11:05 - 11:15 (10 min)

10. Inpatient Safe Staffing Report

- 7.4.1 DHC Community Hospital Bi-Annual Safe Staffing Review.pdf (16 pages)
- 7.4.2 DHC Mental Health Hospital Bi-Annual Safe Staffing Review.pdf (17 pages)
- 7.4.3 DCH Inpatient Safe Staffing Bi-Annual Review Front Sheet.pdf (2 pages)
- 7.4.4 DCH Inpatient Safe Staffing Bi-Annual Review.pdf (13 pages)

11:15 - 11:25 (10 min)

Break

11:25 - 11:35 (10 min)

11. Finance & Performance Committee Assurance Report

- 8.1 Assurance Report May 2026 FPCIC.pdf (7 pages)

11:35 - 11:55 (20 min)

12. Integrated Performance Reports

- 8.2.1 DHC ICD Apr 26 Final and appendices.pdf (38 pages)
- 8.2.3 Integrated performance report for June Board V1.pdf (2 pages)
- 8.2.4 Integrated Board performance report June Board FINAL.pdf (24 pages)

11:55 - 12:10 (15 min)

13. Finance Reports

- 8.3.1 DHC Finance Report Month 1 April 2026.pdf (12 pages)
- 8.3.3 Front Sheet DCH Finance Report Board M1.pdf (2 pages)
- 8.3.4 DCH Finance Report M1.pdf (11 pages)

12:10 - 12:15 (5 min)

14. Health & Safety Annual Compliance Report

- 8.4.1 DHC Annual Health Safety Report 2025_26 Board FINAL.pdf (19 pages)
- 8.4.2 DCH Health and Safety Bi-Annual Report 2025-26.pdf (8 pages)

12:15 - 12:25 (10 min)

15. People & Culture Committee Assurance Report

- 9.1 PCCIC May 2026 Assurance Report.pdf (6 pages)

12:25 - 12:35 (10 min)

16. Freedom to Speak Up Annual Report

- 9.2.1 FTSU Quarter 4 Annual Board Report June 2026.pdf (19 pages)
- 9.2.2 DHC FTSU Annual Report April 2026.pdf (8 pages)

12:35 - 12:45 (10 min)

17. Guardian of Safe Working Report

- 9.3.1 DHC GOSW Report Q4 25-26 for Board June 2026.pdf (4 pages)
- 9.3.2 DCH GoSW_FRONT PAGE 2526 Annual Board.pdf (12 pages)

12:45 - 12:55 (10 min)

18. Equality, Diversity and Inclusion Annual Report & Equality Plan Update

- 9.4 PCCIC DHC and DCH EDI Annual Report 2025-2026 FINAL_.pdf (21 pages)

Ellis Jarvis
10/06/2026 16:10:45

12:55 - 13:05 (10 min)

19. Reducing Violence & Aggression Update

- 9.5 Joint VA Strategy.pdf (6 pages)

13:05 - 13:30 (25 min)

Lunch

13:30 - 13:40
10 min

20. Strategy, Transformation & Partnership Committee Assurance Report

- 10.1 Assurance Report May 2026 STPCIC.pdf (6 pages)

13:40 - 13:50
10 min

21. Strategy Delivery Review

- 10.2 Strategy review and dashboard FINAL.pdf (19 pages)

13:50 - 14:00
10 min

22. Joint Green Plan

- 10.3.1 Joint Green Plan 2026 2029.pdf (6 pages)
- 10.3.2 Joint Green Plan DHC DCH 2026-2029 Jt Template version 5.pdf (62 pages)

14:00 - 14:10
10 min

23. Senior Information Risk Owner Annual Report

- 10.4.1 DHC SIRO annual report 2025.26.pdf (3 pages)
- 10.4.2 DCH SIRO annual report 2025.26.pdf (5 pages)

14:10 - 14:20
10 min

24. Audit Committee Assurance Reports

- 11.1.1 Assurance Report DHC Audit Committee May 26.pdf (3 pages)
- 11.1.2 Assurance Report DCH Audit Committee June 2026.pdf (3 pages)

14:20 - 14:30
10 min

25. Mental Health Legislation Committee Assurance Report

- 11.2 Assurance Report May 2026 MHLCIC.pdf (6 pages)

14:30 - 14:40
10 min

26. Board Effectiveness Review (& NHS Code of Governance, Provider License & Fit and Proper Persons Compliance)

- 11.4.1 DHC and DCH Governance and Board Effectiveness Report Board May 2026.pdf (13 pages)

14:40 - 14:40
0 min

27. Charitable Funds Committee Assurance Report

- 12.1 Assurance Report - DCH Charitable Funds Committee (19.5.26).pdf (2 pages)

14:40 - 14:40
0 min

28. Estates Compliance Report

- 12.2 Estates and Facilities Compliance May 2026.pdf (20 pages)

14:40 - 14:40
0 min

29. DCH SubCo Assurance Report, Effectiveness Reviews & Terms of Reference

- 12.4.1 DCH SubCo Assurance Report 20 05 2026 ST AT NJ CA.pdf (6 pages)
- 12.4.2 DCH SubCo Performance Report Apr 2026 v2.pdf (6 pages)
- 12.4.3 DCH SubCo Effectiveness Evaluation and TOR 2025-26 (Trust board).pdf (6 pages)
- 12.4.4 2026 DCH SubCo Management Group TOR.pdf (2 pages)

14:40 - 14:45
5 min

30. Questions from the Public

Elvina
07/08/2026 16:20:45

14:45 - 14:45
0 min

31. Any Other Business

Dorset HealthCare University
NHS Foundation Trust

Report to	Board of Directors	
Date of Meeting	17 June 2026	
Report Title	STRIVE (Support, Treatment, Risk Management, Identity, Values and Enabling)	
Prepared By	Rachael Pankhurst - Patient Experience Facilitator	
Approved by Accountable Executive	Cara Southgate - Director of Nursing (Mental Health & Community)	
Previously Considered By	N/A	
Action Required	**Approval**	N
	Assurance	N
	Information	Y

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety SR2 Culture SR5 Estates SR8 Transformation and Improvement	
Financial	No implication	
Statutory & Regulatory	No implication	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary

This patient story highlights the experience of an individual engaging with STRIVE, the Trust's community-based Offender Personality Disorder service. Part of a joint NHS and HMPPS pathway, STRIVE provides specialist psychological and occupational therapy support, including the Intensive Intervention and Risk Management Service (IIRMS), to high-risk individuals on probation, with a strong focus on recovery, risk management and successful resettlement.

The patient describes how trauma, substance misuse, and imprisonment shaped his life, and how engagement with STRIVE and Schema Therapy supported a significant transformation in his emotional wellbeing, self-understanding, and sense of purpose.

He reflects on the importance of a safe, non-judgemental therapeutic environment and the development of practical psychological tools. The patient reports stability, resilience, and a sustained sense of hope and freedom.

Recommendation

Members are requested to: Consider and discuss the patient's story and consider his experience.

Ellis Kara
10/06/2026 16:10:45

Patient Story

1. Executive Summary

1.1. This patient story provides a positive account of an individual's experience of the Trust's Offender Personality Disorder Service (STRIVE).

2. Introduction

2.1. A patient/carer story is produced by the Patient Experience team and is a regular item at Board meetings.

2.2. Stories are submitted and presented by the Corporate Governance Team.

2.3. The patient has been supported in giving his story by Rachael Pankhurst, Patient Experience Facilitator.

3. Main narrative

3.1. The patient describes a traumatic childhood, including experiences of physical and emotional abuse within his family, which he says played a significant role in shaping who he was. He reflects that these experiences had a lasting impact on his ability to cope, communicate, and form relationships. He recalls feeling isolated, withdrawn, and highly self-conscious, with no ambition or sense of purpose or belonging, and describes a belief that he "didn't belong in this world."

3.2. He says that, to manage those feelings, he turned to substance misuse and acknowledges that this further compounded his difficulties and ultimately led to severe consequences, including imprisonment. He explains that his engagement with the STRIVE service, and the tools he has gained through this, have had a significant impact on his life, and that without this support he would not be who or where he is today.

3.3. Towards the end of his sentence, he was introduced to STRIVE and describes this as a turning point and the beginning of his journey in developing an understanding of himself. From the outset, he reports feeling comfortable and safe, and under no pressure, which supported his engagement with the service for nearly three years.

3.4. The therapeutic process involved exploring his history and experiences, which he found emotionally painful and, at times, difficult. However, he says that staff supported him to move beyond his fear. The reassurance, consistency, and sense of safety provided by staff enabled him to begin addressing experiences he had never previously shared and did not think he ever would. He emphasises that he was never pressured and that therapy progressed at his own pace, which helped to build trust.

Ellis Kara
10/06/2025 16:10:45

3.5. Through Schema Therapy, the patient developed insight into how his early experiences shaped his thinking, emotional responses, and behaviours. He describes this as a series

of “penny dropping and lightbulb moments,” gaining clarity and understanding which at times felt overwhelming, and as an “educational awakening,” as he began to understand why he felt and behaved as he did.

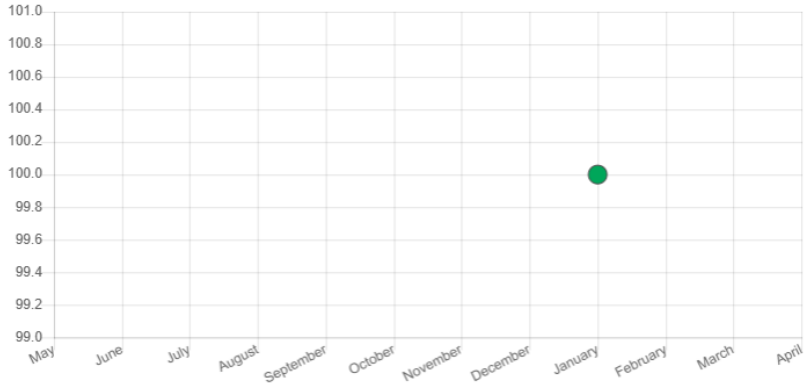
3.6. The patient states that each session left him feeling lighter, calmer, and reassured. For the first time, he felt a sense that “everything was going to be okay,” which he says he had never previously experienced prior to engaging in therapy with STRIVE. The consistent, non-judgemental approach of staff was central to his experience and to the positive outcomes of Schema Therapy. He says that he felt well supported by staff and was particularly struck by the level of care and support provided, as well as the sense of safety he experienced, and the way staff presented themselves.

3.7. A key outcome of his engagement has been the development of a “toolbox” of psychological strategies, which he now applies in his daily life. Through these tools, he has developed motivation, ambition, and a sense of control.

3.8. As a result, the patient reports significant improvements in his wellbeing. He describes having peace of mind, emotional stability, and the ability to experience happiness and joy. He reflects that he now feels “free” from the patterns that previously defined his life and describes this stage of his life as the “best he has ever been.”

4. Triangulation data: 01/05/2025 – 30/04/2026

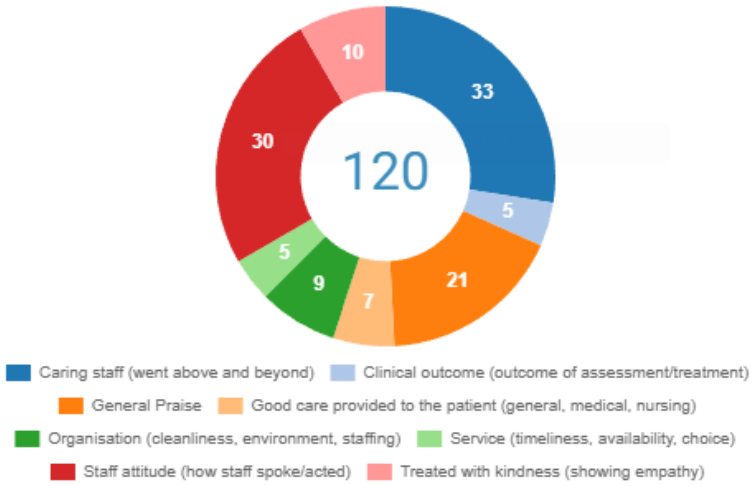
4.1. **Friends & Family Test** – STRIVE received 1 response from feedback with an FFT score of 100% during this reporting period. There is insufficient data to generate a meaningful trend over time, and therefore the graph does not display a continuous score.



4.2. **Complaints** - Nil complaints were recorded.

4.3. **Compliments & Categories** A total of 41 compliments were received for the service with a breakdown of the categories (a compliment may have more than one category).

Ellis,Kara
10/06/2026 16:10:45



4.4. **Survey Comments & Sentiment Analysis** - There were 7 survey comments sentiment analysed. These are further broken down by theme.



4.5. **Service Developments & Improvement 'You Said, We Did' (YSWD)** – Nil.

4.6. **Online Comments** - Nil.

5. Conclusion

5.1. Key points raised in the video are:

- Access to service
- Engagement with service
- Therapeutic approach
- Staff attitude
- Communication
- Self-management tools
- Patient outcomes

5.2. **Response to the story from Jen Devine, Principal Forensic Psychologist in STRIVE:**

Ellis,Kara
10/06/2026 16:01:45

We are hugely appreciative to our service user for taking the time to share his experiences of working with STRIVE. His experiences highlight the strength of using the collaborative, psychologically informed, and multi-disciplined approach we use. I was

fortunate enough to work with this service user during his latter stages in our IIRMS service and it was clear that he had shown a strong commitment to change. He did not have a straightforward journey in STRIVE but through our compassionate and consistent support we have been able to support him in better understanding himself and helping him to live the life he wanted to live. Through occupational therapy and psychological sessions, the complimentary disciplines meant we could support him with establishing and navigating a pro-social life in the community.

We continue to wish him all the best for his future and again thank him for openly speaking about his experiences of working with STRIVE and the impact this had had on his life.

6. Recommendations

6.1. The Board / Committee is recommended to:

a. Receive the report for information.

Name and Title of Author: Rachael Pankhurst, Patient Experience Facilitator
Date: 20/05/2026

Ellis Kara
10/06/2026 16:10:45

Meeting of the Boards of Directors (Part 1) of Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust

Wednesday 17 June 2026 at 9:30 to 14:55
Board Room, DHC Headquarters, 2 Nuffield Road, Poole and via MS Teams

AGENDA

Ref	Item	Trust	Format	Lead	Purpose	Timing
1.	**Patient Story**	DHC	Presentation	Dawn Dawson	Information	9:30-9:50
2.	**FORMALITIES** to declare the meeting open.		Verbal	Eiri Jones Trust Deputy Chair	Information	9:50-10:00
	a) Apologies for Absence	Joint	Verbal	Eiri Jones	Information	
	b) Declarations of Interest	Joint	Enclosure	Eiri Jones	Information	
	c) Minutes of the Meeting dated 08 April 2026 Board in Common	Joint	Enclosure	Eiri Jones	Approve	
	d) Matters Arising: Action Log	Joint	Enclosure	Eiri Jones	Approve	
	e) Board workplan	Joint	Enclosure	Eiri Jones	Information	
3.	**Chair's Comments**	Joint	Verbal	Eiri Jones	Information	10:00-10:05
4.	**CEO Report**	Joint	Enclosure	Matthew Bryant	Information	10:05-10:15
5.	**Board Assurance Framework (BAF) and Strategic Review** (May/June Audit Committees)	DHC DCH	Enclosure	Jenny Horrabin	Approval	10:15-10:25
6.	**Corporate Risk Register** (May/June Audit Committees)	DHC DCH	Enclosure	Dawn Dawson	Assurance	10:25-10:35
7.	**Quality**					
7.1.	**Quality Committee Assurance Report**	Joint	Enclosure	Claire Lehman	Assurance	10:35-10:45
7.2.	**Learning from Deaths Report Q4** (May QC)	DHC DCH	Enclosure	Lucy Knight Rachel Wharton	Assurance	10:45-10:55
7.3.	**Maternity Report** (May QC)	DCH	Enclosure	Dawn Dawson	Assurance	10:55-11:05
7.4.	**Inpatient Safe Staffing Report – Bi-annual Review** (May QC)	DHC DCH	Enclosure	Dawn Dawson	Assurance	11:05-11:15
	Break 10 Mins					
8.	**Finance and Performance**					
8.1.	**Finance and Performance Committee Assurance Report**	Joint	Enclosure	Dave Underwood	Assurance	11:25-11:35
8.2.	**Integrated Performance Reports** • **DHC Report** • **DCH Report**	DHC DCH	Enclosure	Chris Hearn Anita Thomas	Assurance	11:35-11:55
8.3.	**Finance Reports** • **DHC Finance Report**	DHC	Enclosure	Chris Hearn	Assurance	11:55-12:10

Ellis Kaye 10/06/2026 10:10:45

	• **DCH Finance Report** (May FPC)	DCH				
8.4.	**Health and Safety Annual Compliance Report** (May FPC)	DHC DCH	Enclosure	Rachel Small Chris Hearn	Assurance	12:10-12:15
9.	**People and Culture**					
9.1.	**People and Culture Committee Assurance Report**	Joint	Enclosure	Eiri Jones	Assurance	12:15-12:25
9.2.	**Freedom to Speak Up Annual Report** (May PCCIC)	DHC DCH	Enclosure	Jenny Horrabin (Anne Hiscock Lynn Paterson)	Assurance	12:25-12:35
9.3.	**Quarterly Guardian of Safe Working Report** (May PCCIC)	DHC DCH	Enclosure	Lucy Knight (Claire Vick) Rachel Wharton (Andy Macklin)	Assurance	12:35-12:45
9.4.	**Equality, Diversity and Inclusion Annual Report (incl. equality plan update)** (May PCCIC)	Joint	Enclosure	Nicola Plumb	Assurance	12:45-12:55
9.5.	**Reducing Violence and Aggression Update** (May PCCIC)	Joint	Enclosure	Chris Hearn Anita Thomas	Approval	12:55-13:05
	Lunch Break 25 mins					
10.	**Strategy, Transformation and Partnership**					
10.1.	**Strategy, Transformation and Partnership Committee Assurance Report**	Joint	Enclosure	Andreas Haimbock-Tichy	Assurance	13:30-13:40
10.2.	**Strategy Delivery Review**	Joint	Enclosure	Nicola Plumb	Assurance	13:40-13:50
10.3.	**Joint Green Plan** (May STPCIC)	Joint	Enclosure	Chris Hearn	Approval	13:50-14:00
10.4.	**Senior Information Risk Owner Annual Report** (May STPCIC)	DHC DCH	Enclosure	Jenny Horrabin	Assurance	14:00-14:10
11.	**Audit and Governance**					
11.1.	**Audit Committee** • **DHC Assurance Report** • **DCH Assurance Report**	DHC DCH	Enclosure	Nikki Rowland Dave Underwood	Assurance	14:10-14:20
11.2.	**Mental Health Legislation Committee in Common Assurance Report**	Joint	Enclosure	Andreas Haimbock-Tichy	Assurance	14:20-14:30
11.3.	**Board Effectiveness Review, incl. NHS Code of Governance, NHS Provider Licence, and Fit and Proper Persons Compliance** (May/June Audit Committees)	Joint	Enclosure	Jenny Horrabin	Assurance	14:30-14:40
12.	**Consent Section**					
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.					
12.1.	**Charitable Funds Committee Assurance Report**	DCH	Enclosure	Dave Underwood	Assurance	

Public Board 06/06/2024 10:45

12.2.	**Estates Compliance Report** (May STPCIC)	Joint	Enclosure	Chris Hearn	Assurance	
12.3.	**DCH SubCo Ltd Assurance Report** **DCH SubCo Ltd Effectiveness review and Terms of References**	DCH	Enclosure	Anita Thomas	Assurance Approval	
13.	**Questions from the Public**	All	Verbal	Eiri Jones		14:40-14:45
	In addition to being able to ask questions about discussion at the meeting, members of the public are also able to submit any other questions they may have about the trust in advance of the meeting to Abigail.baker@dchft.nhs.uk or jim.bailey2@nhs.net					
14.	**Any Other Business** Nil notified	All	Verbal	Eiri Jones	Information	14:45
15.	**Date and Time of Next Meeting**					
	The next part one (public) Boards of Directors' meeting of **Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust** will take place at **9.30am** on **Tuesday 11 August 2026** in **Committee Room 2, Colliton Park, Dorchester and via MS Teams**.					
	Resolution Regarding Press, Public and Others: To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.					

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

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

Voting rights:
The Board of Directors is to comprise:

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

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

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

Ellis.Jarrett 10866 2026-06-01 07:44

Part 2 Items

- Chair's Comments
- CEO Update
- NHSE Transforming People Services
- HealthSet Governance Proposals

- Joint Infrastructure Strategy
- Our Dorset Provider Collaborative Board Minutes
- Memorandum of Understanding

Ellis,Kara
10/06/2026 16:10:45

Minutes of a public (Part 1) meeting of the Boards of Directors of Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University Foundation Trust held at 9.30am on 08 April 2026 at Board Room, Dorset HealthCare HQ, Dorset HealthCare University Foundation Trust and via MS Teams videoconferencing.

Present:		
Joint Board Members		
David Clayton-Smith	DCS	Joint Trust Chair (Chair)
Matthew Bryant	MBr	Joint Chief Executive
Dawn Dawson	DD	Joint Chief Nursing Officer
Chris Hearn	CH	Joint Chief Finance Officer
Jenny Horrabin	JeH	Joint Director of Corporate Affairs
Eiri Jones	EJ	Joint Non-Executive Director (Joint Deputy Chair)
Claire Lehman	CL	Joint Non-Executive Director
Nicola Plumb	NP	Joint Chief People Officer
David Underwood	DU	Joint Non-Executive Director
DCH Board Members		
Margaret Blankson	MBl	Non-Executive Director (DCH) (via videoconference)
Stuart Parsons	SPa	Non-Executive Director (DCH)
Anita Thomas	AT	Chief Operating Officer (DCH)
Stephen Tilton	ST	Non-Executive Director (DCH)
DHC Board Members		
Suresh Ariaratnam	SA	Non-Executive Director (DHC) (via videoconference)
Andreas Haimboeck-Tichy	AHT	Non-Executive Director (DHC)
Lucy Knight	LK	Chief Medical Officer (DHC)
Nikki Rowland	NR	Non-Executive Director (DHC)
In Attendance:		
Alex Lister	AL	Integrated Community Service Director (DHC)
Adam Nicholls	AN	Deputy Chief Medical Officer (DCH)
Mandy Ford	MF	Joint Deputy Director of Corporate Affairs
Jim Bailey	JB	Corporate Governance Manager (DHC)
Jo Hartley	JHa	Head of Midwifery (DCH) (BoDiC26/011)
Helena McKeown	HM	UHD Non-Executive Director (Observer)
Alan Streets	AS	Financial Recovery Director
Ryan Setchell	RSe	Corporate Governance Officer (DHC)
Nathan Curtis	NC	Consultant Colorectal Surgeon
Sarah Doyle	SD	Joint Head of Research
Vivian		Patient/Research Participant (BoDiC26/001)
Members of the Public (observing via videoconference):		
Andy Burgen	AB	DHC Governor
Becky Aldridge	BA	DCH Governor
David Dickson	DDi	DHC Governor
Kathryn Harrison	KH	DCH Lead Governor
Lynn Taylor	LT	DCH Governor
Jean-Pierre Lambert	JPL	DCH Governor
Lisa Upchurch	LU	Observer
Apologies:		
Beverley Bryant	BB	Joint Chief Digital Officer
Rachel Small	RS	Chief Operating Officer (DHC)

Uncontrolled when printed

Rachel Wharton	RW	Chief Medical Officer (DCH)

BoDiC26/001	**Patient Story**	
	The Board received the patient (research participant) story via a video link introduced by DD. The patient Vivian (Viv) recounted her positive experience of participating in an advanced therapy colorectal cancer research trial at DCH which provides patients access to cutting-edge treatment which historically would have only been offered by large teaching hospitals. NC, Clinical Director for Research explained the process and benefits of the cutting-edge world-leading research which has also attracted interest from 5 other hospitals that do not have the capacity to deliver the trial. Viv described how her health, well-being and happiness was a top priority for the research team and could not praise her treatment enough and has no regrets participating in this successful research trial. CL asked if Viv (who was present at the meeting) had encountered any problems or difficulties in the trial. Viv explained how smooth and efficient the whole process and experience has been with no negatives. Viv has never had so much faith and trust as that for the research team. EJ reflected that if seamless efficient pathways can be achieved within research it would be helpful to share learning for 'normal' treatment pathways. MBr asked how the organisation would need to equip itself if this trialled treatment comes to mainstream realisation. NC responded that a singular organisation would not be able to deliver, but by building up networks and relationships with partner organisations this could be delivered in mainstream care. Viv stated that the research team has elevated themselves above what any patient would think possible of the NHS. The Board gave collective thanks for sharing the story.	
	Resolved by the DHC Board: that the Patient Story be received for information. **Resolved by the DCH Board: that the Patient Story be received for information.**	
BoDiC26/002	**Formalities**	
Ellis,Kara 10/06/2026 16:10:00	The Chair declared the meeting open and quorate. Apologies received from Beverley Bryant, Rachel Small and Rachel Wharton. The Board thanked Stephen Tilton for all his contributions as a non-executive director noting this was ST's last Board meeting.	
BoDiC26/003	**Conflicts of Interest**	

	None declared.	
BoDiC26/004	**Minutes of the Meeting held on the 10 February 2026 (Board in Common)**	
	The minutes were accepted as an accurate subject to minor amendments.	
	Resolved by the DHC Board: that the Minutes of the Meeting held on the 10 February 2026 be approved. **Resolved by the DCH Board: that the Minutes of the Meeting held on the 10 February 2026 be approved.**	
BoDiC26/005	**Matters Arising: Action Log**	
	The action log was considered, updates received in the meeting were recorded within the log, and approval was given for the removal of completed items. Internal Audit of Consultant Job planning: JeH confirmed that this had been replaced and is not in the 2026/27 audit plan. It was last undertaken in 2023/24. Action to be re-opened and updated once background discussions are complete. No concerns were raised in relation to cross-referrals to other committees which are all on schedule to take place in future committee cycles. All recommendations to close actions were accepted as per action tracker with the exception of internal audit consultant job planning referenced above.	
	Resolved by the DHC Board: that updates to the action log be noted with approval given for the removal of completed items. **Resolved by the DCH Board: that updates to the action log be noted with approval given for the removal of completed items.**	
BoDiC26/006	**Board Workplan**	
	JeH explained that the Board workplan has been updated for 2026/27 recognising that work is underway to reduce the volume of papers and what needs to be reported at Board meetings versus that which is reported through committee assurance reports.	
	Resolved by the DHC Board: that Board Workplan be received for information. **Resolved by the DCH Board: that Board Workplan be received for information.**	
BoDiC26/007	**Chair's Comments – DHC and DCH**	
	DCS noted the ongoing Advanced Foundation Trust (AFT) application, acknowledging that the outcome was not expected for some time.	

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	At a national level, there are more positive signals regarding the overall NHS financial position and waiting list reductions, while recognising the immediate operational pressures currently affecting hospitals across the system, which would be addressed later in the agenda. The federation is now entering its next stage of development, moving beyond establishment towards a stronger focus on service transformation across the Dorset system. An update was provided on the ongoing Non-Executive Director recruitment process, emphasising that appointments were being made with a view to future Board capability and succession planning, rather than like-for-like replacement. DCS concluded by reaffirming the importance of continued Board collaboration as the federation moved forward into more integrated transformation activity.	
	Resolved by the DHC Board: that the Chair's comments be received for information. **Resolved by the DCH Board: that the Chair's comments be received for information.**	
BoDiC26/008	**CEO Report – DHC and DCH**	
	MBr presented the Chief Executive's Report, taking the written report as read and highlighting key matters for the Board's attention as follows: • MBr addressed the current period of industrial action involving resident doctors, expressing disappointment that industrial action continued to impact services and thanked colleagues across both Trusts who had stepped forward to support safe service delivery. An apology was extended to patients whose care, including planned care, had been delayed. • The consequences of the national Striker cyber-attack were still being assessed, and the incident reinforced the importance of cyber vigilance. A further update on local cyber security arrangements would be provided in Part 2 of the meeting. • Some corridor care had been required at DCH during winter pressures which is not an acceptable care environment. Maintaining a strong focus on quality of care and support for patients, families and staff remained a priority, recognising this is also a national challenge across acute services. • An update was provided on the Provider Capability Assessment (PCA), noting that this first iteration validated the Trusts' self-assessments. • A new draft NHS Oversight Framework was expected shortly and would introduce additional indicators, particularly for community and mental health services. Preparatory work was underway to support implementation. • In relation to St Andrew's Mental Health Hospital, MBr acknowledged the distressing nature of recent events, with confirmation that DCH currently had no patients placed there.	

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	• Recognition of the appointment of the Joint Chief Digital Officer, reflecting on the strength of partnership working across Dorset and Somerset under the new cluster arrangements and the opportunities this creates for transformation. • Update provided on the Vista Health review, a significant system-wide piece of work commissioned by the ICB. The review addresses underlying demand and financial challenges and supports the medium-term financial plan, whilst aligning with improvements in patient care and the shift towards prevention, neighbourhood working, integrated urgent care and future elective care models. • Dorset HealthCare will undergo a Well-led CQC inspection, running through to late June. • Positive reflection on the joint Quality Conference held across both Trusts, the awarding of the HealthSet contracts, and a number of staff and service achievements, including the Coffee Connection service, Talking Therapies staff transferring to Hampshire and Isle of Wight, accreditation achieved by DCH Sterile Services, and Cultural Day events across both Trusts. EJ sought clarity on the Board's role and expected oversight in relation to eliminating corridor care, including timescales and governance routes. AT and DD provided assurance that existing work aligned with urgent and emergency care transformation, GIRFT guidance and CQC findings which was progressing through Quality Governance Group and onward to the Quality Committee. EJ requested a walkaround during periods of corridor care, which was supported. **ACTION:** AT and EJ to arrange a quality walkaround during periods where corridor care is taking place. CL queried the impact of proposed fire station closures on Trust estates. In response, MBr confirmed that formal assessments had identified no impact on Trust estates from fire service changes. CL queried whether the transfer of Southampton Talking Therapies services constituted decommissioning. MBr and DD confirmed that Talking Therapies services were being transferred following commissioning decisions, not decommissioned, aligning provision with the local Hampshire system. DU asked about any impact of the Striker cyber-attack on orthopaedic services. AT confirmed that no patient impact had occurred to date, although the situation continued to be closely monitored. ST asked about the impact of industrial action on waiting lists and cancelled activity. MBr advised this would be addressed in Part 2 to ensure accuracy, with further reporting to follow. AHT raised supply chain resilience risks linked to cyber incidents. AT confirmed that work was underway, initially focusing on high-risk areas such as orthopaedics, with plans to review procurement routes and supplier diversification.	**AT/EJ**

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	The Chair thanked MBr for a comprehensive report.	
	Resolved by the DHC Board: that the CEO Report be received for information. **Resolved by the DCH Board: that the CEO Report be received for information.**	
BoDiC26/009	**Quality Committee Assurance Report - Joint**	
	CL presented the Quality Committee Assurance Report, noting that since the previous Board meeting both informal and formal Quality Committee meetings had taken place and were well attended with the following highlights and escalations: • The Dorset HealthCare Coronavirus Vaccination Service has received national recognition through an award from the Royal College of Midwives. • The ongoing impact of the fire at Southampton Hospital which had occurred approximately one month earlier continues to affect service delivery through a delayed digital upgrade required for endoscopy units. Work is underway to expedite resolution. • Antimicrobial resistance (AMR) is a key area of focus noting that each organisation is required to produce a position statement in response to the November 2025 national publication *"Protect our present, secure our future"* AMR Action Plan. A presentation had been received from colleagues across DHC and DCH outlining a system-wide approach. Assurance was provided that baseline arrangements were strong, whilst recognising there remained scope for further improvement. • Work continues towards the planned reopening of Yeovil maternity services in April, with close collaboration between the organisations to ensure this was undertaken safely and with clear communication to women and families. • positive discussion at the Informal Quality Committee meeting on a preventative medicine approach within DCH, supporting the NHS "left shift" agenda by improving patients' health prior to surgery. • The Committee also discussed emerging issues within One Dorset Pathology, which were being progressed through the Quality Governance Group. AT provided context in relation to the delayed endoscopy digital upgrade, explaining that the supplier upgrade had been withdrawn due to defects and re-prioritised nationally. While this had delayed local implementation, assurance was provided that the Trust had avoided the wider system issues experienced elsewhere. DD updated the Board on current CQC activity, noting that a number of inspection reports are awaited, including Twynham Ward, Pebble Lodge (expected imminently), Emergency Department and Medicines Services at DCH, and an ongoing unannounced inspection of Older People's Mental Health services. It was confirmed that inspection reports would be shared with the Board on receipt, with action plans progressing through the Quality Committee.	

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	DD also highlighted the recent meningitis B outbreak over the Easter weekend, noting a resultant increase in emergency department attendances and associated pressures, and extended thanks to staff for their response. EJ asked whether CQC activity levels were increasing in advance of the upcoming Well-led inspection. DD explained that the CQC had publicly stated its intention to increase inspection activity and confirmed that additional inspections were expected ahead of the well-led review. MBr explained that Board members would receive further briefings and support through dedicated sessions and existing NED forums. NR raised a query regarding national changes to requirements for mental health nurses undertaking physical observations. DD provided assurance that local mitigation was in place, including targeted training, support from physical health teams within mental health services, and engagement with local universities to strengthen physical health competencies within mental health nursing education.	
	Resolved by the DHC Board: that the Quality Committee Assurance Report be received for assurance **Resolved by the DCH Board: that the Quality Committee Assurance Report be received for assurance**	
BoDiC26/010	**Learning From Deaths Report Q3 – DHC & DCH**	
Ellis,Kara 10/06/2026 16:10:45	LK presented the Quarter 3 DHC Learning from Deaths Report. There were 30 inquests concluded, with no Regulation 28 reports issued. A total of 28 Prevention of Future Death (PFD) notifications were received across the system. Eight child deaths were reported, none of which were under the direct care of the Trust. There were no deaths reviewed through the LeDeR (Learning from Deaths of People with a Learning Disability) programme during the period. A total of 35 unexpected deaths were recorded, including three inpatient mental health deaths. LK noted that the absence of Regulation 28 reports from the coroner provided strong assurance, reflecting both the quality of care delivered and the effectiveness of local learning and improvement arrangements, including the Patient Safety Incident Response Framework (PSIRF) process. Reviews of learning disability deaths continue to be undertaken internally at DHC. The LeDeR process appears to be encountering difficulties from the ICB perspective which may warrant further enquiries. Assurance was provided that learning is being captured and acted on regardless of national process delays. AN confirmed that DCH had also not had any deaths for review through the LeDeR process, noting that internal mortality governance arrangements continued to provide assurance, including review of community-based deaths, while system-level and regional processes were being clarified. The Board discussed whether the operation of the LeDeR process required escalation to system partners. It was agreed that further assurance should be sought through Quality Committee.	

	ACTION: LeDeR process and current governance arrangements with system partners to be cross-referred to Quality Governance Committee for discussion and clarification and verbally fed back to Board. NR asked for assurance regarding the proportion of inquests relating to suicide and whether learning associated with psychological, social and spiritual support had been embedded, including whether individuals had accessed crisis services. LK advised that detailed case-level discussion would be more appropriately undertaken through Quality Committee and existing mortality governance arrangements, ensuring learning was reviewed in depth and escalated where required. AHT asked how the Trust assured itself that learning from deaths translated into demonstrable improvement in practice. LK and DD provided assurance that robust review processes were in place, with thematic analysis, action planning, audit loops and annual priorities supporting learning. The importance of moving beyond policy compliance to understanding real-world impact was recognised. The Chair requested that further consideration be given to how learning impact could be evidenced, with progress reported through Quality Committee. MBr suggested that a thematic look-back analysis could further strengthen assurance and inform future improvement priorities. DD outlined that thematic review of Learning from Deaths was embedded within the reporting framework. **ACTION:** LK to provide a brief summary in the Q1 Learning from deaths report on the plans and progress on undertaking thematic analysis. AN presented the Learning from Deaths Report for DCH and highlighted the key areas of assurance and learning. the Hospital Standardised Mortality Ratio (HSMR) remained within the expected range and continued to show a downward trend with no concerns raised with national indicators or metrics. AN focused on learning themes identified through mortality review processes, particularly clarity and visibility of treatment escalation planning for end-of-life care. Reviews had highlighted occasions where it was not always clear what advance care planning discussions had taken place in the community prior to admission. Work was underway to improve coordination and access to treatment escalation plans so that care delivered in hospital better reflected patients' preferences. SP commended the continued focus on mortality improvement, noting that despite improvements in HSMR, the Trust had not become complacent and was continuing detailed analysis and quality improvement activity, providing strong assurance. CL reflected on the learning in relation to end-of-life care, linking it to wider system challenges associated with an ageing population, dementia pathways and living arrangements. CL suggested that	**LK/CL** **LK**

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	end-of-life care warranted a broader and more proactive quality focus across both organisations and with system partners, including the ICB. AN confirmed that an end-of-life care audit was due to be considered by Quality Governance Group and subsequently through the Quality Committee. DD confirmed that end-of-life care would be one of the topics for discussion at a forthcoming informal Quality Committee, allowing an "in the round" discussion and consideration of next steps. MBr supported the approach to continued oversight through the Quality Committee with the option of future Board development discussion if required. The Board confirmed it was content with the assurance provided.	
	Resolved by the DHC Board: that the learning from deaths report be received for assurance. **Resolved by the DCH Board:** that the learning from deaths report be received for assurance.	
BoDiC26/011	**Maternity Report – DCH**	
	JHa presented the Maternity Safety Report, clarifying that the reporting period referred to January and February 2026, rather than November and December 2025 and highlighted the following: • Assurance was provided that no alerts have been triggered for DCH from the Maternity Outcomes Signal System (MOSS) during the period. • the neonatal unit was closed to admissions on three occasions due to workforce shortages, which had also necessitated temporary closure of the maternity service. Recruitment into neonatal vacancies is ongoing to support stabilisation. • Mandatory training figures are not currently compliant. The reasons are understood, and an action plan is in place to recover. • Joint Safety champion & QUDAD meetings continue noting strong engagement. • The risk associated with a second theatre being required in an emergency has been reduced to moderate following a thematic review of incidents. • Progress towards Saving Babies Lives Care Bundle progressing well with compliance >94%. • Outline of current significant risks and mitigations including call losses on Maternity Advice Line, fire evacuation arrangements in SCBU and Neonatal staffing constraints. DCS requested an update on the reopening of Yeovil maternity services. DD and AT provided assurance that reopening was planned later in April 2026, supported by a dynamic system risk assessment and regular system-level meetings. While some residual risks remained, including staffing movement and women's choice of place of birth, these were being actively managed and mitigated.	

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	MBI asked about timescales and impact relating to the Maternity Advice Line. JHa advised that funding for the Healthier Together App had been approved and procurement was underway. While no formal benchmarks existed nationally for acceptable call answer rates, assurance was provided that safety incidents linked to access issues were monitored through Datix and that no significant harm had been identified. EJ, as Board Safety Champion escalated workforce pressures affecting anaesthetic cover and workload in general for medical colleagues. Positive assurance was provided regarding successful neonatal nurse recruitment and strong feedback from the Maternity and Neonatal Voices Partnership, particularly around compassionate care and staff kindness.	
	Resolved by the DCH Board: that the DCH Maternity Report be received for assurance.	
BoDiC26/012	**Health Inequalities Report and Patient Carer Race Equality Framework – DHC & DCH**	
	LK presented the Health Inequalities Update, providing an overview of progress against the 2025/26 Joint Health Inequalities Plan. It was noted that the report aligned closely with the Equality Delivery System (EDS2) and highlighted the significant overlap between quality, equality and health inequalities duties. LK also updated the Board on progress in relation to the Patient and Carer Race Equality Framework (PCREF) recognising its complexity and that many mental health providers are finding implementation a challenge. Work to date includes: • progress across leadership and governance arrangements, • prioritisation of competencies relating to co-production, • workforce cultural awareness, • workforce knowledge and skills, largely delivered through the Culture of Care programme. LK explained that as part of Advanced Foundation Trust (AFT) work, further clarity was required on how health inequalities duties were reported and how these relate to wider equality responsibilities. The intention is to bring these strands together into a more coherent approach over the next six months which includes mirroring and adopting the mature Health Inequalities Dashboard developed and used by DCH. DCS asked if there is enough resource available to support the planned improvement approach. LK confirmed that additional Business Intelligence resource and capability is expected to help support the work. MBr supported the direction of travel, emphasising the importance of meeting statutory and regulatory requirements while also moving beyond compliance to articulate a clear ambition on health inequalities. He highlighted the role of co-production in shaping meaningful priorities	

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	and outcomes, linked to neighbourhood working and place-based approaches. The Chair asked for an update on staff awareness and impact of the recently launched Anti-Racism Charter. DD and NP advised that awareness was growing and that embedding would take time. A staff engagement campaign was planned for June 2026, with further visibility to be achieved through executive briefings and staff networks. The Board discussed timing and governance for future updates. It was agreed that: • Development of the integrated equality and health inequalities approach would take place over the summer with a more substantial update to Board in Quarter 2 including dashboard development. • An interim update on the equality plan should be brought alongside the annual EDI annual report for June 2026 Board. • Quality Committee would provide oversight of the proposed health inequalities dashboard and framework. Several members emphasised the importance of focusing on outcomes and impact, rather than activity alone, and ensuring that dashboards clearly demonstrated whether actions were making a tangible difference to population health. The Board noted the update and endorsed the proposed direction of travel.	
	Resolved by the DHC Board: that the Joint Health Inequalities Workstream Update (including DHC PCREF) be received for assurance **Resolved by the DCH Board: Joint Health Inequalities Workstream Update be received for assurance**	
BoDiC26/013	**Finance and Performance Committee Assurance Report – Joint**	
Ellis,Kara 10/06/2026 16:10:45	DU summarised the report with the following highlights: • A deep dive into the FutureCare programme was undertaken, with particular focus on the pre-programme baseline, agreed targets, performance trajectories and current position. with a detailed discussion on the scope and limitations of the programme's metrics, noting significant dependency on system partners for delivery of the wider programme. • Consideration of 2025/26 financial performance for both Trusts, based on Month 11 data with a high level of confidence that DHC would deliver the planned surplus and acknowledgment that actions were still being implemented to deliver the planned deficit at DCH. • Recognition that ED attendance growth and increasing demand across all services at DCH should be recognised in contract negotiations and deconstructing the block contract work which is underway. • Discussion on Martyn's Law, which came into force in late 2025, noting the requirement for both Trusts to have robust arrangements in place in relation to potential terrorist activity. It was recognised	

	that compliance would be particularly complex for the DHC estate, given the number and diversity of sites, and that this would require ongoing Board-level oversight and potentially future capital consideration DCS asked if Martyn's Law compliance was likely to have capital implications. CH confirmed that this would be considered as part of the joint estates strategy, aligned with outputs from the six-facet estates survey, which would clarify future capital requirements. EJ welcomed the assurance provided on the FutureCare deep dive but sought further clarity on cost-benefit realisation, progress with One Dorset Procurement, and the impact of recently approved business cases on increased workforce numbers, particularly in the context of headcount reduction expectations. AT advised that benefits realisation from FutureCare remained difficult to assess due to rising demand and system pressures, noting that further analysis and a refresh of assumptions were underway. It was acknowledged that this represented a gap in assurance on outcomes rather than process. The Board noted that while assurance was provided on FutureCare governance, engagement and delivery activity, further assurance was required on cost-benefit realisation and population-level outcomes and that this would be escalated appropriately. MBr suggested that a system-level conversation with partners may now be required to reset expectations and focus. It was agreed that escalation of this issue via the Chair and Chief Executive Forum would be appropriate, enabling wider system discussion on outcomes, dependency on partner delivery, and future direction of the programme. **ACTION:** Chair and Chief Executive to escalate FutureCare outcomes and cost-benefit assurance through system leadership forums and report back to Board. In relation to EJ's question about One Dorset Procurement CH explained that consultation had completed and that transfer of procurement staff to UHD was planned for 1 May 2026, with implementation of the target operating model expected by September 2026. It was noted that recruitment to the Director of Procurement role had been delayed, with interim arrangements in place. CH also addressed the question on workforce headcount explaining that while some approved changes increased headcount, others (including procurement transfers) would reduce it, and that decisions were being tracked across quality, finance and workforce metrics to ensure transparency and justification.	**DCS/ MBr**
Ellis,Kara 10/06/2026 16:10:45	**Resolved by the DHC Board: that the Finance and Performance Committee Assurance Report be received for assurance.** **Resolved by the DCH Board: that the Finance and Performance Committee Assurance Report be received for assurance.**	

BoDiC26/014	Integrated Performance Reports – DHC and DCH	
	For **DHC**, in relation to quality metrics DD highlighted: • Performance remains below the threshold for C-difficile infections and six cases of E. coli infection had been recorded during the year, with learning set out in the report. • falls incidents have been above the Trust mean for the past eight months with three deep-dive reviews being undertaken to better understand contributory factors and inform mitigating actions • Positive performance was reported in relation to venous thromboembolism assessment compliance and pressure ulcer prevention. • Friends and Family Test continued to fall slightly below the Trust's internal ambition, with 91.9% of respondents reporting a positive experience, against a target of 95%. • The introduction of an early resolution approach to complaints, aligned with DCH's model, has resulted in a significant improvement with the number of open complaints reducing to 13, representing good progress. • A revised process for reporting the Duty of Candour metric will be implemented from April 2026 which will improve identification and reporting going forward. SP asked for assurance that falls prevention learning and improvement work was being shared across both Trusts. DD confirmed that DHC and DCH falls teams worked closely together and actively shared good practice. NR raised a concern regarding patient feedback relating to Tarrant Ward, noting comments about staff attitudes in addition to the elevated falls data. DD confirmed that this would be explored as part of the ongoing deep-dive review. For **DHC**, in relation to workforce metrics, NP highlighted: • Focussed work continues to improve appraisal rates which is not at an acceptable position. A clear set of remedial actions was in progress and improvement over the next two months was anticipated and performance will be monitored through the Financial Recovery Board • Employee Relation Case volume is high but benchmarking shows numbers are low compared to similar organisations. Ongoing thematic analysis was being undertaken, with monthly Executive oversight in place. • Staff turnover had reduced, retention was stable, and wider workforce indicators triangulated positively with emerging staff survey themes. • Sickness absence remained above target; however, long-term sickness absence had reduced on a sustained basis over recent months. JeH suggested the level of detail in the enclosed paper would be more appropriate for discussion in the People and Culture Committee as the information is potentially patient identifiable and too detailed for Board. In addition, JeH noted inconsistencies between DHC and DCH	

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	workforce metrics and suggested this was an appropriate time, ahead of 2026/27, to review and align the core workforce metrics reported across both organisations. For **DHC**, in relation to performance metrics, AL highlighted: • Performance for Integrated Urgent Care Service (IUS/111) call-backs remained below target at just under 50%, reflecting an increase in demand of approximately 8%. Around 86% of call-backs were completed within 20 minutes. Robust clinical triage arrangements were in place to prioritise calls according to risk. A service redesign programme, including pod-based working, was underway. • The elective waiting list increased marginally, driven primarily by audiology demand. There were no 52-week waits, and long waits were limited to a small number of specialties where mitigation plans were in place. • Performance against the Urgent Community Response (UCR) standard remained strong at over 90%. • The six-week diagnostic target continued to be challenged, again largely attributable to audiology demand, staff absence and vacancy levels. Demand management actions, including review of referral criteria, were ongoing. • The proportion of patients in community beds with no criteria to reside remained above 30%, which was recognised as unacceptable. Mitigating actions continued through the FutureCare programme, supported by enhanced escalation processes introduced following winter pressures. • Children and Young People access standard remained ahead of plan despite a 27% increase in referrals. • Out-of-area placements were low at the time of reporting, but a small number of further placements had occurred subsequently due to capacity pressures and continued to receive Executive oversight. • A paper was in development to support delivery of required standards for 'Talking Therapies' and would inform next steps. • Perinatal access metric remains a concern. CL asked about assurance on the prioritisation and triage of IUS call-backs. AL confirmed that allocation was driven by the national NHS Pathways algorithm, with local clinical triage providing ongoing risk management. CL also sought further visibility of the breakdown of long waits within audiology and how waiting time information was communicated to patients. AL confirmed that this information could be incorporated into the next performance report for the FPC committee **ACTION:** Breakdown of long waits within audiology and how waiting time information is communicated to patients to be incorporated into the next performance report for the FPC committee. NR commended the performance of both the perinatal vaccination service and separately, the achievement of the CYP access standard	**RS**

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	and reflected these would be good examples of where learning could be shared and any lessons learned. **ACTION:** RS to provide brief update on continued achievement of the CYP access standard despite a 27% increase in referrals and what learning can be taken/shared from this. NR also queried if the capacity within the New Hospital Programme can accommodate out-of-area mental health placements and whether current block and spot purchasing arrangements remained appropriate. A detailed conversation followed amongst Board members and DD and CH explained that while modelling indicated a requirement for 10 additional beds, pressures were driven both by capacity gaps and by patients with no criteria to reside due to housing or social care delays. A flexible contracting arrangement had been agreed, allowing savings where capacity was not fully used. MBr reflected that mental health flow, particularly delayed discharges represented a significant quality concern. The committee agreed this would form part of a future informal quality committee meeting (recognising that it is also routinely discussed in the FPC committee due to the performance and NOF implications). **ACTION:** Cross-refer quality concerns related to mental health inpatient flow to the Quality Committee (informal). Members noted opportunities to improve alignment of virtual ward / hospital at home models across community, mental health and acute services, with a greater focus on outcomes rather than activity metrics. DD confirmed that work was underway to align models across providers, including a move towards an East/West Dorset configuration. JeH highlighted that average length of stay for mental health services, a known area under-performance, did not feature explicitly in the performance report. MBr confirmed this would be revisited once the draft national framework was finalised, alongside review of reporting measures for 2026/27. JeH also highlighted declining ethnicity data completeness, noting this would undermine future health inequalities reporting. Action was requested to strengthen focus on data quality and timescales for improvement. **ACTION:** Clarify actions and completion dates to improve ethnicity data completeness. For **DCH**, in relation to performance metrics AT highlighted the following: • A sustained and exceptional increase in demand, with year-to-date emergency attendances up 10.6% and admissions up 7%. • Whilst performance of UEC metrics was good in January it could not be sustained in February due to the cumulative impacts of admissions, winter pressures, bed closures for norovirus, and system-wide constraints.	**RS** **RS/CL** **NP**

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	• AT noted that corridor care and escalation areas were subject to regular senior oversight, including quality walkarounds, with patient feedback acknowledging the difficulty of the environment while recognising the professionalism and care provided by staff • Performance against the Urgent Care Response (UCR) standard exceeded target by the end of March, reflecting improved flow and system recovery, supported by seasonal easing and sustained workforce effort. • Elective activity was significantly impacted by winter pressures. urgent pathways were prioritised, and performance against 28-day cancer standards continued to improve. While the 62-day standard was not fully achieved, the position had improved. • While the Trust avoided growth in 65-week waits, the number of 52-week waiters increased, reflecting prioritisation of urgent and longest-waiting patients. • Reduction of approximately 900 patients on the RTT waiting list overall. CL asked if winter escalation measures with cost implications were being sustained. AT explained most areas had been de-escalated by March. For **DCH**, in relation to quality metrics DD highlighted: • Infection Control performance remains generally strong with Rates of C-difficile were well controlled, while gram-negative infections were slightly above trajectory. Targeted quality improvement work was underway, particularly focused on catheter care. • positive performance in relation to falls, with rates below 2024/25 levels, and a 12% year-on-year reduction in pressure ulcers, representing a significant improvement. Venous thromboembolism (VTE) assessment compliance also remained strong. • In relation to complaints, the early resolution process continued to perform well, with timely responses and improved oversight. • Update provided on work undertaken on ophthalmology patients lost to follow-up, noting that assurance had been received by the Quality Committee that the identified issues had been addressed and risks mitigated. • Further improvement in mixed-sex accommodation breaches. SPa sought further assurance that ophthalmology capacity does not present a risk of patient harm. AT confirmed capacity issues were managed through system working with UHD, including shared clinical support where required, and that patient safety remained the priority. For **DCH**, in relation to workforce metrics NP reported that overall workforce stability remained encouraging, particularly in the context of sustained operational pressure. Staff turnover had reduced for five consecutive months, supporting improved retention. While the vacancy rate had increased, this reflected a deliberate approach to holding non-critical vacancies as staff exited, ensuring effective resource management and financial control.	

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	Temporary staffing usage continues to be monitored closely. Progress has been made in reducing agency use, though some further work was required to optimise bank utilisation. Short-term sickness absence was noted to be marginally higher, consistent with seasonal trends, while the Trust continued to perform comparatively well regionally, with recognition from NHS England and regional colleagues. EJ re-iterated that any vacancies that are being held are not business or safety critical and reflected that good workforce performance during an exceptionally demanding winter was indicative of a positive organisational culture. NP confirmed that vacancy controls were applied selectively, with ongoing oversight to ensure patient safety and service standards were maintained.	
	Resolved by the DHC Board: that the Integrated Performance Reports be received for assurance. **Resolved by the DCH Board: that the Integrated Performance Reports be received for assurance.**	
BoDiC26/015	**Finance Reports – DHC and DCH**	
Ellis,Kara 10/06/2026 16:10:45	CH presented each of the trust's Month 11 finance reports. For **DHC**: • £8.5m surplus, which was £0.8m favourable to plan and aligned with the revised H2 trajectory previously agreed with system partners • Out-of-area placements continued to be a significant pressure, with an overspend of approximately £3.4m • Medical agency expenditure also remained an area of overspend, although improvements had been delivered over the course of the year. • These pressures were offset by underspends on clinical supplies, improved control of temporary staffing, and delivery of the Trust's efficiency programme. • The full-year efficiency target was £38.5m (8.7%), of which £31.8m had been delivered by Month 11, in line with plan. • Agency expenditure overall was approximately £2.5m lower year-to-date than the previous year. While bank usage had increased representing improved value for money and reduced reliance on agency staffing. • Cash balance of £46.5m at Month 11 • Confirmation that the internal capital programme was expected to be fully spent by year end. EJ welcomed the positive financial position but queried the sustainability of performance, noting that most divisions remained overspent despite the overall surplus. CH explained that budget overspends are being off-set by underspends and non-recurrent benefits. Delivering efficiency in 2026/27 will be a key focus and the financial plan assumes a significantly lower surplus of approximately £1m. Increased early support to divisions, clearer accountability through the Financial Recovery Board, and improved phasing of efficiency delivery would form part of the 2026/27 approach.	

	For **DCH**: • In-month surplus of £1.9m at month 11, which is £0.7m adverse to the original plan but aligned to the revised H2 trajectory. • The year-to-date position showed a £13.4m deficit, with confidence that the Trust remained on track to deliver the planned £9.8m year-end deficit. • Active discussions were underway with Somerset ICB regarding reimbursement of associated income from Yeovil maternity service closure with confidence that the majority of costs will be covered. • In relation to pay expenditure, £4.3m overspent year-to-date. Bank staffing costs were overspent by £4.8m. Mitigating actions are in place to reduce reliance on temporary staffing. • Agency expenditure is in line with plan. • The Trust's efficiency programme totalled £29.1m (8.7%), with £22.6m delivered to Month 11, in line with plan. • Month 12 delivery remains challenging; however, a key efficiency relating to the disposal of Trust accommodation has been completed ahead of year end and would materially support the full-year position. • Cash balance of approximately £38.7m • On track to deliver its internal capital plan SPa sought assurance regarding recovery of Yeovil maternity funding and the apparent under-spend on NHP capital. CH reiterated confidence in materially recovering the maternity income and confirmed that capital variance was attributable to timing of drawdown and payment milestones, with robust external scrutiny and agreement in place.	
	Resolved by the DHC Board: that the Finance Reports be received for assurance. **Resolved by the DCH Board: that the Finance Reports be received for assurance.**	
BoDiC26/016	**People and Culture Committee Assurance Report - Joint**	
Ellis,Kara 10/06/2026 16:10:45	EJ presented the assurance report, noting that the Committee had held an informal meeting in February and a formal meeting in March. Both meetings had a strong focus on delivery of the People Plan, which continued to act as the core work programme for both Trusts and would extend into the forthcoming year. An area of discussion and escalation related to the quality dashboards and the visibility of staffing impacts on quality outcomes. At present, the absence of an integrated digital solution limited the ability to triangulate staffing and quality metrics effectively, and this remained an identified gap. Discussion arising from the Equality Delivery System (EDS2) framework, particularly around Board visibility and engagement with staff. To address this, the April informal People and Culture Committee meeting would be held face-to-face, with staff-side representatives	

	attending the session. Staff network leads and lead resident doctors would also attend, with the intention of creating an interactive discussion to strengthen relationships between Board members and staff networks and explore what meaningful Board engagement looked like from a workforce perspective. Appraisal and supervision remained a key focus of Committee discussion, recognising their importance not only for compliance but also for staff wellbeing, culture, values and behaviours. The Committee also discussed the specific support arrangements for locally employed doctors, particularly in relation to supervision. The Committee's annual effectiveness review has been completed and that meetings continue to be well-attended and constructive. In response to a question from DU regarding safer staffing and reliance on a digital solution, DD explained that Dorset HealthCare currently lacked a consolidated quality dashboard, requiring manual triangulation of staffing and quality data, while the DCH dashboard did not yet integrate safer staffing measures. It was agreed that a combined digital approach would significantly improve early identification of emerging issues at ward level. While this work sat within the digital programme, it had not yet been prioritised high enough given competing pressures. The issue had therefore escalated to Board for awareness, with a commitment to continue progressing it through digital governance routes.	
	Resolved by the DHC Board: that the People and Culture Committee Assurance Report be received for assurance. **Resolved by the DCH Board: that the People and Culture Committee Assurance Report be received for assurance.**	
BoDiC26/017	**Annual Staff Survey Report – DHC & DCH**	
	NP presented the **DCH** Staff Survey results, noting that these had been considered in detail by the People and Culture Committee. The response rate for DCH was slightly lower than in previous years and below the benchmark for comparator Trusts. However, NP advised that results remained above benchmark for key indicators within the *People Promise*, including engagement and morale, which were considered among the most important measures of staff experience. NP reported that the proportion of staff recommending DCH as a place to work had reduced by four percentage points but remained five percentage points above benchmark. Similarly, the proportion recommending DCH as a place to receive treatment had reduced slightly but also remained above benchmark. None of the year-on-year changes were statistically significant, indicating overall stability of staff experience, rather than a substantive decline. Taken alongside workforce metrics demonstrating reduced turnover, stable vacancy levels and controlled sickness absence, NP advised that	

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	the survey supported an overall position of resilience and stability within the workforce. Consistent with previous years and national findings, there remained a disparity in experience between staff with protected characteristics and those without, which was identified as a key area of concern and focus for further work. EJ cautioned against over-reliance on statistical significance alone and emphasised the importance of proactive action to support staff wellbeing, particularly given the likelihood of sustained pressures. Strong comparative performance should not detract from learning from high-performing peer organisations. DU observed that RES data relating to discrimination from fellow staff members showed a narrowing of the gap between ethnic minority and white staff experience at DCH and queried whether this might be linked to civility and respect initiatives. It was suggested that learning from this work could inform approaches elsewhere. SA highlighted an increase in reports of harassment, bullying or abuse from patients or relatives, noting the need to understand both scale and prevention. NP advised that DCH operated a clear zero-tolerance policy, supported by strong local leadership. Preventative approaches included clear public messaging, strengthened organisational stance on unacceptable behaviour, and wider work through the Anti-Racism Charter and staff networks. The Board recognised the overall positive results despite exceptional operational pressure, while agreeing that inequalities and staff experience under pressure must remain a priority focus. NP presented the **DHC** Staff Survey results explaining that DHC remained above benchmark across all People Promise elements, with the exception of *"We are a learning organisation",* which was driven primarily by appraisal performance, which had already been discussed with NHS England as part of the Advanced Foundation Trust process. A recovery plan was in place. The survey response rate had increased to 50%, up from 47% in the previous year, and remained close to the national benchmark of 52%. overall, changes across survey indicators were small and broadly aligned with national trends. there were statistically significant reductions in staff engagement and perceptions of flexible working. Which need to be considered in the context of the Trust delivering approximately 7% productivity improvement, alongside workforce resizing, increased short-term sickness absence, and reduced temporary staffing. DHC continues to perform strongly on cultural indicators, ranking highest within the comparator group.	

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	As with DCH, inequalities in staff experience for colleagues with protected characteristics remained evident and were identified as a key area requiring continued focus. Rather than a single Trust-wide action plan, teams and services will be required to develop and share local action plans, recognising that staff experience is shaped primarily at team level. Learning from these plans will inform refinement of the existing People Plan. NR reflected whether learning from top-performing organisations could be explored to inform improvement. NP agreed that triangulation with peer data could be explored to better understand the relationship between performance, productivity and staff experience. CL noted that "*We are a learning organisation*" had also emerged as a weaker domain and asked how this would be addressed. DD confirmed that local team-level survey results would enable targeted action, with greater central visibility and oversight than previously in place. The Board thanked colleagues across DHC and DCH for their continued commitment under significant pressure.	
	Resolved by the DHC Board: that the DHC Staff Survey results be received for assurance. **Resolved by the DCH Board: that the DCH Staff Survey results be received for assurance.**	
BoDiC26/018	**Gender, Disability and Ethnicity Pay Gap Report – DHC & DCH**	
Ellis,Kara 10/06/2026 16:10:45	NP presented the Reports, noting that the ethnicity and disability reports were being published in advance of statutory requirement, reflecting the Trusts' commitment to best practice and transparency. NP reminded the Board that the gender pay gap relates to the distribution of men and women across pay bands, rather than unequal pay for the same roles. For Dorset HealthCare, the gender pay gap remained in favour of men with approximately 82% of the workforce female, and higher-paid senior roles being disproportionately occupied by men. For Dorset County Hospital, the gender pay gap similarly remained in favour of men and reflected under-representation of women in senior, higher-paid roles, rather than unequal pay. In relation to ethnicity, Dorset Healthcare demonstrates stronger ethnic diversity at Band 5-7 with a marked reduction at 8a and above. For Dorset County Hospital, ethnic under-representation was more pronounced at senior levels and less balanced through the mid-bands, indicating both entry-level and progression challenges. Addressing both recruitment and development pathways was therefore required. Disability pay gaps across both Trusts were smaller and less consistent Very limited senior representation of staff declaring a disability was noted, and improving disclosure and confidence in workplace support remained a priority.	

	Triangulation with staff survey results suggested that, while inclusive cultures were evident, there remained structural barriers to progression for some groups. Improving career development, progression support, and workplace adjustments would therefore form key focus areas. The Board noted the marked differences between the two Trusts and the opportunity for shared learning. It was suggested that the findings would benefit from deeper exploration at a future development session. **ACTION:** Findings of the DCH and DHC Gender, Disability and Ethnicity Pay Gap Report to be discussed in detail at a future development session. LK added that, particularly within medical roles, pay inequity could arise despite individuals being on the same contractual grade, noting that access to pay-enhancing mechanisms such as Clinical Excellence Awards and negotiated job plan PA allocations could result in materially different remuneration. As part of ongoing work on medical job planning and workforce oversight, a review would be undertaken to assess how these factors contributed to observed pay gaps.	**JeH**
	Resolved by the DHC Board: that the DHC Gender, Disability and Ethnicity Pay Gap Report be received for approval. **Resolved by the DCH Board: that the DCH Gender, Disability and Ethnicity Pay Gap Report be received for approval.**	
BoDiC26/019	**Guardian of Safe Working Report – DHC and DCH**	
	LK presented the report for **DHC**, noting that it was being considered in the context of ongoing resident doctor industrial action and heightened emotions within the resident doctor workforce. The reported position remains consistent with previous quarterly reports, with a number of breaches recorded and associated fines levied. Overall assurance was provided that the level of breaches remains acceptable and within expected tolerance, and that patient safety is not compromised. There are ongoing challenges in relation to the use of fines, noting that while financial penalties continued to accrue, resident doctors were keen to see more tangible wellbeing benefits rather than direct financial remedies. Work is underway to explore alternative, compliant wellbeing interventions, including structured wellbeing events. There is improved engagement with resident doctors, including the introduction of a senior resident doctor representative, which has strengthened communication and visibility of concerns. Early feedback suggested this has begun to improve morale following a period of significant distress among resident doctors. LK acknowledged that while the overall position has stabilised, further work is required, particularly to strengthen Board-level awareness and ongoing engagement.	

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	AN presented the report for **DCH**, providing assurance that guardian arrangements were operating effectively. Exception reports have increased year-on-year. These increases are not associated with individual performance concerns or conduct issues among resident doctors but reflect previously discussed themes of operational pressure and workload, with a consistent pattern of reports arising from the same service areas. Ongoing reliance on locum staffing was highlighted as a key risk. While locum use supported immediate patient safety and mitigated risk, the expenditure needs to translate into more sustainable staffing solutions to improve working conditions and resilience over time. Targeted work is underway within Orthopaedics, which will act as a pilot in exploring how locum usage can be converted into a more sustainable workforce model. No new or unexpected themes were identified.	
	Resolved by the DHC Board: that the DHC Guardian of Safe Working Report be received for assurance. **Resolved by the DCH Board: that the DCH Guardian of Safe Working Report be received for assurance.**	
BoDiC26/020	**Strategy, Transformation and Partnership Committee Assurance Report – Joint**	
	DCS summarised the report with the following highlights: • The Committee has received assurance on the transformation work underway to improve mental health length of stay, which continues to be a high-profile and priority area. • Improvement activity is progressing; however, it was noted that further work was required to strengthen the overall strategy, delivery arrangements, reporting and assurance framework. • The Committee's focus has increasingly shifted from programme design to delivery and demonstrable impact, with governance mechanisms now established and enabling more effective scrutiny of transformation progress. • Key risk for Digital Services is workforce capacity to deliver all requirements. This risk is being actively monitored, with the Joint Chief Digital Officer now engaged with the group, providing greater senior oversight and coordination. • The forthcoming informal committee meeting will focus on transformation impact measures and milestones. This will support deeper discussion on the extent to which transformation activity was delivering the intended outcomes, how progress was being measured, and whether pace and direction remained appropriate, particularly in the context of Advanced Foundation Trust ambitions.	
Ellis,Kara 10/06/2026 16:10:45	**Resolved by the DHC Board: that the Strategy, Transformation and Partnership Committee Assurance Report be received for assurance.**	

	Resolved by the DCH Board: that the Strategy, Transformation and Partnership Committee Assurance Report be received for assurance.	
BoDiC26/021	**Audit Committee Assurance Reports – DHC and DCH**	
	NR summarised the **DHC** report with the following highlights: • The Committee recommended the Risk Management Strategy for approval, noting a reservation that the forthcoming Joint Risk Management Policy had not yet been reviewed. Given the inter-dependency between the two documents, the Committee requested that both be considered together once the joint policy was finalised. • The Committee received assurance that an appropriate timetable was in place for production of the 2026/27 accounts, • Noted the extensive preparatory work undertaken regarding the implementation of the One Dorset Procurement Service, and the number of governance routes through which the proposals had progressed, providing confidence that significant risks had been appropriately mitigated. • Noted progress on the Modern Equivalent Asset (MEA) revaluation, with External Audit having commenced their work and no material issues anticipated at that stage. • The Committee also reviewed the *going concern assessment*, with no concerns raised. EJ raised a governance observation regarding the perceived proliferation of strategies, expressing concern that multiple documents could create confusion relative to the overarching Trust Strategy. In response, MBr and JeH confirmed that: • the Trust operated a single core strategy. • subsidiary documents were enabling strategies or plans, aligned to that strategy; and • clearer distinction between mandated strategies and enabling plans with consistent terminology would be helpful and support Board oversight. SPa summarised the **DCH** report with the following highlights: • The Committee reviewed the strategic and operational audit plan for the coming year, noting that it has progressed through Joint Executive consideration and will return for finalisation. • The Committee received a progress report on the Equality and Quality Impact Assessment audit, which received moderate assurance on both design and operational effectiveness. • In relation to the One Dorset Procurement Service, the Committee noted that auditors will review the Standing Financial Instructions (SFIs) and Scheme of Delegation to ensure that delegations remain appropriate and proportionate, providing assurance that accountabilities are neither overly constrained nor excessively permissive. • The external audit plan for DCH is currently in progress. • The auditor's Value for Money risk assessment has identified financial sustainability as a significant risk. The Committee noted	

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	that this is not unexpected and does not anticipate this risk resulting in a qualification of the accounts. • The Committee reviewed and recommended approval of the Going Concern Statement, noting no major changes to accounting policies for the forthcoming year. • The Committee approved the Anti-Bribery and Counter-Fraud Policy. • A report was received detailing contracts executed under seal during the year, which was noted as a welcome improvement in governance transparency. • A positive Committee effectiveness review was noted. • Finally, the Committee formally recorded its thanks to Stephen Tilton for his contribution, recognising that this was his final Audit Committee meeting following the conclusion of his tenure.	
	Resolved by the DHC Board: that the Audit Committee Assurance Report be received for assurance. **Resolved by the DCH Board: that the Audit Committee Assurance Report be received for assurance.**	
BoDiC26/022	**Risk Management Strategy - Joint**	
	DD presented the Risk Management Strategy, which sets out the overarching framework for how both Trusts identify, assess, manage and review risk. The Strategy covers key elements including risk appetite, target risk levels, the Board Assurance Framework, use of the risk management system, governance arrangements, training and development, and assessment of organisational risk maturity. It also outlines the forward risk management work programme. It was noted that the Strategy had been considered by both Audit Committees, subject to extensive consultation across both organisations, and had incorporated significant feedback. The Strategy supported the introduction of a shared risk management platform across the federation, with future alignment to UHD, and the establishment of new risk management groups alongside strengthened training arrangements. EJ welcomed the quality of the document and the reference to key national guidance and suggested that future iterations could include more detailed reference to sources such as the HM Treasury Orange Book. CL also raised a query about the designation of the two Directors of Nursing as having oversight of risks, expressing concern that this could imply inappropriate concentration of responsibility and insufficient reflection of wider medical and operational accountability. DD and MBr clarified that the reference related to oversight of the risk management process, rather than ownership of individual risks, which continued to sit with executive leads through established governance routes. It was acknowledged that this distinction could be made clearer and that the wording should be reviewed to avoid misinterpretation.	

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	DCS proposed that the Strategy be approved subject to review and clarification of the specific wording relating to Directors of Nursing oversight, and with the understanding that the forthcoming Joint Risk Management Policy would provide additional operational detail and alignment. The Board agreed this approach.	
	Resolved by the DHC Board: that the Joint Risk Management Strategy be approved subject to clarification of roles and responsibilities; (noting that the Strategy will be reviewed alongside the Joint Risk Management Policy once finalised). **Resolved by the DCH Board: that the Joint Risk Management Strategy be approved subject to clarification of roles and responsibilities; (noting that the Strategy will be reviewed alongside the Joint Risk Management Policy once finalised).**	
BoDiC26/023	**Committee Annual Reports, Effectiveness Reviews and ToRs – Joint**	
	JeH summarised the report noting that all committees had completed their effectiveness reviews and that these had been reported to the respective committees, with the exception of the Mental Health Legislation Committee in common and Remuneration Committee in common, where timing issues meant reviews would be completed in May 2026. The review concluded that all committees had discharged their responsibilities in line with their Terms of Reference and had provided appropriate assurance to the Boards through established reporting and assurance routes. Minor amendments to committee Terms of Reference had been identified, including small movements of responsibilities between committees. These changes had been discussed and agreed at committee level and were summarised in the executive summary of the report.	
	Resolved by the DHC Board: that the Joint Committee Effectiveness Review be received for assurance and Revised Terms of Reference be received for approval. **Resolved by the DCH Board: that the Joint Committee Effectiveness Review be received for assurance and Revised Terms of Reference be received for approval.**	
BoDiC26/024	**Constitution Review – DHC & DCH**	
Ellis,Kara 10/06/2026 16:10:45	JeH presented the proposed Constitution amendments for DHC and DCH. While the amendments were presented as two separate documents, it was noted that the changes were largely aligned. JeH explained that, in anticipation of expected national governance changes from April 2027, both Constitutions have been amended to include an option to extend the current term of office for governors by	

	up to 12 months. This flexibility would allow the Trusts to respond appropriately once greater clarity was available regarding future governance arrangements. It was emphasised that this provision did not prevent elections taking place sooner should circumstances allow. An additional amendment proposed for Dorsets County Hospital related to: • replacing two named partner organisations (Age UK and Weldmar Hospice Care), which can no longer provide Appointed Governors, with broader categories representing older people and palliative care, therefore allowing the Trust to appoint suitable partners; and • introducing a virtual voting clause, consistent with the Dorset HealthCare Constitution, to support aligned governance processes and timely decision making between formal meetings. In response to a query by CL, JeH confirmed that the proposed amendments had been considered through the Membership Committee and shared with the Councils of Governors. As the changes did not alter the statutory powers of the Councils of Governors, it was confirmed that approval by the Annual Members' Meeting was not required. In response to a query from EJ regarding the extension of governor terms, JeH advised that the Constitutions had been amended to allow for such extensions in exceptional circumstances, for a maximum of 12 months.	
	Resolved by the DHC Board: that the DCH Constitution amendments be receive for approval. **Resolved by the DCH Board: that the DHC Constitution amendments be receive for approval.**	
	CONSENT SECTION	
	The following items were taken without discussion:	
BoDiC26/025	**Modern Slavery and Human Trafficking Statement 2026/27 – DHC & DCH**	
	Resolved by the DHC Board: that the DHC Modern Slavery and Human Trafficking Statement 2026/27 be received for approval. **Resolved by the DCH Board: that the DCH Modern Slavery and Human Trafficking Statement 2026/27 be received for approval.**	
BoDiC26/026	**Annual Going Concern Statement – DHC & DCH**	
	Resolved by the DHC Board: that the DHC Annual Going Concern Statement be received for approval. **Resolved by the DCH Board: that the DCH Annual Going Concern Statement be received for approval**	
BoDiC26/027	**Charitable Funds Committee Assurance Report – DCH**	

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	Resolved by the DCH Board: that the Charitable Funds Committee Assurance Report be received for approval.	
BoDiC26/028	**Questions from the Public**	
	JPL asked if the slow DCH implied productivity growth could be explained by operational pressure. AT explained that it is partially about operational pressure with costs increasing faster than activity taking place. Also, more work can be done on data recording. LT asked if the NHS 10 Point plan for resident doctors had been attended to within the deadline. LK provided assurance that the requirements had been responded to, and the board are sighted on progress.	
BoDiC26/029	**Any Other Business**	
	None	
BoDiC26/030	**Date and Time of Next Meeting**	
	The next part one (public) meeting of the Boards of Directors of Dorset HealthCare University NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust will take place at **9.30am** on **Wednesday 17 June 2026** Dorset Healthcare HQ, 2 Nuffield Road, Poole	
BoDiC26/031	**Resolution Regarding Press, Public and Others**	
	To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.	

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BoDiC Action Tracker, Part 1 - 2026/27

Topic	Minute Reference & Name	Date of Meeting	Action	Lead	Deadline	Response	Status
Consultant Job Planning	BoDiC25/151/ DHC Audit Committee Assurance Report	10.02.2026	Confirm when the consultant job planning audit is scheduled to take place.	CH	31.03.2026	By end of Q2, as per the internal audit plan reported to Audit Committee. Recommend close.	Complete
Quality Walkaround (Corridor Care)	BoDiC26/008/ CEO report	08.04.2026	AT and EJ to arrange a quality walkaround during periods where corridor care is taking place	AT/EJ	10.06.2026	Site tour of DCH escalation areas (corridor care) undertaken as part of the April Informal Quality Committee in Common. Attended by Director of Nursing, EJ & CL. Recommend close	Complete
Approach to thematic anlysis - Learning from Deaths	BoDiC26/010/ Learning from Deaths Report (Q3)	08.04.2026	LK to incorporate a brief summary in the Q1 Learning from deaths report on the plans and progress on undertaking thematic analysis.	LK	10.08.2026	Not yet due - for Q1 reporting	Open - Not yet due
FutureCare Cost-Benefit analysis and outcomes.	BoDiC26/013/ FPCiC Assurance Report	08.04.2026	Chair and Chief Executive to escalate FutureCare outcomes and cost benefit assurance through system leadership forums and report back to Board.	MBr/DCS	10.06.2026	MBr has contacted CEO of ICB (J Higman) to outline the discussion, including local authority aswell as NHS CEO's, to look at outcomes and financial benefits of Future care as the work supported by Newton comes to an end. Recommend close	Complete
Achievement of CYP access targets (DHC)	BoDiC26/014/ DHC Integrated Performance Report	08.04.2026	RS to provide brief update on continued achievement of the CYP access standard despite a 27% increase in referrals and what learning can be taken/shared from this.	RS	10.06.2026	Within the ICD report, the CYP access standard included refers to the number of CYP receiving 1+ contact, as opposed to a waiting time standard (which also remains compliant). The reason that the service has overachieved against the target for the 1+ contact is due to the funded recovery plan put in place in October 2025 to improve performance and increase access. Additional staffing has provided the required capacity. Recommend close	Complete
Ethnicity Data Completion (DHC)	BoDiC26/014/ DHC Integrated Performance Report	08.04.2026	Clarify actions and completion dates to improve ethnicity data completeness.	NP/CH	10.06.2026	Further detail on actions and recovery is included via exception reporting in the Integrated Corporate Dashboard on agenda	Complete
Differences between DCH and DHC Gender, Disability and Ethnicity Pay Gap Reports	BoDiC26/018/ Gender, Disability and Ethnicity Pay Gap Report	08.04.2026	Findings of the DCH and DHC Gender, Disability and Ethnicity Pay Gap Report to be discussed in detail at a future development session.	JeH	10.06.2026	Scheduled for a review at the informal People and Culture Committee in October 2026 (with an overview of this reported to Board via Committee Assurance Report) Recommend close	Complete

Actions to other Committees								
Topic	**Minute Reference & Name**	**Date of Meeting**	**Action**	**Lead**	**Deadline**	**Response**	**Status**	**Committee referred to**
Maternity staffing strategic review	BoDiC25/085 / Maternity Safety Report (DCH)	09.12.2025	A strategic overview of staffing in maternity to be returned to Quality Committee in Common in March	AT/JoH	46120	**March**: To be taken through SLG in April and then FPCIC due to financial ask of the paper.	Open - Update provided	Quality
Resident doctors experience	BoDiC25/094 / Annual GMC National Training Survey Results and Action Plan	09.12.2025	Update on the impact of works to improve resident doctors experience to be provided to People and Culture Committee in Common	LK/RW	09.06.2026	Discussed in May meeting, update provided in committee assurance report. Recommend close	Complete	PC
DCH High Scoring Risks	BoDiC25/137/ Corporate Risk Register	10.02.2026	Quality Committee in Common to review high scoring risks for DCH.	DD	31.05.2026	Reviewed as part of the quarterly Corporate Risk Register review at the May meeting. Recommend close	Complete	QCiC
Better Payment Practice	BoDiC25/143/ Finance Report	10.02.2026	CH to bring a breakdown of the constituent areas that form part of the Better Payment Practice performance and areas of non-compliance to the FPC Committee.	CH	~~31/05/2026~~ 31/07/2026	Postponed until July 2026 due to system wide changes in Trust Procurement Teams. Agreed by FPC committee 28/05/2026	Open - Update provided	FPC
LeDeR Process/Goverance arrangements with system partners	BoDiC26/010/ Learning from Deaths Report (Q3)	08.04.2026	LeDeR process and current governance arrangements with system partners to be cross-referred to Quality Governance Committee for discussion and clarification and verbally feedback to Board..	LK	01.06.2026	Included in Learning from Deaths report. Recommend close	Complete	QCiC
Mental Health Inpatient Flow	BoDiC26/014/ DHC Integrated Performance Report	08.04.2026	Cross-refer quality concerns related to mental health inpatient flow to the Quality Committee **(informal)**.	RS	01.06.2026	Mental health flow to be discussed in July informal Quality Committee in Common.	Open - Update provided	QCiC
Audiology Service Long Waits	BoDiC26/014/ DHC Integrated Performance Report	08.04.2026	Breakdown of long waits within audiology and how waiting time information is communicated to patients to be incorporated into the next performance report for the FPC committee in July.	RS	~~10/06/2026~~ 31/07/2026	This will be included for July FPCIC.	Open - Not yet due	FPC

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Board of Directors - Workplan 2026/27													
Activity (* indicates item can be taken under consent)	**Purpose**	**Comments**	**DCH**	**DHC**	**Joint**	**Frequency**	**Apr-26**	**Jun-26**	**Aug-26**	**Oct-26**	**Dec-26**	**Feb-27**	**Executive Owner (Author)**
Minutes of the previous meeting	Approval				**X**	**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Chair
Action Tracker	Review				**X**	**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Chair
Business Calendar	Review				**X**	**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Chair
Review of meeting	Review				**X**	**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Chair
Register of Interests	Information				**X**	**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Chair
Patient story	Information		**X**	**X**		**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Chief Nursing Officer (DHC - contact AJ, DCH - contact JoH)
Chair's Comments	Information				**X**	**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Chair
CEO Report	Information				**X**	**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Chief Executive Officer (JH, SN)
Board Assurance Framework (incl strategic review and risk appetite)	Assurance		**X**	**X**		**Quarterly**		**x And approval of strategic review and risk appetite**	**X**		**X**	**X**	Director of Corporate Affairs
Corporate Risk Register	Assurance		**X**	**X**		**Quarterly**		**X**	**X**		**X**	**X**	Chief Nursing Officer
Quality and Safety													
Quality Committee Assurance Report	Assurance				**X**	**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Quality Committee Chair
Safe Staffing Report (incl.Developing Workforce Safeguards)	Approval		**X**	**X**		**Bi-annual**		**X Mid point review**			**X Annual review**		Chief Nursing Officer
Learning from Deaths Report	Assurance		**X**	**X**		**Quarterly**	**Q3**	**Q4**		**Q1**	**Q2**		Chief Medical Officer
Maternity Report(s)	Assurance		**X**			**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Chief Nursing Officer
Quality Walkaround Report	Assurance		**X**	**X**		**Bi-annual**			**X**			**X**	Chief Nursing Officer
Patient Safety Incidence Response Plan (PSIRP)	Approval		**X**	**X**		**4 yearly (minimum)**		**June 2029 (latest)**					Chief Nursing Officer
Quality Account (To be taken alongside Annual Report and Accounts	Approval		**X**	**X**		**Annual**		**X**					Chief Nursing Officer
Health Inequalities Report	Assurance		**X**	**X**		**Bi-annual**	**X**			**X**			Chief Nursing Officer (DCH), Chief Medical Officer (DHC)
Patient Carer Race Equality Framework (PCREF)	Assurance			**X**		**Annual**	**X**			**X**			Chief Medical Officer
Experience of Care Annual Report (including complaints)	Assurance		**X**	**X**		**Annual**				**X**			Chief Nursing Officer
Nutrition Strategy Update	Assurance		**X**	**X**		**Annual**			**X**				Chief Nursing Officer
Infection Prevention and Control Annual Report	Assurance		**X**	**X**		**Annual**			**X**				Chief Nursing Officer
Safeguarding Adults and Children Annual Report	Assurance		**X**	**X**		**Annual**			**X**				Chief Nursing Officer
Annual Clinical Audit Assurance Report	Assurance		**X**	**X**		**Annual**		**X**	**X**				Chief Medical Officer
Finance and Performance													
Finance and Performance Committee Assurance Report	Assurance				**X**	**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Finance and Performance Committee Chair
Finance Report	Assurance		**X**	**X**		**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Chief Finance Officer
Performance Dashboard (DCH - Integrated Board Performance Report) (DHC - Integrated Corporate Dashboard)	Assurance		**X**	**X**		**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Chief Operating Officer (DCH) Chief Finance Officer (DHC)
Seasonal Surge (Winter) plan	Approval		**X**	**X**		**Annual**			**X**				Chief Operating Officer
Emergency Preparedness Resilience and Response (EPRR) Compliance Letter Self Assessment	Assurance		**X**	**X**		**Annual**				**X**			Chief Operating Officer (DCH IK, DHC SH)
Emergency Preparedness Resilience and Response (EPRR) Annual Report	Assurance		**X**	**X**		**Annual**					**X**		Chief Operating Officer (DCH IK, DHC SH)
Any financial items requiring Board approval	Approval		**X**	**X**		**As required**							As required
DCH SubCo Ltd. Performance Report*	Information		**X**			**Quarterly**	**X**	**X**		**X**	**X**		Chief Operating Officer (DCH)
DCH SubCo Ltd. Annual Report and Accounts	Assurance		**X**			**Annual**					**X**		Chief Operating Officer (DCH)
DCH SubCo Ltd. Terms of Reference*	Approval		**X**			**Annual**		**X**					Chief Operating Officer (DCH)
Premises Assurance Model	Approval		**X**	**X**		**Annual**			**X**				Chief Finance Officer (DM)
Estates Compliance Report	Assurance		**X**	**X**		**Bi- Annual**		**X**			**X**		Chief Finance Officer
Health and Safety Compliance Report	Assurance		**X**	**X**		**Bi- Annual**		**X**			**X**		Chief Finance Officer (DCH) / Chief Operating Officer (DHC)
Modern slavery and human trafficking statement*	Approval		**X**	**X**		**Annual**	**X**						Chief Finance Officer
Green Strategy Annual Report	Assurance		**X**	**X**		**Annual**			**X**				Chief Finance Officer
Estates Strategy	Approval		**X**	**X**		One off	**X**						Chief Finance Officer
People and Culture													
People and Culture Committee Assurance Report	Assurance				**X**	**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	People and Culture Committee Chair
Equality Delivery System	Assurance		**X**	**X**		**Annual**						**X**	Chief People Officer
Gender, Ethnicity and Disability Pay Gap Report	Assurance		**X**	**X**		**Annual**	**X**						Chief People Officer
Freedom to Speak Up and Whistleblowing Report	Assurance		**X**	**X**		**Bi-annual**		**X Annual report**			**X**		Director of Corporate Affairs (FTSU Guardians)
Guardian of Safe Working Report	Assurance		**X**	**X**		**Quarterly**	**Q3**	**Q4 and Annual report**		**Q1**	**Q2**		Chief Medical Officer (DCH - AM, DHC - CV)
GMC National Training Survey Results and Action Plan	Assurance		**X**	**X**		**Annual**				**X**			Chief Medical Officer (DCH -PMy, DHC - IR)
Medical Appraisal and Revalidation Annual Report (and statement of compliance)	Approval		**X**	**X**		**Annual**			**X**				Chief Medical Officer (DCH - CY, DHC - CL)
Staff Survey Report	Assurance		**X**	**X**		**Annual**	**X**						Chief People Officer
Equality, Diversity and Inclusion Annual Report	Approval		**X**	**X**		**Annual**		**X**					Chief People Officer
Workforce Race Equality Standard (WRES)	Assurance		**X**	**X**		**Annual**				**X**			Chief People Officer
Workforce Disability Equality Standard (WDES)	Assurance		**X**	**X**		**Annual**				**X**			Chief People Officer
Violence & Aggression reduction strategy, action plan, and policy	Approval		**X**	**X**		**Annual**		**X**					Chief Operating Officer (DCH) / Chief Finance Officer (DHC)
Strategy, Transformation and Partnership													
Strategy, Transformation and Partnership Committee Assurance Report	Assurance				**X**	**Bi-monthly**	**X**	**X**	**X**	**X**	**X**	**X**	Strategy, Transformation and Partnership Committee Chair
Strategy Delivery Report	Assurance				**X**	**Bi-annual**			**X**			**X**	Chief People Officer
Senior Information Risk Owner Annual Report	Assurance		**X**	**X**		**Annual**		**X**					Chief Digital Information Officer

Public Trust Board Meeting - 09.01.24

Activity (* indicates item can be taken under consent)	Purpose	Comments	DCH	DHC	Joint	Frequency	Apr-26	Jun-26	Aug-26	Oct-26	Dec-26	Feb-27	Executive Owner (Author)
Audit and Governance													
Audit Committee Assurance Report	Assurance		X	X		Bi-monthly	X	X	X	X	X	X	Audit Committee Chair
Risk Management Strategy	Approval				X	3 yearly	Apr 29						Joint Chief Nursing Officer
Risk Appetite Statement Annual Review	Approval		X	X		Annual	2027						Joint Director of Corporate Affairs
Going Concern Statement	Approval		X	X		Annual	X						Chief Finance Officer
Annual Self-Certification of Licence Conditions	Approval		X	X		Annual		X					Director of Corporate Affairs
Fit and Proper Persons Compliance	Assurance		X	X		Annual		X					Director of Corporate Affairs
Standing Orders	Approval		X	X		Three-yearly					2027		Joint Director of Corporate Affairs
Standing Financial Instructions and Scheme of Delegation	Approval		X	X		Three-yearly					2027		Joint Director of Corporate Affairs
Charitable Funds Consolidation	Approval	At a meeting of the Charitable Trustees	X			Annual						X	Chief Finance Officer
DCH Charity Business Plan	Approval	At a meeting of the Charitable Trustees	X			Annual						X	Chief Finance Officer
Committee Annual Reports including effectiveness evaluation and terms of reference	Approval				X	Annual		X					Director of Corporate Affairs
Board effectiveness review	Assurance				X	Annual		X					Director of Corporate Affairs
Constitution Review	Approval				X	3-yearly	Apr-28						Director of Corporate Affairs
Charitable Funds Committee Assurance Report	Assurance		X			Bi-monthly	X	X	X	X	X	X	Charitable Funds Committee Chair
Charitable Funds Annual Report and Accounts	Information	At a meeting of the Charitable Trustees	X	X		Annual				X DHC	X DCH		Chief Finance Officer
Mental Health Legislation													
Mental Health Legislation Committee Assurance Report	Assurance				X	Quarterly		X	X		X	X	Mental Health Legislation Assurance Committee Chair
Mental Health Scheme of Delegation	Approval			X		Annual			X	X			Chief Medical Officer
Approval of Associate Hospital Managers	Approval			X		Annual					X		Chief Medical Officer

Ellis,Kara
10/06/2026 16:10:45

DCH & DHC Board of Directors Declarations of Interest 2026 - 2027

					Type of Interest				Date of Interest
First Name	Surname	Trust	Current Position Held	Declared Interest (Name of the Organisation and nature of the business)	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect	Declaration reviewed
David	Clayton-Smith	Joint	Joint Trust Chair	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust Chair		✓			16/03/2026
				Unity Insights Ltd, Director and Chair		✓			16/03/2026
				National Centre for Creative Health		✓			16/03/2026
Matthew	Bryant	Joint	Joint Chief Executive Officer	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			26/03/2026
				Member of Dorset Integrated Care Board (Mental Health Partner Representative).		✓			26/03/2026
				Trustee, NHS Providers (NHS Alliance but will NHS providers will remain until Summer 2026		✓			26/03/2026
				Trustee, NHS Alliance		✓			26/03/2026
Dawn	Dawson	Joint	Joint Chief Nursing Officer and Deputy CEO for Dorset HealthCare	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			25/03/2026
				Son is a sales representative for Stryker IVS South & Southwest				✓	25/03/2026
				Daughter is Associate Director of People & Transformation in NHS Somerset				✓	25/03/2026
				Daughter in law is Assistant Divisional Management Accountant at Royal Devon and Exeter NHS Foundation Trust				✓	25/03/2026
				Son in law is a RMN in Dorset Healthcare				✓	25/03/2026
Chris	Hearn	Joint	Joint Chief Finance Officer	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			18/03/2026
Jenny	Horrabin	Joint	Joint Executive Director of Corporate Affairs	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			16/03/2026
				Trustee – Coventry Sports Foundation			✓		16/03/2026
				Independent Audit Committee Member - Citizen Housing	✓				16/03/2026
				Member of HFMA Audit and Governance Committee		✓			16/03/2026
Nicola	Plumb	Joint	Joint Chief People Officer	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			01/04/2026
Anita	Thomas	Dorset County Hospital	Chief Operating Officer	Director at DCH Pharmacy SubCo Ltd		✓			16/03/2026
Rachel	Wharton	Dorset County Hospital	Chief Medical Officer	Nil					17/03/2026
Lucy	Knight	Dorset HealthCare	Chief Medical Officer	Husband is Locality Manager in Dorset Social Care				✓	16/03/2026
Rachel	Small	Dorset HealthCare	Chief Operating Officer	Magistrate in HM Courts and Tribunals Service			✓		16/03/2026
				Sister-in-Law works as a district nurse in Bournemouth team				✓	16/03/2026
Eiri	Jones	Joint	Joint Non-Executive Director	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			18/03/2026
				Non-Executive Director at Salisbury NHS Foundation Trust	✓				18/03/2026
				Interim Chair at Salisbury NHS Foundation Trust	✓				18/03/2026
Claire	Lehman	Joint	Joint Non-Executive Director	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			18/05/2025
				Non-Executive Director at Southwest Ambulance	✓				08/04/2026
				Non-Executive Director at Great Western Hospital	✓				08/04/2026
				Advocacy for Parkinson's Disease				✓	08/04/2026
Dave	Underwood	Joint	Joint Non-Executive Director	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			17/03/2026
				Chair of Royal British Legion Club West Hill Ltd Registered IP23677R on the FCA Mutuals Public Register			✓		17/03/2026
				Policy Board member of the SW Business Council - The economic partnership for the South West of the UK			✓		17/03/2026
				Member of the University of Exeter Digital Advisory Network			✓		17/03/2026
Margaret	Blankson	Dorset County Hospital	Non-Executive Director	Nil					01/04/2026
Stuart	Parsons	Dorset County Hospital	Non-Executive Director	Nil					22/03/2026
Stephen	Tilton	Dorset County Hospital	Non-Executive Director	Director and Chairman of DCH Pharmacy SubCo Ltd		✓			01/04/2026
Suresh	Ariaratnam	Dorset HealthCare	Non-Executive Director	Director, Sprung Sultan	✓				01/04/2026
				Director, Norland College			✓		01/04/2026
				Non-Executive Director, NHS Somerset	✓				01/04/2026
				Trustee, Trussell			✓		01/04/2026
				Honorary Fellow, Royal Society of Literature			✓		01/04/2026
				Member, Advisory Council of The British Library			✓		01/04/2026
				Trustee, Literature Works South West			✓		01/04/2026
				Deputy Lieutenant, Somerset Lieutenancy			✓		01/04/2026
Andreas	Haimböeck-Tichy	Dorset HealthCare	Non-Executive Director	Director, Harbour View (Swanage) Management Company Ltd	✓				22/03/2026
				Managing Director and shareholder of Accenture Plc	✓				22/03/2026
				Wife is HR Director for DJO Ltd, a Medical Device Company				✓	22/03/2026
				Wife is HR Director for ThermoFisher Scientific				✓	22/03/2026
Nikki	Rowland	Dorset HealthCare	Non-Executive Director	Deputy Chair and NED at Care Dorset Limited and Care Dorset Holdings Limited	✓				23/03/2026
Beverley	Bryant	Joint	Joint Chief Information Officer	Director, Wildtrack Telemetry Systems Ltd	✓				07/04/2026

Definitions

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

Ellis Kara
10/06/2026 16:10:45

Dorset County Hospital
Dorset HealthCare

Report to	Board of Directors in Common – DHC and DCH	
Date of Meeting	17 June 2026	
Report Title	Chief Executive Officers Report	
Prepared By	Jonquil Williams, Corporate Business Manager	
Approved by Accountable Executive	Matthew Bryant, Chief Executive Officer	
Previously Considered By	N/A	
Action Required	**Approval**	N
	Assurance	N
	Information	Y

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

Executive Summary

This report provided an update on issues affecting the strategic and operating environment for the Dorset HealthCare (DHC) and Dorset County Hospital (DCH).

Throughout the report there is clear evidence to demonstrates the importance of our partnerships and collaboration and the positive direction of travel in achieving our strategic objectives.

The report also celebrates our workforce and the collective and individual successes of colleagues across both organisations and our commitment to providing high quality, safe and effective care for the population of Dorset.

National

- Lord Mann report on antisemitism and racism in the NHS and our signing of the Anti-Racism Charter
- New Secretary of State for Health and Social Care
- Health Bill
- Neighbourhood health centres
- Priorities for Mental Health

Local

- New Chair of South West Region for NHSE
- ICB Cluster Statement: 10 Year Health Plan and Our Strategic Ambitions
- Bournemouth, Christchurch and Poole SEND improvement letter

Federation

- Pan-Dorset Governor workshop
- Medium term plan acceptance

Ellis,Kara 10/06/2026 16:10:36

- Advanced Foundation Trust
- Memorandum of understanding with GP alliance
- New Hospital Programme updates
- One Dorset Procurement Service

Trust specific

- DHC – Meningitis B
- DHC – CQC well led
- DCH – Bird Flu vaccination
- DCH – Yeovil Hospital maternity re-opening
- DCH – Practice supervisor of the year

Recommendation
Members are requested to receive the report for information.

Ellis,Kara
10/06/2026 16:10:45

Chief Executive Officer's Report – June 2026

1. National/regional:

1.1 Lord Mann report on antisemitism and racism in the NHS and our signing of the Anti-Racism Charter

On 4th June Lord Mann's recommendations to tackle antisemitism and racism in the NHS were published.

The report sets out recommendations to tackle "routine ostracism" of Jewish people in the NHS, including stronger accountability and mandatory training. It emphasises the role of NHS employers as first line of defence against racism and discrimination for patients and staff.

These recommendations have been accepted by the NHS in full and over the next few months actions at a national level will include:

- Holding Trusts accountable through the publication of a new NHS Staff Standard focused on tackling racism, setting minimum expectations for how organisations must prevent, respond to, and learn from incidents of racism
- Mandatory anti-racism training, specifically including antisemitism, for the chairs and chief executives of all NHS provider trusts within six months
- Updating mandatory training on Equality, Diversity and Human Rights — accessed by 1.5 million staff — to include quality-assured content on antisemitism and anti-Muslim hostility
- NHS England adopting the seven anti-racism principles of the NHS Race and Health Observatory and encouraging all NHS organisations to do so
- Clear national guidance on uniform and NHS-issued equipment to ensure patients can access care with confidence, free from any perception of bias and on how Trusts should respond to racist behaviour from the public
- Setting out a single set of national guidance for employers, clearly defining employers' responsibilities in tackling discrimination incidents and providing guidance and examples of the types of incidents that may require a regulatory referral

On behalf of our trusts I condemn racism in any form and believe the recommendations of the Mann report and the actions identified above are important. They support the actions we have taken over the past few months which have included formally signing up to the Anti-Racism Charter developed by Unison. This is a public, voluntary commitment to go beyond statutory requirements and take meaningful action to improve experience and outcomes for staff, patients and communities.

Following this in May we launched our anti-racism campaign within both trusts, which is called "We all belong". We know we need to go further to create an environment where all colleagues to feel able to raise concerns about racism, discrimination or culturally and racially harmful behaviour safely, and without fear, and as part of the campaign we are emphasising the role our Freedom to Speak Up Guardians can play in supporting colleagues who are worried about raising concerns.

Not only is this morally the right thing to do, but we also know in healthcare, that our teams and decision making is better if we are more diverse, and working in an environment where there is civility, respect and empathy leads to better outcomes. We will continue to update the board on this work, and it will also feature through the Staff Voices report and other updates at the People and Culture Committee.

[illegible] 10/06/2026 11:20:45

1.2 New Secretary of State for Health and Social Care

On 14 May 2026, James Murray was announced as the new Secretary of State for Health and Social Care. He was previously Chief Secretary to the Treasury from 1 September 2025 to 14 May 2026, and prior to that was Exchequer Secretary to the Treasury, having been shadow Financial Secretary for three and a half years before the 2024 election.

James has been the MP for Ealing North since 2019. He was an elected councillor in Islington for a decade from 2006 before becoming deputy London Mayor with a responsibility for housing under Sadiq Khan in 2016. He has been open about his own diagnosis of a long-term health condition and in his maiden speech to Parliament said that in the late 2000s "the NHS came to my rescue. My wonderful consultant and all his colleagues got me through a major operation and on to a painstakingly calibrated set of medications. I have been symptom-free since the early 2010s, and I will fight every day for our NHS with the strength that it has given me back".

I joined a call with James, Jim Mackey and NHS Chief Executives from across the country on 3rd June and James spent an hour giving his first impressions, outlining priorities and answering questions.

1.3 Health Bill

On 14 May 2026 the Health Bill was introduced to the House of Commons.

The Health Bill is integral to the government's investment and modernisation agenda to improve patient care. The bill will:

- improve patient safety and experience through a new single patient record, enabling joined-up, proactive care and empowering patients
- put power and resources in the hands of frontline NHS organisations by abolishing NHS England and stripping back national bureaucracy
- clarify the role of local health bodies, giving them real flexibility to design and deliver health services to best meet the needs of their local populations

As such the bill supports delivery of the goals of the 10-year plan for health in England, and many of the ambitions set out in our own strategy.

1.4 Neighbourhood Health Centres

On 16 April NHSE published guidance on Neighbourhood Health Centres (NHCs) including design and performance specification for regions and ICBs. The Neighbourhood health centre guidance for regions and Integrated Care Boards sets out the practical planning instructions for developing NHCs in the current planning period. The Neighbourhood Health Centres: design and performance specification supports the planning and delivery of new-build neighbourhood health centres (https://www.england.nhs.uk/long-read/neighbourhood-health-centre-guidance-for-regions-and-integrated-care-boards/).

The Integrated Neighbourhood programme team have started to use the published guidance to develop the programme further, and proposals will be developed in due course. It is possible that the capital freedoms offered by Advanced Foundation Trust status will support the development of some of these facilities.

Lewis Lara
10/06/2026 16:10:45

1.5 Priorities for Mental Health

In February Dr Nick Broughton was appointed as NHS England's new National Priority Programme Director for Mental Health, Learning Disability and Neurodevelopmental Conditions.

Nick will also continue in his role as Chief Executive of the NHS Buckinghamshire, Oxfordshire, Berkshire West and Frimley Integrated Care Boards Cluster. He is a forensic psychiatrist by background and is known to us from previous roles, including being Chief Executive of Somerset Partnership Trust and Southern Health.

Having been in post since February, Nick has now identified some priority delivery actions for mental health over the next year. These are:

- Out of area placements: a 95% reduction for adult acute patients over the next year based on March 2026 levels. This is a milestone towards eliminating out of area placements by the end of March 2028
- 12-hour breaches for mental health patients in Emergency Departments (ED): a plan will be developed to reduce these to the lowest possible level with a target being set to be achieved by March 2027. The initial thinking is to measure the proportion of ED referrals to liaison psychiatry for people who are already known to services
- Children and Young People (CYP) Mental Health waiting times: a target will be set to double the number of children who start treatment within four weeks. By March 2027 all trusts will be required to have at least 50% of CYP referral spells receiving a full clock stop in less than 4 weeks

Alongside the above there are also plans to focus on an initiative for staff engagement based on information provided in the staff survey and a requirement for trusts to ensure we capture the experience of people waiting for care.

We welcome the focus on these areas and have begun an assessment of our own position and actions required to deliver the national requirements. This will be presented at a future Finance and Performance Committee with any quality and workforce issues clearly identified and referred to the appropriate committee. We also welcome the breadth of Nick's role with its focus across mental health, learning disability and neurodevelopmental conditions and the opportunity to work in an integrated way across these areas to make a difference for children and young people in particular.

2. Local/Regional Updates:

2.1 New Chair of South West Region for NHSE

On 19 March it was announced that Dame Gill Morgan has been appointed as the NHS England South West Regional Chair.

The Regional Chair will work with Provider and ICB Chairs to deliver against the strategy and ensure high performing Boards, and work with the regional executive team to support improvement and intervention.

Wills Kara
10/06/2026 16:16:17

Gill brings extensive experience of board-level leadership, having had a long and distinguished career in the NHS, government and third sector, including being Chair of Gloucestershire Integrated Care System, Permanent Secretary to the Welsh Government and Chief Executive of the NHS Confederation. I worked for Gill for a period in the late 1990s when she was Chief Executive of

North and East Devon Health Authority and it is great to have all the experience she brings to this important role for healthcare in the South West.

2.2 ICB Cluster Statement: 10 Year Health Plan and Our Strategic Ambitions

On 15th May our ICB submitted a response to NHS England's request to articulate its strategic ambitions. This response had been informed by a board development session on 7th May which I participated in, along with Siobhan Harrington (UHD) and Forbes Watson (GP Alliance) as well as other colleagues across the three clusters who are members of the new cluster board.

The submitted document describes the strategic ambition for the ICB cluster which, taken together, will:

- Rebuild our system around people, place, communities and prevention, abolishing the current arrangements and historical pathways
- End hospital as the default setting for care, using acute settings only where they add greatest value
- Dismantle legacy pathways, behaviours and power structures that currently lock resource into low-value activity

In setting out this ambition, the document describes that this is not a marginal adjustment to today's model. It is a decisive move to a system that is commissioned, funded and organised around outcomes for defined populations.

Particular aims set out in the document include goals to:

- Strengthen commissioning capability across the Cluster ahead of full ICB merger in April 2027
- Rebalance resources at scale, reducing the acute share of spend and deliver transformation
- Accelerate the build and adoption of our integrated data & insights systems
- From 2027/28, commission for defined populations, starting by focussing on CYP and people aged 65+ living with frailty/multiple long-term conditions, targeting prevention, proactive care and earlier intervention in neighbourhoods to deliver radically different models of care and support
- Ensure delivery is through neighbourhood care, with high-functioning Integrated Neighbourhood Teams, expanded outcomes-based/IHO contracts, and stronger VCSE and local authority partnerships

In terms of an approach to commissioning it describes an ambition to achieve within the cluster:

- Integrated Health Organisation (IHO) contracts by the end of 2027/28
- More than half of all contracts will move to outcomes- based models by 2028/29
- We will build a 2% transformation fund, starting 2027/28, cumulative over three years
- Increased investment (vs 2025/26 baseline) in priority inequality areas from 2026/27
- Commissioning for defined populations, including testing outcomes-based contracts outside allocation where legally permissible
- A cluster operating model for shadow IHO working during 2026- 2027

Ellis Kara
10/06/2026 16:13:36

This is a welcome document and there is a strong synergy between this, the national 10 year plan for health in England and our own strategy Working Together, Improving Lives with its focus on Healthier Lives, Empowered Citizens and Thriving Communities. In terms of more immediate goals there is also alignment between our transformation priorities and the aims described in the

document, as well as our ambitions to develop locally based Integrated Health Organisation partnerships in Dorset. The next stage will be to take the full document for a discussion about strategic implications and additional actions required at our Strategy, Transformation and Partnerships Committee and through this to the wider board.

2.3 Bournemouth, Christchurch and Poole (BCP) SEND improvement letter

On 15 April BCP received a letter to step down from Statutory Direction to an Improvement Notice. This was due to positive findings identified as below:

- Collaboration, commitment and participation from leaders and practitioners across the local area for the rapid improvement of the provision for Special Educational Needs and Disabilities (SEND)
- Positive changes in SEND governance to help ensure effective oversight and accountability of improvements
- An accurate understanding of the needs of children and young people in BCP from partnership leaders
- Effective Improvements in multi-agency working to secures the most appropriate support, guidance and provision for children and young people, including timely access to healthcare interventions that support their individual needs
- More responsive health support, improved multi agency practice, and growing youth voice/co production, all linked to more stable workforce capacity

In March 2026 each Local Area Partnership was commissioned to submit a local SEND Reform Plan by June 2026, which will set out further improvements in the BCP are.

We welcome this marker of progress for children and young people in the BCP area. Dorset HealthCare is a key partner in this work and we will keep a strong focus on the improvement journey as there is still much to do, and some significant changes on the horizon for the organisation of SEND arrangements.

3. Federation Updates

3.1 Pan Dorset Governor Workshop

On 23 April we held a pan-Dorset Governor workshop across Dorset County Hospital, Dorset Healthcare and University Hospital Dorset. It was an opportunity for Governors across the county to come together and to hear from a variety of keynote speakers about the healthcare work that is ongoing in Dorset as well as participate in a tabletop task to consider the future of engagement in the context of the 10-year plan. A list of key topics is listed below:

- Population health and inequalities
- Engagement already happening in Dorset
- Health literacy

3.2 Medium Term Financial Plan – sign off

Miss Kate
10/06/2026 16:10:45

On 22 April both DCH and DHC received their acceptance letters from NHSE with regard to their medium-term plan submission for 26/27-2028/29 and the five-year-Integrated Delivery Plan.

Both were accepted with conditions. These included:

- The need to reduce risk to savings plans by increasing the proportion of identified savings (both trusts)
- Responding to the challenges made about the submitted plan for Talking Therapies (DHC)
- Improving the productivity workforce deliverability plans (DCH)

These letters, conditions and actions were discussed in detail at FPC and will be included in the committee update at today's board.

4. Federation and Trust Updates

4.1 Advanced Foundation Trust (DHC)

On 29 May Dorset HealthCare was announced as one of six first wave Advanced Foundation Trusts in England. This positive outcome reflects strong partnership working within the Dorset and BCP areas, and the work we have done together as a Federation to develop a joint strategy and delivery focused on improving population health and delivering the "left shift" in healthcare.

The national framework for AFTs is still being developed, but we look forward to going further and faster with partners in achieving our ambitions to improve health outcomes for our residents. We will be bringing updates through our Strategy, Transformation and Partnership Committee and also into our board development sessions over the next few months.

The final letter of representation agreed by the Dorset HealthCare board is appended to this report,

4.2 Memorandum of Understanding with the Dorset GP Alliance (DHC)

We know that our partnership with primary care is essential to achieve together the shift to neighbourhood and preventative care. We are already working in partnership to deliver the neighbourhood programme in Dorset, and Forbes Watson, as clinical chair of the GP Alliance has been a member of our Strategy, Transformation and Partnerships Committee since its inception.

To take this partnership to the next stage we have developed a Memorandum of Understanding (MOU) that sets out ambitions and a way of working together. This is intended to:

- Enable a left shift from reactive to preventative, community-led care
- Improve population health outcomes
- Transform community mental health and deliver integrated services (including working together with acute partners through the federation or the Our Dorset Provider Collaborative)

The intention is that this MOU will be discussed and signed in part 2 of board today, and will include arrangements for the GP alliance to nominate an Associate Non-Executive Director to sit on the Dorset HealthCare board. This is an important step forward in our partnership together to improve care for our population.

4.3 Opening of New Hospital Programme developments in Poole and Bournemouth – Dorset HealthCare

In April we opened Chaddesley House, the first part of our major New Hospital Programme developments at the St Ann's campus in Poole. This was the first phase of expanded and improved facilities to support people across Dorset with severe mental issues.

Confidential
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It's been purpose-built to increase capacity and enhance services for local men and women needing 24-hour care and intensive treatment. The two-storey unit hosts two specialist adult wards - Chine Ward for female patients who will relocate from a listed building elsewhere on the site and Haven Ward on the ground floor, divided into eight-bed male and five-bed female psychiatric intensive care units. Further work now continues to improve other facilities on site.

This was closely followed in May by the opening of Seastone in Bournemouth, which will provide 24-hour inpatient care for 13 to 18-year-olds with severe mental health issues. The name has been chosen by service users, who have also been involved throughout in the design of the building.

There has not been a similar facility in Dorset before for this group of children and young people and it is the first ever purpose-built unit of its kind to be provided in the South West. It will make a real difference for people to be cared for closer to home, where their support network can take part in care, and the location and environment will help with recovery and return to normal life at home. The building has eight ensuite bedrooms, seclusion and de-escalation areas, as well as classroom facilities, a gym, a sensory room and space for family visits.

4.4 Progress on the construction of DCH's new Emergency Department and Critical Care Unit

DCH received an exciting delivery in May on the construction site of our new Emergency Department and Critical Care Unit, which is being built as part of the New Hospital Programme.

Bayards Helidecks and Helipads travelled from the Netherlands with the first shipment of the structural parts for our new helipad, which is being funded by the Help Appeal.

Installation is underway and we will mark another major milestone later this summer when we hold a topping out ceremony to celebrate the building reaching its highest point.

There has also been progress with a number of other estates and facilities initiatives on the DCH site:

- **DCH Stroke Unit refurbishment:** Refurbishment works on DCH's Stroke Unit are now complete. The new space has allowed us to increase our capacity to 30 beds, as well as build upon the amazing care that our Stroke Team already provide.

  It also includes additional Hyper Acute Stroke Unit capacity, allowing us to provide high dependency, 72-hour specialist care for patients from both Dorset and Somerset.

- **Stoma care facilities upgrade:** Stoma care facilities have been upgraded at Dorset County Hospital (DCH), thanks to a generous charitable donation.

  Ducks and Drakes Cancer Trust donated just under £1,500 to allow improvements to be made to the bathroom facilities on two of the hospital wards – Lulworth and Abbotsbury.

  The improvements include new mirrors, shelving and hooks, which will enhance patients' experience at the hospital by allowing them to change their stoma bags more easily. The improvements may look very simple, but they will make a significant difference to the experience of our patients with stoma bags. We understand a stoma bag can be a big life

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change for patients and we want to ensure we do everything we can to help people ease into that transition.

- **Funding for sustainability initiative:** We were delighted to be allocated £95,000 from the Government towards replacing lights with LEDs across DCH. The hospital is one of 82 NHS trusts to receive a share of £74million from the Department for Energy Security and Net Zero to adopt clean energy technologies and improve our energy efficiency.

  As a result of previous successful funding bids, we have already begun replacing some lights around the hospital and this latest funding allows us to continue with this work. We must thank our Sustainability Team and estates and facilities colleagues for securing the grant and carrying out the work.

4.6 New shared One Dorset Procurement Service

Procurement colleagues have launched a new shared service for all three NHS provider trusts in Dorset as part of our closer collaboration.

The new 'One Dorset Procurement Service' (ODPS) will provide procurement and inventory management services for Dorset County Hospital (DCH), Dorset HealthCare (DHC) and University Hospitals Dorset (UHD). An integrated single service will bring financial and efficiency benefits, better staff opportunities for career progression and training, plus a more streamlined and efficient purchasing process.

The service will be hosted by UHD, but the focus is very much on a One Dorset service. Procurement colleagues are going through a period of consultation and change, and DCH and DHC staff transferred to UHD on 1 May 2026. The new shared service is due to formally launch in September 2026.

Bringing three services together is a complicated piece of work and we have greatly appreciated the understanding and support of procurement colleagues during this period of change.

4.5 Meningitis B outbreak in Weymouth and Portland – Dorset Healthcare

In April we had 3 confirmed cases of Meningitis B in Weymouth and Dorset HealthCare was commissioned by the UK Health Security Agency to lead on standing up an antibiotics and vaccination service for eligible young people in the area. The team mobilised effectively and an Incident Co-ordination Centre was set up to ensure efficient and effective running of the incident.

Phase one involved administering antibiotics and first vaccinations to around 6,000 young people, working with partners including the local authority, schools, NHS organisations and volunteers to deliver clinics in school and college sites. Take-up for antibiotics was 73% and for the first vaccination 72%. The second vaccinations are currently being delivered using the same model.

I want to thank all those involved for the impressive teamwork across multiple teams around the trust and with partners which allowed us to deliver this important protection for children and young people.

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4.6 CQC well led inspection – Dorset Healthcare

On 31 March 2026 we were notified that CQC will carry out a Well Led inspection of Dorset Healthcare on Tuesday 23 June to Thursday 25 June. It was noted that members of the NHS England (NHSE) team will join the inspection to assess financial and resource governance. As part of the lead up to the inspection the CQC team will conduct several unannounced service visits. During May and June unannounced inspection visits have been continuing to our services

We have begun preparation for this inspection and have hosted briefings for staff, senior leads and Board members. We have a central team managing and supporting the process, the team meet weekly to ensure the smooth running of the inspection and to ensure that the Trust is well informed of any updates.

4.7 Bird flu vaccine trial launch

Since April 2026 Dorset County Hospital and Dorset HealthCare have been delivering a national priority trial evaluating an investigational mRNA vaccine designed to protect against potential avian influenza (also known as bird flu).

The study is being delivered through the Weymouth Research Hub under the Wessex Commercial Research Delivery Centre model, in collaboration with Bournemouth and Southampton hospitals. The Wessex CRDC is the only NHS site in the UK selected to participate in this study, providing a unique opportunity for people living in our rural and coastal communities to access cutting edge research. This is particularly relevant given Dorset's strong agricultural sector including poultry farming.

Since opening, 90 clinic slots have been used to date with 37 participants enrolled. Although uptake has been lower, and cancellations or non-attendance higher, than anticipated, we are predicting a total of 50-55 participants if current performance is maintained, with the study scheduled to close on 22 June.

4.8 Re-opening of Yeovil District Hospital's maternity service

The DCH maternity team received thanks from NHS colleagues in Somerset for the support the hospital provided during the temporary closure of Yeovil Hospital's maternity services.

When inpatient maternity services at Yeovil District Hospital (YDH) were temporarily closed in May 2025, rapid changes were put in place to create extra space and capacity in the maternity units at Dorset County Hospital and Musgrove Park Hospital.

DCH maternity colleagues, along with maternity and support workers from YDH who joined them, worked incredibly hard to manage increased demand and maintain high standards of care for women who were booked to give birth away from Yeovil - 444 babies were born between May 2025 and April 2026 who would normally have been born at Yeovil.

Somerset colleagues said that no words could do justice to the depth of gratitude for the support, challenge and care the DCH maternity team provided through what was an exceptionally difficult period for their services, their colleagues and, most importantly, their service users. DCH staff worked alongside Yeovil colleagues at a time of real pressure and uncertainty, and did so with

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professionalism, generosity, compassion and an unwavering focus on doing the right thing to support families during this time.

4.9 Practice Supervisor of the Year

We were immensely proud of Pauline Kirtley from DCH's Ridgeway Elective Orthopaedic Unit for winning Practice Supervisor of the Year at the Student Nursing Times Awards.

Pauline has mentored over 100 nursing and nursing associate students during her time at DCH and was recognised for her experience, dedication and enthusiasm for developing learners.

One of Pauline's students wrote: "Pauline is one of the most compassionate, supportive, and knowledgeable ward sisters I have ever had the privilege to learn from. She always made time for questions, encouraged me to explore learning opportunities, and helped me grow in confidence. She has an incredible ability to bring out the best in people. She nurtures your curiosity, pushes you to reach your potential and makes you believe you can succeed. Her dedication to her students is genuine and consistent. She doesn't just teach skills; she teaches compassion, professionalism and resilience by embodying these qualities every day."

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Dorset HealthCare University
NHS Foundation Trust

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20 April 2026

PRIVATE & CONFIDENTIAL

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Dear Sir / Madam

Re: Application for 'Advanced Foundation Trust' status – management representations

This letter of representation is provided in connection with your assessment of Dorset HealthCare NHS Foundation Trust's ('the trust') application for 'advanced foundation trust' status, for the purpose of determining whether the trust meets the assessment criteria set out in the '*Advanced Foundation Trust Programme – guide for applicants'*.

The trust's board of directors ('the board') have considered and agreed this letter. I have been authorised to write to you on its behalf. The board confirms that the representations it makes in this letter are in accordance with the definitions set out in the appendix to this letter.

Representations

The board confirms, to the best of its knowledge and belief at the date of this letter, having made all such inquiries as it considered necessary for the purpose of informing itself, that:

Relevant information

1. The board has:

- disclosed to you all information of which it is aware having made reasonable inquiries that are both relevant and material to the assessment of the trust such as records, documents and other matters. For the avoidance of doubt, this includes all material reports and peer review information (or latest draft where reports have not been finalised) commissioned either internally or

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externally and covering governance arrangements or the quality of services at the trust within the last two years.

- provided you with all information requested during the course of the assessment.

- disclosed all relevant information pertaining to the review at this point in time, and the board is not aware of any material facts that will alter the approval. The board will inform NHS England of any material information that may alter the approval as soon as the information is known.

Internal control

2. The board acknowledges its responsibility for such internal control as it determines necessary for the conduct of the trust's business and the preparation of information, including that provided to NHS England, which is free from material misstatement, whether due to fraud or error. In particular, the board acknowledges its responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

3. The board has disclosed to you the results of any assessment of the risk that the information it has reported to NHS England may be materially misstated as a result of fraud.

4. There have been no instances of material or suspected fraud that the board is aware of, other than those already reported to NHS England as part of the assessment process, that involve:

    a. management and, where appropriate, those charged with governance

    b. employees who have significant roles in internal control, or

    c. other employees where the fraud could have a material effect on the information provided to NHS England.

Legal compliance

5. The board has disclosed to you all known material instances of non-compliance or suspected non-compliance with laws and regulations which affect the matters considered as part of the assessment.

6. The board has disclosed to you all known material instances of actual or possible litigation and claims which affect the matters considered as part of the assessment.

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Other matters

The board has actively considered all information provided to NHS England and has not identified any other matters it deems material to the assessment.

Signed for and on behalf of the board:



Title: David Clayton-Smith, Chair, Dorset HealthCare NHS Foundation Trust

Date: 20th April 2026

Trust: Dorset HealthCare NHS Foundation Trust

Definitions (for letter of representation)

Material matters: Material omissions or misstatements of items are material if they could, individually or collectively, influence NHS England's view on the trust's eligibility and suitability for approval as an Advanced Foundation Trust. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size and/or nature of the item could be the determining factor.

Fraud: Fraudulent reporting involves intentional misstatements including omissions of amounts or disclosures in the information provided to deceive the user of the information.

Error: An error is an unintentional misstatement in the information provided. Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts.

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Report to	Board of Directors DHC and DCH	
Date of Meeting	17 June 2026	
Report Title	Board Assurance Framework – Quarter 4 2025/26 and Risk Review	
Prepared By	Jenny Horrabin, Joint Director of Corporate Affairs	
Approved by Accountable Executive	Jenny Horrabin, Joint Director of Corporate Affairs	
Previously Considered By	Assigned risks considered by Committees w/c 25 March 2026 Full Board Assurance Framework considered by Audit Committee 29 May 2026 (DHC) and 1 June 2026 (DCH)	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	These are the risks from the BAF assigned to this Committee	
Financial	No financial implications arising from the BAF	
Statutory & Regulatory	There is a regulatory requirement to have a BAF in place	
Equality, Diversity & Inclusion	There are no specific EDI implications arising from this report	
Co-production & Partnership	We will consider system risks and alignment to the system BAF as part of the development of the BAF.	

Executive Summary

1. Overview

The Joint Strategy 'Working together, improving lives' was approved at the DCH and DHC Boards on 31 July 2024 and 7 August 2024 respectively. Alongside the development of the Joint Strategy work on developing the Joint Principal Risks to achieving the Joint Strategic Objectives continued and these were approved by the DHC and DCH Boards on the same dates.

Each Trust has a joint set of strategic risks, and the template and review process are the same, as described below. However, the BAF is separate for each organisation as the controls and assurances and risk scores are different between DCH and DHC.

The Boards held a workshop on 02 September 2025 to review the Risk Appetite statements of each organisation to see if they could be aligned, recognising that each organisation's tolerance may be different. This was approved by the Boards in December 2025. The risk appetite statements have been incorporated into this report.

The risk appetite and target scores do not align and a review of each risk and the target scores for 2026/27 has been undertaken and is included with this report.

Appendix One to this report is the DHC BAF for Quarter 4 2025/26

Appendix Two to this report is the DCH BAF for Quarter 4 2025/26

Appendix Three to this report is the proposed strategic risks and target scores for 2026/27.

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2. Board Assurance Framework: Review Process

A standard template is in place. for the Board Assurance Framework, with a consistent framework across both Trusts. This template has been developed to show 'a risk on a page' with an overview of all risks.

Each risk has an unmitigated, mitigated and target score using the 5x5 scoring matrix previously reported. The unmitigated score is the level of risk before any mitigating actions are taken. The mitigated score is the level of risk with the controls and assurance in place and the implementation of the identified actions.

Controls and assurances are identified in terms of:

a. Priority Strategies and Plans
b. Risk controls and Plans
c. Oversight Governance and Engagement

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

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

Each action is marked as:

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

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

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

Assigned risks were considered by Committees w/c 25 March 2026 and the full Board Assurance Framework considered by Audit Committee 29 May 2026 (DHC) and 1 June 2026 (DCH).

A verbal update will be provided to reflect discussions and areas of focus in Committees.

Dorset HealthCare - Quarter Four Board Assurance Framework

Risk Scores

The highest scoring risk identified within the assurance framework (based on the mitigated risk score) are SR3: Workforce Capacity and SR9: Digital (each with a score of 15 or more).

There has been one change in score since the Q3 review:

SR6 – Finance with a reduction in the score from 16 to 12. This reflects the year end surplus position for 2025/26, the submission of surplus financial plan in the Medium-Term Plan (MTP) and the level of identified CIP. It is recognised there is risk associated in delivering the level of CIP associated with the plan and the risk will be subject to close review throughout the year.

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Actions

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

Three out of ten risks have one action that is behind schedule (compared with three in the previous quarter) with revised dates agreed. In total there are three overdue actions (compared to three in the previous quarter). The overdue actions have been considered by Committees.

Dorset County Hospital - Quarter Four Board Assurance Framework

Risk Scores

The highest scoring risk identified within the assurance framework (based on the mitigated risk score) continue to be SR1: Safety and Quality; SR3: Workforce Capacity; SR5 Estates; SR6: Finance and SR9: Digital Infrastructure (each with a score of 15 or more).

The score for SR6: Finance has been reduced from 20 to 16 (as a result in a decrease of the likelihood score). The reflects the year end position, the submission of a break-even financial plan in the Medium-Term Plan (MTP) and the cash position. However, it is recognised that there is significant risk associated with CIP delivery and the risk is subject to ongoing review.

Actions

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

Three out of ten risks have at least one action that is behind schedule, with revised dates agreed (compared to four risks at the last review). In total there are three overdue actions. Revised dates and updates have been provided in respect of all overdue actions.

Risk Review 2026/27

In accordance with good practice the strategic risks have been subject to annual review, and the proposed revisions are set out in the table at Appendix 3.

The proposed revisions to the wording were discussed with the Executive Risk Owners individually to review their assigned risks, and they also had the opportunity to comment on the revisions of risks that sat with other leads. This collated information was then presented to the Joint Executive Management Team, before being shared with the relevant Committees.

In addition, target scores have been reviewed as it was recognised that the target scores were set before completion of the Boards approval of the Risk Appetite and on review did not align. Each risk has been aligned to a risk appetite category (as shown in the BAF at Appendix One (DHC) and two (DCH)) and the target scores have been reviewed with a proposed revision to bring the target score in line with the approved risk appetite. This is an indicative target score which will be reviewed at the end of quarter one to ensure that they correctly reflect the Trust position against the refreshed risks.

The risk appetite definitions are included on the guidance (final page) of the attached Board Assurance Framework.

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Recommendation
Members are requested to: • Receive **assurance** on the process in place to review the Board Assurance Framework • Review and scrutinise the risks and identify any areas where further assurance is required and provide any further commentary on the controls, assurance and actions. • **Approve** the Strategic Risks and indicative target scores for 2026/27

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Dorset HealthCare University NHS Foundation Trust
Board Assurance Framework
Quarter 4 April 2026

Ellis Kara
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Dorset HealthCare University NHS Foundation Trust

Board Assurance Framework Overview -Q4 April 2026	Strategic Objectives				Responsibility		Score									
Strategic Risks	Care	Communities	Colleagues	Sustainability	Committee	Executive	Unmitigated Score	Mitigated Q2 24-25 Score	Mitigated Q3 24-25 Score	Mitigated Q4 24-25 Score	Mitigated Q1 25-26 Score	Mitigated Q2 25-26 Score	Mitigated Q3 25-26 Score	Mitigated Q4 25-26 Score	Target Score	Alignment to RiskAppetite
SR1: Safety and Quality If we are not able to deliver the fundamental standards of care in all of our services we will not be providing consistently safe, effective and compassionate care	X				**Quality**	Chief Nursing Officer	16	12	12	12	12	12	12	12	9	**Patient Safety and Quality- Cautious**
SR2: Culture If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.	X		X		**People and Culture**	Chief People Officer	10	8	8	8	8	12	12	12	6	**Workforce - Seek**
SR3: Workforce Capacity If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources	X		X		**People and Culture**	Chief People Officer	20	15	15	15	15	15	15	15	9	**Workforce - Seek**
SR4: Capacity and Demand If we do not meet current and expected demand and achieve local and national measures and targets within available resources we may face regulatory action and patients outcomes will be adversely affected	X	X		X	**Finance and Performance**	Chief Operating Officer	16	12	12	12	12	12	12	12	4	**Operational Performance - Open**
SR5: Estates If we do not have an estate that is fit for purpose and economically and environmentally viable we will be unable to provide the right places for our staff to deliver high quality services to the communities that we serve	X		X	X	**Finance and Performance**	Chief Finance Officer	16	12	12	9	9	9	9	9	9	**Finance and Value for Money - Open**
SR6: Finance If we do not deliver on our financial plans, including the required level of savings, then and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position				X	**Finance and Performance**	Chief Finance Officer	16	16	12	16	16	16	16	12	12	**Finance and Value for Money - Open**
SR7: Collaboration If we do not have effective and positive partnerships within the ICS then we will not be able to shape decisions and deliver the transformation required.		X		X	**Strategy, Transformation & Partnerships**	Chief Executive Officer	12	9	6	9	9	12	12	12	6	**Innovation, Partnerships and Commercial – Seek**
SR8: Transformation and Improvement If we do not seek and respond to the views of our communities to co-produce and continuously improve and transform our services, we will not contribute to the reduction of health inequalities within our communities.	X	X		X	**Strategy, Transformation & Partnerships**	Chief Nursing Officer	16	12	12	12	12	12	12	12	6	**Innovation, Partnerships and Commercial – Seek**
SR9: Digital Infrastructure If we do not advance our digital and technological capabilities, including achieving our EHR ambitions, we will not deliver the innovative and sustainable services and the delivery of safe services could be compromised.		X		X	**Strategy, Transformation & Partnerships**	Chief Finance Officer (Chief Digital Officer)	20	9	16	16	16	16	16	16	6	**Digital - Seek**
SR10 Cyber security If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents	X			X	**Strategy, Transformation & Partnerships**	Chief Finance Officer (Chief Digital Officer)	16	9	9	9	9	9	9	9	9	**Digital - Seek**

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Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care	**SR1: Safety and Quality** **If we are not able to deliver the fundamental standards of care in all of our services we will not be providing consistently safe, effective and compassionate care**	Quality

Executive Lead: Chief Nursing Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	4	=	16
Mitigated	4	x	3	=	12
Target	3	x	3	=	9

Rationale for Score: No change in score. Good progress made in respect of PSIRP and reporting arrangements in place. Strengthened quality oversight arrangements in place. Risk and incident management system procured and implementation plans in place. As at April 26 CQC Comprehensive Inspection underway and Well Led scheduled

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Quality Priorities 25/26 (each have a subject matter expert owner) and review for 26/27 commenced	Board approved 25/26 Quality priorities; 24/25 Quality Report approved and published and regularly reporting in place to Quality Committee for oversight	Positive	Green
PSIRF Response Plan	Board approved PSIRF Response Plan, updates to Quality Committee (QC) - approved April 25. Board Development session July 25. PSII areas for 25/26 agreed. PSIRP plan progressing with organisational PSII's agreed and in progress.	Positive	
Patient flow workstream for Mental Health and delivery of new inpatient environment through New Hospitals Programme and bed reconfiguration plan in place	Monthly reporting and ICD to Board, OOA continues to be an area of focus with monitoring and oversight, including audit of patients who are being cared for by other providers. Melstock now up to full capacity to support improved patient flow across the service. Average Length of Stay 47/47 nationally in NOF Q2 - reflected in capacity and demand risk	Positive	
Risk Controls and Plans			
Quality Priority Improvement Plan (inc agreed standards and measurement)	Quarterly Quality Priorities reported to QG Group (progress against KPIs) and upwards to Quality Committee via the Quality Report.	Positive	Green
Patient Experience Metrics and Improvement Plans	Patient Experience Annual Report and Annual Complaint Report Quality Committee Nov 25 (inc local surveys and metrics), Friends and Family Test National Surveys, Patient Story to Board bi-monthly. Positive progress with collaboration of patient participation and patient experience.National Experience of Care framework to be adopted - in progress	Positive	
Complaints Protocol and Information	Proactive review and management aligned with the new policy and improved quality and learning recording and oversight to improve outcomes and experience of complainants. Complaints performance in Integrated Corporate Dashbaord to Board bi-monthly	Positive	
Quality Committee Framework and Contractual obligations 25-26 and 26-27 and National Quality Board (NQB) quality priorites	KPI monitoring and Quality Dashboard and Quality Reports. EQIA SOP approved and in line with national template with bi-monthly reporting to Quality Committee (June July Sept Nov 25 Jan March 26). For 26/27 further work on reporting capability and refining of quality report to ensure compliance with contractual reporting obligations and national requiremements (MTP and NQB)	Neutral	
Quality oversight arrangements and assurance reporting	CQC Report Pebble Lodge's comprehensive inspection 'good' in all domains. Draft CQC Report from Twynham received (publication awaited). Comprehensive inspection concluded St Brelades & Herm ward's & Blandford & Wimborne MIUs 7/5/26, high level feedback received - reports expected (50 working days). CQC Well led inspection to commence 23/06/26. EQIA SOP approved, in line with national template -bi-monthly reporting to QC- June July Sept 25. EQIA internal audit review completed – to be reported to Audit Committee May 26. Reviewed internal quality oversight arrangements - and being piloted. Work ongoing to finalise procurement and implementation of risk and incident management system which will further enhance reporting and triangulation.	Positive	
PSIRF implemented to improve patient safety	PSIRF Oversight Panel, External Niche Review (reported to QGC) and Board Development Session July 25. Positive progress continues	Positive	
Health Inequalities Plan	Joint Health Inequalities Steering Group commenced, health Inequalities Improvement Plan in place. PCREF reported to Board Oct 25 March 26. Work required to become more outcomes focussed in reporting	Neutral	
Oversight Arrangements for Governance & Engagement			
Quality Governance Group reporting to Quality Governance Committee	Escalations through Quality Governance Group and Quality Committee in Common from Q1 25/26. Six month review of progress at informal Quality CiC Oct 25. Quality Governance Framework to Quality Committee Sept 25.	Positive	Green
PSIRF Oversight Group	Patient Safety Incidents Investigations to QGC (via PSIRF Oversight Group)	Positive	
Complaints Review Group reformed as Experience of Care Oversight and Improvement Group with partner membership	Complaints reporting to QGC. Now being progressed with consideration of key stakeholders - group now commenced	Positive	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Review metrics and reporting - for 26/27 further work on reporting capability and refining of quality report to ensure compliance with contractual reporting obligations and national requiremements (MTP) - Previous action re NQB expanded and later date proposed - reviewed all metrics and reporting and now waiting for BI for implementation - June 26 (end of Q1)	CS	~~Dec 25~~ ~~Mar 26~~ July 26	Behind Schedule
Review of reporting of health inequalities metrics with clearer focus on outcomes	LK	Jul-26	On Plan

Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR2: Culture** **If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.**	People and Culture

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score	Rationale for Score
Chief People Officer	Unmitigated	5	x	2	=	10	No change in score. Much work done inc Joint Inclusion and Belonging Group, anti-racism framework, managers guidance on unacceptable behaviours and the Inspire awards - continue to launch and embed and measure impact. Increased demand for services impacts on workload coupled with a high degree of uncertainty due to local and national changes. Appraisal rates have declined due to new system, recovery plan in place. Staff survey improved response rates and in line wuth national benchmarks and strong performance for 'we are always learning'
	Mitigated	4	x	3	=	12	
	Target	3	x	2	=	6	

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Inclusion & Belonging Strategy	Board approved Joint Inclusion and Belonging Strategy and Plan. Cultural maturity assessment - internal audit - provided positive assurance. Joint Inclusion and Belonging Group met from September 25 and reports to PCC quarterly	Positive	Green
Leadership and Management Development Strategy and Respect & Resolution Policy	Staff survey reported to PCC March 26 and Board April 26. FTSU bi-annual Report to PCC May 25 Nov 25 and annual report for 25/26 May 26/ Employment Relations Report in Workforce Dashboard bi-monthly to PCC and Board. Leadership Forum with refresh planned for 26/27	Positive	
Joint Workforce Wellbeing Plan	Plan approved Dec 24, Delivery Action Plan report to PCC Nov 25	Positive	
Enabling People Plan DCH/DHC in place and delivery mechanisms	Joint Strategy and Enabling Plans PCC April 26, Workforce KPI Dashboard to PCC and Board bi-monthly, People Plan Delivery Framework apoproved PCC July 25, Progress against Joint People Plan to PCC July 25 and People Plan Delivery Update PCC March 26	Positive	
EDS 2	EDS 2 Self Assessment Annually - to PCC and STP CiC Jan 26	Positive	
Staff Engagement Programme	Staff Survey / Pulse Survey - Report to SLG and PC CiC in March 2025 - inspire awards, leadership forum, staff networks (informal PCC focus March 26), coffee van tour, wellbeing initiatives, coaching - to be included in Staff Voice Report - PCC May 26	Neutral	
Risk Controls and Plans			
Workforce Delivery Framework 2025/26 - and to review for 26/27	WRES & WDES - to Board Oct 25/EDS2 PCC Jan 26 Board Feb 26 /Pay Gap Reports PCC March 26 Board Apr 26 / Staff Survey PCC March 26 Board Apr 26/ Workforce report to PCC on progress against key metrics - Year one deliverables reviewed at PCC informal April 25. Board Development Session on Anti-Racism and Inclusion Nov 25 and anti-racism framework to PCC Nov 25 and anti-racism charter Jan 26 - board approved Feb 26.	Positive	Amber
Staff Survey Action Plan and Staff Voice Reporting	Staff survey reported to PCC March 26 and Board April 26. To strengthen staff voice reporting via review and refresh approach to review and analysis of Pulse and Staff Surveys - to report to SLG and JEMT and to summarise in reporting to PCC to be introduced for 26/27 reporting	Neutral	
Policies and training - Freedom to Speak Up; Respect and Resolution; Conscious Inclusion	Freedom to Speak Up bi-annual Reports to Board and Committees (May & Nov 25 and May 26). Respect and resolution and conscious inclusion training launched. New joint FTSU policy ratified at TUPF May 2025. Self-assessment tool actions significantly complete. Board Briefing Dec 25 provided positive assurance and action plan PCC Jan 26	Positive	
Joint Inclusion and Belonging Action Plan	Reprioritisation of priorities and timeframes reported to PCC; Conscious inclusion and respect and resolution training launched. Review of Joint Inc and Belonging Group to be undertaken	Neutral	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee in Common (DCH & DHC) from Sept 24	Assurance Report to Board	Positive	Green
Directorate DMG - any areas escalation via governance routes	KPI's in Workforce Dashboard to PCC and ICD to Board bi-monthly	Positive	
Staff Networks and Culture & Inclusion Group and Workforce Wellbeing Steering Group	Annual EDI Report and Minutes reported to PCC from Sept 24 and exec leads for all networks. Health and Wellbeing champions in place.	Positive	
Joint Culture and Belonging Group	Commenced Sept 25 with reporting to PCC from Nov 25	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Launch of Mangers Guidance on Unacceptable Behaviour - review impact in line with EDI review and reporting cycle	NP	Jul-26	On Plan
Review and refresh approach to review and analysis of Pulse and Staff Surveys - to report to SLG and JEMT and to summarise in reporting to PCC to be introduced for 26/27 reporting - Complete - on PCC Agenda May 26	NP	Mar-26	Complete
Review and update Workforce Delivery Framework 26/27 - Complete PCC May 26	NP	Mar-26	Complete
Review of EDI and Health Inequalities governance across DCH and DHC	JH	Jul-26	On Plan
Review of format and function of Joint Inclusion and Belonging Group	EH	Jul-26	On Plan

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Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR3: Workforce Capacity** **If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources**	People and Culture

Executive Lead	Risk Score	Consequence		Likelihood		Score
Chief People Officer	Unmitigated	5	x	4	=	20
	Mitigated	5	x	3	=	15
	Target	3	x	3	=	9

Rationale for Score

Score unchanged. WTE reductions- did not achieve WTE reductions but did not impact year end financial position. Continued focus on reduction of temp staffing

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint People Plan	High level agreement at PC CiC for four strategic objectives, final plan to PCC May 25. Progress against Joint People Plan to informal PCC Mar 26 and People Plan Delivery Update to PCC March 26	Positive	Green
Workforce Planning Strategy and workforce reduction plan	Workforce Metrics in ICD. Workforce reduction plan in place - reported to Board Oct 25 and Board Development session Nov 25	Neutral	
Grow your Own Strategy (apprenticeships)	Reported to People Committee in bi-annual progress review for the new Joint People Plan. Apprentice framework being developed to improve retention - Update PCC July 25	Positive	
People Promise Retention Exemplar Programme	Progress to NHSE and Board - Closure Report May 25	Positive	
Retention Strategy	Staff Turnover metrics in Workforce Dashboard to PCC. Ten Point Resident Doctors Plan to PCC Jan 26, and May 26	Positive	
Risk Controls and Plans			
Joint People Plan delivery framework 25/26	Workforce dashboard to People and Culture Committee bi-monthly and in Integrated Corporate Dashboard to Board Bi-monthly. Safer Staffing Report to Board. Annual Workforce Safeguards Declaration (approved March 26). Workforce reduction tracking and reporting in place to PCC. Staff Survey to PCC and Board - latest March/April 26. Workforce Operational Plan to PCC Mar 26	Positive	Amber
Whole Time Equivalent Reduction Plan	WTE Reduction Plan to PCC Sept 25. Recruitment Control Panel in place with weekly reporting to exec team. Financial Recovery Board established with weekly reporting on WTE reduction with progress reporting to PCC bi-monthly. Control and QIA provide assurance that safe services not impacts. MARS scheme closed. Reported to PCC and Board. Did not achieve WTE reduction plan - driven by vacancy levels and sickness absence.	Neutral	
Learning Needs Analysis	Annual Education Quality Self-Assessment - PCC Nov 25 / Learning Needs Analysis & affordability	Positive	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee in Common (DCH & DHC)	Assurance Report to Board	Positive	Green
Directorate DMG - any areas escalation via governance routes	KPI's in Workforce Dashboard to PCC and ICD to Board bi-monthly	Positive	
Workforce Programme System Groups (Widening Participation and Apprenticeship) with recruitment considered at Provider Collaborative	System groups - awaiting development of new system cluster reporting arrangements and meeting	Neutral	
Safer Staffing Group	Staff Staffing Report to Board. Annual Review approved Dec 25, Developing Workforce Safeguards Report March 25 and March 26	Positive	
Vacancy Control Panel	Weekly Reporting to Executives and System	Positive	
Financial Recovery Board to maintain oversight of workforce reductions	FRB from July 25 with assurance reporting to FPC	Neutral	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Look for opportunity to work more closely in Provider Collaboratuve to address common workforce issues - Ongoing and to be considered in line with People Target Operating Model issued by NHSE	NP	May-26	On Plan

Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR4: Capacity and Demand** **If we do not meet current and expected demand and achieve local and national measures and targets within available resources we may face regulatory action and patients outcomes will be adversely affected**	Finance and Performance

Executive Lead

Chief Operating Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	4	=	16
Mitigated	4	x	3	=	12
Target	4	x	1	=	4

Rationale for Score

No change in score. Whilst performing well against some national standards, below thresholds in some areas - remained NOF 2 for Q3, slight deterioration in overall score. Where below thresholds clear understanding of underlying issues and improvement plans and/or recovery trajectories in place. Dedicated programme launched to address ALOS in mental health beds - trust ranked 47/47.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Access Wellbeing Programme Mobilisation (community mental health transformation)	Development milestones for the Wider Access Wellbeing initiative - included in Highlight reports to Committee from March 25. MH DMG performance report showing year end performance for access wellbeing. Internal Audit review of OOA bed process.	Positive	Green
Children, Young Person and Adolescent Mental Health (CYP MH) Transformation Programme	System programme approach and governance structure in place with clear outcomes and milestones - ICB approved buiness case with partial funding envelope agreed with remainder confirmed via medium term financial planning. Recovery plan agreed for 25/26 metric with ICB for CYP 1+ contacts	Positive	
Integrated Neighbourhood Teams (INT) Transformation Programme (aligned to UEC transformation)	System governance and reporting for INT's established. Ongoing programme board oversees progress with workstreams - those that are not funding dependent remain on track. Catalyst funding agreed - further work to mobilise. Programme governance reset Sept 25. (complete) to aid mobilisation. Future Care Update FPC March 26	Positive	
Risk Controls and Plans			
Access Wellbeing - performance monitoring on access times and due reviews in community teams / Performance monitored and demand/capacity issues responded and escalated as BAU whilst transformation programmes are implemented / Monitoring via daily sitrep of bed occupancy, OOA bed utilisation and NRTR	Monthly Performance Report to Directorate Management Group (DMG) / System OPEL levels for MH capacity escalation & resilience structure in place (ICB Tactical Resilience Group) to manage demand/surges. Out of area bed - 2 over target at end March 26 due to inc PICU demand - in response relaunched as Peri-health MH transformation programme (STP Committee March 26). Access wellbeing slighty below 25/26 trajectory (526 off plan but data validation ongoing) but no longer metric for 26/27 but will continue to maintain oversight.	Neutral	Amber
CYP MH Programme - Performance monitoring on access times and due reviews in community teams.	Monthly Performance Report to DMG / Performance monitoring System CYP Delivery Group / One Transformation Approach Portfolio reporting for Joint Transformation and Innovation Board (JTIB) in development however will capture risks/ issues for awareness and escalation - access wait time was under performing and a formal recovery plan put in place to recover by end march - as at year end overachieved target	Positive	
Productivity Plans for Community Services	Plans reported on and monitored via Directorate Management Group / ICB Performance and Contracts Review Meeting	Neutral	
Oversight Arrangements for Governance & Engagement			
Directorate Management Groups	Monthly Performance Reports, and Integrated Corporate Dashboard	Neutral	Green
Finance and Performance Committee	DHC Performance Report to F&P and assurance report to Board	Positive	
JTIB reporting to Strategy, Transformation and Partnerships Committee	Transformation Highlight Reports	Positive	
Access Wellbeing Steering Group (membership include DHC, ICB, VCSE, LA, DMHF)	Internal programme assurance with links to contract reporting, DMG, VCSE assembly	Positive	
MTP Weekly Governance Meeting to oversee plan from 1st to final submission	MTP Updates to FPC - now complete as plan submitted	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Review metrics and performance plans in response to NOF and segmentation - new reporting framework presented to Finance and Performance Committee Sept 25 - changes to reporting from Q1 26/27	RS	~~01/08/2025~~ June 26	Behind Schedule
Undertake part mobilisation in 25/26 to address access and waiting times challenges - to recover access standard by 31.3.26. Complete and achieved	RS	Mar-26	Complete
Peri-hospital mental health flow programme to launch from April 2026 - to review impact at end of Q1	RS	Jul-26	On Plan

Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues Sustainability	**SR5: Estates** **If we do not have an estate that is fit for purpose and economically and environmentally viable we will be unable to provide the right places for our staff to deliver high quality services to the communities that we serve**	Finance and Performance

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Finance Officer	Unmitigated	4	x	4	=	16
	Mitigated	3	x	3	=	9
	Target	3	x	3	=	9

Rationale for Score

No change in score - plans for shared services across DHC DCH being developed, work completed to identify gaps in compliance & mitigating plans evidenced. Six facets survey complete and backlog maintenance increased. Infrastructure straegy to STP Committee May 26. Joint Green Plan Annual Plan FPC May 26

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
New Hospital Programme	NHP Business Case, programme approved and build progressing	Positive	Amber
Joint Estates Strategy	Joint Infrastructure Strategy - to be presented to STP Committee May 26 and Board June 2026	Neutral	
Review of operating model estates and facilities	OBC approved by Board Apr 25 and FBC May 25. NHS guidance received that cannot progress without Union support. Now progressing options for joint working across DCH and DHC - Operating model reviewed and proposing federated structure that increases joing working to be implememnted in phases to deliver efficiences through joint working and building sustainable workforce model	Positive	
Capital Programme	Monitoring to Finance and Performance Committee - Five year plan submitted to Dorset ICB - prioritised for one project with remaining funding to be identified	Neutral	
Risk Controls and Plans			
Estates compliance functions	Compliance reports in estates Function and reported to compliance groups. Reporting in place on progress and provides positive assurance reported to November 25 and Jan 26 FPC. PAM complete reported to FPC Jan 26.	Positive	Amber
Backlog maintenance plan	On track and reported to Capital Investment Meeting - six facets complete Quarter 4 - funding for backlog not yet identified. Informed Infrastructure Strategy May 26 STP Committee	Neutral	
Green Plans	Net zero progress report STP March 26, Sustainability Working Group to STP Nocv 25 and Mar 26. Joint Green Annual Plan developed for approval FPC May 26	Neutral	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee for estates planning and compliance and Strategy Transformation and Partnerships Committee for transformation	Assurance reports to Board - reported Dec 24 onwards	Positive	Green
Capital Investment Meeting	QIA of capital schemes	Positive	
Estates related compliance groups in place (water, fire, health and safety)	Reporting into F&P routinely	Positive	
New Hospital Programme Board	Programme approved, NHP Programme Board report to STP Committee & NHSE	Positive	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Develop Joint Estates Strategy - Ageed date change to Nov 25 as the enabler for Estates Strategy is a Six Facet Survey to be completed across DCH and DHC - Now postponed to Jan 26 as awaiting six facets results for DHC and progressing options for joint working across DCH and DHC - Complete STP Committee May 26 and Board June 26 for approval	CH	~~Jul 25~~ ~~Nov 25~~ ~~Jan 26~~ Mar 26	Complete
Backlog maintenance - funding required to maintain safe site - funding to be identified and plan for 26/27 as part of Capital Plan and then ongoing - April 26 - prioritising highest risk - ongoing monitoring - leave ongoing action to maintain oversight with Dec 26 completion date	DM	~~Mar 26~~ Dec 26	On Plan
Joint Green Annual Plan developed	DM	May-26	Complete

Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Sustainability	**SR6: Finance** **If we do not deliver on our financial plans, including the required level of savings, then and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position**	Finance and Performance

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Finance Officer	Unmitigated	4	x	4	=	16
	Mitigated	4	x	3	=	12
	Target	4	x	3	=	12

Rationale for Score

Reduced likelihood score - achieved 25/26 year end position of £14.68m and met capital plan. Submitted MTP with £0.5m surplus annually. At at April 26 c80% identified.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	Outcome of assurance	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
25/26 operational plan to deliver a surplus position of £9.8m, within the Dorset system breakeven position (£38.2m efficiency target required to deliver the planned surplus - 40% agency reduction, 20% bank reduction, 10% reduction in corporate services costs. Nominal target of 411 WTE reduction to support delivery of efficiency target)	Finance and Operational Plan approved by Board April 2025 for 25/26. Board Assurance Template agreed Board April 25. Oversight via Efficiency Delivery Group and FPC and Financial Recovery Board established Oct 25. Outputs from independent review to FPC July 25 and recommendations to be implemented - Financial Delivery Director in post from Oct 25 - ext to July 26.	**Positive**	**Green**
H2 agreed trajectory plan with effect from month 7, to achieve FOT.	Financial Recovery Board and Financial Delivery Director operating / in post. Triple Lock governance - £25k limit - all trust exp to go through triple lock meet. Regular updates provided - NED briefings; Board and Committee reports and Board Development. Finance Report May 26 FPC Board June 26 confirmed year end position achieved in accordance with plan	**Positive**	
Medium Term Financial Plan - underlying position recovery and improve future sustainability	Medium Term Financial Plan. Draft organisational plan submitted on 17 Dec 25 showing a planned surplus of £500k. Medium Term Plan (MTP) and Board Assurance Statements for 3 year period from 26/27 approved Feb 26. Focus in 26/27 on temp staffing reductions planned	**Positive**	
Risk Controls and Plans			
Regular budget meetings, regular attendance at DMGs, budget manager training	Finance Reporting to Finance and Performance Committee and Trust Board; IA review of budgetary control provided positive assurance	**Positive**	**Amber**
System wide working and scrutiny	System groups - awaiting development of new system cluster reporting arrangements and meeting	**Neutral**	
Increased focus on delivery of efficiencies and establishment of stakeholder groups to support delivery of plans	Efficiency delivery group oversight, with reporting to Finance and Performance Committee. MTP- 3 year revenue plans and 4 year capital plans. Regular updates NED briefings; Board and Committee reports and Board Development. NHSE Closedown letter on MTP reported to FPC May 26 - 'Compliant with conditions' actions - update to be included in Q1 BAF	**Neutral**	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Assurance Reports to Board, Finance Report to Committee and Board	**Positive**	**Green**
Efficiency Delivery Group and Financial Recovery Board	Internal audit of process and recommendations implemented Efficiency Delivery Group reports to FPC and Financial Recovery Board established	**Positive**	
System wide working - Medium Term Plan Group, CEO Escalation meeting	System groups - awaiting development of new system cluster reporting arrangements and meeting	**Neutral**	
MTP Weekly Governance Meeting to oversee plan from 1st to final submission	MTP Updates to FPC - now complete at end of Q4	**Positive**	

Ellie Kaye 10/06/2026 16:10:45

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Substantive recruitment to financial delivery leadership post - Advertise May 26 aim to have in post Sept 26 (current post holder leave end July)	CH	Dec-26	On Plan
Address actions in NHS MTP Closedown letter by required deadlines	CH	Dec-26	On Plan
Establishment review to remove vacanct post and achive recurrent CIP	CH	Jun-26	On Plan
Continued focus on monitoring and timely reporting on financial position through to year end to ensure delivery - Complete, reporitng in place	CH	Apr-26	Complete

Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Communities Sustainability	**SR7: Collaboration** **If we do not have effective and positive partnerships within the ICS then we will not be able to shape decisions and deliver the transformation required.**	Strategy, Transformation & Partnerships

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Executive Officer	Unmitigated	4	x	3	=	12
	Mitigated	4	x	3	=	12
	Target	3	x	2	=	6

Rationale for Score

No change in score. Locally clinical services strategy review complete and action plans being developed with partners. DHC selected to apply for wave 1 Advanced Foundation Trust status (board approved 22 Dec 25) - ICB letter of support received - outcome due May 26. MOU being developed with Dorset GP Alliance. Governance review of ODPC planned Q1/2 26/27

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Forward Plan, supports NHS system focus on the same priorities. Ten year plan published	ICB-led Provider Relationship meetings to March 25 replaced with contract meeting and System Executive Group. Review of clinical strategy work complete and reported via Board Seminar March 26	**Positive**	**Amber**
Our Dorset Provider Collaborative	Our Dorset Provider Collaborative(PC) Board - Programme Director in post / ODPC minutes to Board / NED PC Oversight Group in place from Nov 24/ B2B2B March 25 and Sept 25/ Joint CDIO appointed April 25. Governance review of ODPC planned Q1/2 26/27	**Neutral**	
One Transformation Approach	One Transformation Approach - reporting to Joint Transformation and Improvement Board (JTIB) and STP Committee from Sept 24. 25/26 Transformation work plan to JTIB and STP CiC May 25 - there is not a single transformation approach across the system but the strategy review may achieve this	**Neutral**	
Electronic Health Record (EHR) Programme across Dorset and Somerset	EHR OBC and preferred supplier approved by Board, Final FBC to extra-ordinary board Jan 26, national approval Feb 26 and Board approved supplier and inter-trust agreement March 26	**Positive**	
Risk Controls and Plans			
Compliance with NHS Provider Licence and Code of Governance re duty to collaborate	Provider Licence and Code of Governance Compliance Report to Audit Committee annually reported to Audit Committee May 25 and May 26	**Positive**	**Green**
Alignment of Joint Strategy to 10 year health plan (and 3 shifts)	Joint Strategy aligned to Joint Forward Plan-from November 24 forms part of prioritisation process via JTIB, Initial assessment of alignment of Joint Strategy to 10 year plan showed strong alignment - STP July 25. Further analysis of alignment to 10 YP and 3 shifts to STP Jan 26.	**Positive**	
Portfolios of change - Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow	Reporting to JTIB and to STP Committee - JTIB refreshed and recommenced Nov 25. STP CiC Informal session Oct 25 reviewed priorities and agreed at STP Nov 25.	**Positive**	
Oversight Arrangements for Governance & Engagement			
ICB Membership	New cluster board arrangements established of which we are a part	**Neutral**	**Amber**
Strategy, Transformation and Partnership Committee - from Sept 2024	Assurance Reports to Board	**Positive**	
Portfolio Boards - Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow	Transformation Reports to STP	**Positive**	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Review of function and membership of STP with a question about strengthening the involvement of other partners - Complete TOR approved Mar 26	JH	Feb-26	Complete
ODPC oversight to be reviewed, with agreement with partners - oversight arrangements in place with reporting to Board and NED Oversight Group	JH	Feb-26	Complete
ODPC Governance Review Q1/2 2026/27	JH	Sep-26	On Plan
Memorandum of Understanding with Dorset GP Alliance to be estabilised - STP Committee agenda May 26	JH	Jul-26	On Plan

Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR8: Transformation and Improvement** **If we do not seek and respond to the views of our communities to co-produce and continuously improve and transform our services, we will not contribute to the reduction of health inequalities within our communities.**	Strategy, Transformation & Partnerships

Executive Lead: Chief Nursing Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	4	=	16
Mitigated	4	x	3	=	12
Target	3	x	2	=	6

Rationale for Score

Score unchanged, progress continues -to implement methodology and reporting mechanism to demonstrate progress on strategy delivery - Year end strategy delivery report to be presented May 26. New JTIB arrangements embedded and DCH/DHC. Transformation function in place. Programmes and governance in place - assurance on delivery to be more firmly established and embedded

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Strategy	Approved Strategy - Metrics approved at STP CiC Sept 25 - to implement methodology and reporting mechanism to demonstrate progress on strategy delivery - report on approach to STP Jan 26 and annual update to STP May 26 for 25/26 delivery (with 26/27 metrics to be agreed)	Neutral	Green
One Transformation Approach (Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow)	One Transformation Approach - Flagship Programme reporting to Joint Transformation and Improvement Board (JTIB) and STP Committee. 25/26 Transformation work plan to JTIB and STP CiC May 25 - JTIB refreshed and recommenced Nov 25. STP CiC Informal session Oct 25 reviewed priorities and agreed at STP Nov 25. Transformation programmes agreed - Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow	Positive	
New Hospital Programme	Programme approved, NHP Programme Board report to STP Committee & NHSE	Positive	
Electronic Health Record (EHR) Programme	EHR OBC and preferred supplier approved by Board, Final FBC to extra-ordinary board Jan 26, national approval Feb 26 and Board approved supplier and inter-trust agreement March 26	Positive	
Risk Controls and Plans			
Strategy Implementation Plan and enabling plans; Clinical & Quality, People, Digital, Finance (MTP) and Infrastructure	Approved plan in place - assurance to be via bi-annual delivery reports, strategy dashboard to STP Committee- approach Jan 26 STP and year end report May 26 STP. Enabling Plans approved April 25 and published Sept 25, Digital Strategy to STP CiC Nov 25 and Board Dec 25 , Finance Plan is Medium term Plan Board approved Feb 26, Infrastrcuture Plan scheduled May 26	Positive	Amber
Alignment of Joint Strategy to 10 year health plan (and 3 shifts)	Joint Strategy aligned to Joint Forward Plan-from November 24 forms part of prioritisation process via JTIB, Initial assessment of alignment of Joint Strategy to 10 year plan showed strong alignment - STP July 25. Further analysis of alignment to 10 YP and 3 shifts to STP Jan 26.	Neutral	
Joint Improvement Framework approach	Approved Joint Improvement Framework approach implemented. Continued momentum and celebration of improvement taking place alongside programme - Participated in NHS Impact operational improvement training. Improvement Plan to STP May 26	Neutral	
Implementation of Patient Care Race Equality Framework (PCREF)	Self-assessment against national organisational competencies - reporting to STP Committee March 25 and Board Oct 25 which identfiied progress made and actions required, followed by by Board Dev session Nov 25 on anti-racism and inclusion. PCREF Report to Board April 26	Positive	
Oversight Arrangements for Governance & Engagement			
Portfolio Boards -Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow	Transformation Reports	Positive	Green
Joint Transformation Improvement Board	One Transformation Highlight Reports - Reporting to JTIB and to STP Committee - JTIB refreshed and recommenced Nov 25.	Positive	
STP Committee from Sept 24	Assurance Reports to Board	Positive	

Ellis Watkins 10 Nov 2026 16:10:45

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Reporting arrangements to be established for reporting and oversight of Improvement Plan delivery	PL	Jul-26	On Plan
Agree and implement a methology and reporting framework to demonstrate strategy delivery - **Update:** Report on Strategy Delivery 25/26 to be presented to STP and to agree approach for 26/27 metrics and reporting	PL	May-26	On Plan

Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Communities Sustainability	**SR9: Digital Infrastructure** **If we do not advance our digital and technological capabilities, including achieving our EHR ambitions, we will not deliver the innovative and sustainable services and the delivery of safe services could be compromised.**	Strategy, Transformation & Partnerships

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Finance Officer (Chief Digital Information Officer)	Unmitigated	5	x	4	=	20
	Mitigated	4	x	4	=	16
	Target	3	x	2	=	6

Rationale for Score

No change in score. Strategy approved Dec 25. Roadmap will seek to mitigate risks with legacy infrastructure. Appointments made to senior team and new layer of management to be in place by 1 July 26. Planning workshop held re strategy implementation, fully implemented TOM by end 26/27. New EHR system procured and implementation plans, with required capacity, being developed.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint digital strategy for DCH/DHC	NHSE Digital Maturity Assessment (DMA), NHSE What Good Looks Like (WGLL)BDO Audit of digital maturity. Dorset Wide Digital Strategy (DCH/DHC/UHD) approved Committee Nov 25 STP Committee and Dec 25 Board	**Positive**	**Green**
EHR Programme (HealthSet)	EHR OBC and preferred supplier approved by Board, Final FBC to extra-ordinary board Jan 26, supplier selected and contract and inter-trust agreeement approved by Board Feb 26. Digital and HR update to STP March 26. As at end of April joint recruitment for Epic commenced	**Positive**	
Risk Controls and Plans			
Digital risks monitored and reported - non clinical risk register	Monthly to DHC SLG and Audit Committee - Non Clinical Risk Register. New Director of IT and Infrastrcure in post from Oct 25 and reviewed all digital risks. Technology Roadmap to STP Nov 25. Review and reporting of digital clinical risks to STP Jan 26 and May 26	**Neutral**	**Amber**
Data Security & Protection Toolkit	Submission is via Audit Committee, and audited by BDO, reviewed by SIRO. IA reports on DSPT 25/26 to Audit Committee May 26. SIRO Annual Report to Board May 25 and June 26	**Positive**	
Target Operating Model (TOM)	In development - Stage 1 was establishment of leadership team from Jan 26. Focus on Q4 is to fully develop Target Operating Model and commence strategy delivery. Update provided to STP Jan 26 and Mar 26	**Neutral**	
Oversight Arrangements for Governance & Engagement			
Joint Digital Services Leadership Group DCH & DHC	Governance and reporting reviewed and strengthened - reviewed across all 3 Dorset providers within the context of the development of a Dorset wide Target Operating Model	**Positive**	**Green**
Strategy, Transformation and Partnership Committee from September2024	TOR approved - Reporting to Board commenced October 2024	**Positive**	
EHR Programme Board and EHR Advisory Group	EHR Report into Board. TOR refreshed to reflect Implementation Phase	**Positive**	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Implementation of Federated Data Platform (NHSE Mandate) - Implemented, close	BB	Mar-26	Complete
Development of Infrastructure roadmap to support joint digital strategy - postponed to Dec 25 as new joint CDIO in post from April 25 and will form part of Dorset wide strategy and integrated approach across Dorset - on plan for previously agreed revised date- To follow Digital Strategy - revised to March 26. **Update** - Workshop April 26 and work to be completed be end June 26	RK	~~Mar 25~~ ~~Dec 25~~ ~~Mar 26~~ July 26	Behind Schedule
Full infrastrcuture audit of revenue and capital requirements moving forward - Complete - Considered at Capital Planning meeting	RK	Mar-26	Complete

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Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Sustainability	**SR10 Cyber security** **If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents**	Strategy, Transformation & Partnerships

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Finance Officer (Chief Digital Information Officer)	Unmitigated	4	x	4	=	16
	Mitigated	3	x	3	=	9
	Target	3	x	3	=	9

Rationale for Score

No change in score - continue to understand and mitigate threat landscape. Regular reporting to STP Committee and Board. Fully implemented TOM by end 26/27.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint DCH/DHC Digital Strategy (inc cybersecurity)	NHSE Digital Maturity Assessment & NHSE What Good Looks Like (WGLL) Dorset Wide Digital Strategy (DCH/DHC/UHD) presented to Committee Nov STP Committee and Dec Board	Positive	Green
Risk Controls and Plans			
Data Security & Protection Toolkit	Submission is via Audit Committee, and audited by BDO, reviewed by SIRO. IA reports on DSPT 25/26 to Audit Committee May 26	Positive	Amber
Monitoring of alerts, patching & maintenance, password controls, multifactor authentication	Cyber Reports to STP Committee and Board - March/April 26	Neutral	
Use of Microsoft Defender for Endpoints and other NHSE central services for cyber security	Cyber Reports to STP Committee and Board - March / April 26	Neutral	
Oversight Arrangements for Governance & Engagement			
Digital Services Leadership Group	Cyber exposure score reported monthly Digital Services Leadership Group -To be reviewed across all 3 Dorset providers within the context of the development of a Dorset wide Target Operating Model	Neutral	Amber
IG Group (covers cyber)reporting to STP Committee from September2024	Reports to STP Committee March 26	Positive	
Strategy Transformation and Partnerships Committee from Sept 24	Assurance Report to Board (from Sept 24) Cyber Report to Board Dec 24 and Dec 25 April 26	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
To implemented refreshed national cyber security training	RK	Sep-26	On Plan
Full audit to be undertaken of cyber security arrangemnents (inc governance and technology) to be undertaken - Cyber Reports to STP Committee and Board - March/April 26	RK	Mar-26	Complete

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ASSURANCE ASSESSMENT

GREEN	AMBER	RED
Well functioning controls in place to manage risks and deliver objective	Some key controls in place, but may not cover all risks or elements of objective	Clear gaps in controls for management of risks and delivery of objective
Assurance available for key controls	Some assurances available, but may not cover all controls	Limited or no assurance available
Assurance is overall **positive**	Assurance is overall **neutral**	Assurance is overall **negative**
	Clear actions to address gaps in controls and/or assurances	Plan not sufficient to address gaps in controls and/or assurances

RISK SCORING MATRIX

		LIKELIHOOD SCORE				
		1	2	3	4	5
CONSEQUENCE SCORE		**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic		5	10	15	20	25
4 Major		4	8	12	16	20
3 Moderate		3	6	9	12	15
2 Minor		2	4	6	8	10
1 Negligible		1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

0 - 3	Very low risk
4 - 6	Low risk
8 -12	Moderate risk
15 - 25	High risk

Risk Appetite Approved December 2025

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

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

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Dorset County Hospital
NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust
Board Assurance Framework
Quarter 4 April 2026

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Dorset County Hospital NHS Foundation Trust

Board Assurance Framework Overview - Quarter 4 April 2026	Strategic Objectives				Responsibility		Score									Alignment to Risk Appetite
Strategic Risks	Care	Communities	Colleagues	Sustainability	Committee	Executive	Unmitigated Score	Mitigated Q2 24-25 Score	Mitigated Q3 24-25 Score	Mitigated Q4 24-25 Score	Mitigated Q1 25-26 Score	Mitigated Q2 25-26 Score	Mitigated Q3 25-26 Score	Mitigated Q4 25-26 Score	Target Score	
SR1: Safety and Quality If we are not able to deliver the fundamental standards of care in all of our services we will not be providing consistently safe, effective and compassionate care	X				**Quality**	Chief Nursing Officer	16	12	12	12	12	12	16	16	12	**Patient Safety and Quality- Cautious**
SR2: Culture If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.	X		X		**People and Culture**	Chief People Officer	15	12	12	12	9	12	12	12	6	**Workforce - Seek**
SR3: Workforce Capacity If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources	X		X		**People and Culture**	Chief People Officer	15	15	15	15	15	15	15	15	9	**Workforce - Seek**
SR4: Capacity and Demand If we do not meet current and expected demand and achieve local and national measures and targets within available resources we may face regulatory action and patients outcomes will be adversely affected	X	X		X	**Finance and Performance**	Chief Operating Officer	16	9	9	9	9	9	9	9	6	**Operational Performance - Open**
SR5: Estates If we do not have an estate that is fit for purpose and economically and environmentally viable we will be unable to provide the right places for our staff to deliver high quality services to the communities that we serve	X		X	X	**Finance and Performance**	Chief Finance Officer	20	12	16	16	20	20	20	20	9	**Finance and Value for Money - Open**
SR6: Finance If we do not deliver on our financial plans, including the required level of savings, then and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position				X	**Finance and Performance**	Chief Finance Officer	20	16	20	20	20	20	20	16	12	**Finance and Value for Money - Open**
SR7: Collaboration If we do not have effective and positive partnerships within the ICS then we will not be able to shape decisions and deliver the transformation required.		X		X	**Strategy, Transformation & Partnerships**	Chief Executive Officer	12	9	6	9	9	12	12	12	6	**Innovation, Partnerships and Commercial – Seek**
SR8: Transformation and Improvement If we do not seek and respond to the views of our communities to co-produce and continuously improve and transform our services, we will not contribute to the reduction of health inequalities within our communities.	X	X		X	**Strategy, Transformation & Partnerships**	Chief Nursing Officer	16	12	12	12	12	12	12	12	6	**Innovation, Partnerships and Commercial – Seek**
SR9: Digital Infrastructure If we do not advance our digital and technological capabilities, including achieving our EHR ambitions, we will not deliver the innovative and sustainable services and the delivery of safe services could be compromised.		X		X	**Strategy, Transformation & Partnerships**	Chief Finance Officer (Chief Digital Officer)	20	12	16	16	16	16	16	16	6	**Digital - Seek**
SR10 Cyber security If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents	X			X	**Strategy, Transformation & Partnerships**	Chief Finance Officer (Chief Digital Officer)	15	12	12	12	12	12	12	12	9	**Digital - Seek**

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Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care	**SR1: Safety and Quality** **If we are not able to deliver the fundamental standards of care in all of our services we will not be providing consistently safe, effective and compassionate care**	Quality Committee

Executive Lead: Chief Nursing Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	4	=	16
Mitigated	4	x	4	=	16
Target	3	x	4	=	12

Rationale for Score: No change in score. Ongoing checks and balances in place to manage safe levels of staffing according to operational pressures, acuity and dependency -continued internal critical incident in the quarter and increased demand for temporary staffing. Ongoing review of red shifts and mitigations

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Quality Priorities 25/26 (each have a subject matter expert owner)	Board approved 25/26. 25/26 reporting on track for Quality Report (24/25 approved and published in year) Regular reporting Quality Committee for oversight	Positive	Green
PSIRF Response Plan	Board approved PSIRF Response Plan, updates to Quality Committee (QC) - approved April 25. Board Development session July 25. PSII areas for 25/26 agreed	Positive	
Maternity Incentive Scheme (MIS)	Maternity Report, Quality Committee and Board bi-monthly , LMNS oversight and reporting, MIS End Point Review Outcome - Compliance; Internal Audit Report provided positive assurnace and in Internal Audit Plan 26/27. MIS to Board Feb 26	Positive	
Risk Controls and Plans			
Quality Priority Improvement Plan (inc agreed standards and measurement)	Quarterly Quality Priorities Report to QC (progress against KPIs)	Positive	Amber
Patient Experience Metrics and Improvement Plans	Patient Experience monthly, quarterly and Annual Complaints Report (inc local surveys and metrics), Friends and Family Test National Surveys, Patient Story to Board, 15 Steps Challenge; Complaints Policy in line with PHSO standards. Maternity CQC Inspection Report 2025 'Good'.	Positive	
PSIRF implemented to improve patient safety and Patient Safety Incident Response Plan	PSIRF Huddles, Patient Safety Committee oversight of Patient Incident response Plan and Quality priorities. Process of oversight of CQC self-assessents to CQC Compliance Group commenced (with reporting through to Quality Committee via QGC)	Positive	
Quality Committee Framework and Contractual obligations 25-26 and 26-27 and National Quality Board (NQB) quality priorites	KPI monitoring and Quality Dashboard and Quality Reports. EQIA SOP approved and in line with national template with bi-monthly reporting to Quality Committee (June July Sept 25 and bi-monthly thereafter). For 26/27 further work on reporting capability and refining of quality report to ensure compliance with contractual reporting obligations and national requiremements (MTP and NQB)	Neutral	
Health Inequalities Plan	Joint Health Inequalities Steering Group scoped and to commence, with a Joint Health Inequalities Improvement Plan developed and reported to QC Nov 25, Jan 26 and Board April 26 and Health Inequalities Steering Group in place (reporting to QC)	Positive	
Operational oversight of quality impact as a result of operational demands	Seasonal Surge Plan approved by Board. Operational policies and procedures including escalation plans. Emergency Planning and Business Continuity arrangements - assurance to Board Dec 25.New Models of Care Patient Flow Programme commenced	Neutral	
Somerset maternity collaboration	Continued joint working with Somerset FT on delivery of maternity services (since May 25) with transition plan to be developed jointly - Report on YDH services to QC Mar 26 - moving 31/04/26	Positive	
Oversight Arrangements for Governance & Engagement			
Quality Committee	Assurance Reports to Board, Quality Assurance Group in place. Quality Committee in Common from Q1 25/26. Six month review of progress at informal Quality CiC Oct 25	Positive	Green
Patient Safety Committee	Patient Safety Incidents Report and Assurance Reporting to Quality Committee	Positive	
Quality Governance Framework reporting into Quality Committee	Quality Governance Framework to Quality Committee Sept 25. Cadence of escalation and assurance report to Quality Governance Group and through to Quality Committee	Positive	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Review metrics and reporting - for 26/27 further work on reporting capability and refining of quality report to ensure compliance with contractual reporting obligations and national requiremements (MTP) - Previous action re NQB expanded and later date proposed - reviewed all metrics and reporting and now waiting for BI for implementation - June 26 (end of Q1)	Jhow	~~Dec 25~~ ~~Mar 26~~ July 26	Behind Schedule
Somerset maternity collaboration - to review governance and reporting as part of transition plan - Complete - Report on YDH services to QC Mar 26 - moving 31/04/26	Jhow	Mar-26	Complete

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR2: Culture** **If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.**	People and Culture

Executive Lead: Chief People Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	5	x	3	=	15
Mitigated	3	x	4	=	12
Target	3	x	2	=	6

Rationale for Score

No change in score. Much work done inc Joint Inclusion and Belonging Group, anti-racism framework, managers guidance on unacceptable behaviours and the Inspire awards - continue to launch and embed and measure impact. Increased demand for services impacts on workload coupled with a high degree of uncertainty due to local and national changes. Staff Survey scores remained above average in all areas of people promise and in morale and eng. Culture strong but tested by operational pressures and need to see impact of longer term cultural programmes for example anti-racism framework

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	*Assessment (See assessment guidance)*
Priority Programmes and Strategies			
Joint Inclusion & Belonging Strategy	Board approved Joint Inclusion and Belonging Strategy and Plan. Cultural maturity assessment - internal audit - provided positive assurance. Joint Inclusion and Belonging Group met from September 25 and reports to PCC quarterly	Positive	Green
Leadership and Management Development Programme	Staff survey reported to PCC March 26 and Board April 26. FTSU bi-annual Report to PCC May 25 Nov 25 and annual report for 25/26 May 26. Leadership Forum with refresh planned for 26/27	Positive	
EDS in place	EDS 2 Self Assessment Annually - to PCC and STP CiC Jan 26	Positive	
Programme of staff engagement activity	Staff Survey / Pulse Survey - Report to SLG and PC CiC in March 2025 - inspire awards, leadership forum, staff networks (informal PCC focus April 26), wellbeing initiatives, coaching - to be included in Staff Voice Report - PCC May 26	Neutral	
Joint Workforce Wellbeing Plan	Plan approved Dec 24, Delivery Action Plan to report to PCC Nov 25	Positive	
Enabling People Plan DCH/DHC in place and delivery mechanisms	Joint Strategy and Enabling Plans PCC April 26, Workforce KPI Dashboard to PCC and Board bi-monthly, People Plan Delivery Framework apoproved PCC July 25, Progress against Joint People Plan to PCC July 25 and People Plan Delivery Update PCC March 26	Positive	
Risk Controls and Plans			
Policies and training - Freedom to Speak Up; Respect and Resolution; Conscious Inclusion	Freedom to Speak Up bi-annual and Annual Reports to Board and Committee (PCC) (May and Nov 25 and May 26) Respect and resolution and conscious inclusion training launched. Joint FTSU policy ratified at TUPF. Self-assessment tool actions significantly complete. Sexual Safety Action Plan in place	Positive	Amber
Staff Survey Action Plan and Staff Voice Reporting	Staff survey reported to PCC March 26 and Board April 26. To strengthen staff voice reporting via review and refresh approach to review and analysis of Pulse and Staff Surveys - to report to SLG and JEMT and to summarise in reporting to PCC to be introduced for 26/27 reporting	Neutral	
Joint Inclusion and Belonging Action Plan	Reprioritisation of priorities and timeframes reported to PCC; Concious inclusion and respect and resolution training launched. Review of Joint Inc and Belonging Group to be undertaken	Neutral	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee in Common (DCH & DHC)	Assurance Report to Board	Positive	Green
Equality and Inclusion Group Health and Wellbeing Steering Group	Assurance Reports to People and Culture Committee. Joint Inclusion and Belonging Group in place from Sept 25 with reporting to PCC from Nov 25	Positive	
Staff Networks, Executives now aligned to networks	Annual EDI Report and Minutes reported to PCC from Sept 24; execs assigned	Positive	
Joint Culture and Belonging Group	Commenced Oct 25 with reporting to PCC	Positive	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Staff engagement capacity and plan to be considered as part of People Team Collaboration (DCH/DHC) - in progress - moved to March 26 when process expected to be complete - Complete leadership formalised in new structure - joint working in place with support across federation	NP	~~Sept 25~~ Mar 26	Complete
Launch of Managers Guidance on Unacceptable Behaviour - review impact in line with EDI review and reporting cycle	NP	Jul-26	On Plan
Review and refresh approach to review and analysis of Pulse and Staff Surveys - to report to SLG and JEMT and to summarise in reporting to PCC to be introduced for 26/27 reporting - Complete Staff Voice Report on PCC Agenda May 26	NP	Mar-26	Complete
Review and update Workforce Delivery Framework 26/27 - Complete and reported to PCC March 26	NP	Mar-26	Complete
Review of EDI and Health Inequalities governance across DCH and DHC	JH	Jul-26	On Plan
Review of format and function of Joint Inclusion and Belonging Group	EH	Jul-26	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR3: Workforce Capacity** **If we are not able to recruit and retain the required number of staff with the right skills we will not be able to deliver high quality and safe sustainable services within our resources**	People and Culture

Executive Lead	Risk Score	Consequence		Likelihood		Score
Chief People Officer	Unmitigated	5	x	3	=	15
	Mitigated	5	x	3	=	15
	Target	3	x	3	=	9

Rationale for Score

Score unchanged. WTE reductions- did not achieve WTE reductions but did not impact year end financial position. Continued focus on reduction of temp staffing - ward headroom reduction programme establised for 26/27 (phase 1 and 2) and phase 2 + 4 27/28.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	*Assessment (See assessment guidance)*
Priority Programmes and Strategies			
Joint People Plan	High level agreement at PC CiC for four strategic objectives, final plan to PCC May 25. Progress against Joint People Plan to informal PCC Mar 26 and People Plan Delivery Update to PCC March 26	Positive	Amber
Workforce Planning aproach and workforce reduction plan	Workforce Metrics in Balanced Scorecard - assurance reporting workforce reductions with tracker in place and fortnightly reporting to FRB - highlighting deviation from WTE reduction plan (with FRB reporting to FPC bi-monthly)	Negative	
Apprenticeship & Widening Participation Programme	Regular report from Education Team to People and Culture Committee (Oct 25 PCC)	Positive	
People Promise Retention Exemplar Programme	Progress to NHSE and Board - closure report to PCC May 25	Positive	
Ten Point Resident Doctors Plan	Ten Point Resident Doctors Plan to PCC Jan 26 and May 26	Positive	
Risk Controls and Plans			
Annual Workforce Plan and Priorities - New Joint People Plan developed together with a new joint delivery framework 25/26	Workforce dashboard to People and Culture Committee bi-monthly and in Integrated Corporate Dashboard to Board Bi-monthly. Safer Staffing Report to Board. Annual Workforce Safeguards Declaration (approved March 26). Workforce reduction tracking and reporting in place to PCC. Staff Survey to PCC and Board - latest March/April 26. Workforce Operational Plan to PCC Mar 26	Positive	Amber
Learning Needs Analysis	Annual Education Quality Self-Assessment / Learning Needs Analysis. Amended our stat/mand training requirements to meet national framework for 25/26	Positive	
Whole Time Equivalent Reduction Plan	Recruitment Control Panel in place with weekly reporting to exec team. Financial Recovery Board established with fortnighly reporting on WTE reduction with progress reporting to PCC bi-monthly. Control and QIA provide assurance that safe services not impacted. MARS scheme completed. DCH WTE continues to be away from plan - predom due to temp staff usage in response to increased demand at the hospital - reported to PCC - plan in place to increase headroom and reliance on temp staff approved as part of safer staffing report Dec 25	Negative	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee	Assurance Report to Board	Positive	Green
Workforce considered at Our Dorset Povider Collaborative	Minutes reported to Board	Positive	
Safer Staffing Review	Staff Staffing Report to Board, Annual Review approved Dec 25. Developing Workforce Safegards Report March 25 and March 26	Positive	
Recruitment Control Panel	Weekly Reporting to Executives (system reporting ceased Jan 25)	Positive	
Financial Recovery Board to maintain oversight of workforce reductions	FRB from July 25 with assurance reporting to FPC	Neutral	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Look for opportunity to work more closely in Provider Collaboratuve to address common workforce issues - Ongoing and to be considered in line with People Target Operating Model issued by NHSE	NP	May-26	On Plan
Headroom programme 26/27 and 27/28. Agreement for phase 1 and 2 - to confirm governance arrangements for oversight of progress	NP/DD	May-26	On Plan

Public Trust Board 16-10-25

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR4: Capacity and Demand** **If we do not meet current and expected demand and achieve local and national measures and targets within available resources we may face regulatory action and patients outcomes will be adversely affected**	Finance and Performance

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Operating Officer	Unmitigated	4	x	4	=	16
	Mitigated	3	x	3	=	9
	Target	3	x	2	=	6

Rationale for Score

No change in score. NOF 3 - driven by financial override and not operational performance. Did not have capacity to manage emergency and elective care. Future Care moving to BAU from June 26

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Patient Flow Program (Internal to DCH with partners)	Regular updates against key plans and outcomes via F&P reporting	Positive	Green
UEC Review (Newton - Future Care) with System partners	Board Development Session Nov 24 and Approved Partnership Agreement Dec 24; Board Development session May 25 and report to board Aug 25. Future Care Update FPC March 26. Future Care moving to BAU from June 26. More focus needed on KPI's and tracking to ensure delivering expoected outcomes	Positive	
Operational Plan 25/26 (in accordance with national planning guidance and inc Elective Recovery Fund - ERF)	Reported to F&P and Board (including risks to achievement of plan). Underpinning governance shared with FPCIC and agreed	Positive	
Single Services Reviews	Single services gateway process with UHD- ODPC approved gateway process and to Committee March 26. South Coast Pathology Network - FPC Jan 26 (Full Business Case) - Agreed by Board and progressing to next gateway	Neutral	
Risk Controls and Plans			
Elective Recovery activities and mornitoring against Performance Assessment Framework **change to NOF**	Work underpinning is within Divisional Performance and F&P reports / regional oversight of recovery. FPC Nov 25 - updates on Q2 performance productivity measures. FPC received update on protected characteristics and staus with access measures. Paediatric DNA level - action to address. MTP - 1st submission Dec 25 - weekly governance meeting to oversee from 1st to final submisison - approved Feb 26 and NHSE Closedown letter on MTP reported to FPC May 26 - 'Compliant with conditions' actions - update to be included in Q1 BAF. Integrated Performance Report aligned to NOF. For the 2025/26 operating plan, return to a focus on the 62-day RTTstandard, with Trusts required to achieve 75% by March 2026. DCH achieved 76.49% in February 2026 and 74.70% in March. Progress in reducing the number of patients waiting over 52 weeks, from 448 to 245.	Neutral	Green
UEC Improvement Plan	Work underpinning is within Divisional Performance and F&P reports - and underpinned by Divsional Improvement Plans and Patient Flow Program achieving key targets for ambulance handovers and 4 hous ED performance. Combined Type 1 and Type 3 performance (Emergency Department and Urgent Care Centre) did achieve national ask of 78%, 9 out of 12 months. Performance all year tracked above the national performance	Positive	
Performance Management Framework (and resulting deep dive reviews) **NOF**	Performance Report to F&P and Board and Deep Dives / Internal Audit Reports. FPC Nov 25 - deep dive report on theatre productivity	Positive	
Seasonal surge plan	Surge plan reported to F&P with monitoring via Performance Report, Sesaonal Surge Plan Plan approved	Positive	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Performance Report to F&P and Assurance Report to Board	Positive	Green
System Planned Care Delivery Group /Elective Performance Management Group (EPMG) /Productivity weekly meetings / weekly regional meetings for oversight of the operational plan performance delivery	Performance Report to F&P and Board	Positive	
UEC System meetings - weekly/monthly/Qtrly and Seasonal Surge Planning	Surge plan reported to F&P with monitoring via Performance Report	Positive	
Divisional Performance Meetings	Performance Report to F&P and Board and Deep Dives	Positive	
UEC (Newton) Governance framework agreed and in place	Performance Report to F&P and Board and Deep Dives	Positive	
MTP Weekly Governance Meeting to oversee plan from 1st to final submission	MTP Updates to FPC	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Three speciality business case to board in Q3 26/27	AT	Dec-26	On Plan
Future Care - More focus needed on KPI's and tracking to ensure delivering expoected outcomes	AT	Sep-26	Complete

Public Board of Directors

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues Sustainability	**SR5: Estates** **If we do not have an estate that is fit for purpose and economically and environmentally viable we will be unable to provide the right places for our staff to deliver high quality services to the communities that we serve**	Finance and Performance

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Finance Officer	Unmitigated	4	x	5	=	20
	Mitigated	4	x	5	=	20
	Target	3	x	3	=	9

Rationale for Score

Score unchanged - plans for shared services across DHC DCH being developed. Six facets survey identified increased level of unfunded backlog maintenance - two major project funding approved. Funding for remaining projects to be identified. Infrastructure straegy to STP Committee May 26.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
New Hospital Programme	NHP Business Case, programme approved and build progressing	Positive	Amber
Joint Estates Strategy to be developed - not yet in place	Six facets survey complete and will inform strategy - six facets survey to FPC July 25 and Board Aug 25. Joint Infrastructure Strategy - to be presented to STP Committee May 26 and Board June 2026	Neutral	
Review of the operating model for estates and facilities	OBC approved by Board Apr 25 and FBC May 25 Programme Board in place. NHS guidance received that cannot progress without Union support. Currently reviewing options. Progressing options for joint working across DCH and DHC - Operating model reviewed and proposing federated structure that increases joing working to be implememnted in phases to deliver efficiences through joint working and building sustainable workforce model	Positive	
Capital Programme	Monitoring to Finance and Performance Committee - Internal capital programme with prioritised schemes ranked across digital, estates and medical devices overseen by CAPSUG - Six facets survey identified gap in finance related to critical infrastructure and backlog. We have submitted bids for funding for six facet priorities and favourable responses for high risk schemes.	Neutral	
Risk Controls and Plans			
Estates compliance functions	Compliance reports in estates function and reported to compliance groups - working to identify gaps and mitigations. Reporting in place on progress and commissioning external PAM assessment - Report to F&P May 25 - Compliance and reporting in place - As at Oct 25 90% compliant. PAM complete and provides positive assurance reported to November FPC.	Positive	Amber
Fire safety compliance	Further assurance required on fire safety - review completed to assess gaps and issues and plans in place and ongoing - to F&P May 25 - Monthly meets with fire safety team from fire brigade and content with tracking on imp plan. Good progress made - new Fire Safety Manager in post and local area Fire Service provdiing positive feedback on progress with update provided to November FPC. Assurance neutral until backlog addressed.	Neutral	
Backlog maintenance plan	Rported to Capital Investment Meeting - increased funding due to successful bid. Six facets survey identified increased level of unfunded backlog maintenance - need new 5 year plan and funding to be identifed - Submitted bids for funding for six facet priorities - two major project funding approved. Funding for remaining projects to be identified - Informed Infrastructure Strategy May 26 STP Committee	Neutral	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee for estates planning and compliance and Strategy Transformation and Partnerships Committee for transformation	Assurance Reports to Board	Positive	Green
Capital Investment Meeting	QIA of capital schemes now in place	Positive	
Estates related compliance groups in place (water, fire, health and safety)	Compliance reports on estates and health and safety from Nov 24 to F&P	Positive	
New Hospital Programme Board	Programme approved, NHP Programme Board report to STP & NHSE	Positive	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Develop Joint Estates Strategy - Ageed date change to Nov 25 as the enabler for Estates Strategy is a Six Facet Survey to be completed across DCH and DHC - Now postponed to Jan 26 as awaiting six facets results for DHC and progressing options for joint working across DCH and DHC - Complete STP Committee May 26 and Board June 26 for approval	CH	~~Jul 25~~ Nov 25 ~~Jan 26~~ Mar 26	Complete
Backlog maintenance - funding required to maintain safe site - funding to be identified and plan for 26/27 as part of Capital Plan and then ongoing - April 26 - prioritising highest risk - ongoing monitoring - leave ongoing action to maintain oversight with Dec 26 completion date	DM	Ongoing	On Plan
Joint Green Annual Plan developed	DM	May-26	Complete

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Sustainability	**SR6: Finance** **If we do not deliver on our financial plans, including the required level of savings, then and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position**	Finance and Performance

Executive Lead: Chief Finance Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	5	=	20
Mitigated	4	x	4	=	16
Target	4	x	3	=	12

Rationale for Score

Reduced consequence score. 25/26 Bridged unidentified gap modelled through H2 trajectory, NHSE confirmed income related to cessation of shared services and industrial action for H2. Delivered year end position - all risks mitigated for Q4. £9.8m deficit.. Submitted break even plan as part of Medium Term Plan (MTP). For 26/27 Deficit Support Funding received and regional risk reserve.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Operational Plan 2025/26 deficit plan of £9.8m for DCH within overall Dorset system plan requirement.	Oversight via Finance Reporting to Finance & Performance Committee and Senior Leadership Group and Trust Board, plus bi-weekly Financial Recovery Board established to support Trust delivery. Outputs from independent review to FPC July 25 and recommendations to be implemented - Financial Delivery Director in post from Oct 25. Delivered year end position - Report to FPC and Board and Annual Accounts (subject to Audit)	Positive	Amber
H2 agreed trajectory plan with effect from month 7 - 2025/26 8.6% CIP target of £29m required in full to meet £9.8m deficit plan. As part of £29m CIP £4.5 million classed as undentified with further £1.5m system high risk schemes. Following mid year (H2) rveiew revised trajectory developed to bridge gap of £6m and deliver to plan.	Financial Recovery Board and Financial Delivery Director operating / in post. Triple Lock governance - £25k limit - all trust exp to go thorugh triple lock meet. Within efficiency programme assumption to deliver £11.6m through shared services (sub co) - plans include income accrual based on NHSE support related to cessation of shared services which has been confirmed. Regular updates provided - NED briefings; Board and Committee reports and Board Development	Positive	
Medium Term Financial Plan - underlying position recovery and improve future sustainability inc cash focus	Draft organisation submission Dec 25 and final submission Feb 26 (Board approved). 3 year revenue plans and 4 year capital plans. Developed plans in accordance with timetables. Regular updates provided - NED briefings; Board and Committee reports and Board Development, Financial Recovery Board bi-weekly and weekly working groups to support timely completion of plans to timetable and reporting to Board. Submitted break even plan as part of Medium Term Plan (MTP). For 26/27 Deficit Support Funding received and regional risk reserve. Risk associated with CIP Plan	Neutral	
Mitigating risk of cash shortfall - without delivery of efficiency programme and effective cost contrrols and treatment of shared service non-delivery the Trust is at risk of cash shortfall in current and next financial year	Daily cash monitoring; KPI review and action; efficiency delivery and cost controls and ongoing discussions with NHSE regarding treatment of deliverabilty - plans include income accrual based on NHSE support related to cessation of shared services which has been confirmed.A t £30m April 26 but need to maintain focus with daily cash monitoring	Positive	
Risk Controls and Plans			
Operational workbook completion supported by Transformation & Finance with EQIA process updates - Trust CIP Tracker master for recording, CFO led support review meetings with all areas. Value Delivery Board expanded to include producity opportunities	Value Delivery Board Executive SRO oversight and reporting to Finance & Performance Committee, bi-weekly Financial Recovery Board re-established with reporting to FPC.	Neutral	Amber
Regular budget meetings, enhanced budget manager training, recovery plans required for all overspending areas, linked to Productivity saving opportunities	Finance Reporting to Divisional Performance Meetings, Finance and Performance Committee & Trust Board	Positive	
System wide working & development	System groups - triple lock meeting and Medium term Plan Meeting (ICB chair + providers + NHSE - weekly), Segmentation driven by financial deficit. In place for Q4 - changing for 26/27	Neutral	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Escalation Reports to Board, Finance Report to Committee and Board	Positive	Green
Financial Recovery Board established to prevent deterioration in financial position and workforce controls and support delivery of plans	bi-weekly Financial Recovery Board to be re-established and Financial Delivery Director in post	Positive	
Value Delivery Board (VDB) - CFO Chair & Executive SROs in place per identified themed area, EQIA process enhanced	Internal audit report HFMA checklist assessment and CIP process audit conducted, EQIA panel being constructed overseen by CNO with reporting to Quality Committee; new grip and control template reviewed and submitted to NHSE. IA review of EQIA - moderate assurance	Positive	
System wide working - Medium Term Financial Plan Group CEO Escalation meeting	System groups - awaiting development of new system cluster reporting	Neutral	
MTP Weekly Governance Meeting to oversee plan from 1st to final submission	MTP Updates to FPC - now complete at end of Q4	Positive	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Substantive recruitment to financial delivery leadership post - Advertise May 26 aim to have in post Sept 26 (current post holder leave end July)	CH	Dec-26	On Plan
Address actions in NHS MTP Closedown letter by required deadlines	CH	Dec-26	On Plan
Focus on reducing temporary staffing spend - work focussing on bank and agency spend in progress - Op pressures in Q4 significant and inc in bank and agency increased. Needs more work - in progress and ongoing	NP	01/09/2025 July 26	Behind Schedule

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Communities Sustainability	**SR7: Collaboration** **If we do not have effective and positive partnerships within the ICS then we will not be able to shape decisions and deliver the transformation required.**	Strategy, Transformation & Partnerships

Executive Lead

Chief Executive Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	3	=	12
Mitigated	4	x	3	=	12
Target	3	x	2	=	6

Rationale for Score

No change in score. Locally clinical services strategy review complete and action plans being developed with partners. Governance review of ODPC planned Q1/2 26/27

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Forward Plan, supports NHS system focus on the same priorities. Ten year plan published	ICB-led Provider Relationship meetings to March 25 replaced with contract meeting and System Executive Group. Review of clinical strategy work complete and reported via Board Seminar March 26	**Positive**	**Amber**
Our Dorset Provider Collaborative	Our Dorset Provider Collaborative(PC) Board - Programme Director in post / ODPC minutes to Board / NED PC Oversight Group in place from Nov 24/ B2B2B March 25 and Sept 25/ Joint CDIO appointed April 25. Governance review of ODPC planned Q1/2 26/27	**Neutral**	
One Transformation Approach	One Transformation Approach - reporting to Joint Transformation and Improvement Board (JTIB) and STP Committee from Sept 24. 25/26 Transformation work plan to JTIB and STP CiC May 25 - there is not a single transformation approach across the system but the strategy review may achieve this	**Neutral**	
Electronic Health Record (EHR) Programme across Dorset and Somerset	EHR OBC and preferred supplier approved by Board, Final FBC to extra-ordinary board Jan 26, national approval Feb 26 and Board approved supplier and inter-trust agreement March 26	**Positive**	
Risk Controls and Plans			
Compliance with NHS Provider Licence and Code of Governance re duty to collaborate	Provider Licence and Code of Governance Compliance Report to Audit Committee annually reported to Audit Committee May 25 and May 26	**Positive**	**Green**
Alignment of Joint Strategy to 10 year health plan (and 3 shifts)	Joint Strategy aligned to Joint Forward Plan-from November 24 forms part of prioritisation process via JTIB, Initial assessment of alignment of Joint Strategy to 10 year plan showed strong alignment - STP July 25. Further analysis of alignment to 10 YP and 3 shifts to STP Jan 26.	**Positive**	
Portfolios of change - Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow	Reporting to JTIB and to STP Committee - JTIB refreshed and recommenced Nov 25. STP CiC Informal session Oct 25 reviewed priorities and agreed at STP Nov 25.	**Positive**	
Oversight Arrangements for Governance & Engagement			
ICB Membership	New cluster board arrangements established of which we are a part	**Positive**	**Green**
Strategy, Transformation and Partnership Committee - from Sept 2024	Assurance Reports to Board	**Positive**	
Portfolio Boards - Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow	Transformation Reports to STP	**Positive**	

Ellie Kerr (Dorset Council) 17/11/25 11:45

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Review of function and membership of STP with a question about strengthening the involvement of other partners - Complete TOR approved Mar 26	JH	Feb-26	Complete

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR8: Transformation and Improvement** **If we do not seek and respond to the views of our communities to co-produce and continuously improve and transform our services, we will not contribute to the reduction of health inequalities within our communities.**	Strategy, Transformation & Partnerships

Executive Lead: Chief Nursing Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	4	=	16
Mitigated	4	x	3	=	12
Target	3	x	2	=	6

Rationale for Score

Score unchanged, progress continues -to implement methodology and reporting mechanism to demonstrate progress on strategy delivery - Year end strategy delivery report to be presented May 26. New JTIB arrangements embedded and DCH/DHC. Transformation function in place. Programmes and governance in place - assurance on delivery to be more firmly established and embedded

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Strategy	Approved Strategy - Metrics approved at STP CiC Sept 25 - to implement methodology and reporting mechanism to demonstrate progress on strategy delivery - report on approach to STP Jan 26 and annual update to STP May 26 for 25/26 delivery (with 26/27 metrics to be agreed)	Neutral	Green
One Transformation Approach (Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow)	One Transformation Approach - Flagship Programme reporting to Joint Transformation and Improvement Board (JTIB) and STP Committee. 25/26 Transformation work plan to JTIB and STP CiC May 25 - JTIB refreshed and recommenced Nov 25. STP CiC Informal session Oct 25 reviewed priorities and agreed at STP Nov 25. Transformation programmes agreed - Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow	Positive	
New Hospital Programme	Programme approved, NHP Programme Board report to STP Committee & NHSE	Positive	
Electronic Health Record (EHR) Programme	EHR OBC and preferred supplier approved by Board, Final FBC to extra-ordinary board Jan 26, national approval Feb 26 and Board approved supplier and inter-trust agreement March 26	Positive	
Risk Controls and Plans			
Strategy Implementation Plan and enabling plans; Clinical & Quality, People, Digital, Finance (MTP) and Infrastructure	Approved plan in place - assurance to be via bi-annual delivery reports, strategy dashboard to STP Committee- approach Jan 26 STP and year end report May 26 STP. Enabling Plans approved April 25 and published Sept 25, Digital Strategy to STP CiC Nov 25 and Board Dec 25 , Finance Plan is Medium term Plan Board approved Feb 26, Infrastrcuture Plan scheduled May 26	Positive	Amber
Alignment of Joint Strategy to 10 year health plan (and 3 shifts)	Joint Strategy aligned to Joint Forward Plan-from November 24 forms part of prioritisation process via JTIB, Initial assessment of alignment of Joint Strategy to 10 year plan showed strong alignment - STP July 25. Further analysis of alignment to 10 YP and 3 shifts to STP Jan 26.	Neutral	
Joint Improvement Framework approach	Approved Joint Improvement Framework approach implemented. Continued momentum and celebration of improvement taking place alongside programme - Participated in NHS Impact operational improvement training. Improvement Plan to STP May 26	Neutral	
Implementation of Patient Care Race Equality Framework (PCREF)	Self-assessment against national organisational competencies - reporting to STP Committee March 25 and Board Oct 25 which identfiied progress made and actions required, followed by by Board Dev session Nov 25 on anti-racism and inclusion. PCREF Report to Board April 26	Positive	
Oversight Arrangements for Governance & Engagement			
Portfolio Boards - Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow	Transformation Reports	Positive	Green
Joint Transformation Improvement Board	One Transformation Highlight Reports - Reporting to JTIB and to STP Committee - JTIB refreshed and recommenced Nov 25.	Positive	
STP Committee from Sept 24	Assurance Reports to Board	Positive	

Ellie Hall (E) 26/02/2026 16:10:43

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Reporting arrangements to be established for reporting and oversight of Improvement Plan delivery	PL	Jul-26	On Plan
Agree and implement a methology and reporting framework to demonstrate strategy delivery - **Update:** Report on Strategy Delivery 25/26 to be presented to STP and to agree approach for 26/27 metrics and reporting	PL	May-26	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Communities Sustainability	**SR9: Digital Infrastructure** **If we do not advance our digital and technological capabilities, including achieving our EHR ambitions, we will not deliver the innovative and sustainable services and the delivery of safe services could be compromised.**	Strategy, Transformation & Partnerships

Executive Lead

Chief Finance Officer (Chief Digital Information Officer)

Risk Score	Consequence		Likelihood		Score
Unmitigated	5	x	4	=	20
Mitigated	4	x	4	=	16
Target	3	x	2	=	6

Rationale for Score

No change in score. Strategy approved Dec 25. Roadmap will seek to mitigate risks with legacy infrastructure. Appointments made to senior team and new layer of management to be in place by 1 July 26. Planning workshop held re strategy implementation, fully implemented TOM by end 26/27. New EHR system procured and implementation plans, with required capacity, being developed.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint digital strategy DCH/DHC	NHSE Digital Maturity Assessment (DMA), NHSE What Good Looks Like (WGLL) Dorset Wide Digital Strategy (DCH/DHC/UHD)approved Committee Nov STP Committee and Dec 25 Board	Positive	Green
EHR Programme (HealthSet)	EHR OBC and preferred supplier approved by Board, Final FBC to extra-ordinary board Jan 26, supplier selected and contract and inter-trust agreeement approved by Board Feb 26. Digital and HR update to STP March 26. As at end of April joint recruitment for Epic commenced	Positive	
Risk Controls and Plans			
Digital risks monitored and reported	Monthly to DHC SLG and Audit Committee - Non Clinical Risk Register. New Director of IT and Infrastrcure in post from Oct 25 and reviewed all digital risks. Technology Roadmap to STP Nov 25. Review and reporting of digital clinical risks to STP Jan 26 and May 26. Monthly Report to Digital Transformation and Assurance Group (DTAG). New IT demand at DCH paused to allow focus on triaging backlog and review of how digital decisions made - ongoing to end Feb 26. Technology Roadmap to STP Nov 25.	Neutral	Amber
Data Security & Protection Toolkit	Submission via Finance and Performance Committee and audited by BDO, reviewed by SIRO. IA reports on DSPT 25/26 to Audit Committee May 26. SIRO	Positive	
Target Operating Model (TOM)	In development - Stage 1 was establishment of leadership team from Jan 26 - interim arrangements across DCH and DHC. Focus on Q4 is to fully develop Target Operating Model and commence strategy delivery. Update provided to STP Jan 26 and Mar 26	Neutral	
Oversight Arrangements for Governance & Engagement			
Strategy Transformation and Partnerships Committee - From Sept 2024	TOR approved - Reporting to Board commenced October 2024	Positive	Green
EHR Programme Board and EHR Advisory Group	EHR Report into Board. TOR refreshed to reflect Implementation Phase	Positive	
DCH Digital Transformation & Assurance Group	Monthly reporting includes risks, cyber, projects - redefined to have stronger governnace and clarity on decision making role - new membership and TOR strengthened. New Director of IT and Infrastrure in post from Oct 25 and undertaking a review	Positive	
Joint Digital Services Leadership Group DCH & DHC - Dorset wide forum	Governance and reporting reviewed and strengthened - reviewed across all 3 Dorset providers within the context of the development of a Dorset wide Target Operating Model	Positive	
Information Governance Group (also covers cyber)	Bi-monthly report to STP	Positive	

Elys.Kaye
10/06/2026 16:10:42

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Implementation of Federated Data Platform (NHSE Mandate) Implemented, close	BB	Mar-26	Complete
Development of Infrastructure roadmap to support joint digital strategy - postponed to Dec 25 as new joint CDIO in post from April 25 and will form part of Dorset wide strategy and integrated approach across Dorset - on plan for previously agreed revised date- To follow Digital Strategy - revised to March 26 - Update - Workshop April 26 and work to be completed be end June 26	RK	~~Mar 25~~ ~~Dec 25~~ ~~Mar 26~~ July 26	Behind Schedule
Full infrastrcuture audit of revenue and capital requirements moving forward - Complete - Considered at Capital Planning meeting	RK	Mar-26	Complete

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Sustainability	**SR10 Cyber security** **If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents**	Strategy, Transformation & Partnerships

Executive Lead

Chief Finance Officer (Chief Digital Information Officer)

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	3	x	5	=	15
Mitigated	3	x	4	=	12
Target	3	x	3	=	9

Rationale for Score

No change in score - continue to understand and mitigate threat landscape. Regular reporting to STP Committee and Board. Fully implemented TOM by end 26/27.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint DCH/DHC Digital Strategy (inc cybersecurity)	NHSE Digital Maturity Assessment & NHSE What Good Looks Like (WGLL) Dorset Wide Digital Strategy (DCH/DHC/UHD) presented to Committee Nov STP Committee and Dec Board	Positive	Green
Secure email accreditation	ISO 27001 compliance linked to secure email accreditation (DCB1596)	Positive	
Risk Controls and Plans			
Data Security & Protection Toolkit	Submission is via Audit Committee, and audited by BDO, reviewed by SIRO. IA reports on DSPT 25/26 to Audit Committee May 26	Positive	Amber
Regular phishing campaigns conducted, monitoring of alerts, patching and maintenance, password controls	Cyber Reports to STP Committee and Board - March/April 26	Neutral	
Cyber Security monitoring arrangements and system controls	Cyber Reports to STP Committee and Board - March/April 26	Neutral	
Oversight Arrangements for Governance & Engagement			
Information Governance Group (also covers cyber)	Bi-monthly report to Finance and Performance Committee, STP from Sept 24	Positive	Amber
Monthly Digital Transformation & Assurance Group	Monthly reporting includes risks, cyber, projects - New Director of IT and Infrastrcure in post from Oct 25 and undertaking a review	Neutral	
Digital Services Leadership Group (recently implemented - with only digital team representation)	Governance and reporting to be developed - to be reviewed across all 3 Dorset providers within the context of the development of a Dorset wide Target Operating Model	Neutral	
Strategy Transformation and Partnerships Committee	Escalation Report to Board (from Sept 24) Cyber Report to Board Dec 24 and Dec 25	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Full audit to be undertaken of cyber security arrangemnents (inc governance and technology) to be undertaken - Cyber Reports to STP Committee and Board - March	RK	Mar-26	Complete
To implemented refreshed national cyber security training	RK	Sep-26	On Plan

Ellie Kemp
12/06/2026 16:10:45

ASSURANCE ASSESSMENT

GREEN	AMBER	RED
Well functioning controls in place to manage risks and deliver objective	Some key controls in place, but may not cover all risks or elements of objective	Clear gaps in controls for management of risks and delivery of objective
Assurance available for key controls	Some assurances available, but may not cover all controls	Limited or no assurance available
Assurance is overall **positive**	Assurance is overall **neutral**	Assurance is overall **negative**
	Clear actions to address gaps in controls and/or assurances	Plan not sufficient to address gaps in controls and/or assurances

RISK SCORING MATRIX

		LIKELIHOOD SCORE				
		1	2	3	4	5
CONSEQUENCE SCORE		Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic		5	10	15	20	25
4 Major		4	8	12	16	20
3 Moderate		3	6	9	12	15
2 Minor		2	4	6	8	10
1 Negligible		1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

0 - 3	Very low risk
4 - 6	Low risk
8 -12	Moderate risk
15 - 25	High risk

Ellis Kara 10/06/2026 16:10:45

Risk Appetite Approved December 2025

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

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

Appendix Three: 2026/27 Strategic Risk Review

	Strategic Risks	Current Target Score	Indicative Target Score	Alignment to Risk Appetite
Safety and Quality	**CURRENT WORDING SR1 Safety and Quality** If we are not able to deliver the fundamental standards of care in all of our services we will not be providing consistently safe, effective and compassionate care **PROPOSED NEW WORDING** If we are not able to deliver the fundamental standards of care and if we do not consistently create a positive safety culture, we will not be able to provide safe, effective and compassionate care across all settings that places peoples experience of care at the heart **Quality Committee comments:** Committee requested further clarity around whether the proposed statement was linked to process or outcomes. Further clarity provided by amended wording.	**9 (DHC)** **12 (DCH)**	**6 (DCH & DHC)**	**Patient Safety and Quality- Cautious**
Culture **New Title Empowerment**	**CURRENT WORDING SR2: Culture** If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care. **PROPOSED NEW WORDING** If we do not create the culture and conditions where people thrive and feel empowered in their role, our ability to deliver improved patient outcomes and experience of care and high-quality compassionate and safe care will be compromised. **People and Culture Committee comments:** Revised wording agreed and clarified that the aim of the proposed wording is to reframe that the culture and conditions create empowerment. Revised target score reflects agreed risk appetite	**6** **DCH & DHC**	**9** **DCH & DHC**	***Workforce – Seek***

Ellis,Kara
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	Strategic Risks	Current Target Score	Indicative Target Score	Alignment to Risk Appetite
Workforce Capacity	**CURRENT WORDING SR3: Workforce Capacity** If we are not able to recruit and retain the required number of staff with the right skills, we will not be able to deliver high quality and safe sustainable services within our resources. **PROPOSED NEW WORDING** If we do not reshape and modernise the workforce, underpinned by effective purposeful recruitment and retention, to ensure we have the required skills and capability, we will not be able to deliver the 3 shifts in accordance with the 10-year plan. **People and Culture Committee comments:** Revised wording supported subject to reference to recruitment and retention to be included	**9 DCH & DHC**	**9 DCH & DHC**	***Workforce – Seek***
Capacity and Demand	**CURRENT WORDING - SR4: Capacity and Demand** If we do not meet current and expected demand and achieve local and national measures and targets within available resources, we may face regulatory action and patients' outcomes will be adversely affected **PROPOSED NEW WORDING** If we do not meet current and expected demand, and achieve local and national metrics within available resources, patient outcomes and experience will be adversely affected, and we may face reduced autonomy and regulatory action. **Finance and Performance Committee comments:** Typo removed. Revised wording agreed.	**4 DCH & DHC**	**8 DCH & DHC**	***Operational Performance: Open***

Ellis Kara
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	Strategic Risks	Current Target Score	Indicative Target Score	Alignment to Risk Appetite
Estates	**CURRENT WORDING - SR5: Estates** If we do not have an estate that is fit for purpose and economically and environmentally viable, we will be unable to provide the right places for our staff to deliver high quality services to the communities that we serve **PROPOSED NEW WORDING** If we do not have access to an estate that is fit for purpose and economically and environmentally sustainable, we will be unable to provide the right environments for our staff to deliver high quality services to the communities that we serve. **Finance and Performance Committee comments:** Slight amendment to wording, Revised wording agreed	**9 DCH & DHC**	**9 DCH & DHC**	***No specific appetite***
Finance	**CURRENT WORDING - SR6: Finance** If we do not deliver on our financial plans, including the required level of savings, then and this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position **PROPOSED NEW WORDING** If we do not deliver on our financial plans, including the required level of savings, it will adversely impact our ability to provide safe, sustainable services within the context of the developing NHS funding model and the 10-year plan. **Finance and Performance Committee comments:** Revised wording agreed	**12 DHC** **9 DCH**	**8 DCH & DHC**	***Finance and Value for Money: Open***
Collaboration **NEW Partnerships and Transformation**	**CURRENT WORDING – SR7: Collaboration** If we do not have effective and positive partnerships within the ICS then we will not be able to shape decisions and deliver the transformation required. **PROPOSED NEW WORDING** (merge with SR8) If we do not have effective and positive partnerships, with clear governance and accountability frameworks and a commitment to work in collaboration to transform	**6 DCH & DHC**	**9 DCH & DHC**	***Innovation, Partnerships and Commercial – Seek***

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	Strategic Risks	Current Target Score	Indicative Target Score	Alignment to Risk Appetite
	services, then we will not be able to shape decisions and deliver the transformation required to deliver the ambitions of the 10-year plan and address the health inequalities within our population **Strategy, Transformation and Partnership Committee comments** Agreement to merge SR6 and SR7 - noting that collaboration is part of business as usual.			
Transformation and Improvement	**CURRENT WORDING – SR7: Transformation and Improvement** If we do not seek and respond to the views of our communities to co-produce and continuously improve and transform our services, we will not contribute to the reduction of health inequalities within our communities. **PROPOSED NEW WORDING -** Merge with 7	**6 DCH & DHC**	**N/A – see above**	***N/A – see above***
Digital Infrastructure	**CURRENT WORDING - SR9: Digital Infrastructure** If we do not advance our digital and technological capabilities, including achieving our EHR ambitions, we will not deliver the innovative and sustainable services, and the delivery of safe services could be compromised. **PROPOSED NEW WORDING** If we do not address and improve our digital and technological capabilities, including implementing our new EHR system, and utilising new digital technologies, we will not deliver safe and sustainable services. **Strategy, Transformation and Partnership Committee comments:** Revised wording agreed	**6 DCH & DHC**	**9 DCH & DHC**	***Digital - Seek***
Cyber security	**CURRENT WORDING - SR10 Cyber security** If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incident. **NO CHANGE PROPOSED TO WORDING**	**9 DCH & DHC**	**9 DCH & DHC**	***No specific appetite***

Ellis,Kara
10/06/2026 16:10:45

Dorset HealthCare University
NHS Foundation Trust

Report to	Board in Common (DHC)	
Date of Meeting	17th June 2026	
Report Title	Corporate Risk Report	
Prepared By	Karen Fulford, Joint Head of Risk and Clinical Legal Services	
Approved by Accountable Executive	Dawn Dawson, Joint Chief Nursing Officer	
Previously Considered By	Risks scoring 15+ have been previously considered by the relevant committees at their meetings in May 2026. • Quality Committee • Strategy, Transformation Partnerships Committee • People & Culture Committee • Finance & Performance Committee • Mental Health Legislation Assurance Committee • Audit Committee	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

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

Ellis,Kara
10/06/2026 16:10:45

Executive Summary

This report has been produced to assure the Board of management of all risks across Dorset HealthCare. Relevant risks scoring 15+ have been considered.

This report is a snapshot of relevant risks on the risk register on 18 May 2026. Subsequent updates to risks may be made before the Board convenes and updates will be provided.

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

- Two risks currently score 15+.
- There has been one new risk scoring 15 added to the register since the last Board report.
- One risk has been added to the report following an increase of risk score from 12 to 20.
- There have been seven reductions in risk score since the last report, all risks fall below the Board's review threshold.
- Two risks have been closed since the last report.
- No risks are overdue for review.
- Full details of all risks are contained in Appendix 1.

Recommendation

Members are requested to:

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

Ellis Kara
10/06/2026 16:10:45

Dorset HealthCare University
NHS Foundation Trust

Risk Report

1. Executive Summary

1.1 Risks scoring 15+ have been previously considered by the relevant committees at their meetings in May 2026.

- Quality Committee
- Strategy, Transformation Partnerships Committee
- People & Culture Committee
- Finance & Performance Committee
- Mental Health Legislation Assurance Committee
- Audit Committee

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

2 Introduction

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

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

1.3 This report was compiled 18 May 2026 and is a snapshot of the risk register on that date; therefore, subsequent updates may be made before the Board convenes.

3. Summary of current risks

3.1 <u>New Risks</u>

One new risk scoring 15 has been added to the risk register since the last report to the Board. Table 1 below sets out basic details of the new risks.

Risk Reference	Risk Title	Risk score
2063	Consultant vacancy on Seastone CAMHS high intensity unit which may prevent the unit opening as planned and commissioned.	15

3.2 <u>Changes in Risk Score – Appendix 1</u>

Since the last report here have been one increase in risk score resulting in the addition of a risk to the corporate risk register.

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Risk Reference	Risk Title	Rationale for score increase	New risk score
2016	New Build project, poor subcontractor performance on delivery of Mechanical, Electrical and Plumbing - Risk G18 on project risk register	The risk score increase has coincided with the new builds at St. Ann's Hospital and Alumhurst Road nearing completion. Issues identified in getting contractors to sign off the ventilation pressure testing became prevalent in April and early May 2026 delaying access to both sites. This therefore increased the risk score.	20

At the time of writing this report, we are aware the risk is currently under review and is likely to be reduced as access to the CAMHS site has been provided and handover of the St. Ann's site was expected on 13 May 2026.

Seven risks have had their risk scores reduced since the last report with all risk scores now below the Board's threshold for review.

3.3 Risk Reviews

At the time of writing, no risks are overdue for review.

3.4 Closed Risks

Two risks have been closed since the last report. One relating to physical health care provision within mental health services and the other relating to bed availability within adult and older people mental health. Both risks have been closed following an in-depth review of these longstanding risks. Risk 1782 related to the health care provision has been rearticulated in a new risk and scores 9. The bed management risk is currently in the process of being added with the score expected to be below the Board review threshold.

3.5 Risk Register – Appendix 1 (Excel Sheet)

There are two risks currently scoring 15 or above.

4 Conclusion

4.1 The number of risks currently scoring 15+ is lower than usual reflects the ongoing work between operational services and the risk management to improve the organisations risk management.

4.2 There are no risks currently overdue for review. Work continues to raise awareness with risk owners and senior colleagues regarding the importance of reviewing and updating risks as per Trust policy.

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4.3 Training materials have been reviewed and updated to support colleagues to manage risk effectively following feedback.

4.4 Staff are being actively encouraged to complete risk management training available on eHub.

4.5 Risk and risk management training continues to be included on Trust induction for discussion, on Managers induction in addition to bespoke events (such as Ward Managers Workshop).

5 Recommendations

Members are requested to:

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

Karen Fulford
Joint Head of Risk and Clinical Legal Services.
19 May 2026.

6 Appendices

6.1 Appendix 1 – Copy of Trust Risk Register (15+)

Ellis,Kara
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Risk Movement since last Report	Date added to register	Risk Ref	Directorate	Service	Risk Lead	Description of risk Cause, effect, impact	Initial risk score	Current score	Key Controls	Progress	Target risk score	Date for next review	Assurance Strucure Groups, Primary and Secondary Committees	Strategic Objective	Strategic Risks
Riskscore increased from 12 to 20	31/07/2025	2016	MH - CAMHS CAMHS HE	Estates CAMHS HE	Christopher Hearn	**New Build project, poor subcontractor performance on delivery of Mechanical, Electrical and Plumbing - Risk G18 on project risk register** There is a risk that the delivery date for the new build for CAMHS HE will be exceeded as one of sub-contractors on build is not delivering to programme Impact: There is a risk of delayed opening of the new CAMHS HE - this would result in an inability to admit young people into local services. This would result in children and young people continuing to be treated out of area. This could impact the young person's health and wellbeing being so far from home. It would also affect family and friends who would be unable to support the young person as they could if they were in a local bed. There may also be an impact on the staff recruited to the new services and delayed commencements to posts.	15	20	1) Main Contractor is working with sub-contractor in open and transparent way to identify further mitigations, additional resources where this would support and options on additional working days	05/05/2026 Access to the CAMHS site has been provided and the vent system has completed testing, snagging across the site continues in tandem with new staff induction and training. At St Anns we still have problems although still have 13th May as handover date, this is subject to daily review. Severity rating therefore left in place as any delay would affect our ability to move CHINE ward on 3rd June, which would knock on to refurbishing old Chine (Coral) ward for Alumhurst females to move into.	9	04/06/2026	MH/LD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee People and Culture CIC	Care Colleagues Transformation	SR1: Safety and Quality SR6: Estates
New risk	19/03/2026	2063	MH - CAMHS	Seastone	Rebecca Matoug	**Consultant vacancy on Seastone CAMHS High Intensity may prevent the unit opening as planned and commissioned.** Consultant vacancy on Seastone will mean we are unable to deliver care to young people, as in order to be admitted to a secure inpatient ward you would need an RC under the MHA. Seastone are commissioned to have 1.0 WTE consultant psychiatrist and there is a risk that the unit may not be able to open as planned after significant investment. Impact: Financial risk if this needs to be backfilled by a Locum and if we are unable to open as planned after funding the new build and recruiting staff. Regulatory risk if we are inspected without RC cover. Reputational risk due to poor quality care and risk of complaints through poor patient experience.	15	15	1) Recruitment attempts have taken place	13/05/2026 added narrative around recruitment solutions - attempted to engage with Locums, no one has currently agreed no consultants via agency have currently sent a suitable CV that they could safely RC in CAMHS inpatient we have one applicant who is not currently a CAMHS Consultant on trac, would need to complete a portfolio remains out to advert HR resources continue to approach Agencies and Locums	5	12/06/2026	MH/LD/CYPF DMG PC Sub-DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee	Care Colleagues	SR1: Safety and Quality SR4: Capacity and Demand
Risk reduced from 15 to 12	11/08/2021	1273	Risk Trustwide	Risk Trustwide Medicines Management	Natasha King	**Prescribing and review of valproate to persons of childbearing potential and men younger than 55-years without following the national standards** Failure to comply with the current regulatory measures for prescribing of valproate including oversight of new patients and existing female patients may lead to pregnancies with a high risk of birth defects and neurodevelopmental disorders. Men exposed to valproate carry a risk of impaired fertility. Per NatPSA-2023/0013/MHRA (28-Nov-2023) the relevant standards are: A Valproate must not be started in new patients (male or female) younger than 55 years, unless two specialists independently consider and document that there is no other effective or tolerated treatment, or There are compelling reasons that the reproductive risks do not apply	12	12	1) Baseline and follow-up audits looking at standards relating to prescribing of valproate to women of childbearing potential and men <55yrs. 2) Audit reports and action plans highlighted within Trust to Mental Health Medicines Management Group, Medicines Safety Group, Medicines Management Group, Medical Advisory Committee, and Clinical Audit Group. Actions also coordinated via Dorset Medicines Quality & Safety Group. NHS Dorset Medicines Optimisation and Patient Safety teams.	05/05/2026 Email with details of patients requiring a risk assessment to be completed has been sent to MH Medical Director for onward cascade. Database of patients has been created which will be monitored by the MSO to check that risk assessments have been completed now and on an annual basis.	4	04/08/2026	Nursing Therapies and Quality DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee	Care	SR1: Safety and Quality SR5: Estates SR6: Finance
Risk reduced from 15 to 12	05/08/2024	1925	Risks Trustwide	Risk Trustwide	Martin Wilkins	**Lack of an Asset Management Plan for DHC** The Trust does not currently have an Asset Management Plan (AMP) in place. An AMP sets out how the Trust will manage its assets to support the delivery of strategic objectives and services. This should set out 5 distinct areas: 1) a Handbook for how we do asset management in DHC (policies, processes, systems) 2) a Performance Review - provides an understanding of how our assets are performing now, how we want to improve this, and what assets we need in the future (key areas for change); and 3) a Strategy for the future with an Action Plan setting out all the key asset related activity DHC will undertake over the next 1 - 5 years. This should be developed in support of the Trust's strategic aims and any other strategies such as the clinical and digital strategies. Without a clear strategy how does the Trust know it has the right buildings in the right places. An AMP is essential to support BCBV, capital planning investment, and the carbon zero journey. Impact: Unable to respond to new requests as teams unwilling to let go of surplus space or share space - therefore affecting services / patients/ staff - culture of My Space not Our Space. This may affect service delivery across the Trust. Lack of long-term planning, efficiency and opportunity. Without a comprehensive AMP, the Trust may miss opportunities to optimise its estate, leading to inefficient use of resources and increased costs.	16	12	1) Accommodation Principles were approved by the Executive at the beginning of 2024 - these principles set out how we can make better use of our estate and move from a 'my' space to 'our' space culture. 2) There is a Property Asset Management Policy but this only one small part of having a comprehensive Asset Management Plan. 3) MW has raised the lack of support and adherence to the Accommodation Principles with Nicola Plumb, Chris Hearn and Nick Johnson. Issue to be raised at Joint Exec on 20 August. MW highlighted the need for an Asset Management Plan. Advised that this would be considered as part of the Joint Estates & Infrastructure Strategy NJ was leading on.	03/03/2026 Through federated working with DCH the Trust is now progressing with a Joint Estates & Infrastructure strategy. This will look at where we are now, where we want to be and how we will get there. However, integral to this is a clinical strategy as well as other supporting strategies like Digital.	4	02/06/2026	Information Governance Group Senior Leadership Group Audit Committee Finance and Performance Committee	Care Colleagues Sustainability	SR1: Safety and Quality
Risk reduced from 15 to 12	17/12/2025	2048	Trust Central Services	IT Support	Chris Hearn	**IT Resourcing is insufficient to meet the need of the Commissioning and Operational Readiness requirements of the New Hospital Programme project** The IT team find themselves with many competing project priorities and are therefore constrained in the ability to respond to the needs of the commissioning and operational readiness elements of the two new builds which are being delivered as part of the project in March and April 2026. Key elements of digital infrastructure not updated in accordance with the commissioning schedule timelines (e.g. security, cctv). Equipment procurement is delayed. Equipment installation is delayed. Activation tasks are not adequately resourced, extending timelines and impacting other dependent elements. Should the St Anns build be delayed then this will impact on the project benefits - OOA costs will be extended, capacity increased on the AMH PICU and CHINE wards will be delayed. It will potentially knock on to the start	20	12	1) Using project funding to fund additional resource to install WiFi controllers. Other areas can be considered if need arised. IT have confirmed deliverables and tasks. meet weekly to ensure communication on progress.	27/04/2026 Meetings progressing - Peter Kelsall attending project boards to confirm all IT actions monitored and up to date and to review any potential issues for solutions.	4	06/07/2026	Senior Leadership Group Audit Committee Board Information Goverance Group	Communities Sustainability	SR3: Workforce Capacity SR4: Capacity and Demand SR5: Estates SR6: Finance SR7: Collaboration
Risk reduced from 15 to 9	24/12/2025	2049	Risks - Trustwide	Risks - Trustwide	Louise Jewson	**Lack of mandatory training places available due to long term sickness in L&D team** Due to 5 long term/ unplanned sicknesses in the Clinical and Mandatory education team, the provision of training in a number of core mandatory subjects is significantly reduced/ compromised. Impact: Staff may not receive the relevant training to maintain confidence and competence in the required mandatory skill Patients may be impacted by staff not having sufficient training The organisation may suffer reputation challenge if we are unable to provide appropriate training for staff to keep patients safe.	15	9	1) Directing staff to the level 1 and 2 Moving and Handling videos on E-hub. 2) In discussions with Immerse medical who deliver our ILS and PILS training to see if they can deliver 500 BLS places for us to support the nexus team in patching us with themselves and freeing time to deliver other programs. 3) Helen and Loretta are delivering the e-certificate. 4) The REC are picking up the delivery of the suicide prevention work and we have some ADPs helping with the Therapeutic Engagement 5) OMM7 are are working with and external provider to provide courses	06/05/2026 2 new trainers appointed which will support delivery RD progress as need to plan how to cover this roles whilst off. nexus team in patching us with themselves and freeing time to deliver other programs. Continue to utilise external provider. New base may offer increased opportunity to manage increased capacity on courses for MIH	4	05/06/2026	Senior Leadership Group Audit Committee Pepole and Culture Committee	Care Colleagues Sustainability	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand
Risk reduced from 15 to 6	05/05/2022	1567	CYPF/MHLD	CAMHS	Dudley Marins	**Lack of Medic Staff across CAMHS services** Numerous and longstanding medic vacancies for consultant psychiatry including community, psych liaison and inpatient CAMHS. Existing medics capacity is stretched as is the Out of Hours rota Impact of clinical safety on a patient level in that there is no medic within some CAMHS teams, therefore limiting access to timely medic input (prescribing, medication reviews etc). Impact on existing staff as additional pressure to cover on call rotas and cross cover for services with no medic. Impact to service delivery as medics are key to the senior clinical leadership to CAMHS services.	12	6	1) Some cross cover provision from services that do have medics aligned to them. Some cross cover on the On Call rota.	13/03/2026 Successful recruitment to a range of community CAMHS posts is in train, with offers made. Inpatient consultant recruitment effort is ongoing	4	11/09/2026	MH/LD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee	Care Colleagues	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand SR6: Finance SR7: Collaboration
Risk reduced from 15 to 12	03/04/2023	1754	Trustwide	Trustwide MH Community	Marianne Gillingham	**Significant staff issues in Bournemouth West CMHT.** Due to long term sickness and staff vacancies, several teams are experiencing severe staff shortages. Teams most impacted are Bournemouth West and Poole. Some medic vacancies are impacting on availability for new assessments and waiting list performance. Impact: Unless staffing issues can be resolved, this will impact on the morale and wellbeing of staff. Patients may experience long delays in being offered an appointment, which will have a detrimental affect on their condition and risk of deterioration of their mental health possibly resulting in hospital admission. Capacity of Care Co-ordinators is also limited for allocation to new patients, completion of care planning and statutory paperwork, ie social circumstance reports for and risk management.	20	12	1) BCPs are enacted 2) Ongoing recruitment is in place 3) Ongoing discussions with HR and resourcing team within the Trust including recruitment campaigns 4) Escalated to Chief Nursing Officer and Service Director and discussed at Safe Staffing Forum 5) Bank and agency options explored 6) 2 services have been referred to Star Chamber. (Christchurch and ICSS) for reduction in service delivery to be approved 7) Attempting to commission agency worker - person identified and TL is pursuing this.	14/05/2026 x2 Clinical staff recruited into vacant posts due to start June 2026. Ongoing plans to recruit into remaining vacant post. Agency Worker remains in post. International Medic due to start in Team in Summer 2026.	4	13/09/2026	MH/LD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee People and Culture CIC	Care Communities Colleagues	SR1: Safety and Quality SR3: Workforce Capacity
Risk reduced from 15 to 6	21/08/2025	2019	MH AMH/CPMH Community	Custody Liaison Service	Anna Fitzsimmons	**Reconnect Low staffing levels** Reconnect are not fully recruited for both qualified practitioners and support workers. They are at risk of not being able to carry out assessments/interventions in the time frames specified in our contract Not receiving the necessary support normally provided by Reconnect, on leaving prison.	15	6	1) Recruitment to posts is ongoing. Bank staff specific to our service (Prison and Police vetted) are being sought to cover vacancies. Permanent staff will be requested to cover gaps in assessments if no other solution can be found	22/04/2026 Practitioners are now in place and LE STR Worker is progressing towards carrying a caseload. Reconnect is now longer in BCP	6	01/10/2026	MH/LD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee	Care Colleagues Sustainability	SR1: Safety and Quality SR4: Capacity and Demand SR7: Collaboration
Risk closed 15/02/2026	05/07/2023	1782	CYPF/MHLD	MH AMH/CPMH Inpatients	James Smith	**Physical Health Care provision in Inpatient Mental Health Services** There has been a significant increase in complex physical health comorbidities that Mental Health Inpatient Services are being expected to manage and treat. The capacity of the Physical Health Team that supports inpatient services has limited capacity to support this increased level of acuity being faced by the inpatient services. This is along side fluctuating junior medical support on the wards with the required level of skill to manage these increasingly complicated comorbidities. Impact: This may lead to delays in patients having their physical health care needs met along leading to increased risk of patient becoming physically compromised and deterioration.	16	16	1) Escalated to Service Manager and Lead Consultant who are escalating further 2) Incident reports relating to patients for whom there was a missed deterioration in their condition and requiring transfer to acute care have been raised. 3) Physical health staff team had Safe staffing report undertaken. This identified an increase in staffing levels required.	18/02/2026 Following a indepth review of this risk, it has been closed, allowing the risk to be rearticulated and two risks added.	3		MH/LD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Audit Committee People and Culture CIC	Care	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand
Risk closed 15/05/2026	02/09/2024	72	CYPF/MHLD	CYPF/MHLD St Ann's Hospital MH Inp	Anna Chaney	**Bed availability** High demand and acuity, alongside a lack of capacity of inpatient beds both locally and out of area mean that there is a risk to service delivery across the system. High number of delayed transfers of care and clinically ready for discharge patients unable to be discharged due to lack of housing and supported accommodation provision means that patients are waiting longer for inpatient beds, resulting in patients remaining in inappropriate places such as the acute hospitals or within the community placing higher risk on both themselves and the teams supporting them. This could result in compromising the quality of care for the patient. The level of increased risk in the community and acute trusts could create high costs to the Trust. Impact: Patients held on TCI list for extended periods of time Delay in care resulting in the potential for inappropriate treatment or treatment that is less effective Large number of patients being held in acute trusts High risk being held by community teams due to the time required to access an inpatient bed Large numbers of patients being transferred to out of area beds due to lack of local bed availability	6	16	1) Reports to and monitoring by the Quality Governance Group 2) All out of area placements require senior management authorisation prior to the individual being placed out of area 3) Lenth of stay task and finish group 4) Out of area SOP developed for process to support flow and manage oversight of the quality of OOA placements. 5) OOA co-ordinator now in post to work alongside care co-ordinators to have oversight of risk assessments, care plans, incidents and discharge/repatriation plans of OOA placed service users.	15/05/2026 Risk is very old and due to significant work that has been undertaken, the risk does not accurately reflect the current risk. This risk will be closed and a new risk opened.	4	04/06/2026	MH/LD/CYPF DMG Quality Governance Group Quality Governance Committee Senior Leadership Group Finance and Performance Committee Audit Committee	Care Communities Sustainability	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand =H13K12A12:P13

Ellis, Kara
10/06/2026 16:10:45

Report to	Board in Common (DCH)	
Date of Meeting	17th June 2026	
Report Title	Corporate Risk Register	
Prepared By	Karen Fulford, Joint Head of Risk and Clinical Legal Services	
Approved by Accountable Executive	Dawn Dawson, Joint Chief Nursing Officer	
Previously Considered By	Risks scoring 15+ have been previously considered by the relevant committees at their meetings in May 2026. • Quality Committee • Strategy, Transformation Partnerships Committee • People & Culture Committee • Finance & Performance Committee • Mental Health Legislation Committee • Audit Committee	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

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

Mrs Kara
10/06/2026 16:10:45

Executive Summary

This report has been produced to assure the Board of management of all risks across Dorset County Hospital. Relevant risks scoring 15+ have been considered.

This report is a snapshot of relevant risks on the risk register on 11 May 2026. Subsequent updates may have been made to some of these risks before the Board convenes and changes to risks will be highlighted

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

- 43 risks currently score 15+, three score at 20.
- There have been eight new risks recorded since the last report that meets the Board's review threshold.
- 63 risks have been closed or are now being managed/tolerated within the risk appetite.
- Eight risks are currently past their expected review date.
- Full details of all risks are contained in Appendix 5.

Recommendation

Members are requested to:

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

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Corporate Risk Report

1. Executive Summary

1.1 Risks scoring 15+ have been previously considered by the relevant committees at their meetings in May 2026.

- Quality Committee
- Strategy, Transformation Partnerships Committee
- People & Culture Committee
- Finance & Performance Committee
- Mental Health Legislation Assurance Committee
- Audit Committee

1.2 This data for the report was compiled 11 May 2026 and is a snapshot of the risk register on that date; therefore, subsequent updates may be made before the Board convenes.

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

2 Introduction

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

2.2 The data is based on extraction from the Datix risk management system.

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

2.4 This report and appendix are accurate at the time of data extraction on 11 May 2026.

3. Summary of current risks

3.1 <u>New Risks</u>

There is one new risk scoring 20 which has been reported since the last Board report. Table 1 sets out the basic details

Risk Reference	Risk Title	Risk score
2309	Failure to meet statutory and clinical timelines for ADHD medication titration and follow ups	20

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There are seven new risks scoring 15 or 16 which have been reported since the last Board report. Table 2 below sets out basic details of the new risks.

Risk Reference	Risk Title	Risk score
2138	Inadequate supply of all stock, implants and equipment.	16
2291	Day surgery being used as an escalation space for inpatients.	15
2293	Endoscopy admissions – Booking Team (maintenance of forward bookings)	15
2295	Endoscopy Admission – Booking Team (workforce absences/fagility)	15
2209	ICU consultant medical staffing currently does not meet minimum standards as set out in GPICS V3 released 28 January 2026	15
2324	Limited dietetic service for renal patients – inpatients and outpatients	15
2294	Outpatient clerks	15

3.2 Risk Reviews

Eight risks are currently past their expected risk review dates, four of these are more than one month overdue.

Table 2 below identifies which service of responsibility overdue risks are in.

Table 1

Service of responsibility	Total number of overdue risks	Risk Reference
Emergency (ED) Services	1	1914
Endoscopy Service	1	2161
Central Appointments	2	1221, 2294
Elective Admissions	2	2293, 2295
Clinical IT systems	1	1912
Critical Care Service (CRC)	1	2290
Total	**8**	

It has been identified that in some areas there is a training need related to the use of the Risk Management system (Datix). Training materials are in the process of being shared with teams to support use the system correctly (including a step-by-step guide).

3.3 Closed Risks

Since the last report 63 risks have either been closed or identified as being managed /tolerated within the risk appetite.

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3.4 Risk Register – Appendix 4 (Excel Sheet)

There are 43 risks currently scoring 15 or above and they are detailed in full, Appendix 1 (pages 2 – 16).

4 Conclusion

4.1 Organisational expectation for risks scoring 15+ would be a review to be performed on each risk at a minimum of once per month. There are currently eight risks showing as overdue for review, four of these are more than one month overdue and are new risks the risk register. Support is being offered to risk leads to update these risks and this is evidenced in the improved position from the last two reports (January 2026 – nine overdue, November 2025, 19 overdue).

4.2 Work continues to raise awareness with risk owners and senior colleagues regarding the importance of reviewing and updating risks as per Trust policy.

4.3 Training materials are in the process of being reviewed for the Trust to ensure these reflect not only how to use Datix to record and manage risks, but to support users to greater understand risk management, its importance, operational and strategic responsibilities and how to proactively manage and mitigate risks through the progression of SMART actions.

5 Recommendations

Members are requested to:

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

Karen Fulford
Joint Head of Risk and Clinical Legal Services
18 May 2026.

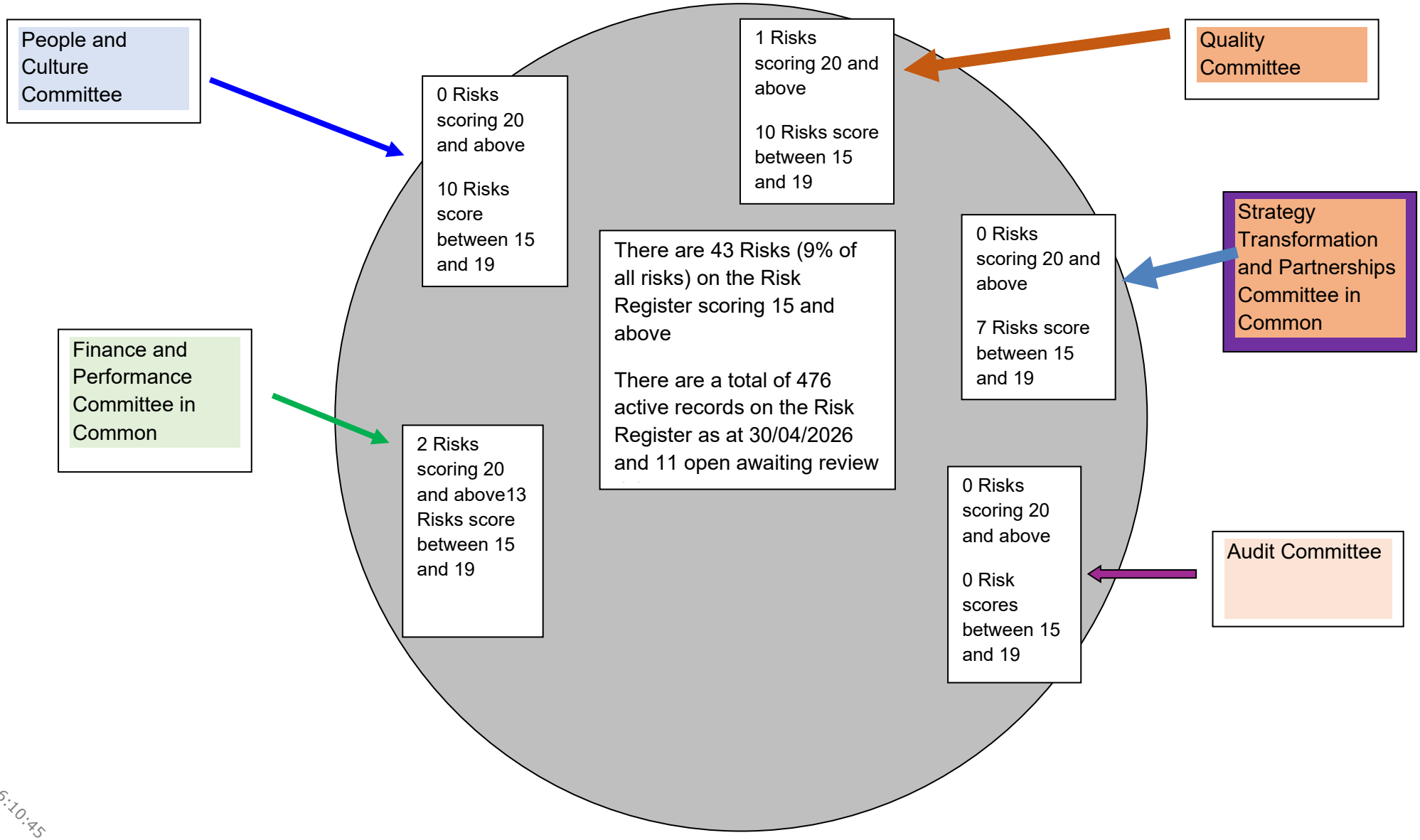
6 Appendices

6.1 Appendix 1 – New Risks
6.2 Appendix 2 – Risks overdue for review
6.3 Appendix 3 – Corporate Risk Register

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Appendix 1

Corporate Risk Register – Risk scoring for Primary Reporting Committees on 30/04/2025



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Appendix 2 20+ RAC

Approval status	ID	Title	Review date	Opened	Care Groups	Service of responsibility	Risk level (initial)	Previous current risk level	Risk level (current)	Risk level (Target)	Type of Risk	Mitigations/Controls
Active	1914	ED crowding	03/04/2026	08/07/2024	Unscheduled Care (A3)	Emergency (ED) Services	20		20	9	Finance and Performance Committee	There are a number of plans in place: - Implementation of extra staff for pressured times, including extra RNs to mitigate extra patients in the department, - ACPs on the night to reduce unnecessary admissions and improve rapid decision making. - UEC recovery plan/ ICS recovery plan - Joint SOP with SWAST - alternative pathways with ICS & system partners - Patient flow and transformation board - future NHP and AAU project - UTC implementation. bed reconfiguration introduction of frailty SDEC agreement to expand nursing coordinator shift to 3 from 2 recruitment underway agreement to expand consultant numbers to 12 with locum and agency filling immediate gaps and increasing senior decision makers at the front door during times of pressure
Active	2309 NEW	Failure to meet statutory and clinical timelines for ADHD medication titration and follow ups	18/05/2026	12/03/2026	Family Services (B4)	Paediatrics Service	20	NEW risk added	20	2	Quality Committee	Triage system - weekly triage meeting held for individual patient discussions with the MDT More work needed on mitigations

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Active	472	Patient Safety Concerns and Increased Risk of Adverse Outcomes Due to Prolonged Wait Times in Community Paediatrics	18/05/2026	10/09/2018	Family Services (B4)	Paediatrics Service	15		20	10	Finance and Performance Committee	18/12/2025 12:38:58 Waiting List Reduction in OWL - 2659 1852 waiting over 52 weeks Insourcing Work continues with Psicon 24 new CYP to be sent over for assessment Work to conclude by March 31st 2026 Workforce Out to advert for 1.6wte Nurse / AHP non-medical prescriber post Internal fixed term increase in Clinical Psychology hours pending advertisement for 0.5wte Clinical Psychologist Grading New process continues Weekly monitoring of outstanding referrals awaiting grading Grading needs to be factored within job planning (outstanding) Risk Scoring Now completed for every new referral and expedite request For review in February 2026

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Appendix 3 15-19 RAC

Approval status	ID	Title	Review date	Opened	Care Groups	Service of responsibility	Risk level (initial)	Previous current risk level	Risk level (current)	Risk level (Target)	Type of Risk	Mitigations/Controls
Active	1752	2003 Servers Out of Support Since 2010	05/06/2026	01/11/2023	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		16	4	Strategy Transformation and Partnerships Committee in Common	Systems will be migrated to supported platforms when commitment from projects and other digital staff become available.
Active	1735	2008 Servers Out of Support Since January 2020	05/06/2026	01/01/2020	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		16	4	Strategy Transformation and Partnerships Committee in Common	Plans are ongoing to reduce the no of legacy systems within the Trust, these are evidences in the Trusts quarterly cyber report, which is discussed at both DTAG and IGG (summary is as below) Reducing the presence of systems that no longer receive vendor patches or support considerably improves the Trusts cyber posture. Legacy systems contain known vulnerabilities and backdoors which are frequently abused by online crooks in large scale malicious campaigns. In retaining these known susceptible systems inevitably opens the Trust to unacceptable levels of risk. Through the snapshots below it is clear to see the departments commitment to reducing legacy systems wherever possible. 07/01/22 EoL Endpoint estate – 30.30% 27/03/23 EoL Endpoint estate – 10.62% 21/06/23 EoL Endpoint estate – 7.5% Note: A portion of the remaining 7.5% requires additional hardware to replace the EoL kit that does not support software upgrades to the latest iterations of Windows OS. The department continued to make progress with the server estate following a similar trend as the endpoints above. This typically takes longer due to the associated resources required (financial, operational & staffing) to successfully plan and implement system level upgrades. This process is also frequently held up due to contractual reasons – with suppliers not being liable for replacing/upgrading systems. As of the close of Q1, DCH has reduced the percentage of legacy servers down from 18.2% to 6.8% at the start of January. In addition, the department has been proactively upgrading the Server 2012 estate which is due go EoL in October, halving the number of these devices from 86 to 50.
Active	1745	2012 Servers Out of Support Since October 2023	05/06/2026	16/10/2023	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16		16	3	Strategy Transformation and Partnerships Committee in Common	list of servers is regularly reviewed with Technical support teams and cyber, risks are shared at IGG and through quarterly cyber reporting

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Active	2030	Administration Risk	16/05/2026	19/12/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Across all specialties	12	Risk was raised from 12 on 2/2/26	16	4	Quality Committee	Hot desk space within departments are available Use of bank where possible Support from Operational team and team leaders acting as secretarial staff Review of all processes across the care group secretarial teams underway
Active	1903	Age of Washers in EDU	08/06/2026	06/06/2024	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Decontamination Service	16		16	2	Finance and Performance Committee	5/5/26 Update from COO-There is now a full replacement plan. Assistant service manager update- happy to update the risk once I have the details. EDU Washer 1 [redacted]H100255 EDU Washer 2 [redacted]H100256 EDU Washer 3 [redacted]H100257 All washers renamed Summer 2024 as all reached maximum counts on TDOC. IHSS Southampton are our contingency site. ALL breakdowns are recorded as an incident on Datix - details of frequency can be seen in linked records and progress notes.
Active	1550	ambulance delays and hospital flow	02/06/2026	17/11/2022	Unscheduled Care (A3)	Emergency (ED) Services	16		16	6	Finance and Performance Committee	the splitting of the blue light and walk in entrances has allowed the department to manage ambulance offloads better SWAST is currently implementing work to reduce conveyances THP has been implemented and this risk remains open while policy is embedded with plans to close once your next patient is embedded THP has further reduced ambulance delays but bed flow has declined meaning more patients are cared for in the THP corridor. ambulance delays are still higher than target therefore the risk remains open Monitoring via 3 times daily bed meetings with executive oversight. Additional staff to ensure safety in expanded ED footprint and escalation areas utilised within the hospital. Performance remains high particularly in respect of ambulance handover times. SWAST have implemented changes to their SOP to support trusts with reap 1-4 actions continued pathways meetings with SWAST to reduce patients being conveyed to ED
Active	1152	Current Digital Staffing levels present risk to both operational and strategic activities	08/06/2026	14/09/2021	Chief Information Officer	Clinical IT Systems	16	Risk was reduced from 20 on 3/2/26	16	9	People and Culture Committee, Digital Systems Risk	Development of Dorset Digital Strategy and Digital Target Operating Model (2026). Ongoing dialogue with Trust leadership and finance colleagues, to protect as much of the existing resource capacity as possible. Large scale review of digital demand and implementation of new digital demand management processes.

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Active	1782	Diabetic Follow Up Long Waiters	09/06/2026	04/01/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	20		16	6	Finance and Performance Committee, Patient Safety Group	Plan to support clinical team to increase experience and knowledge over the next 3 months (as of May). To provide further stability within the sub speciality Awaiting D&C at sub specialty level for the service to ensure future workforce/ capacity can be planned, this will be a sub group of the One Dorset work that is underway Monitoring the waiting list monthly, however due to the current backlog, risk needs to remain high Returning Consultant on an as & when basis undertaking virtual FOWL review and undertaking additional clinics. In house Diabetic Consultant undertaking additional clinics as and when capacity allows. All patients overdue that were clinically appropriate were called back in July 2024 to DESP for community review. Reviewing further patients to be called back to DESP once capacity allows
Active	1965	Endoscopy - Replacement of AER's	31/08/2026	06/09/2024	Chief Finance Officer	Estates Department	16		16	9	Finance and Performance Committee	06.09.24 Reviewed taking account of current financial position and adjusted risk accordingly Currently there is no funding in the budget for this work but it is being kept in sight if capital becomes available.
Active	1886	financial sustainability	30/01/2027	09/05/2024	Chief Finance Officer	Finance	16		16	6	Finance and Performance Committee	Budget meetings, monitored at FPC and the introduction of the financial recovery board and interim inprovemnet director the focus on cost improvement delivery.
Active	1781	Glaucoma FOWL Long Waiters	09/06/2026	04/01/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	20		16	6	Finance and Performance Committee, Patient Safety Group, Clinical Effectiveness Group	Awaiting D&C at sub specialty level for the service to ensure future workforce/ capacity can be planned, this will be a sub group of the One Dorset work that is underway Monitoring the waiting list monthly, however due to the current backlog, risk needs to remain high Additional (in-house) activity is being put on as and when staffing allows. B4 technicians running assessment clinics to release clinicians time needed for F2F appointments Additional virtual reviews being put on as and when staffing allows. Insourcing additional activity with Medinet at the weekend Additional sessions from Consultant due to change in job plan

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Active	2161	HICCS Endoscopy system nearing end of life	01/05/2026	13/05/2025	Surgery & Gastroenterology (B1b)	Endoscopy Service	16		16	4	Strategy Transformation and Partnerships Committee in Common	Must be completed by the time rollout of Windows 11 is complete. HICCS is the only system available for booking endoscopy procedures within the Wessex region.
Active	2144	Home Enteral Nutrition (HEN) Service Risk - Growing demand, insufficient staff & supply chain for enteral and SIP feed supplies	19/06/2026	15/04/2025	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	16		16	6	Finance and Performance Committee	Internal skill mix review undertaken to increase staffing allocation to HEN service with Band 5 rotational support. Dietetic assistant role in place, with planned progression to registered dietitian through apprenticeship for staff member (LH) commencing Sep-25 Service provision has been reviewed to maximise opportunities for remote reviews. Monthly Datix reporting of missed reviews in place to ensure that risk remains sighted. Future opportunity to explore mitigation of risk through vertical integration / system working with Dorset Healthcare. Future mitigation plan in advanced stages of discussion now with reprioritisation of funding allocation within department budget to create an additional post to support the service. This will remain a financial risk to the organisation, but will mitigate the clinical risk to patients and also support succession planning for the highly specialised team.
Active	2138 NEW	Inadequate supply of all stock, implants and equipment.	25/05/2026	07/04/2025	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	16	NEW risk added	16	8	Quality Committee	Implant levels are checked prior to or on the day of surgery. Out of stock implants are often sourced from other healthcare providers prior to or on the day of surgery. A new Inventory Management System (IMS) is in the process of being rolled out for Orthopaedics in Main Theatres. This system will automatically reorder items (except loan kit), thereby minimising the risk of human error and speeding up the ordering process. More benefits are expected once the system is fully up and running. The system has generated a list of our stock and this is currently in the process of Theatre and then Orthopaedic clinical review and validation, to ensure the held stock levels are appropriate for the level of activity undertaken at DCH.
Active	2007	Lack of Adequate Support for Digital Systems in a 24/7 Acute Trust	01/07/2026	19/11/2024	Chief Information Officer	Clinical IT Systems	12		16	8	Strategy Transformation and Partnerships Committee in Common	Clinical systems support provided for out of hours. Greater number of on-call analysts to cover all areas of DTI.

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Active	1780	Macular FOWL Long Waiters	09/06/2026	04/01/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	20		16	6	Finance and Performance Committee, Patient Safety Group, Clinical Effectiveness Group	Awaiting D&C at sub specialty level for the service to ensure future workforce/ capacity can be planned, this will be a sub group of the One Dorset work that is underway Monitoring the waiting list monthly, however due to the current backlog, risk needs to remain high Plans to implement Treat and Extend pathway within service. Identifying trial period for the service to allow PDSA cycle of the pathway Additional (in week) activity is being created when staffing allows. Failsafe Officer monitoring waiting list and escalating any clinical concerns to Macular Lead Consultant. Insourcing at weekends with Medinet, using the agreement funds from the LTFU and ERF work Utilising nurse led clinics for Risk 2 patients following macular meeting 19/11/25.
Active	2253	Mental Health bed delays	02/06/2026	18/11/2025	Unscheduled Care (A3)	Emergency (ED) Services	16		16	1	Quality Committee	Process between DCH and DHC ongoing with meetings and development of pathways. The focus being on the patient receiving the correct treatment plan and having everything commenced in ED or where the patient is within DCH. Mental Health Steering group has as an agenda item which has executive oversight. Some improvements recently to help see & treat patients in the community with MH cars. Escalation to execs process is established for MH patients who remain in ED or the in patient wards. process for all 12 hour waits to be worked up through steering group

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Active	1629	Move of Hampshire Trust to a Sectra PACS	02/07/2026	21/04/2023	Chief Information Officer		16	⇔	16	9	Finance and Performance Committee	October 2023 - guidance to be provided to DCH clinicians in the specialities most effected (colorectal and liver cancers) they will have a change of process to request access to imaging if they believe it has been done by Hampshire hospitals. Rowe, Ian - PACS / RIS / IT Manager 22/10/2025 14:10:09 The risk remains. The additional risk around how the Trust will fund the solution beyond 2026 remains. The functionality proposed for the mitigation of the loss of the full DCH<>HHFT patient imaging record will not be achieved. Final functionality is still being developed and live product deployment anticipated in 2026, date to be confirmed. Testing and development of product functionality continues. Recent advice from SWASH is that only the HHFT imaging that has been stored on the SWASH Sectra PACS, following the HHFT PACS changeover , will be available via the XCAi solution being developed. Previous imaging of DCH patients that is on their systems from the HHFT Intelerad PACS will be unavailable to DCH PACS via this solution.
Active	1881	Neonatal Nursing & Medical Staffing	20/05/2026	01/05/2024	Family Services (B4)	Special Care Baby Unit (SCBU)	16	⇔	16	6	People and Culture Committee	New business case approved by Trust Board, that improves part of the gap in the nursing establishment as per BAPM guidance. This has increased slightly the establishment and allowed to recruit more wte in the next few months (hopefully by September 2025). However, to achieve full BAPM compliance we require the establishment to increase by 4.0wte still. Bank staff working in SCBU increased recently, with at least 8 new members of staff joining our team and covering significant gaps in the rota. Symes, Laura - Quality Manager-Family and Surgical Division 19/11/2025 11:21:19 Discussed at Divisional Business & Governance Meeting 19/11/25 - agreed increase to high risk and added to corporate risk register.

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Active	2265	Patients presenting with acute oncological need may not receive care from the DCH AOS resulting in sub-optimal care & interventi	20/05/2026	15/12/2025	Integrated and Holistic Care (A2)	Acute Oncology	12	 Risk was raised from 12 on 18/2/26	16	6	Quality Committee	Over time, the trust has created opportunities for increased cover for the Acute oncology service with externally funded posts such as Macmillan posts, which has improved staffing levels to current levels, but falls short of actual requirements. A proposal has been submitted for the 26/27 business planning round, but this has not been concluded yet, so no outcome known. Given the financial position of the trust and wider system, it will be a challenge for the trust to increase staffing provision. The service has been bolstered with more time allocated from a shared Physician Assistant post and the creation of a new Lead Acute Oncology Nurse post in addition to the core staffing numbers for Acute Oncology established in budget. UHD has attempted to mitigate the risk with additional support from registrars and agency locums, but this has had limited success and impact. Service is supported with access to UHD oncology on call team - first line response from a registrar grade and backup of an oncologist, but neither nursing or medical teams are staffed for a 7 day service and require longer term investment and growth to meet the growing demands on the service. Difficulties in accessing support from UHD occurs regularly and is being monitored via the incident reporting system. As part of the planned move to Royal Bournemouth Site all contact numbers / details will remain the same.
Active	1167	Replacement of Prismaflex Machines in Critical Care	15/05/2026	05/11/2021	Theatres, Anaesthetics, Critical Care & Decontaminati on (B3a)	Critical Care Service (CRC)	16	 This was raised to 16 on 15/4/26	16	2	Finance and Performance Committee, Medical Devices Group	Yearly maintenance contract has been extended 2025-26. Costly bills for regular repairs being paid. Hire machines being used during times of failure- at cost. On capital replacement programme - escalated to division, risk register updated.

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Active	2012	Revalidation Officer	30/10/2026	25/11/2024	Workforce and Human Resources	Human Resorces	16		16	9	People and Culture Committee	Banding has been reviewed as we are an outlier in comparison to many other Trusts. It is now a B5, as of October 2024, although other comparable roles are a B6 and have administrative support. Approved 6hrs a week overtime; but added to end of existing working days. Post holder does not want permanent additional hours. Significant work re centralisation of the management of Drs At DHC before we can explore collaborative options. 30/07 update - Additional 0.4WTE now in place so 1 WTE in total. Improved resilience however significantly low total WTE in place for size of medical workforce and dedicated LED appraisal process. 22/04 - The 0.4WTE is attached to a graduate visa; this role does not qualify for sponsorship so the postholder will be leaving the trust. Unless we are able to replace like for like, the risk level will revert to the same level as when this risk was first logged.
Active	2145	Risk of eating disordered patients not receiving expert specialist care both in hospital and community.	26/05/2026	15/04/2025	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	12		16	6	Quality Committee	Inpatients: Protocols in place for management of these patients. Easting disorder MDT's in place. Ability to convene system MDT for patients with Psych Liaison support / Gastro. ACP support (BS). Adequate MDT support and policies in place. Community Patients: This is area of greatest risk. Ultimate mitigation of inpatient admission.
Active	2139	Risk to the Maternity Advice Line Provided by UHD for all of Dorset	22/05/2026	07/04/2025	Family Services (B4)	Maternity Service	12	 Risk was raised from 12 on 6/3/26	16	1	Quality Committee	none required as currently the service is being provided by UHD

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Active	1168	System revenue affordability pressures	30/06/2026	11/11/2021	Chief Finance Officer	Strategic Estates	16		16	8	Finance and Performance Committee	Updated risk title 07/03/24 Continued review of revenue requirements for NHP project Dorset Healthcare are leading the system wide discussions with DoFs and we will keep them appraised on the timetable for the DCH OBC to ensure we can minimise any potential delay. Revenue Affordability -proposal of baseline assumptions went to OFRG last Friday 03/12, a team is being put together to look at the strategy and use those baseline assumptions to hit OBC timings Early indications are that timetables will correlate. OBC submitted 10.06.22 OBC on schedule for submission at end of May. 5/8/24 FBC submitted January 2024. Trust submitted a balanced plan for 24/25 fy. 5/3/25 - System has provided a letter of support to the FBC which has now been approved. There is still a high revenue risk across the system. 12/05/25 - Unchanged 12/11/25 - Unchanged. Continue to manage the workforce plans in the context of system affordability challenges. Starting business planning round shortly. 01/04/25 - Workforce business case approved at March FPC (Finance & Performance Committee)
Active	1221	Tackling the backlog of elective care	04/05/2026	09/03/2022	Chief Operating Officer	Central Appointments	20		16	8	Finance and Performance Committee, Clinical Effectiveness Group	The trust has had a challenging cancer performance year to date, but a strong elective performance with all key metrics meeting plan until Q4. With operational pressures (winter) and IA action, elective metrics started to go off plan from Jan 2026. On-going actions include 1) Comprehensive insourcing plan, with all activity insourced below the tariff rate 2) 12-week validation programme, which means all patients on the waiting list are contacted every 12 weeks to ensure they still want to be on the waiting list and their condition has not changed 3) PTL management process, which includes clinical oversight to ensure patients clinical priority is regularly reviewed 4) The trust is currently not in any performance management process for cancer or elective care.

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Active	2291 NEW	Day Surgery being used as an Escalation Space for Inpatients	08/06/2026	03/02/2026	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	15	NEW risk added	15	2	Quality Committee	Awaiting publication of SOP. Currently using agency nurses 24/7 (not established for this) to provide nursing care. These nurses work with the escalation bed patients, who are mixed cohort in two bays and two side rooms. The day surgery elective activity is run by the substantive team in the same area. There are situations when the work of both teams overlap, the DCH team support the agency nurses when required with drug checks and tasks. The agency nurses do not assist with the management of the day case patients, unless they fail to hit their recovery goals and turn into overnight patients, as there is no ward space for them to be transferred into. The escalation patients are provided with meals, delivered by hot locks. They are able to use the toilets or commodes on the ward, but leave the ward to shower on another ward. Privacy is provided with the use of curtains, the bed spaces are too small to allow for patient lockers or chairs. The basic patients needs are met, in the limited space, however it is far less than would be provided on a ward.
Open - Waiting for review	2293 NEW	Endoscopy Admissions - Booking Team	06/04/2026	05/02/2026	Operational Support	Elective Admissions	8	NEW risk added	15	6	Quality Committee	1. Additional resource from within other Operational Support Teams 2. Weekend booking sessions to mitigate weekday shortfall 3. Recruitment of 2x WTE admission officers - March start dates 4. Weekly booking ahead review and staffing level review
Open - Waiting for review	2295 NEW	Endoscopy Admissions - Booking Team	06/04/2026	05/02/2026	Operational Support	Elective Admissions	8	NEW risk added	15	6	Quality Committee	1. weekend booking sessions running most weekends since Sep25 2. staff with experience allocated to support in week with booking initial from with Operational Support teams, but now incorporates staff from within the Division Jan26 3. Weekly meeting to review booking and staffing Feb26 4. 2.0 WTE new recruits to join the team Mar26
Active	1912	ICE - unsent EDS (Electronic Discharge Summary) issues	01/05/2026	03/07/2024	Chief Information Officer	Clinical IT Systems	20	⇔	15	12	Strategy Transformation and Partnerships Committee in Common	Reports currently being generated by ICE. These notify each ward of incomplete EDS's that need to be actioned and are displayed in date order with alerts as the EDS's get older. We understand there are escalation routes to Divisions for outstanding summaries. Some EDS's aren't sent timely as they may have been created in a outpatient spell instead of an inpatient spell on ICE. CSST receive a daily report and move any incorrect spells and to the correct spell.
Active	2290 NEW	ICU Consultant Medical Staffing currently doesn't meet minimum standards as set out in GPICS V3 released 28/1/2026	06/04/2026	30/01/2026	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Critical Care Service (CRC)	15	NEW risk added	15	2	Finance and Performance Committee, Quality Committee	6/5/26 Business case to be presented at next Divisional Business Quality Governance meeting. Met with Divisional Director and raised to Divisional Management for support to complete a gap analysis and business case to fulfil the shortfall. Added to risk register.

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Active	2072	Lack of networking segmentation - supplier	05/06/2026	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	20		15	6	Strategy Transformation and Partnerships Committee in Common	Segmentation of contractors being tested by Networks Team which will mitigate this issue entirely. Discussed at CAB on 8th September 2025 and approved for progress.
Active	2232	Limited dietetic service for oncology and haematology patients - inpatients and outpatients	19/06/2026	02/10/2025	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	12	 Risk was raised from 12 on 21/4/26	15	6	Quality Committee	- A number of clinics have been cancelled as unable to support - Prioritisation of patients and asking acute dietetic team for support with urgent patients where possible (appreciating that acute services also on the risk register) - In process of submitting a salary justification form as B6 working up to support whole oncology services - Highlighted to wider oncology team that dietetic service is short staffed
Open - Waiting for review	2324 NEW	Limited dietetic service for renal patients - inpatients and outpatients	29/05/2026	28/04/2026	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	15	NEW risk added	15	9	People and Culture Committee	Using bank and agency staff to support patient caseload, meeting regularly with senior management to escalate concerns, prioritising caseload and highlighting areas we can cover/ can't cover at the upcoming strategy meeting w/c 4th May 2026.
Active	1539	Medical and Nursing Agency Costs	02/06/2026	04/11/2022	Unscheduled Care (A3)	Emergency (ED) Services	15		15	6	People and Culture Committee	Recruitment continues for both the medical and nursing vacancies. This includes domestic and internationally sourced staff. Recent proposal to increase the percentage of head room to recognise general absences due to study leave etc has been accepted and recruitment to address the establishment shortfall is underway. Budget and costs are monitored through governance meetings and performance meetings with executives and the Financial Recovery Board. increase in numbers of substantive MG, cons, ACP and nursing workforce to reduce locum costs and support workloads 24/7.
Active	1852	Neurophysiology Workforce levels not meeting Demand	29/05/2026	27/03/2024	Radiology & Neurophysiology (B3b)	Neurophysiology Service	12		15	3	People and Culture Committee	Job planning will be reviewed to address the balance of work to support clinical and quality of service. We are going to review how urgent and IP are covered. There are times when we struggle to meet the IP demand We have created protected time for reporting ambulatories and will review if that is on track For a small team we also need to reflect on impact of this on health and well being for small team This situation is developing the DM01 is currently in a poor position and urgent and IP has doubled for escalation. Review KPI and TATs Stats to be weighted in respect to complexity to help monitor the system

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Open - Waiting for review	2294 NEW	Outpatient Clerks	06/04/2026	05/02/2026	Operational Support	Central Appointments	12	NEW risk added	15	6	People and Culture Committee	1. Reception consolidation programme, paper to SLG 19.02.26, will result in 3x desks closing and existing staff moved to the consolidated desks - Apr26 2. 1x member of Reception staff - who works flexi hours (not always easy to accommodate on a desk) to move to Central Appts - Apr26 3. review with recruitment as to different approach to recruitment for remaining vacancies - Feb26 4. Digitisation of some of the 'churn' functions to speed up processes, Mar26 5. Weekend outpatient team - offered as o/time 6. Support from other Operational Support teams (Validation Team / Clinic Management)
Active	1664	Skill Mix within -Paediatric Outpatient Department - No Registered or Lead Nurse	29/05/2026	05/06/2023	Family Services (B4)	Paediatrics Service	12	⇔	15	6	People and Culture Committee	Rely on Kingfisher staffing and available Bank staff to support the children's centre with staffing gaps for sickness and training. 4 additional HCAs have been recruited - currently going through recruitment checks.
Active	1556	Theatre Staffing Sustainability	11/05/2026	20/03/2025	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	15	⇔	15	6	People and Culture Committee, Clinical Effectiveness Group	Workforce review completed, decision on next steps pending. Current mitigation strategy is voluntary overtime and bank shifts being undertaken by Theatre staff in order to reduce the amount of lists stood down due to understaffing. However, this is not a sustainable solution as it is leading to burnout for staff taking on additional hours and is costing the Trust more than substantive staff would.
Active	1607	Tier 2 Paediatric Registrar - BAPM Compliance in SCBU	18/05/2026	08/02/2023	Family Services (B4)	Paediatrics Service	12	⇔	15	3	People and Culture Committee	Rota reviewed to have consultant and tier 2 cover - needs funding and recruitment of additional tier 2 cover. Following ICB investment in response to Yeovil Maternity closure funding to cover 9 month fixed term 0.43 WTE tier 1, and 1.16 WTE tier 2. This will increase the fixed term establishment of tier 2 to 4.16 WTE and achieve BAPM standards for SCU low activity, recognising this is fixed term. This facilitates a dedicated Registrar in SCU. Long term substantive post will need to be part of business planning 2026/27. The ANNP posts will also be transferred into Registrar vacancies due to unsuccessful recruitment into training posts.

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Appendix 4 Closed RAC

Approval status	ID	Title	Review date	Opened	Care Groups	Service of responsibility	Risk level (initial)	Risk level (current)	Risk level (Target)	Type of Risk	Mitigations/Controls
	2266	3 month extension to external scanning project	26/01/2026	17/12/2025	Chief Information Officer	Medical Records	12	12	6		If the decision not to extend the contract is decided, this will have significant consequences, we would be required to send paper notes out for IP and OPA attendances, have mixed economy for clinical staff, health records does not have the resource to undertake the scanning currently done by SBS. Health records would be able to deal with day forward scanning only and the use of bank and excess hours would be needed to maintain this.
Managed / Tolerated within Risk appetite	2137	Careflow Printing & Re-Scanning	10/04/2026	04/04/2025	Chief Information Officer	Clinical IT Systems	16	8	8	Strategy Transformation and Partnerships Committee in Common	CSST are liaising with Training team to see if there is any enhancement to training that could help mitigate this issue.
Managed / Tolerated within Risk appetite	1754	Changes to DNAR sharing	10/06/2026	13/11/2023	Chief Information Officer	Clinical IT Systems	9	6	6	Finance and Performance Committee, Digital Systems Risk	Process on how to share DNACPR information with SWAST. SWAST are no longer accepting DNAR documentation and special messages, therefore patients need to have printed paper copy in the home.
Managed / Tolerated within Risk appetite	2118	Clinical Coding Backlog	27/07/2026	05/03/2025	Chief Information Officer	Clinical Coding	9	6	6		The measures being considered to reduce the risk of clinical coding for 2024/25 year not being completed by data submission deadline: Temporarily coding admissions up to 7 days in length and without procedures from EDS/ICE/DCR only (coding of deceased patient excluding). Increasing the hours completed by agency and bank clinical coders. This however will have an associated cost pressure.

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Managed / Tolerated within Risk appetite	641	Clinical Coding Resource	27/07/2026	17/05/2019	Chief Information Officer	Clinical Coding	20	6	8	Strategy Transformation and Partnerships Committee in Common	In line with the Clinical Coding Workforce Strategy, which was shared with FPC September 2024, a number of actions have been taken to mitigate this ongoing risk including recruiting 2 additional trainee coders further to the previous trainee coders taken on in 2023. We continue to recruit on an ongoing basis to accredited clinical coders but so far this has proved unsuccessful. Also in line with the Strategy we have now introduced a new recruitment retention premium (RRP), which is first being applied to existing clinical coding staff and will be added to new coders recruited. We are however still reliant on agency and bank coders to augment our established resource. We have also now implemented improvements to the coding software that will have a small positive impact on improving productivity for the coders. As part of the digital strategy for Dorset we will be including a shared approach across DCH, DHC and UHD, which may involve pooling resources across the organisations and
	1108	DAMERS COURT / ALBANY COURT Accommodation Lifecycle Maintenance	23/04/2026	06/06/2021	Chief Finance Officer	Facilities Department	9	9	3	Finance and Performance Committee	Secure funding undertake improvement works and redesignate use. Close as sold to PRIME
	2119	Delayed EDSs sent to GPs as part of bulk 'clean up'	06/02/2026	05/03/2025	Chief Information Officer	Clinical IT Systems	9	9	6		These Datix incidents are currently being reviewed by the Digital Clinical Incident Working Group that meets weekly. Where one ward clerk had initiated this 'clean-up'exercise the matron was informed and a full review of all the delayed EDS's conducted to identify if any patient harm may have occurred, whereas it was identified that no patient harm had occurred there are now decisions on how these very delayed EDNs should be sent given the impact on GP systems.

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	2259	ELCS Theatre Provision	14/01/2026	03/12/2025	Family Services (B4)	Maternity Service	12	9	2	Quality Committee	requested 3 additional full days in main theatres for ELCS unable to fully staff these sessions to create more slots.
	1815	Electronic Health Record, risk of not receiving FD Funding	13/02/2026	02/02/2024	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	4	8	Strategy Transformation and Partnerships Committee in Common	Update Dec 2025 (JF): Risk score is being lowered because a full business case for a joint EHR (the HealthSet programme) has been completed and submit for review in November 2025. The FBC will go through approvals processes in Jan/Feb 2026. Assuming the FBC is approved, this risk will be closed in Feb 2026. Currently working at pace to develop an outline business case with Somerset that includes options that could be affordable and which work jointly for Dorset and Somerset based on pre-market engagement. Earliest indication of whether an affordable option can be considered in mid February 2024
Managed / Tolerated within Risk appetite	2196	Emergency call cannot be heard in the reporting room or respiratory office	10/02/2026	15/07/2025	Radiology & Neurophysiology (B3b)	Neurophysiology Service	8	2	2		Recommendation that additional audio buzzer and lights are added into the two rooms. Staff are aware of situation Currently there are no mitigations as it is a fire door and cannot be left open Work competed to resolve 18/03/2026
	1008	EPMA duration/supply discrepancy	06/05/2026	21/12/2020	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	9	9	3	Finance and Performance Committee, Digital Systems Risk, Medicine Safety Committee	Training. JAC printed discharge letter with the correct quantity also provided
	2012	EPMA Pharmaceutical checking for combination infusions	23/03/2026	21/12/2020	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	6	6	3	Finance and Performance Committee, Medicine Safety Committee	Training

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Managed / Tolerated within Risk appetite	2254	Erroneous Hampshire results released against DCH patients	13/01/2027	18/11/2025	Pharmacy, Pathology and Medical Physics (A4)	Pathology Service	15	5	5	Finance and Performance Committee	DCH Pathology IT identified all affected patients at this site so that the incorrect results can be removed (11 identified on 07/11/2025 and a further 7 on 10/11/2025.) Clinical locations have been contacted to notify them to remove the results from downstream systems. This could affect any trust in SCPN (UHS, IOW, SFT, PHU), so Pathology IT contacted these sites to make them aware of the issue and take their own measures. HHFT were contacted to ask that they correct the fault or put mitigation in place to prevent the release of further inaccurate results. This led to an Emergency Change Assessment Board (ECAB) on 12/11/2025, where solutions are presented. This was declared as a major issue with CliniSys (ICE and LIMS supplier.) A 4 hourly automated report has been scheduled to pick up any request reported to the wrong order number. HHFT staff have been asked to be more vigilant when checking specimens. Clinisys ICE have checked range of order numbers between systems, only DCH and Southampton have crossover of numbers with

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	1915	Failure to replace Ultrasound equipment on rolling capital replacement plan	12/02/2026	09/07/2024	Radiology & Neurophysiology (B3b)	Radiology Service (DCH)	9	12	8	Finance and Performance Committee, Medical Devices Group	10C3 probe currently has temporary repair, but medical physics assessment has highlighted this is not sustainable. Meeting planned with procurement to discuss plans for replacement. Some work is now booked on alternative systems impacting on service delivery. Currently the lack of probes means that probes are being switched from system to system to maintains a service, this is impacting on throughput of work and increasing pressure on staff (sonographers and admin team). Medical physics have undertaken a review of existing risk assessments for these systems and they are classed as high risk of failure and have recommended urgent replacement. Awaiting final review by the Trust.
Managed / Tolerated within Risk appetite	2302	Flammable Fuel Storage in proximity to Energy Centre.	01/02/2029	18/02/2026	Chief Finance Officer	Estates Department	3	3	1		The building is staff and estates and contractor workers only. The building has an L1 system and multiple escape routes. The fuel has emergency cut off and the fuel is bunded. The building is only attached to the main building via a roof link. In addition Diesel has a low flash point and in the event of a fire the area can quickly and easily be evacuated. These tanks are over 8m from NHP.
	1793	Funding required for GPVTS posts	29/05/2026	10/01/2024	Trauma, Orthopaedics, Urology & Junior Doctors (B1a)	Orthopaedics Service	10	10	1	Finance and Performance Committee	Locum doctors are being brought in to support the wards. This is a cost pressure to the trust.

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Managed / Tolerated within Risk appetite	2095	High risk of data leakage relating to sensitive information	07/08/2026	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	9	6	Finance and Performance Committee	In conjunction with the infrastructure team and IG, the DTI department will regularly review our controls and processes to safeguard the Trust against data leakage We enforce DLP (Data Loss Prevention) on our outbound mail, preventing sensitive data from being mishandled and resulting in susbequent loss. Pertinent awareness material is included within regular Information Governance training and best practice is outlined within the Trusts policies. We enforce Encryption on all small factor laptops and PCs and required to use VPNs to connect into the estate when working remotely. Peripheral control is in place to control access of devices with native storage capacities to address the risk associated with data loss through this medium.
Managed / Tolerated within Risk appetite	2216	ICE Performance Issues	10/04/2026	04/09/2025	Chief Information Officer	Clinical IT Systems	16	4	4	Strategy Transformation and Partnerships Committee in Common	Various checks/suggestions have been put forward by the supplier and DTI. A document of the background and investigations to-date have been attached to this risk. The issue is particularly difficult to troubleshoot due to it's inconsistent nature, can be present on a particular user's session, and seemingly resolve itself and not occur again for some time. Restarting the computer, or sometimes even the browser window can resolve the issue. The problem can be witnessed on ICE Test and via different connection methods. The problem cannot seem to be replicated, and for some users, the problem never occurs.

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Managed / Tolerated within Risk appetite	2217	Inability to integrate with the NHS App	15/04/2026	12/09/2025	Chief Information Officer	Clinical IT Systems	12	4	4		A business case is being developed for the procurement and implementation of a Patient Engagement Portal. This is due to be reviewed in September 2025. The Trust was successful in a bid for national funding to support this - £500k was awarded. However, there is a remaining affordability gap. If the business case is approved in September 2025, then there is an ambitious but feasible project delivery plan which could achieve the required minimum integration by or near 31 March 2026. Update 14/10/2025: Business case has been approved by Trust Board. Wayfinder funds drawn down and commercial discussions underway with supplier. Project to begin in October 2025. Current project plan indicates the minimum requirements will be achieved by 31 March 2026. Risk level lowered, but risk to remain open until this has been achieved. Update Dec 2025 (JF): No change since last update in October, other than to note that the project has started and work is underway. Review timeline remains unchanged, risk score remains unchanged.

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	2133	Inability to undertake necessary clinical systems upgrades	30/01/2026	27/03/2025	Chief Information Officer	Clinical IT Systems	20	12	8	Strategy Transformation and Partnerships Committee in Common	Risk-based approach to reprioritising digital portfolio, has identified the highest risk/most urgent upgrade (Vitals) to be started c May/June 2025. Portfolio prioritisation process going forwards will account for risks and deadlines in the scheduling process; however, this will not address the fundamental issue related to capacity. Digital recovery plan has been initiated. Work has been started with departmental system leads, as part of a digital landscaping exercise, to look for opportunities to put more effective and robust system management controls in place. Similarly, opportunities to utilise departmental CSOs are being explored.
	1847	Information Asset Owners Responsibility	27/03/2026	20/03/2024	Chief Information Officer	Digital Technology and Infrastructure (DTI)	9	4	6	Finance and Performance Committee, Digital Systems Risk	Proposal to raise this @ the next Information Governance Group for discussion in relation to reinforcing the importance of the IAO and the associated responsibilities with actions to embed this within relevant job descriptions.
Managed / Tolerated within Risk appetite	2111	Inherent risk of updating systems/software with the latest feature upgrades	05/08/2026	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	8	6	4		The DTI department does utilise testing groups and piloting within standard patching processes. However, given the nature of some zero day exploits and the subsequent haste in which updates are applied, there have been instances where "hotfixes" have caused operational issues. Pilot/testing processes to be discussed internally and improved where necessary.
Managed / Tolerated within Risk appetite	857	Insufficient OMF Capacity & Impact on Cancer Pathways (Theatres)	29/04/2026	18/12/2019	Head & Neck, Specialist Medicine and Outpatients (B2)	Maxillofacial Service	20	6	4	Finance and Performance Committee	Weekend lists were running until 12th May. Ceased due to utilisation of all lists within OMF service. Working to restart treatment, ensuring clinical space within department isn't impacted. Discussions with division to provide lists that are currently set to run in the Procedure room that is undergoing building work

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Managed / Tolerated within Risk appetite	1773	Insufficient Surgical ANP Service	19/06/2026	06/12/2023	Surgery & Gastroenterology (B1b)	General Surgery Service	8	8	4		At present if only 1 ANP on duty the 'take' will take priority and the ANP will cover the ward in addition as able. The outstanding workload is covered by the surgical clinicians. Over time/bank can be offered to the existing Surgical ANPs within the team; at present no bank ANP options available outside of this due to lack of training and experience. Future resilience should be considered in the form of locums nest if no ANP is available for the day. In the event of gaps in the medical/clinician rota giving rise to the need for additional ANP cover over time may be considered and should be discussed with Matron.
Managed / Tolerated within Risk appetite	1961	Isolation Rooms - Lulworth, ITU 6 Annual Maintenance	30/01/2026	06/09/2024	Chief Finance Officer	Estates Department	9	6	4		Rooms need to be unoccupied and cleaned for validation and to arrange service visits to each room to check and service equipment.
	1630	JAC (EPMA) system out of date	23/03/2026	24/04/2023	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	12	8	1	Finance and Performance Committee, Medicine Safety Committee	Plan to upgrade - support to remain in place.
Managed / Tolerated within Risk appetite	2261	Lack of a Learning Management System for Digital Training	10/04/2026	08/12/2025	Chief Information Officer	Clinical IT Systems	9	6	6		A pan-Dorset LMS procurement is being looked at as an EHR training enabler. Whilst risk is currently within tolerance, risk consequence and risk likelihood will increase as EHR implementation approaches; therefore, this risk is being retained as an active risk as it will require active management.

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Managed / Tolerated within Risk appetite	1981	Lack of Assurance from Fortrus to meet clinical safety processes	16/01/2026	23/09/2024	Chief Information Officer	Clinical IT Systems	16	4	4	Strategy Transformation and Partnerships Committee in Common	Review of the contractual commitments between Fortrus and DCH at an executive level as previous meeting shave not resolved the issues. Resetting the contractual milestones. Should the Trust and Fortrus be unable to provide us with some stability in the system, the Trust would have to revert back to paper records within ED environment.
Managed / Tolerated within Risk appetite	1875	Lack of DCB0129 compliance from Health IT manufacturers	26/01/2026	29/04/2024	Chief Information Officer	Clinical IT Systems	12	8	8	Finance and Performance Committee, Digital Systems Risk	The deployment of Health IT without the DCB0129 evidence is required to be authorised by Top Management as stated in Section 2.2.2 of DCB0160 Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems – Implementation Guidance. Therefore sign off at an Executive level is required in these instances.
[redacted]	1994	Lack of Emergency & Trauma Bookings System in Theatres	09/03/2026	17/10/2024	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	15	12	4	Strategy Transformation and Partnerships Committee in Common	Escalated to Digital team regarding solution (JR2309-00911) and IT team advised in Nov 2023 that they would pick this up with Jo Howarth. In the meantime, existing processes are continuing to be used. We have a CEPOD lead to coordinate in the meantime.
	2015	Lack of Resource for Resuscitation Team to Train Radiographers in ILS	09/03/2026	26/11/2024	Radiology & Neurophysiology (B3b)	Radiology Service (DCH)	10	10	5	People and Culture Committee	Radiographers are undertaking BLS only, which does not include defibrillation.
	2239	Lack of Usable Anaesthetic Ultrasound Equipment to assist with vascular and spinal procedures for maternity theatres	14/11/2025	14/10/2025	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Anaesthetics Service	9	4	4		proposed plan for charity funding, current use of old machine which can not be repaired as parts are not unavailable. In event of failure, use of main theatre machine would be requested , limiting the use across the trust, potentially delay in operations or care.

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Managed / Tolerated within Risk appetite	2222	Maintaining levels of scanning legacy notes	02/03/2026	24/09/2025	Chief Information Officer	Medical Records	9	4	4	Strategy Transformation and Partnerships Committee in Common	6/1/26 no update has been given. Health Records manager have put an options paper together. This will be sent to the CIO.
	2210	Means of Escape from Temporary Stroke Ward	22/09/2025	21/08/2025	Chief Finance Officer	Estates Department	9	9	6		All staff have received information on the adapted Means of Escape and the code to the lock. the 2 wards involved (and divisional management) have been made aware of the strategy as well as codes for means of escape. This will also be captured at all ward briefings/handovers so all are aware. This will be removed once construction works have been completed Construction completed and Stroke ward moved back to its original location
Managed / Tolerated within Risk appetite	2113	Microsoft Teams - multiple social engineering/phishing attacks	05/08/2026	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	8	6	4		After experiencing the first social engineering attack using Teams to target the entire domain, the tech support team promptly enabled the ability to block known malicious domains. This will rely on the prompt reaction in the future. Cyber team to investigate means of constantly updating the list of prohibited domains. It was recently found that the presence of the old version of Teams is causing the MDE security score to increase and has been known to conflict with the new edition, causing performance issues. Removing old iteration wherever possible.

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Managed / Tolerated within Risk appetite	2108	NHS Cyber Alert Residual Risk	05/08/2026	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	12	6	4		Continually review the Trusts Cyber Alert Remediation procedure, in line with national standards and expectations. The trust has opted to accept the residual risk associated with Cyber alerts, on the proviso that where realisticaly possible all devices that are available have been patched to mitigate the associated risk. The Trust is obligated to acknowledge these alerts within 48 hours, and must provide a subseuqent action plan to address within 14 days - this provides assurance that these issues are promptly managed with the appropriate action being undertaken. The Trust also has a process that ensures devices are automatically updated before being able to connect into Trust systems, devices that have not connected to the network will be non compliant and must be brought into DCH to connect to the network, download any missed patches prior to being certified as compliant. And thus, facilitating the remote connection into DCH for the user.
Managed / Tolerated within Risk appetite	1770	No electronic capture and referral process for treating tobacco dependency in the acute sector	16/01/2026	05/12/2023	Chief Information Officer	Clinical IT Systems	15	6	6	Strategy Transformation and Partnerships Committee in Common	Update Dec 2025 (JF): manual processes are in place to capture necessary data and complete manual referrals. This is currently manageable within the service, but if activity levels increase or staffing levels decrease it will become unsustainable. Longterm solution is the implementation of the HealthSet EHR. Discussion around the use of ICE for reporting procedures.
	2211	No Gynae CNS Support	12/02/2026	21/08/2025	Family Services (B4)	Gynaecology Service	6	12	4		UHD are providing some support remotely.
Managed / Tolerated within Risk appetite	1719	Paper based patients notes are not filed in correct order creating multiple risks	12/01/2026	30/08/2023	Chief Information Officer	Medical Records	12	6	6	Quality Committee, Digital Systems Risk, Clinical Effectiveness Group	All ward clerks trained and working to the same standards. Processes in place to monitor quality of work. 7/11/24 Guidance sent to all ward clerks in relation to filing procedures

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Managed / Tolerated within Risk appetite	456	Patient Transport Provision & Urgent Patient Transfers	31/10/2024	01/07/2023	Chief Operating Officer	Discharge Team Service	9	12	6	Finance and Performance Committee, System Risk - sits with ICB or other	Contract changing from Ezec to Emad 01.07.2023 25/20/26 Provider transferred from EZEC to HTG, services improved, regular meetings to discuss issues.
Managed / Tolerated within Risk appetite	1893	Patients arriving more than 30 minutes late for dialysis (Bournemouth site)	14/01/2026	20/05/2024	Vascular and Metabolic (A1)	Haemodialysis Service	12	1	1	Finance and Performance Committee, System Risk - sits with ICB or other	Escalated to ICB as the commissioners of the service and the contract holders Regular meetings between provider and ICB - continue as problems continue. manager appointed to dialysis for direct contact which does help but a lot more risks when she is on leave. 04/11/2025 Transport did improve for a while resulting in the regular meetings with the ICB being discontinued. A manager was appointed by Ezec to deal with the daily problems. She liaised with the units & spoke to the patient's which did manage a lot of the problems with good results. The issues have gradually increased again & while no the same volume of issues as previously the delays seem to affect the same patients. These issues continue to be reported on Datix & divisionally & managed by the flow team.
	2028	Pharmacy ADT Alarm connection failure	09/04/2026	16/12/2024	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	6	6	3	Finance and Performance Committee, Quality Committee	- Security doing additional checks in Pharmacy - Senior team to be notified if the alarm will not set - IT & estates speaking to ADT to fix the alarm fault

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	1837	Pharmacy Aseptic Unit staffing not resilient	09/04/2026	27/02/2024	Pharmacy, Pathology and Medical Physics (A4)	Pharmacy Service	12	8		People and Culture Committee, Medicine Safety Committee	- Taken the only other member of staff who is currently trained within another team and relocated them into Aseptics - One further member of staff received broth test back and awaiting final sign off - Another member of staff started their broth tests - Business case in with NHSE for additional staff to provide resilence - Buying more in to offset 8/10/25 - Currently procuring ready-to-administer products from external commercial providers. Staffing sufficient to support this, and recruitment ongoing to increase establishment. Risk rating likelihood reduced to 3 due to inability of team to prepare products in-house (products are externally purchased while unit is closed).
Managed / Tolerated within Risk appetite	2081	Policy dissemination	02/04/2027	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	20	8	6	Finance and Performance Committee	The Trust must maintain all relevant policies and procedures ensuring they are regularly communicated to staff and applicable personnel, this includes in the event where any major change is made to the existing process and at least annually. Clear responsibility is required. Confirmation of acceptance is required (a huge task in itself). possible through metacompliance upon policy review.
Managed / Tolerated within Risk appetite	2046	RBH dialysis raised counts of legionella	14/01/2026	20/01/2025	Vascular and Metabolic (A1)	Renal Service	12	1	2		Point of use filters on all taps with increased flushing & legionella counts monitored. Mitigation continues - should be to keep an eye on the POU filters and raise the alarm if any go out of date for change.

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Managed / Tolerated within Risk appetite	2298	Reduced capacity within safeguarding administration team due to maternity leave / Reduced capacity in team due to vacancy	01/05/2026	10/02/2026	Chief Nursing Officer	Safeguarding Children Service	9	9	4	Quality Committee	Review workflow to remove low-value admin tasks from practitioner workload. Bank role agreed.As yet no details of admin staff that can fill the gap Vacancy awaiting agreement for Safeguarding practitioner Prioritisation framework for urgent documentation (e.g., conference reports, legal requests). Temporary redistribution of admin tasks across the team where capacity exists. Unable to fulfill face to face training due to annual leave , reduction in team to ensure operational work is completed .
	2102	Retention of legacy accounts	05/08/2026	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	12	9	4		This risk is accepted by the Trust - we need to clarify why.
Managed / Tolerated within Risk appetite	1757	Retention periods for Health Records	15/05/2026	15/11/2023	Chief Information Officer	Medical Records	9	9	6	Finance and Performance Committee, Digital Systems Risk, Information Governance	Working with BI team to produce a report for patients with no PAS activity for +9 years. Notes will be pulled and sent for destruction by off site authorised contractor. Ongoing timescale for initial clearance. The a structured yearly review. Notes are currently held on site at DCH are at Restore. Destruction policy approved May 2025, working on list produced by BI, it has over 90,000 lines to work through. 11/02/26, no work has started yet on reducing the amount of notes required to be destroyed, but plans are in place to start, so this is managed, but only if deputy and health records managers are available to complete
	2218	Risk of Effluent Backing up in Day Surgery	28/04/2026	15/09/2025	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	12	12	1	Quality Committee	When incidences occur infection control and estates are contacted.

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Managed / Tolerated within Risk appetite	2025	Risk of unknown incorrect maternity records in Badgernet as a result of memory leak incident	07/04/2026	11/12/2024	Chief Information Officer	Clinical IT Systems	20	8	8	Finance and Performance Committee	The incident oversight group will meet on 19th December to conclude all outstanding actions including how to mitigate the remaining risks associated with unknown incorrect records.
Managed / Tolerated within Risk appetite	2086	SafePasswords document and general management of sensitive access information	05/02/2027	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	6	4	Finance and Performance Committee	This needs to be investigated when resourcing is available. A more secure and more segregated solution needs to replace the legacy password document. A working group has been set up to meet next week 10/02/2025 Document management now in progress - with access restrictions
Managed / Tolerated within Risk appetite	1723	Septic Tank - Transport Hub	30/01/2026	07/09/2023	Chief Finance Officer	Estates Department	12	6	2	Finance and Performance Committee	Tank is emptied every other week to reduce the risk of overflowing. This is an ongoing risk.
Managed / Tolerated within Risk appetite	2045	Shortage of Sonographers	17/08/2026	15/01/2025	Radiology & Neurophysiology (B3b)	Radiology Service (DCH)	12	6	6		Locum support 2 days weeks with additional support when DM01 targets breach. WLI's currently operational 4 sessions/days at weekends until end February Plan to go out to advert again in Feb/March.
Managed / Tolerated within Risk appetite	1787	Single point of failure for Subject Access Request	15/05/2026	08/01/2024	Chief Information Officer	Medical Records	4	4	4	Finance and Performance Committee, Digital Systems Risk, Information Governance	Records Managers, would need to prioritise SAR's over day to day requirements, cancelling of meetings and potential delays in dealing with records related queries. Train substantive records clerk to support in the day to day running of the department, does leave main library a person day for 3 days a week, which is covered by as 7 when staff. We have appointed a substantive member of staff to support this role, it take approx. 6 months to be proficient in this role, so moving to managed risk

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	2235	Spacelabs Sentinel, Pathfinder and LifeScreen Pro Analysis System NOT Windows 11 compatible	02/02/2026	09/10/2025	Vascular and Metabolic (A1)	Cardiology Service	4	12	4	Finance and Performance Committee	Equipment already on the DTI radar for the Windows 11 upgrade project. Equipment also on the Trust capital bids register for equipment prioritisation. 11 month window covered by the Microsoft extension, this provides scope to build a case for a capital equipment bid.
	2283	Theatre Ventilation Ducts Inspection and Cleaning Overdue	02/03/2026	14/01/2026	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	9	12	1	Quality Committee	The estate team have been asked to provide evidence of adherence to the standards by 21/01/26. A request to have the theatres culture plated has been actioned. An urgent request to complete the inspections and duct cleaning, followed by plate testing has been made.
	2242	T-Max Shoulder Table Replacement	31/03/2026	21/10/2025	Trauma, Orthopaedics, Urology & Junior Doctors (B1a)	Orthopaedics Service	9	12	1		The inability to purchase a second t-max table will create inefficiencies in theatre scheduling and limits operating capacity for the subspecialty. Delays in elective operating resulting in trauma cases being postponed or elective cases being cancelled. Concurrent operating is the only viable way to address increasing demand and manage waiting lists effectively and the impact on safety and sustainability.
	1687	Transition to combined Health Records and scanning service in maintaining scanning volumes for day forward and legacy.	12/01/2026	28/06/2023	Chief Information Officer	Medical Records	12	9	9	Finance and Performance Committee	To maintain running health records as BAU and including the scanning bureau requires adequate work force. Currently if health records department is short staffed, staff are pulled from the scanning bureau, this then means that legacy and day forward scanning is affected.
Managed / Tolerated within Risk appetite	2203	Trust Premises Keys	28/07/2025	18/07/2025	Chief Finance Officer	Facilities Department	6	3	1		The Trust has a number of CCTV cameras around the sight although there are known blind spots (There is a CCTV review and replacement Project), thus advise the Security Team to be vigilant and carryout additional random spot checks of known areas of risk. Regular review of Access Control information as part of audit process.

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Managed / Tolerated within Risk appetite	2079	Understanding the Vulnerabilities within our computing estate	02/04/2027	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	12	6	Finance and Performance Committee	We are constantly trying to address these vulnerabilities through regular and out of band patching. A number of these systems are managed by 3rd parties and we are chasing them around bringing them inline with the Trusts patching policy.
	2215	Urology Stacks and Camera heads require replacement	09/03/2026	02/09/2025	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	15	12	12	Finance and Performance Committee	None at present
Managed / Tolerated within Risk appetite	2169	Video platform for Paediatric epilepsy service (V-create platform)	27/04/2026	04/06/2025	Family Services (B4)	Paediatrics Service	16	15	1	Strategy Transformation and Partnerships Committee in Common	None. Funding request sat on Trust capital expenditure list
Managed / Tolerated within Risk appetite	2078	Zero Day exploits - cyber attacks with no known mitigation	02/04/2027	19/02/2025	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	12	9	Finance and Performance Committee	The DTI department strives to apply updates as quickly as possible to reduce the liklihood of us being vulnerable to zero days, where applicable we apply the necessary patches to address publicised zero days. In addition, as per the NHS E Cybersecurity alerting system we are required to acknowledge and respond to any pertinent High or Critical rated alerts - which can include Zero Days. The department disseminates Cyber related communications and regularly review the security configuration of the Trust perimeter. Cyber team monitors Threat Landscape through ongoing external reports and news articles and the plethora of organisation security monitoring solutions EG SPLUNK SIEM, SOPHOS & MDE AV XDR, NESSUS VULN SCANNER etc Trust respond to NHS Cyber alerts are recorded and reported to the board and IGG, as well as being tracked in an online portal - CEO is contacted if we don't respond in the alotted timeframe. Within Internal Phishing campaigns it is possible to track the time in which the department would have to respond in the event of a true phishing instance.

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Dorset County Hospital
Dorset HealthCare

Quality Committee in Common Assurance Report for the meetings held on Tuesday 28 April 2026 (informal) Tuesday 26 May 2026 (formal)

Chair	Claire Lehman, NED
Executive Lead	Dawn Dawson, Joint Chief Nursing Officer Lucy Knight, Chief Medical Officer (DHC) Rachel Wharton, Chief Medical Officer (DCH)
Quoracy met?	Y
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Draft Quality Accounts for approval (to be presented to the 22nd June Board meeting, alongside the final Annual Report and Accounts) • Positive response to MenB vaccination requirements in Weymouth • Positive recruitment across both trusts of Chief Digital Information Officers, International Medical Graduates, and Consultants • System-level LeDeR reviews are currently paused due to ICB resourcing constraints, with no assurance yet on resumption. • Confirmation of MIS compliance, rebate >£250,000 which funds midwives • National publications anticipated in the coming months including Ockenden, Thirlwell, Baroness Amos, and MMBRACE reports in to maternity care.
Key issues / matters discussed at the meeting	**The informal meeting of the committee held 28th April 2026 received:** • **CQC Well Led Inspection (DHC)** presentation outlining the expectations of the upcoming CQC Well-Led Inspection for DHC. Discussions centred around the need to ensure NEDs were fully appraised ahead of the inspection, utilising experience from the Advanced Foundation Trust application process, and what DCH could learn from the inspection. Consideration would be given to the next informal meeting taking place at St Ann's Hospital, with a site visit included. • **Corridor Care (National Guidance and GIRFT) (DCH)** presentation outlining the work ongoing to eliminate corridor care and improve patient experience and hospital efficiency, noting improved performance, areas of focus, and the need for a system wide approach. • Following the presentations committee members undertook a site tour of the DCH escalation areas. Patients were spoken to and all were complimentary of the care they had received.

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The formal meeting received of the committee held 26th May 2026, discussed and noted the following reports:

Chief Nursing and Chief Medical Officer Update (DHC/DCH)
Dorset HealthCare

- Significant ongoing CQC activity was noted, including inspections of Twynham Ward (report awaited), learning disability teams, and continued review activity for Herm Ward and St Brelade's. Positive feedback was received following a visit to new build sites.
- The 111 service has been temporarily relocated under business continuity arrangements due to an estates issue, with mitigations in place to maintain service delivery.
- Re-accreditation of the PMVA training programme was confirmed.
- An update was provided on the recent meningitis response, with effective system-wide vaccination delivery and planning underway for the second dose.
- Two CMIOs have been appointed to support the Epic implementation.
- Progress with the IMG programme was noted, with eight doctors in post and further recruits expected. Robust onboarding arrangements are in place, with early progress reported as positive.

Dorset County Hospital

- Draft CQC reports for Urgent and Emergency Care and Medicine were received, with factual accuracy review underway.
- System-wide work on the Wessex pathology network continues, with a dynamic approach in place to monitor and manage risks.
- Ongoing pressures relating to patient flow were noted, driven by increasing patient complexity despite stable admission rates.
- Continued use of escalation areas and temporary staffing was highlighted, with a focus on reducing corridor care.
- Positive progress with consultant recruitment and single service developments with UHD was noted.
- Staff engagement on pathology changes is ongoing, alongside Trust involvement in network governance.
- Operational pressures remain elevated, including increased demand and workforce gaps, with mitigations in place to maintain safety.

Board Assurance Framework (DHC/DCH) including proposed revised wording for SR1. For DHC the risk score for SR1 remains at 12 against a target of 9, while for DCH this remains at 16 with a target of 12. One action applicable to both Trusts is behind review but is scheduled to be completed for Q1 reporting. Agreement with the proposed new wording for SR1.

Corporate Risk Register (DHC/DCH)
Dorset HealthCare

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- The Committee noted overall movement in the risk profile, with updates since the reporting date reflecting the dynamic nature of the register.
- Previously high-rated risks have reduced or been redefined, including improvements in CMHT staffing and revision of the mental health bed capacity risk.
- New and ongoing risks relate primarily to workforce pressures, service demand, and specific areas of staffing and service delivery.
- Improved risk management processes and more accurate risk descriptions were noted as key drivers for changes in scoring and assurance.

Dorset County Hospital

- A new high-rated risk relating to ADHD medication follow-up was noted, driven by increased demand following expanded diagnostic capacity. Mitigations are in place, including recruitment and development of a nurse-led model, although impact will take time to be realised.
- Risks relating to acute oncology capacity and specialist dietetic staffing were highlighted, reflecting workforce constraints and increasing demand, with mitigations in progress.
- The maternity advice line risk has reduced following planned implementation of a digital solution to support demand management.
- Additional risks relating to administration capacity, stock management, and use of escalation areas were discussed, with assurances provided that impacts are being monitored and addressed. Broad themes related to workforce pressures, increasing service demand, and the need for longer-term system and workforce planning.

Quality Report (DHC/DCH) updating on core quality metrics and the Safe Staffing Report Mid-point Reviews for each Trust. Of note

Dorset HealthCare:

- Overall performance was noted as positive, with improvements in IPC and complaints handling.
- An increase in falls was highlighted, with review work underway.
- Strengthened duty of candour processes and positive patient feedback were noted.
- Isolated serious incidents were reported, including a patient death and brief use of an adult ward for a young person, with appropriate processes followed.
- Positive national recognition for Westminster Memorial hospital for care for patients at end of life and their families.

Dorset County Hospital

- Strong performance in IPC and tissue viability was noted, with reductions in harm incidents.
- Ongoing improvements in falls, staffing assurance, and complaint handling were highlighted.

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- Mixed sex accommodation breaches and operational pressures continue to be managed.
- Progress on digital improvements and audit processes was noted, with further work underway.

Quality Governance Groups Assurance Reports (DHC/DCH)
Dorset HealthCare:

- Updating on two recent meetings including safer staffing, complaints themes, and ongoing service improvement work.
- Specific focus was given to the meningitis response, audiology services, and adoption record processes, with further work planned.
- The report highlighted isolated partnership challenges, with actions in place to support staff and strengthen system working through the Integrated Neighbourhood Teams

Dorset County Hospital

- System-wide work on pathology, including digital upgrades and associated risks as services transition.
- Improved governance arrangements were reported for point of care testing, providing greater assurance across the system.
- Positive progress in paediatric palliative care and transition arrangements was highlighted.
- Adoption of a system-wide treatment escalation plan was noted, with implementation work underway.
- Updates on corridor care and estates-related risks were noted, with assurance that actions are in progress.

Maternity and Neonatal Quality and Safety Reports (DCH) noting:

- Key safety incidents, including a maternal death and a small number of neonatal cases, with appropriate review processes underway.
- Workforce risks remain across maternity and neonatal services, with recruitment underway and mitigations in place.
- Ongoing service risks were noted, including neonatal equipment, EPAC provision, and theatre capacity, with actions progressing.
- Positive assurance was provided through compliance with perinatal review processes, with learning identified and acted upon.
- National publications anticipated in the coming months including Ockenden, Thirlwell, Baroness Amos, and MMBRACE reports in to maternity care.

Learning from Deaths Report (DHC/DCH)
Dorset HealthCare:

- PSIRF reviews identified no evidence of clinical failings, with recurring themes relating to communication, coordination, and proactive care.
- System-level LeDeR reviews are currently paused due to ICB resourcing constraints, with no assurance yet on resumption. However,

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strong internal learning disability mortality review processes were reported, with plans to further strengthen approaches and learning.

Dorset County Hospital

- Increased focus on learning within the report
- Improvements in mortality indicators, with a continued focus on learning and service development, including orthogeriatrics
- Some backlog in structured judgement reviews and ongoing challenges in clinical coding were highlighted, with actions in place.
- Performance issues in specific pathways (e.g. hip fracture) were noted, with improvement plans underway.

Quality Impact of Medic Vacancies in CAMHS (DHC)

- Referred from People and Culture Committee in Common due to concerns. The risk has now reduced to six, with mitigations from high-quality locums and recent recruitment campaigns.
- Recruitment remains ongoing for high-intensity area of CAMHS, with plans in place for senior oversight and discussions around rightsizing the medical workforce in CAMHS.

Internal Assurance Report (DHC) noting recommendation to close a number of actions relating to St Brelade's and Herm Ward, with assurance provided on completion. Progress on dormitory accommodation works was noted, with construction due to commence shortly and interim mitigations in place.

Draft Quality Accounts

Dorset HealthCare which meets all statutory requirements, includes areas for improvement previously identified by the committee, and captures organisational achievements. The report had undergone extensive stakeholder engagement. The Committee approved the Quality Accounts and recommended to the Board for final approval.

Dorset County Hospital which provided a summary of performance against last year's priorities, and proposed priorities for the year ahead with a continued focus on core quality themes, including harm reduction and maternity safety. The Committee approved the Quality Accounts, subject to final updates, and recommended to the Board for final approval.

Quality Impact of Clinical Supervision Rates (DHC) noting the potential impact of gaps in clinical supervision, including risks to decision-making, staff wellbeing, and patient outcomes. Challenges relate primarily to recording rather than delivery of supervision. A structured improvement plan is in place, with a focus on prioritising clinical staff and strengthening oversight and reporting.

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Decisions made at the meeting	• Approval of the Draft Quality Accounts (DHC & DCH)
Issues / actions referred to other committees / groups	• Nil

Quoracy and Attendance						
	26 May 2026	28 July 2026	29 Sept 2026	24 Nov 2026	26 Jan 2027	23 Mar 2027
Quorate?	Y					
Claire Lehman	Y					
Suresh Ariaratnam	Y					
Dawn Dawson	N					
Eiri Jones	Y					
Lucy Knight	Y					
Stuart Parsons	Y					
Rachel Small	N					
Anita Thomas	Y					
Rachel Wharton	Y					

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Report to	Board in Common (DHC)	
Date of Meeting	17 June 2026	
Report Title	Learning from Deaths Report – Quarter 4 2025/26	
Prepared By	Ellie Lindop, Deputy Director of Nursing, Therapies and Quality	
Approved by Accountable Executive	Lucy Knight, Chief Medical Officer	
Previously Considered By	Mortality Governance Group 22 April 2026, Quality Governance Group 5 May 2026, Quality Committee in Common 26 May 2026	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	Nil	
Statutory & Regulatory	National Quality Board Framework (2017) and Patient Safety Incident Response Framework (2022)	
Equality, Diversity & Inclusion	No implications	
Co-production & Partnership	No implications	

Executive Summary

The following report provides the Trust Quarter 4 update relating to compliance with the National Quality Board Framework (2017) and the Patient Safety Incident Response Framework (2022).
In summary:

- A total of 20 unexpected deaths were reported (of which three were inpatient deaths).
- A total of 36 inquests were listed by the Coroner in relation to the Trust, with one Regulation 28 report received.
- There were no Learning and Disability deaths reviewed under the LeDeR process. The Learning Disability Service continued to complete internal reviews of all deaths.
- In total, 29 expected deaths were reported, all of which were in the Integrated Community Services (ICS).

The group are asked to receive this report as assurance of the processes that are undertaken in relation to the management of learning from deaths and compliance with the reporting requirements associated with the National Quality Board Framework (2017), aligned with Patient Safety Incident Response Framework (PSIRF) methodology. Presented in this report are areas of learning for the Trust, and in some cases the wider Dorset system for discussion, consideration and identification of any further opportunities for improvement.

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Colleagues are asked to consider areas of good practice highlighted for wider sharing and consideration, in addition to areas which require further improvement.

Recommendation
Receive the report for **assurance.**

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LEARNING FROM DEATHS REPORT (QUARTER 4 2025-26)

1.0 INTRODUCTION

1.1 This report provides a quarterly overview of patients who have died whilst under Dorset Healthcare Trust as a primary provider of care (as per the National Quality Board (NQB) framework, 2017).

1.2 Where the Trust is not a main provider, there is consideration on identification of the patient/ service users' death, if it would be appropriate to undertake a full learning review process as a Trust, collaborate with the main provider of care and provide insight into the care/ services provided or whether there is no identified need to review further after initial discussion and consideration (as per the NQB framework). Predominantly, service users of Mental health services are more likely to require a review, especially if their death is confirmed or suspected to be a likely consequence of their mental health diagnosis.

1.3 Expected deaths of inpatients continue to be included for oversight in this report, with a focus on the identification of learning (refer to section 9).

1.4 To highlight, data within this report is based on the date of death (incident date).

2.0 SUMMARY TRUST REVIEW PROCESS

2.1 All inpatients' deaths (expected and unexpected) are reported on the Trust Risk Management System (Ulysses) when identified and a review is undertaken (based on NQB guidance and with the Patient Safety Incident Response Framework (PSIRF) methodology). For deaths of community service users, these are either reported via the service who provided care for consideration, or notification is received from an external source (e.g. the coroner).

2.2 There are multiple tools which can be used to support the review and identification of learning from deaths (refer to Appendix 1).

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3.0 OVERVIEW OF UNEXPECTED DEATHS REPORTED

3.1 In Q4 2025/26, a total of 20 trust wide unexpected deaths were recorded on the Trust's incident reporting system, comprising three inpatient deaths and 17 community deaths.

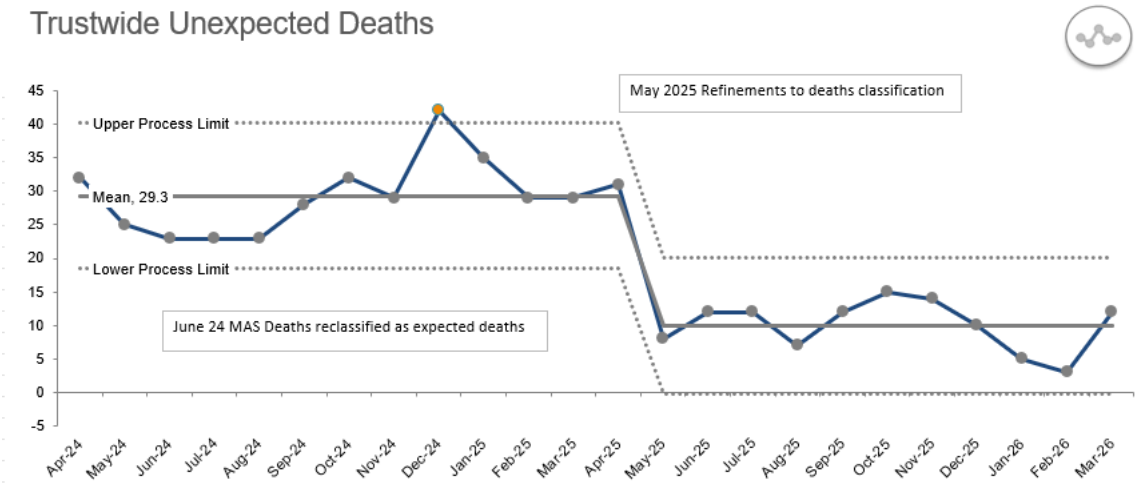
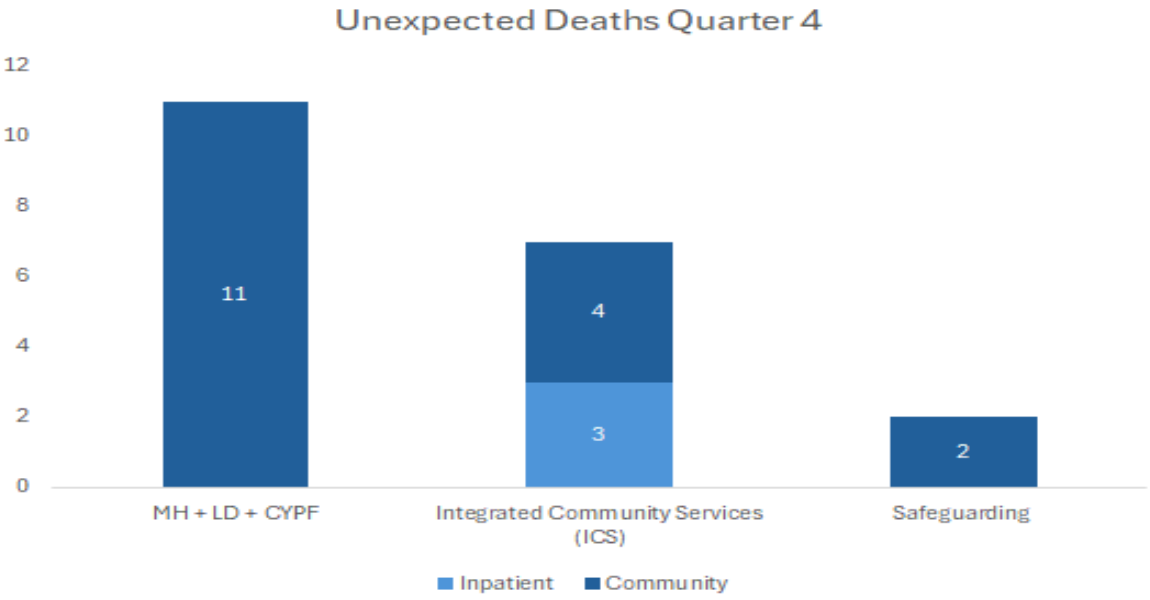


Figure 1 Trustwide Unexpected Deaths

3.2 Of the 20 deaths reported, 11 occurred within the Mental Health, Learning Disabilities, and Children & Family Services Directorate, seven within the Integrated Community Services Directorate and two were recorded under Safeguarding (however neither of these deaths were related to the provision of care from the Trust). The distribution is illustrated in **Figure 2**.



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Figure 2 Unexpected Deaths by Service Setting

3.3 A total of three inpatients deaths were reported, all within the Integrated Community Services Directorate.

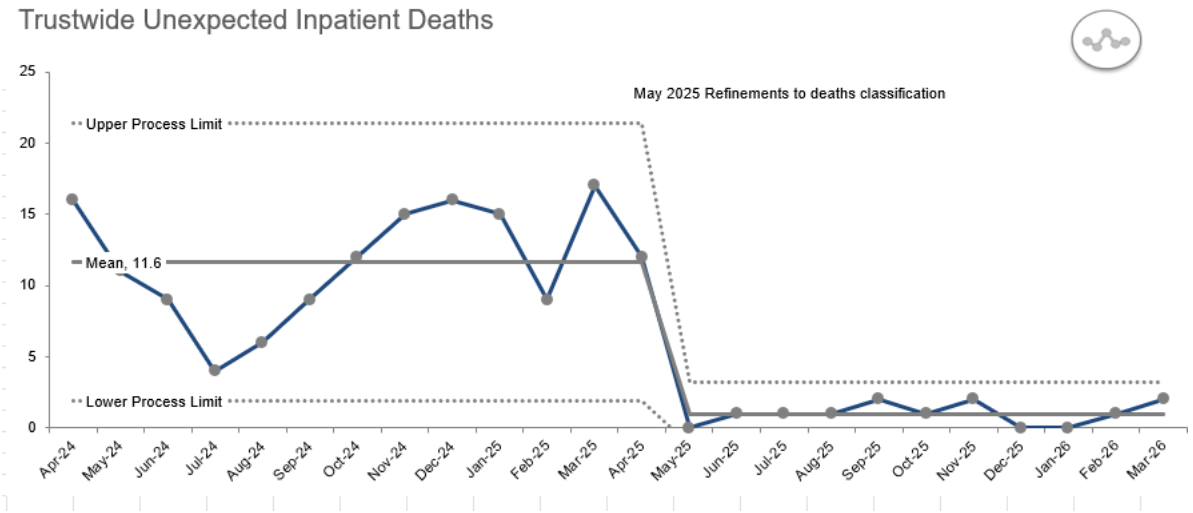


Figure 3 Trustwide Unexpected Inpatient Deaths

3.4 Of the 17 deaths reported in the community, 11 were within the Mental Health Directorate, four within the ICS Directorate and two under Safeguarding services (however neither of these deaths were related to the provision of care from the Trust).

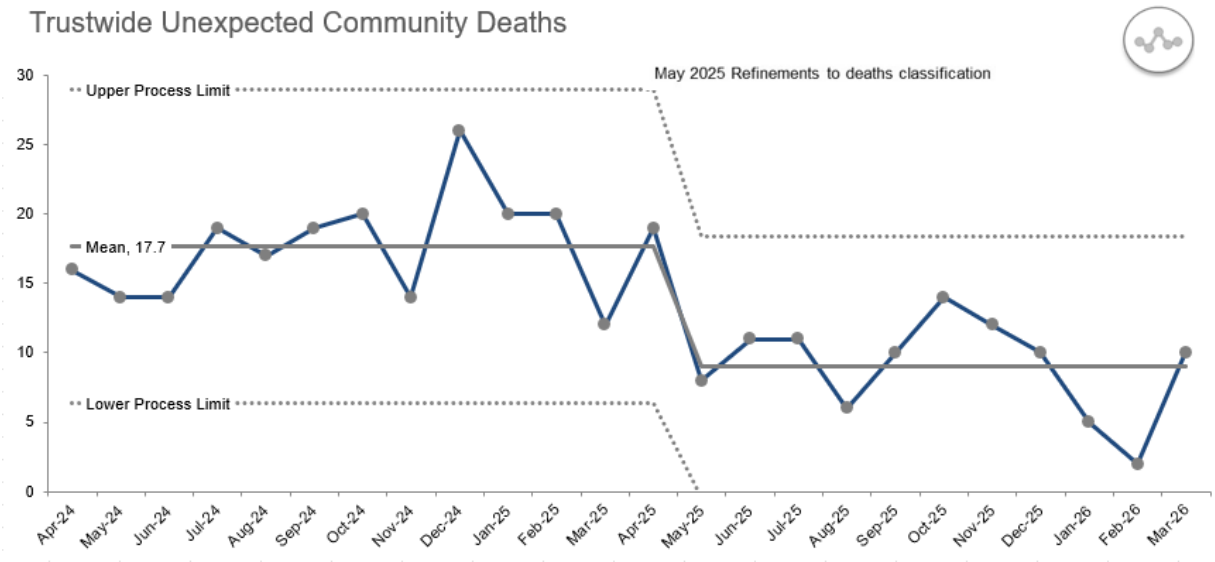


Figure 4 Trustwide Unexpected Community Deaths

3.5 Analysis by directorate shows that the number of unexpected community and inpatient deaths has remained stable overall. The only exception is a sustained reduction observed in the ICS inpatient services, as shown in **Figure 5.**

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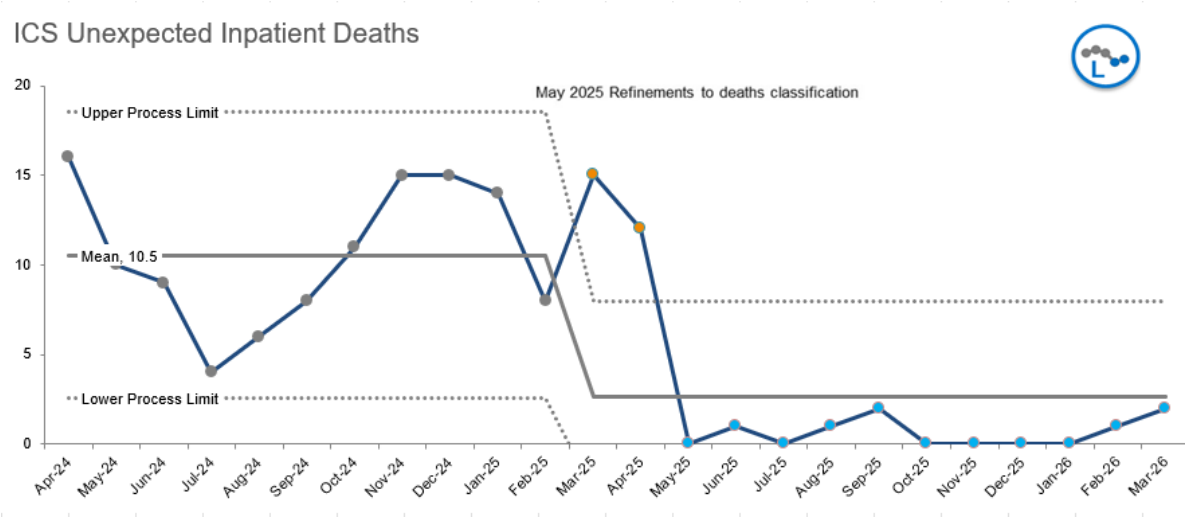


Figure 5 Trustwide Unexpected ICS Inpatient Deaths

4.0 PREVENTION OF FUTURE DEATHS (REGULATION 28) RECEIVED/LEARNING FROM INQUESTS

4.1. In Q4 Dorset Health Care received one Regulation 28 report. The response with assurance regarding the Regulation 28 report has been served on His Majesty's coroner.

4.2. In Q4 a total of 36 inquests were listed.

- Six were Pre Inquest Review Hearings (PIRH).
- Four were documentary Inquests (a documentary inquest (or "inquest in writing") is a UK coroner's process for investigating deaths that relies *only on written evidence*, without witnesses attending court)
- Two inquests were adjourned until later in 2026
- Two PIRH were adjourned
- Seven inquests required no Dorset HealthCare witnesses to attend
- This left 15 inquests that concluded within the quarter. Of these 15 inquests, two inquests were heard in the presence of a jury. Two inquests lasted for three weeks one with a total of 18 staff giving evidence.

The outcomes of the 15 concluded inquests were as follows:

- None returned an open conclusion,
- One concluded natural causes,
- Three had a conclusion of suicide,
- Three recorded a conclusion of a drug-related death,

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- Eight returned a narrative conclusion.

4.3. The following learning prevented the Trust being issued with a regulation 28 report. The assurances given were that the operational policy review for the Psychiatric Liaison Service would include consideration of the processes relating to:

- Administrative timescales and process for issuing correspondence:
  - Routine letters to be sent within 7 days.
  - Did Not Wait patient letters
  - Sending outcome letters urgently when clinically indicated.

- Clarification that staff must follow University Hospitals Dorset policies for:
  - Absent without leave (AWOL) and missing patients (and sign posting staff to those policies).
  - Safeguarding procedures.
  - Other relevant operational and clinical governance processes.

And that if a patient is discharged from the acute hospital before a mental health assessment has occurred:

- A risk assessment will be completed using the information available to Liaison Psychiatry.
- As a minimum, the GP will be notified by letter of the contact and the circumstances.
- If the patient is considered to be at ongoing risk:
- Liaison Psychiatry should attempt a telephone welfare check with the patient

4.4. Learning in respect of the above has already been shared across the Trust's liaison sites and staff will be reminded of the applicable missing person policy.

4.5. The following recurring themes continue to be highlighted and are also shared for consideration through Learning and Review Groups**:**

Communication Failures:

- Communication between teams internally.

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Record keeping concerns:

- Documentation of rationale around decision making.

- Recording of level of risk.
- Discharge decisions - whether inpatient or secondary community services.

5.0. PSIRF Learning

5.1. Learning from Unexpected Deaths – Q3/Q4 2025–2026

This section of the report brings together organisational learning from reviews of unexpected deaths occurring during the latter part of Quarter 3 and the early part of Quarter 4 (December 2025 to February 2026), aligned with PSIRF and Learning from Deaths requirements. While the majority of deaths were assessed as non-preventable and care was generally deemed appropriate, aggregated analysis highlights important system-level learning and opportunities for improvement.

5.2. Overall Findings

Across all periods reviewed, no cases demonstrated evidence of clinical failings. However, thematic analysis identifies recurring opportunities to strengthen communication, coordination, documentation, risk formulation, and proactive care—particularly for individuals with complex physical, mental health, or social vulnerabilities.

5.3. **Quarter 3 (December 2025): Key Themes**

Deaths reviewed in December 2026 predominantly involved individuals with complex health and social needs, often occurring in community settings. While baseline standards of care were largely met, learning centred on the need for enhanced anticipatory care planning and stronger multi-agency coordination. Identified issues included variability in referral clarity, delays in specialist input, gaps in escalation pathways, and insufficient carer training when equipment was provided. Workforce capacity constraints and the influence of social determinants—such as homelessness, substance misuse, and social isolation—were also evident contributors to risk.

5.4. **Quarter 4 (January 2026): Key Themes**

January cases highlighted complex, multi-factorial deaths, including suicide and sudden unexpected events. A consistent theme was the limitation of risk identification where patients disengaged from services or where risk was not overtly expressed. Telephone-based assessments, while useful, were recognised as potentially underestimating emerging risk. Documentation quality was a prominent issue, particularly regarding risk mitigation, capacity assessments, physical health monitoring, and the timely recording of significant events.

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System pressures, referral delays, pathway ambiguity, and deficits in information sharing further impacted care continuity and professional experience.

5.5. **Quarter 4 (February 2026): Key Themes**

The February cohort demonstrated a more positive pattern, with strong evidence of appropriate care delivery, effective emergency response, and robust multi-disciplinary team (MDT) working. Coordinated care planning and clear communication with families were notable strengths. Nonetheless, learning remained around the monitoring of physical health in patients with complex needs, recognising subtle or atypical deterioration, and continuing to address engagement challenges, even when wider care systems mitigate associated risks.

5.6. **Cross-Cutting Learning and System Implications**

Across all periods, consistent learning points emerged:

- The importance of clear, timely, and well-documented communication across services and agencies.
- The need to move beyond risk identification toward explicit risk formulation and mitigation planning, supported by high-quality clinical documentation.
- Recognition that absence of expressed risk does not equate to absence of actual risk, particularly for disengaged or vulnerable individuals.
- The value of proactive, preventative approaches, including anticipatory prescribing, early physical health monitoring, and routine sharing of crisis support.
- The impact of system capacity pressures on access, responsiveness, and continuity of care.
- The need to sustain and spread examples of effective Multi-Disciplinary Team (MDT) working and good practice, particularly evident in later Q4 reviews.

5.7. In summary, Conclusion the reviews identify that the unexpected deaths were either not predictable or preventable, within existing clinical knowledge. However, they do demonstrate clear opportunities for organisation-wide improvement in how risk is assessed, documented, communicated, and managed across complex systems. Addressing these themes will support safer, more coordinated, and more responsive care, particularly for individuals with high levels of vulnerability and complexity. This learning is shared through the Learning and Review Groups within the Directorates, the Patient Safety Oversight group and the Quality Governance Group.

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6.0. CHILD DEATHS

6.1. The following are shared to reflect child deaths across Dorset, they were not directly receiving our care, but details are included for awareness and shared learning and the family may access the Trust for other services and hence valuable for oversight. To note these deaths are reported under the safeguarding team as the team are always notified when a child has passed away, and hence an incident is entered onto the Risk Management system.

6.2. There were three reported baby/child/young person deaths across Dorset in Q4, which were presented to the Child Death Overview Panel for review. Two were expected, one was not.

6.3. All three deaths occurred in the BCP area, none in Dorset Council and none of the children were in receipt of our care. There is no further information available at this time regarding any system learning.

7.0. LEARNING DISABILITY DEATHS (LeDeR)

7.1. In Q4, no LeDeR reviews were completed for people with a learning disability known to Dorset Healthcare at the time of their passing.

7.2. As part of the assurance provided to NHS Dorset for LeDeR reviews and in line with PSIRF, Dorset Healthcare staff within the CTLD complete “learning loops” (learning on one page) when a patient passes away. This enables the team to capture more local learning within a short time of the person’s passing.

7.3. Thirteen learning loops completed for patients that passed away during quarter three have identified the following good practice;

- Full involvement of family and care team in DNAR and End of Life decisions.
- Familiar carers remaining in place throughout hospital admission reduces distress and enables the persons specific needs to be accommodated.
- Rapid liaison between community staff enabled prompt removal of patient equipment after a patient’s death in line with the family’s request for such.

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- Community team making follow-up calls to family over several weeks to ensure their wellbeing following death of a loved one.

7.4. Learning identified included:

- It cannot be assumed that care homes and agencies will complete End of Life plans for people. It would be good practice for health care professionals to sensitively check this at annual reviews.
- Unsuitable placements should be identified as early as possible to avoid the person deteriorating to the point that a move is not appropriate.
- Hospital letters including diagnosis/prognosis can distress family members if they are unprepared for this.
- Diagnostic overshadowing can lead to symptoms being missed by acute care which can delay correct diagnosis and treatment. It can be difficult for community learning disability staff and patient's relatives to ensure that concerns are listened to and acted upon by acute hospitals.

7.5. NHS Dorset are not currently completing LeDer reviews and haven't been doing so since late 2025. Apparently, this is due to staff shortages. Within Dorset Healthcare we continue to complete Learning Loops (Learning on one page) around the deaths of people known to us at the time of their death. Karen Tancock collates these and presents them at the monthly clinical leads meeting which is chaired by Gary Billen. After discussion we determine which are straightforward and have no learning points and which require escalation through PSIRF. Those that we deem straightforward are sent directly to LeDer at NHS Dorset to form assurance regarding our service. Any that are felt to have learning (both positive and negative) are sent by Karen Tancock to Phil Morgan and Deborah Straw for inclusion in PSIRF. Any concerns or actions for system partners are taken forward from there.

7.6. Moving forward, Karen Tancock has been looking at making our internal review of deaths more robust in the absence of any external scrutiny by NHS Dorset. The initial meeting to look at a potential structure for this is on 07/05/26. We plan to look at ways of cross-scrutinising deaths within our service and potentially ways to determine which deaths may have been avoidable (either preventable or treatable).

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8.0. SAFEGUARDING REVIEWS (related to learning from deaths)

8.1. There were fifteen active Safeguarding Adult Reviews (SARs) on going at the end of Q4. Six in Dorset Council, eight in BCP and one out of area.

8.2. Six of the reviews will be incorporated into two thematic reviews

8.3. There were nine active Domestic Homicide Reviews/ Domestic Abuse Related Death Reviews (DHRs/ DARDR) ongoing in Q4, as well as four out of area:

8.4. There was one referral received during Q4, out of area (Somerset).

8.5. There have been no publications in Q4.

8.6. There were no new MAPPA referrals, however one action plan remains ongoing following the last local review.

8.7. There were three ongoing Child Safeguarding Practice Reviews (CSPR) during Q4.

8.8. One local learning review was ongoing throughout Q4; it did not meet the threshold for a CSPR.

9.0. END OF LIFE CARE (Expected Deaths)

9.1. There were 29 expected deaths recorded within inpatient services in Q4 2025/26, all of which occurred within Integrated Community Services.

9.2. A review of learning from these cases identified the following themes during Q4:

Areas of Good Practice Identified

- End of life care continues to be delivered to a high standard across all wards with improved communications with specialist teams both in the community, acute hospital, and hospices

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- Ward teams are continuing to be proactive in the use of the Gold Standards Framework (GSF) to identify patients approaching the end of life and to facilitate the delivery of personalised care.
- Evidence of excellent relationships with patients and their families, even managing quite complex family dynamics.
- Some ongoing utilisation of the last days of life care plan has enhanced documentation of discussions relating to nutrition and hydration, as well as patients' psychological, social, and spiritual support needs.

Areas identified for continued improvement

- To continue to remind ward teams the importance of the last days of life care plan assessment to ensure clear documentation around patient wishes and plans in last days of life, particularly relating to discussions about nutrition and hydration, and psychological, social, and spiritual support, in line with findings from the National Audit of Care at the End of Life (NACEL).
- Evidence of some great conversations with families/loved ones but improvement needed in the documentation of these conversations
- To continue education and support for ward teams to facilitate timely and effective conversations with patients and families regarding Advance Care Planning, ensuring care aligns with patients expressed wishes.
- To address delays or challenges in discharge or transfer arrangements in accordance with patients' preferences, where these are impacted by the availability of community care packages and/or local bed capacity (e.g. hospice or community hospital provision).

10.0 MEDICAL EXAMINER CONTACT

10.1. No feedback was received from the Medical Examiner during Q4.

12.0 SUMMARY

12.1. In summary, the group are asked to receive this report as assurance of the processes that are undertaken in relation to the management of learning from deaths and compliance with the reporting requirements associated with the National Quality Board Framework (2017) and aligned with PSIRF methodology. Presented in this report are areas of learning for the Trust

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and in some cases the wider Dorset system for discussion, consideration and identification of any further opportunities for improvement.

12.2. Colleagues are asked to consider areas of good practice highlighted for wider sharing with colleagues and consideration alongside the Learning and Review groups, in addition to areas which require further improvement and in some cases, further consideration as a Trust.

Author (Overall): Ellie Lindop
Role: Deputy Director of Nursing, Therapies and Quality
Date: 15/04/2026

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APPENDIX 1 REVIEW PROCESS

Review Process	Description
After Death Analysis (ADA)	Can be used for expected deaths on wards.
Structured Judgement Review (SJR)	A review following a death in hospital to determine whether a more in-depth review is required. More detailed reviews will occur where there are concerns about the care delivery. This may lead to a Patient Safety Review (PSR) or Patient Safety Incident Investigation (PSII) review if there is concern of a systemic nature.
Mortality Reviews	A systemic review of a series of case records using a structured or semi-structured methodology.
National Review Process	Within their own internal governance systems NHS organisations also need to adhere to the 'Learning from Deaths' criteria in the event of a death being more likely than not due to problems in care.
Multi-agency Statutory Review Processes	
Learning Disability Mortality Review (LeDeR)	Reviews funded by NHS England into the health and social care provided to people with learning disabilities and autism with the objective of reducing health inequalities.
Domestic Homicide Reviews - now referred to as Domestic Abuse Related Death Reviews.	Reviews commissioned by Community Safety Partnerships into the death of a person (aged 16 or over) which has, or appears to have resulted from violence, abuse, or neglect.
Safeguarding Adult Reviews	Carried out by Safeguarding Adult Boards for the purposes of learning when an adult(s) with care and support needs dies and abuse and/or neglect is known or suspected to be a factor in the death and there are concerns about the way I which agencies have worked together.
Mental Health Homicide Reviews	Independent investigations commissioned by NHS England into homicides that are committed by patients being treated for mental illness.
Child Death Overview Panel (CDOP)	A multi-disciplinary panel which considers information in relation to child deaths to establish and learning and prevent future deaths.

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Review Process	Description
Multi-agency Public Protection Arrangements (MAPPA) Serious Case Review	This review establishes whether multi-agency public protection arrangements were effectively applied in the event of a death caused by someone known to be a sexual or violent offender.
Child Safeguarding Practice Reviews	Following notification of an incident (a child dies or is seriously harmed) a rapid review will be conducted by partners. On receipt of information from the rapid review, a decision will be made as to whether a Child Safeguarding Practice Review should be conducted if it is considered that abuse or neglect was a factor.

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Dorset HealthCare University
NHS Foundation Trust

Report to	Board in Common (DHC)	
Date of Meeting	17 June 2026	
Report Title	Learning from Deaths Report – Annual Overview	
Prepared By	Ellie Lindop, Deputy Director of Nursing, Therapies and Quality	
Approved by Accountable Executive	Lucy Knight, Chief Medical Officer	
Previously Considered By	Mortality Governance Group 22 April 2026 Quality Governance Group 5 May 2026 Quality Committee in Common 26 May 2026	
Action Required	**Approval**	No
	Assurance	Yes
	Information	Yes

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	Nil	
Statutory & Regulatory	National Quality Board Framework (2017) and Patient Safety Incident Response Framework (2022)	
Equality, Diversity & Inclusion	No implications	
Co-production & Partnership	No implications	

Executive Summary

This report provides assurance that during 2025–2026 Dorset HealthCare University NHS Foundation Trust maintained effective and proportionate arrangements for learning from deaths, coronial matters, safeguarding reviews and end-of-life care.

In summary there were:

- 137 unexpected deaths were reported.
- 125 inquests relating to the Trust were listed by the Coroner, from which one Regulation 28 report was received.
- 142 expected deaths were reported, all occurring within Integrated Community Services (ICS).
- 27 deaths of people with a Learning Disability were reviewed through the LeDeR process across Dorset.

Learning identified across the year was consistent and largely system-wide, with no evidence of new or emerging systemic risks. Governance processes for review, escalation and shared learning align with national requirements, including the Patient Safety Incident Response Framework (PSIRF). The Trust continues to demonstrate a compassionate learning culture, with assurance that learning from inquests, safeguarding activity and unexpected deaths is shared and acted upon at all levels.

Item 15/26 - 16.12.25

Recommendation

Receive the report for **assurance.**

Learning from Deaths Report – Annual Overview

1. Introduction

1.1. This report provides an annual summary of the Trusts Learning from deaths data and learning in relation to patients who have died whilst under Dorset Healthcare Trust as a primary provider of care (as per the National Quality Board (NQB) framework, 2017).

1.2. Where the Trust is not a main provider, there is always consideration on identification of the patient/ service users' death, if it would be appropriate to undertake a full learning review process as a Trust, collaborate with the main provider of care and provide insight into the care/ services provided or whether there is no identified need to review further after initial discussion and consideration (as per the NQB framework). Predominantly, service users of Mental health services are more likely to require a review, especially if their death is confirmed or suspected to be a likely consequence of their mental health diagnosis.

1.3. Expected deaths of inpatients continue to be included for oversight in this report, with a focus on the identification of learning.

2. Overview of the Annual Reporting Data

2.1. A review of Dorset Healthcare's annual data for 2025–2026 identified that:

- 137 unexpected deaths were reported.
- 125 inquests relating to the Trust were listed by the Coroner, from which one Regulation 28 report was received.
- 142 expected deaths were reported, all occurring within Integrated Community Services (ICS).
- 27 deaths of people with a Learning Disability were reviewed through the LeDeR process across Dorset.

2.2. The Trust has clear processes in place to ensure that when an unexpected death is reported (either internally, by an external partner, or through notification from the Coroner) each case is reviewed. All unexpected deaths are considered in line with Patient Safety Incident Response Framework (PSIRF) methodology to determine the appropriate level of response, ensuring learning and improvement remain at the forefront. In addition to this, the Trust have begun to reconsider the use of the Structured Judgement tool when a death is to be reviewed, this approach will be further developed over the coming year.

2.3. At present, our ability to provide comprehensive and robust data on levels of response is limited by functionality within the current Risk Management System. We recognise the importance of transparent reporting and acknowledge this as an area for improvement. From 2026–2027, the introduction of the new PSIRF module will support improved data extraction relating to responses undertaken, although some limitations will remain while the system continues to embed.

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2.4. In addition, a new Dorset-wide Risk Management module has been procured and is now progressing through the planning and development phase. The ability to extract high-quality data to support future reporting and learning has been identified as a priority within this work, reinforcing the Trust's ongoing commitment to openness, continuous improvement and compassionate care.

3. Prevention of Future Deaths (Regulation 28) and Inquests

3.1. Across the reporting year, the Trust demonstrated consistent compliance and assurance in its engagement with the coronial system. One Regulation 28 (Prevention of Future Deaths) report was issued, in Quarter 4, and this was responded to within required timescales with assurances accepted by His Majesty's Coroner.

3.2. Inquest activity was consistent across all four quarters, including full inquests, pre-inquest review hearings and documentary inquests. Outcomes most commonly related to death by suicide, drug-related deaths, natural causes, and narrative conclusions.

3.3. No new substantive learning emerged directly from inquest outcomes beyond issues already identified through Patient Safety Reviews and PSIRF processes.

3.4. Recurring themes included:

- communication failures
- documentation and quality issues
- risk assessment and escalation
- discharge planning.

3.5. Of these themes, actions for improvement focused on strengthening policies, improving information, importance of sharing information and reinforcing expectations for clinical documentation.

4. PSIRF and Learning from Unexpected Deaths

4.1. The year represented an important transition period for the embedding of the Patient Safety Incident Response Framework (PSIRF). Initially processes were constrained by system limitations, while the latter half of the year demonstrated maturing organisational insight and wider thematic learning.

4.2. Across the year, reviews concluded that the majority of unexpected deaths were not predictable or preventable, and care was generally appropriate and consistent with Trust policies and procedures. There was no evidence of widespread clinical failings. However, aggregated analysis identified recurring opportunities for improvement.

4.3. Key themes included:

- The need to improve communication and coordination
- Improve the quality of clinical documentation
- Strengthening risk formulation and mitigation
- Adopting more proactive and anticipatory approaches for individuals with complex needs.

4.4. Later-year reviews began to demonstrate improved multidisciplinary working, better care coordination, and stronger engagement with families.

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5. Child Deaths

5.1. Child and young person death information was shared across all the year to support system oversight and shared learning. Of the deaths considered, these were predominantly expected or related to prematurity, congenital conditions, or significant medical complexity.

5.2. A small number of unexpected deaths progressed through appropriate safeguarding and review processes. No Trust-specific systemic failings were identified.

5.3. Learning across the year reinforced the importance of safe sleep messaging, early safeguarding escalation, and managing complex family and environmental risk factors through effective multi-agency working.

6. Learning Disability Deaths (LeDeR)

6.1. LeDeR activity varied across the year, with higher numbers of reviews completed in the first half of the year. This reflected review timing rather than concerns about care quality.

6.2. Consistent good practice was identified across completed reviews, including:

- Effective multi-agency collaboration
- Reasonable adjustments
- Strong community nursing input,
- Good family involvement in end-of-life and DNACPR decisions.

6.3. Learning identified was largely system-wide and included challenges with:

- DNACPR accessibility
- Diagnostic overshadowing in acute settings
- Fragmented digital records
- And the impact of unsuitable placements.
- Learning loops supported timely local dissemination of learning.

6.4. NHS Dorset are not currently completing LeDer reviews and haven't been doing so since late 2025. Apparently, this is due to staff shortages. Within Dorset Healthcare we continue to complete Learning Loops (Learning on one page) around the deaths of people known to us at the time of their death. Karen Tancock collates these and presents them at the monthly clinical leads meeting which is chaired by Gary Billen. After discussion we determine which are straightforward and have no learning points and which require escalation through PSIRF. Those that we deem straightforward are sent directly to LeDer at NHS Dorset to form assurance regarding our service. Any that are felt to have learning (both positive and negative) are sent by Karen Tancock to Phil Morgan and Deborah Straw for inclusion in PSIRF. Any concerns or actions for system partners are taken forward from there.

6.5. Moving forward, Karen Tancock has been looking at making our internal review of deaths more robust in the absence of any external scrutiny by NHS Dorset. The initial meeting to look at a potential structure for this is on 07/05/26. We plan to look at ways of cross-scrutinising deaths within our service and potentially ways to determine which deaths may have been avoidable (either preventable or treatable).

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7. Safeguarding Reviews

7.1. Safeguarding activity remained high throughout the year, including Safeguarding Adult Reviews, Domestic Homicide Reviews, Child Safeguarding Practice Reviews and MAPPA processes.

7.2. Consistent themes across all quarters included the need for clear thresholds between safeguarding and care assessment, strong inter-agency collaboration, and effective information-sharing, particularly where mental health, capacity, self-neglect, domestic abuse and physical health intersect.

7.3. Learning and actions were monitored through established governance arrangements.

8. End of Life Care (Expected Deaths)

8.1. End of life care remained a consistent area of strength across all four quarters. Expected deaths occurred predominantly within Integrated Community Services.

8.2. Evidence across the year demonstrated compassionate, high-quality care, effective use of the Gold Standards Framework, and strong engagement with patients, families and specialist services.

8.3. Areas for improvement were consistent and focused on the need to:

- Strengthening documentation of discussions relating to nutrition, hydration and psychosocial support.
- Continue to improve the recording of Advance Care Planning.
- Address discharge and transfer delays linked to system capacity constraints.

9. Medical Examiner Engagement

9.1. Medical Examiner engagement strengthened during the year, with new formalised communication processes established. Although feedback volumes were low, the arrangements support improved triangulation of learning across mortality, patient safety and experience data.

10. Overall Assurance

10.1. Across the year, the Trust demonstrated strong compliance with national Learning from Deaths and PSIRF requirements, low levels of coronial challenge, and consistent identification of system-level learning.

11. Next Steps

11.1. The Trust will continue to review and consider the approach taken in regard to the way we approach and manage when a death occurs for a patient or service user that we are the primary carer for, alongside our approach to learning, with a specific focus on continued family engagement and the most appropriate methods of supporting the coronial processes. In addition to this, we will continue to consider how we can improve and enhance how we can demonstrate that we are a learning organisation and how learning is subsequently shared and disseminated to improve future outcomes.

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12. Summary

12.1. In summary, the group are asked to receive this report as assurance of the processes that are undertaken in relation to the management of learning from deaths and compliance with the

reporting requirements associated with the National Quality Board Framework (2017) and aligned with PSIRF methodology. The annual report provides an overarching summary of the annual Trust learning.

Author: Ellie Lindop
Role: Deputy Director of Nursing, Therapies and Quality
Date: 16/04/2026

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Dorset County Hospital
NHS Foundation Trust

Report to	Board in Common, Part 1 (DCH Board)	
Date of Meeting	17th June 2026	
Report Title	Learning from Deaths Q4 2025/26	
Prepared By	Dr Adam Nicholls. Deputy Chief Medical Officer	
Approved by Accountable Executive	Dr Rachel Wharton. Chief Medical Officer	
Previously Considered By	Quality Governance Group. 15.05.2026 Quality Committee in Common. 26.05.2026	
Action Required	**Approval**	-
	Assurance	Y
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality	
Financial	No implication	
Statutory & Regulatory	Learning from the care provided to patients who die is a key part of clinical governance and quality improvement work (CQC 2016). Publication on a quarterly basis is a regulatory requirement. An elevated SHMI will raise concerns with NHS E&I and the CQC. The overall trend in DCH's SHMI is favourable.	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary

Learning from Structured Judgement Reviews, Morbidity and Mortality meetings and Hospital Mortality Group discussions this quarter continues to demonstrate good quality care with no deaths judged to be avoidable. Overall mortality indicators, including SHMI, continue to provide assurance.
A recurrent theme has been identified relating to the care of frail and orthogeriatric patients, particularly around consistency of location of care, timely specialist input, escalation decision-making and end-of-life planning. This theme is reflected across divisional SJR findings, M&M discussions and national hip fracture mortality data, and has been escalated through governance structures. Learning from this has directly informed quality improvement activity, including work to strengthen frailty pathways and the development of a business case for an enhanced Orthogeriatrics service.
Work continues to ensure that learning from deaths is being actively translated into improvement.

Recommendation

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

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1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS
2.0 NATIONAL MORTALITY METRICS AND CODING ISSUES
3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE
4.0 QUALITY IMPROVEMENT ARISING FROM SJRs & HMG
5.0 MORBIDITY and MORTALITY MEETINGS
6.0 LEARNING FROM CORONER'S INQUESTS
7.0 LEARNING FROM CLAIMS
8.0 SUMMARY

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1.0 DIVISIONAL LEARNING FROM DEATHS REPORTS

Each Division is asked to submit a quarterly report outlining the number of in-patient deaths, the number subjected to SJR, and the outcomes in terms of assessment and learning.

1.1 Family Services and Surgical Division Report - Quarter 4 2025/26 Report

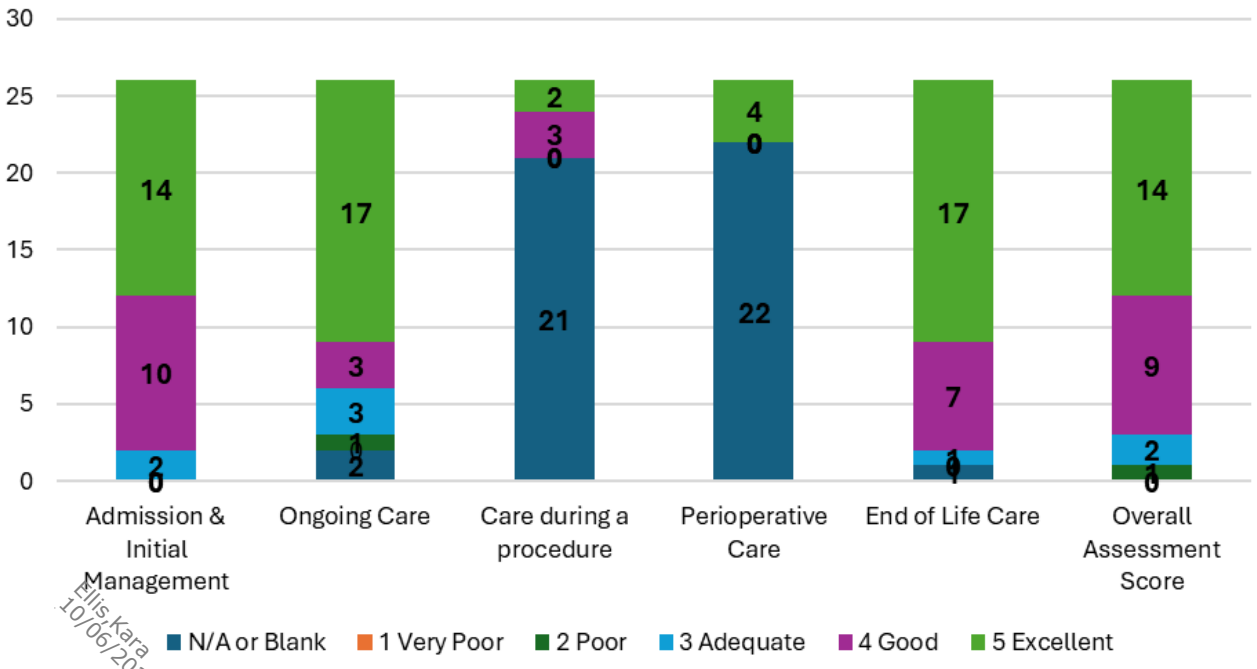
Structured Judgement Review Results:
The Family Services & Surgery Division had 47 deaths in quarter 4, of which 40 that require SJR's to be completed. Within quarter 4 26 SJR's have been completed from this quarter and previous months.

Outstanding SJR's:
The Division have completed a number of SJR's from previous quarters. The backlog of outstanding SJR's (over 2 months) for the Division as at 30/04/2026 is 7:

October	December	January	February
1	1	2	3

Feedback from SJR's Completed in Quarter 4:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	0	2	21	22	1	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	1	0	0	0	1
3 Adequate	2	3	0	0	1	2
4 Good	10	3	3	0	7	9
5 Excellent	14	17	2	4	17	14



Ellis Kara
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Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
0	0	0	2	9	15

- Difficult to follow as some info on Agyle and some on DPR.
- Mostly good documentation. I cannot find any evidence of family discussions apart from note that the team had been unable to contact this gentleman's wife around end of life.
- Good ED and medical clerking- appropriate management of haematuria.
- Excellent surgical clerking. Clear documentation throughout patient admission.
- Generally good documentation although some WR entries documented on surgical note paper rather than EOLC pathway.
- Good documentation by the resident doctors. No entry documented by a Consultant

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	1	4	21

Action Required:

Following completion of these SJR's, 2 were highlighted as requiring actions.

One has the following actions identified:

- Referral Division A for review and case review regarding delay in ICU referral – ongoing with Patient Safety Team.
- Newsletter
- Discussion at another governance meeting

The second has the following actions identified:

- Formal documented feedback to Department or clinical team – this is completed at the time of the SJR completion.
- Newsletter
- Discuss at HMG to make sure doesn't happen again.
- Not for RCA or further review as SJR is so comprehensive.

Areas of good practice and for improvement are discussed at HMG with themes shared through this report. There is an emerging theme around orthogeriatric patients, and where they receive care and this is discussed in the quality improvement section of this report.

1.2 Division of Urgent & Integrated Care – Quarter 4 Report 2025 / 26

	Q4		
	Jan	Feb	Mar
*Completed SJR'S	13	0	0

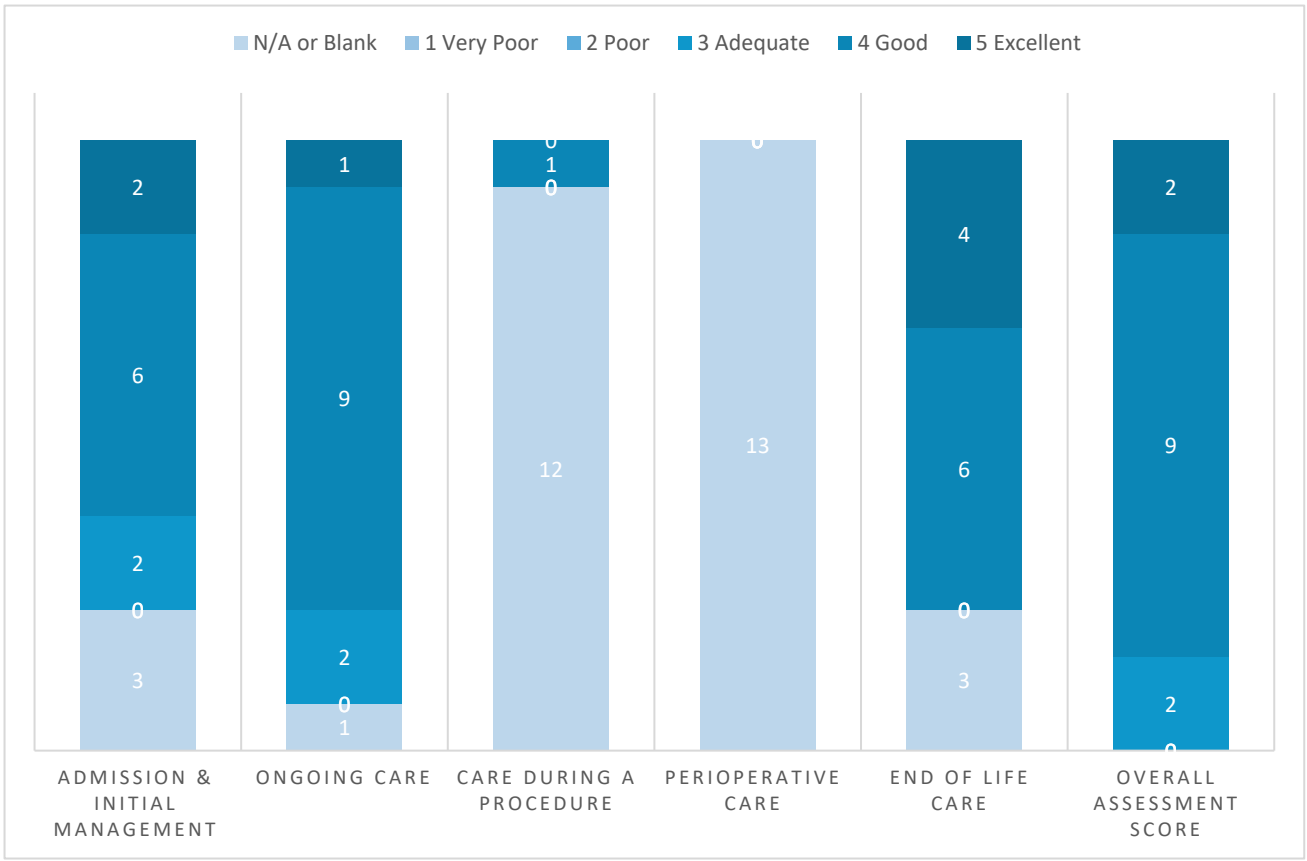
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* Completed SJR'S not necessarily from that month's deaths

During Quarter 4, a total of 25 Structured Judgement Reviews were completed by the Division. Of these, 13 related to deaths occurring within Quarter 4, with the remaining reviews addressing deaths from previous quarters as part of backlog reduction activity. There were 0 SJRs completed in February and March for the division. This has been down to considerable operational pressures, CQC visit and related actions and annual leave. Completion of SJRs has now re-commenced in April.

Phase score from 25 completed SJR's in quarter 4:

Phase Score	Admission & Initial Management	Ongoing Care	Care during a procedure	Perioperative Care	End of Life Care	Overall Assessment Score
N/A or Blank	3	1	12	13	3	0
1 Very Poor	0	0	0	0	0	0
2 Poor	0	0	0	0	0	0
3 Adequate	2	2	0	0	0	2
4 Good	6	9	1	0	6	9
5 Excellent	2	1	0	0	4	2



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Overall Quality of Patient Record:

Blank	Score 1 Very poor	Score 2 Poor	Score 3 Adequate	Score 4 Good	Score 5 Excellent
2	0	0	0	10	1

- Good care, regular reviews. clear documentation.
- Good care. Timely reviews. MDT working well.
- Excellent recognition of EOL & management of treatment plan.
- Good care, clear plans, regular reviews and family input and contact.
- Excellent care

Avoidability of Death Judgement Score:

Score 1 Definitely avoidable	Score 2 Strong evidence of avoidability	Score 3 Probably avoidable (more than 50:50)	Score 4 Possibly avoidable but not very likely (less than 50:50)	Score 5 Slight evidence of avoidability	Score 6 Definitely not avoidable
0	0	0	0	0	13

Action Required:

Following completion of the 13 SJR's, 0 required further action as they were all scored as 'definitely not avoidable'.

Learning from Divisional SJR completion this quarter highlights consistently good standards of care, strong multidisciplinary working and effective end-of-life management. Areas of learning identified relate primarily to documentation quality, recognition of end-of-life trajectories, clarity of diagnosis and cause of death, and communication with families. In a small number of cases, learning also related to escalation and referral processes, including the timing of ICU referral and the importance of clearly documented escalation plans across care settings. These themes are being addressed through divisional governance, newsletters, targeted feedback and discussion at Hospital Mortality Group.

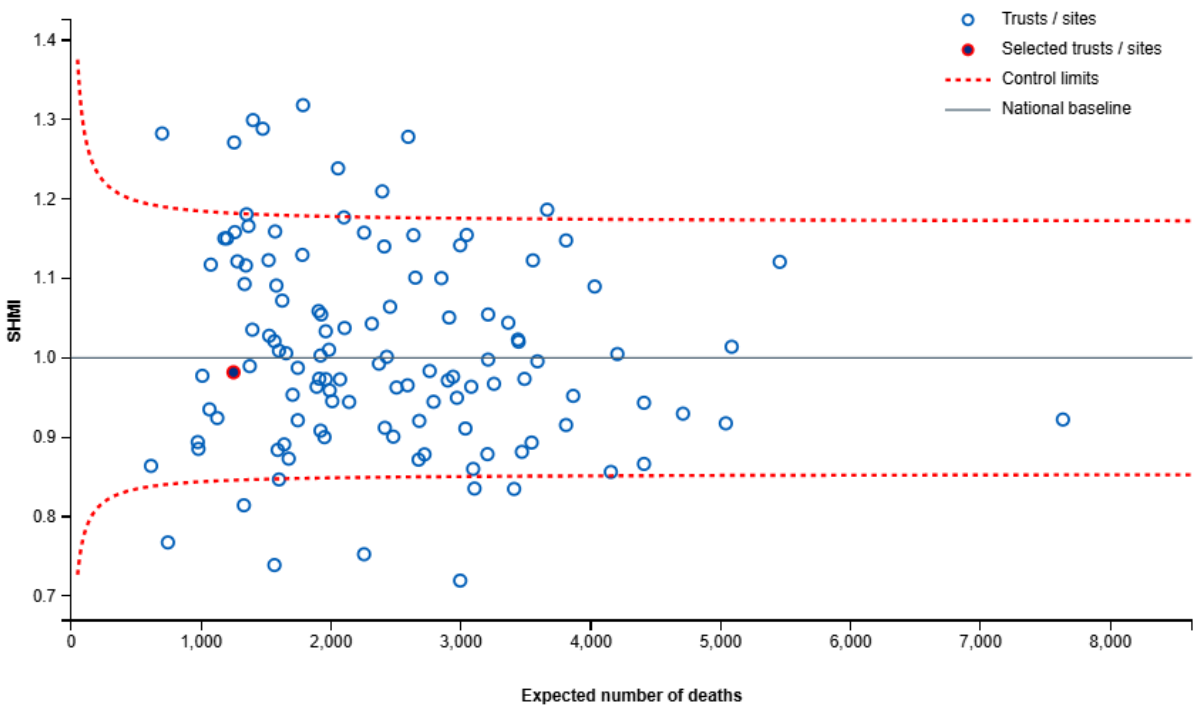
2.0 NATIONAL MORTALITY METRICS AND CODING

2.1 Summary Hospital-level Mortality Indicator (SHMI)

DCH = Ringed in red

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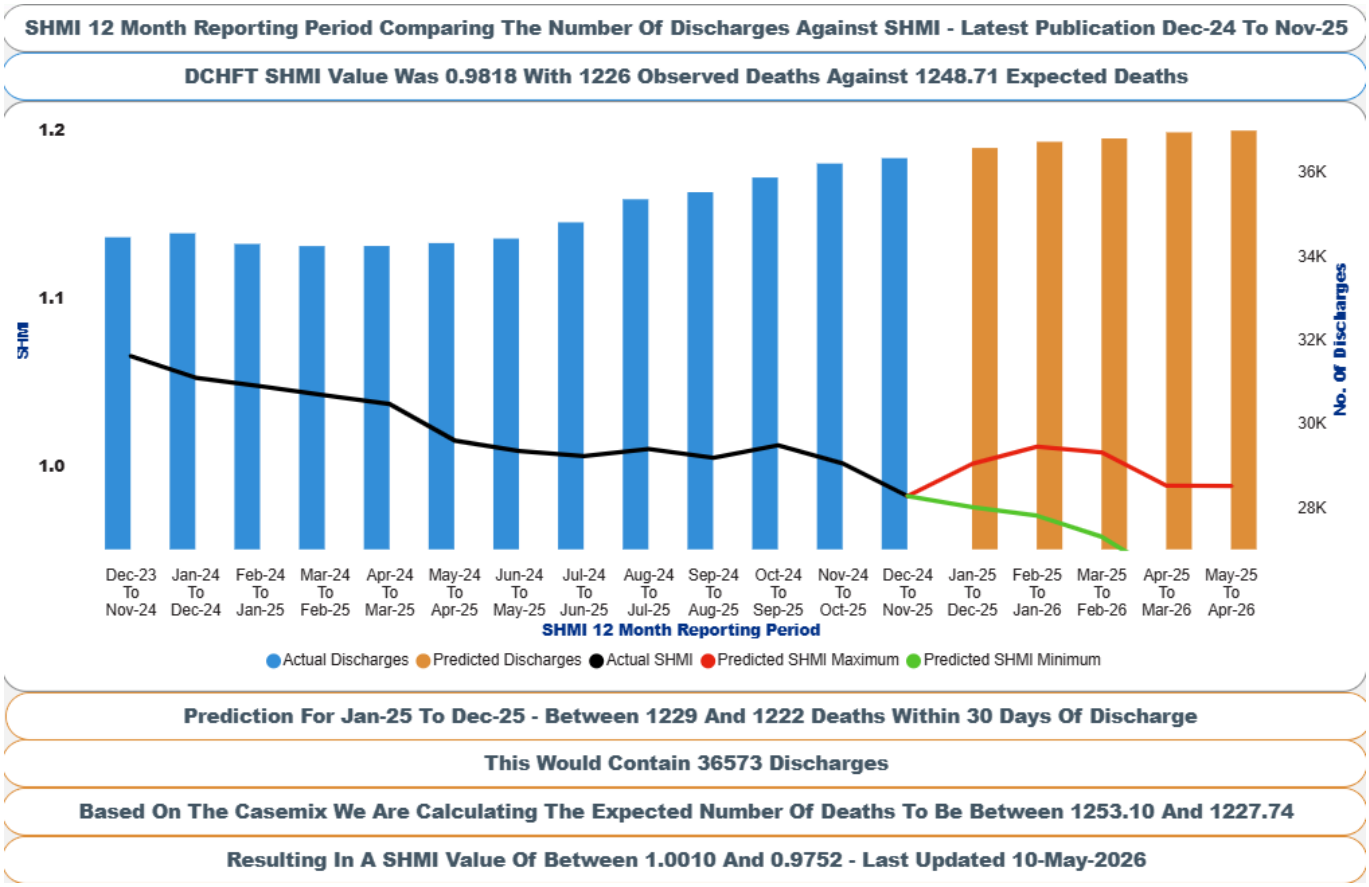
SHMI funnel plot



SHMI data is reported with a 5 month data lag. Our current SHMI is 0.9818. This is the lowest it has been. Our national ranked position is 27.

Our business intelligence team have produced a dashboard which predicts our SHMI aiming to give assurance and the chance to act early if we see a predicted rise in SHMI. Our predicted SHMI gives assurance that we are not seeing excess deaths:

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2.2 Depth of coding: NHS Digital states "*As well as information on the main condition the patient is in hospital for (the primary diagnosis), the SHMI data contain up to 19 secondary diagnosis codes for other conditions the patient is suffering from. This information is used to calculate the expected number of deaths. A higher mean depth of coding may indicate a higher proportion of patients with multiple conditions and/or comorbidities but may also be due to differences in coding practices between trusts*."

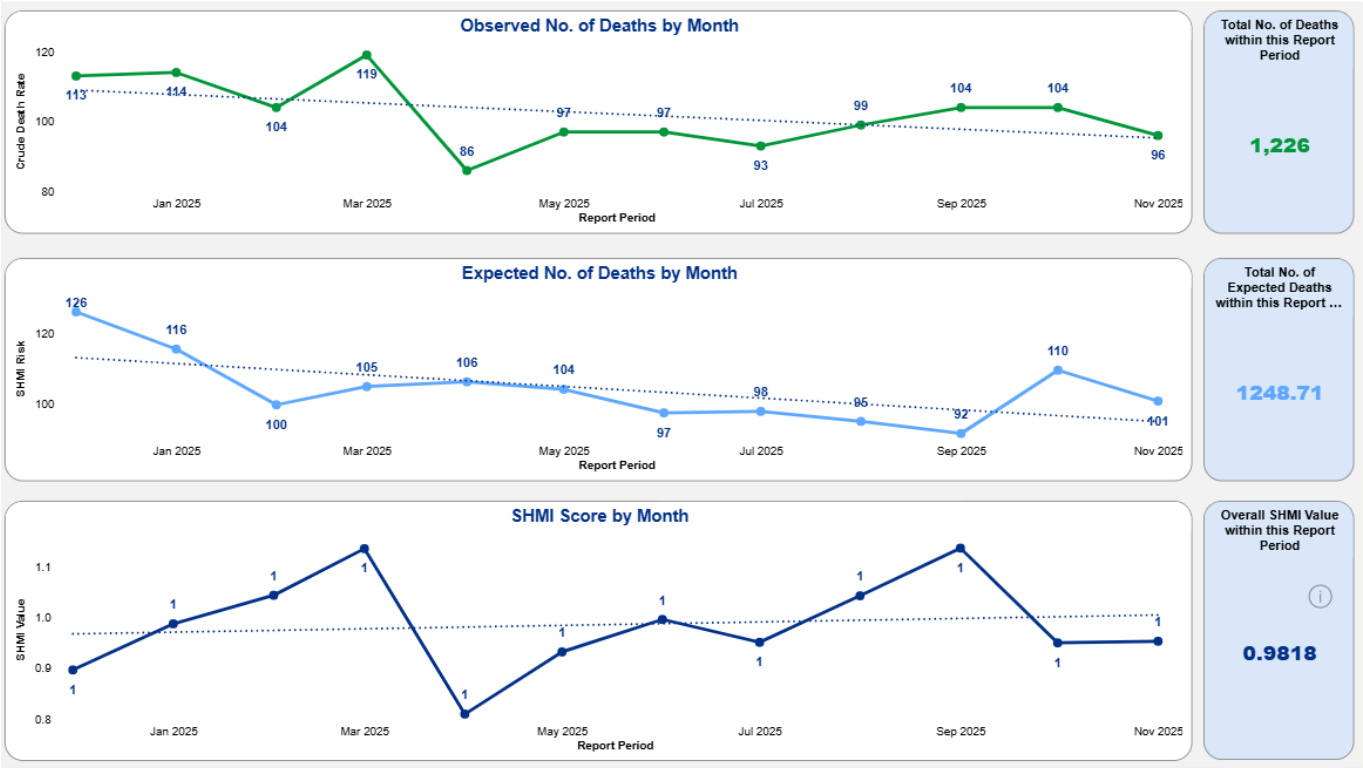
Clinical coding capacity continues to present a significant organisational risk, with ongoing staffing vacancies, a sustained backlog exceeding the manageable threshold and reduced audit capacity due to long-term sickness absence. This creates a risk of under-recording comorbidities, which may adversely affect SHMI and external interpretation of mortality data.

This risk has been escalated through Trust governance routes and is subject to ongoing oversight. Mitigating actions include recruitment and development of coding apprentices, exploration of mutual aid arrangements with neighbouring trusts, and close monitoring through Business Intelligence and Hospital Mortality Group. Learning from this risk has reinforced the importance of accurate and timely clinical documentation to support coding quality and has been shared with clinical teams as part of wider mortality governance.

2.3 Expected Deaths (based on diagnoses across all admissions (except covid) per rolling 12 months):

The chart below shows observed (actual) and expected (calculated by NHS Digital) deaths, the numbers of which are directly influenced by the number of in-patients. Peaks and troughs are expected and the trend lines show a favourable picture.

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3.0 OTHER NATIONAL AUDITS/INDICATORS OF CARE

The DCH Hospital Mortality Group continues to meet on a monthly basis to examine any other data which might indicate changes in standards of care. The following sections report data available from various national bodies which report on Trusts' individual performance.

For other metrics of care including complaints responses, sepsis data, AKI, patient deterioration and DNACPR data and VTE assessment data please see the Quality Report presented on a monthly basis to Quality Committee by the Chief Nursing Officer.

3.1 NCAA Cardiac Arrest data

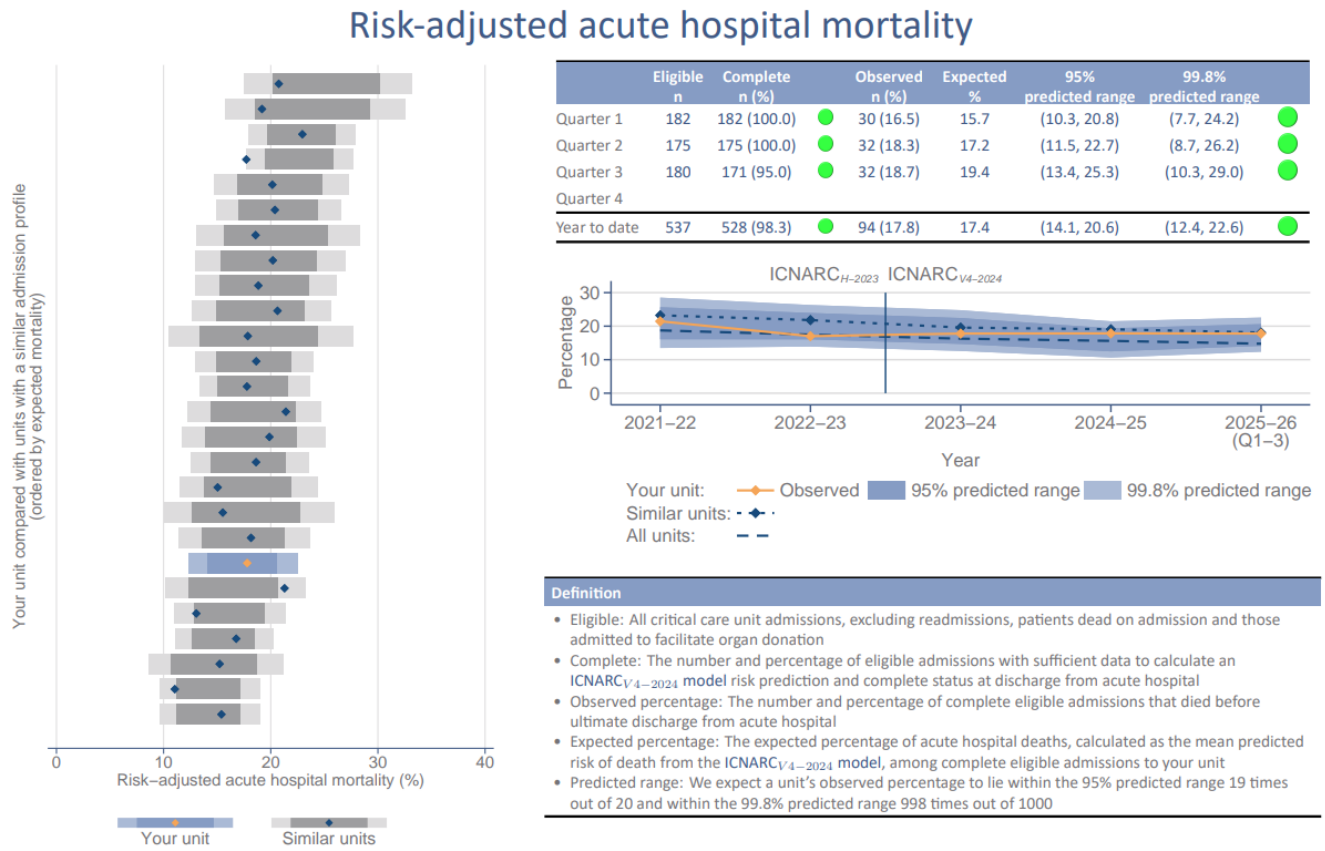
The latest NCAA data we have was published 7/10/25, and reflects a year of data 1/4/24-31/3/25, and was reported in quarter 3, futher updates will be included when published.

3.2 ICNARC Intensive Care survival data 1 April 2025- 30th September 2025

This report focuses on the mortality elemenets of the ICNARC report. All other metrics are reviewed via the ITU clinical governance meetings, and escalated via Division B clinical governance.

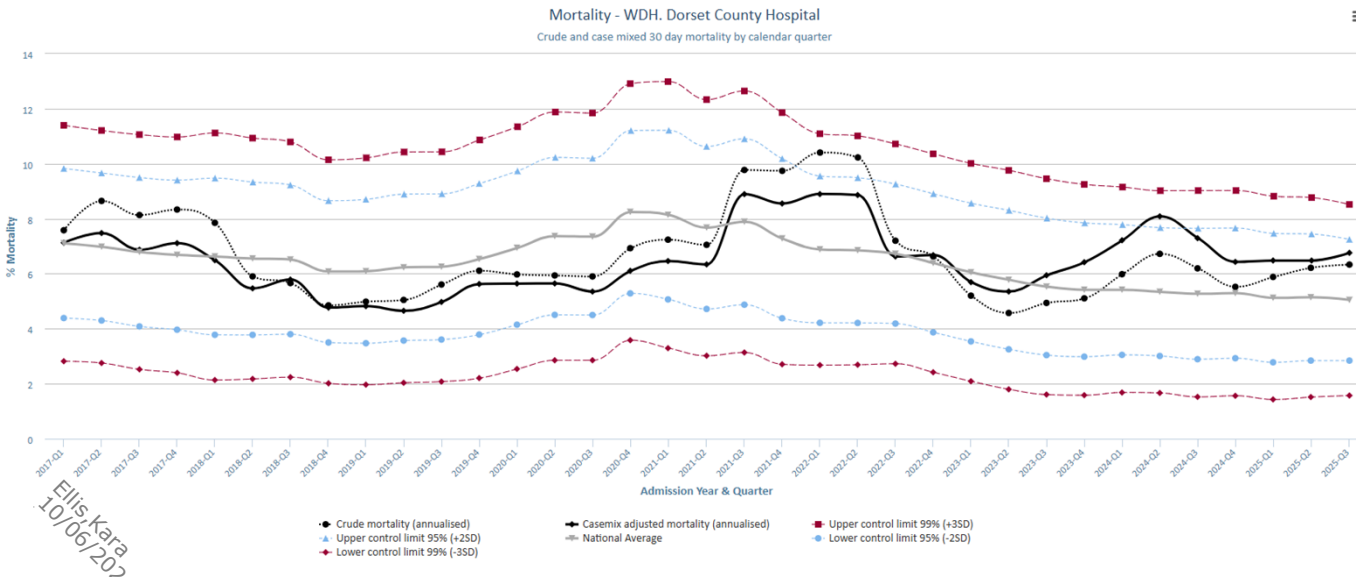
Risk adjusted acute mortality remains within the expected range, as shown in the chart below:

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3.3 National Hip Fracture database

The National Hip Fracture database is run by the Royal College of Physicians and this report comments on the mortality element only. The annualised case mix adjusted mortality has been above the national average, and although it was improving is now increasing again. This is not reflected in our condition specific SHMI. Work has been ongoing in the division to look at this and Division B have been asked to comment on this and this will be reported via HMG.



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3.4 National Child Mortality Database

Locally the child death annual report was presented at paediatrics clinical governance in August 2025 and reviewed at HMG in September 2025. There is no update from this since the last HMG, and further updates will be reported as they come through HMG.

3.5 MBRRACE data and the National Perinatal Mortality Review tool

There has been 1 perinatal death occurring at DCH reported to MBRRACE-UK via the PMRT in Quarter 4. This was an antenatal stillbirth of a baby at 38 weeks gestation, reported in January. This case has been reviewed through the PMRT process and the report published

There was 1 case reported by a tertiary centre that DCH was involved in the care and the review.

Learning from these cases is reported via the maternity safety report.

4.0 QUALITY IMPROVEMENT ARISING FROM SJRs & HMG

The following themes have been identified from SJRs / discussions at HMG with some being translated into quality improvement projects:

- New Dorset TEP and DNAR form
    - Ongoing programme of work to support care planning in the community
- Development of standard mortality agendas
- Use of hip fracture data to inform a business case for the development of a new Orthogeriatrics service
- Ongoing development of a new standard operating procedure for

5.0 MORBIDITY and MORTALITY MEETINGS

Morbidity and Mortality meetings across both divisions continue to generate meaningful learning, which is triangulated with SJR findings and escalated through divisional governance and Hospital Mortality Group. Learning themes this quarter include early recognition and escalation of deterioration, documentation and handover quality, communication with families, and care planning for frail and elderly patients.

Examples of learning arising from M&M discussions include reinforcement of timely senior review and escalation for deteriorating patients, improved documentation of escalation decisions and ceilings of care, learning around post-procedural risk following complex interventions, and the importance of early geriatric input and continuity of care. Specialty-specific learning has resulted in updates to guidelines, targeted teaching sessions and sharing of anonymised learning cases for education.

6.0 LEARNING FROM CORONER'S INQUESTS Q4

16 new Coroner's inquests were opened during Q4 , and 16 inquests were closed during Q4

- 12 inquests were heard as Documentary hearings, not requiring DCH attendance
- 3 required a clinician to attend court in person
- 1 was closed as natural causes (Part B)

During Quarter 4, no Regulation 28 (Prevention of Future Death) notices were issued to Dorset County Hospital. However, learning continues to be identified from Coroner's inquests, including both formal findings and softer learning relating to communication, documentation, escalation and care planning. This learning is captured by clinicians attending inquests and shared through Hospital Mortality Group and relevant divisional governance routes.

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Learning identified this quarter includes recognition that mortality risk remains elevated following complex interventional procedures despite appropriate management, highlighting the importance of post-discharge advice and follow-up for high-risk patients. In addition, learning has reinforced the importance of early and honest conversations with patients and families where frailty, comorbidities or life-limiting conditions are present.
A Regulation 28 notice issued elsewhere in the Dorset area relating to a choking death has also been reviewed for system learning. This case highlighted the risks associated with ineffective handover of patient-specific risks, including swallowing status and dietary requirements. Learning from this case has been shared locally and considered in the context of Trust processes for handover, documentation and communication of risk.

7.0 LEARNING FROM CLAIMS Q4

One potential claim was raised following an inquest. The patient died from an acute myocardial infarction, with the inquest concluding that death resulted from a **recognised complication of a coronary stenting procedure**.

The patient underwent angiography and stenting of a severely diseased and calcified coronary artery. An arterial perforation occurred during the procedure, which was appropriately treated at the time. It is likely this complication contributed to a subsequent septal infarct and a fatal cardiac arrhythmia.

This case highlights the inherent risks associated with complex coronary interventions in patients with severe coronary artery disease. The death was not unexpected in the context of recognised procedural complications, and no specific system or care delivery failings were identified.

8.0 SUMMARY

This quarter's Learning from Deaths report demonstrates that Structured Judgement Reviews, Morbidity and Mortality meetings, Coroner's inquests and national mortality metrics continue to provide assurance that there are no concerns regarding avoidable mortality at Dorset County Hospital. Importantly, triangulation of learning across these sources has identified consistent themes, particularly in relation to the care of frail and orthogeriatric patients, including location of care, escalation decision-making, documentation, handover and end-of-life planning. Learning from deaths has highlighted the importance of timely senior review, clear communication of patient-specific risks, robust handover processes and continuity of care, with examples of learning arising from SJRs, M&M discussions and Coroner's inquests informing quality improvement activity. While overall mortality indicators, including SHMI, remain favourable, risks relating to clinical coding capacity have been recognised and escalated through governance structures. Actions arising from learning continue to be progressed through divisional governance and Hospital Mortality Group, providing assurance that learning from deaths is actively informing service improvement and strengthening patient safety.

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Report to	Board in Common (DCH)	
Date of Meeting	17/06/2026	
Report Title	Maternity and Neonatal Quality and Safety Report (March and April)	
Prepared By	Jo Hartley Director of the Midwifery and Neonatal Service	
Approved by Accountable Executive	Dawn Dawson, Chief Nursing Officer	
Previously Considered By	Quality Committee in Common 26.05.26 Quality Governance Committee 15.05.26	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

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

Executive Summary

This report sets out the quality and safety activity covering the months of March and April 2026 (some dates may vary as specified). This is to provide assurance of maternity and neonatal quality, safety and effectiveness with evidence of quality improvements to the Executive and Non-Executive Team.

Safe – care that protects patients from avoidable harm and abuse through robust processes, incident reporting and risk management systems.

- No MOSS alerts
- 174 incidents have been reported through Datix for the two months.
- There has been one maternal death. MNSI and the Coroner have been informed and the case reported to MBRRACE
- There has been a recent incident of a baby born in poor condition. MNSI will review.

Risk Updates

2312 - Neonatal CPAP devices reaching end of life, no service contracts available – moderate 9 – replacement devices now ordered.
2292 - YDH reopening – moderate 9
1980 - EPAC restricted service – moderate 12
1689 - Second theatre for an elective pathway - moderate 12
2139- Dorset maternity advice line – moderate 12. Healthier Together App now commissioned and implementation in progress
1881 - Neonatal nurse staffing – high 16. All vacancies recruited to but staggered dates for commencement in post.

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Caring – patients treated with compassion, dignity and respect, ensuring their emotional, physical and cultural needs are always met

- 3 complaints received
- **Themes**: Poor communication in relation to moving to a room in SCBU
    - Lack of an obstetric review after caesarean
    - Medication error
    - Poor communication during a complex pregnancy and then afterwards, when baby was in the neonatal unit
    - Management of preterm labour, including the need to transfer to a tertiary unit
    - Management of pain during pregnancy fell short of expectations

Responsive – services organised to meet the needs of patients promptly and flexibly, ensuring timely access, choice and personalised care.

- Obstetric Anal Sphincter Injury (OASI) - 4 third degree tears. No fourth-degree tears. Rates remain consistent.
- Additional MNVP hours for neonatal services secured. This will improve support and feedback with families requiring neonatal care.

Effective – care, treatment and support that are evidence based, achieve positive outcomes and are provided by skilled and competent staff.

- Training data
    - Non-compliant for PROMPT for all obstetric doctors - expected compliance June
    - Non-compliant for PROMPT for obstetric anaesthetists – expected compliance July
    - Non-compliant for neonatal life support for paediatric doctors and neonatal nurses – training day cancelled so new training dates being secured
- Saving Babies Lives (version 3.2)
    - Good compliance for elements 2-5.
    - Element 1 – recruitment into the team will support increase in compliance.
    - Total implementation all elements 96%.

Well-Led – strong leadership, governance and a culture of continuous improvement to ensure accountability and high-quality care across all services.

Scorecard Q4 Jan – Mar 26 – Learning identified - to review threatened pre-term birth (SBL). Review delay in in-utero transfer out. Work withing regional process for maternity mortality. Support for staff engaged.

National reports anticipated during Quarter 2 – Ockenden, Baroness Amos, Thirwell Inquiry and National MBRACE reports anticipated over the summer. Representation and attendance at an NHS England Regional Conference in mid-October is anticipated.

Recommendation

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

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Dorset County Hospital
NHS Foundation Trust

Maternity & Neonatal Quality and Safety Report

March and April (reporting in May) 2026

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Dawn Dawson CNO

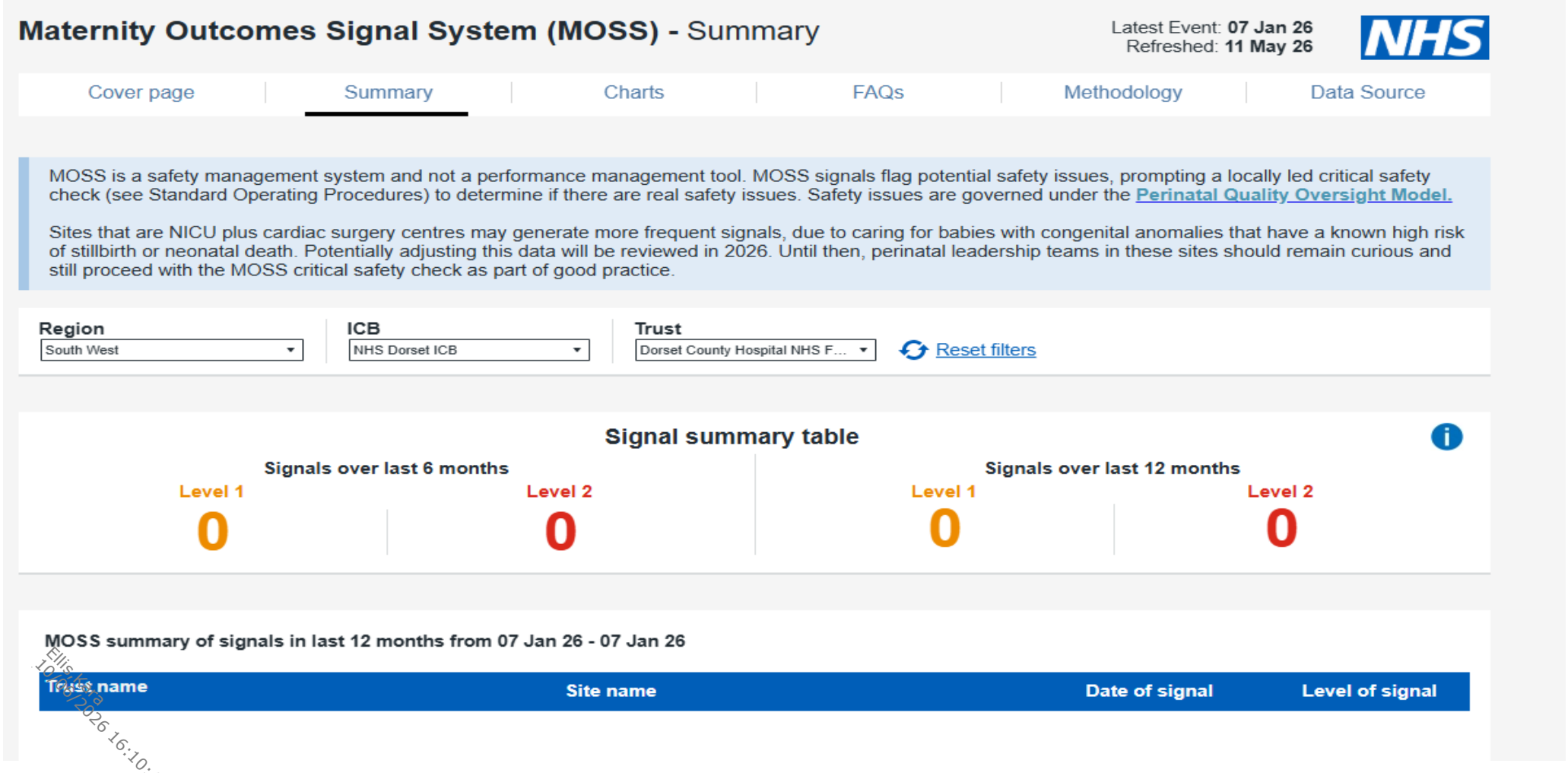


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Executive Summary

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MOSS (Maternity Outcome Signalling System) reporting for DCH



Maternity Outcomes Signal System (MOSS) - Summary

Latest Event: **07 Jan 26**
Refreshed: **11 May 26**

NHS

Cover page | Summary | Charts | FAQs | Methodology | Data Source

MOSS is a safety management system and not a performance management tool. MOSS signals flag potential safety issues, prompting a locally led critical safety check (see Standard Operating Procedures) to determine if there are real safety issues. Safety issues are governed under the Perinatal Quality Oversight Model.

Sites that are NICU plus cardiac surgery centres may generate more frequent signals, due to caring for babies with congenital anomalies that have a known high risk of stillbirth or neonatal death. Potentially adjusting this data will be reviewed in 2026. Until then, perinatal leadership teams in these sites should remain curious and still proceed with the MOSS critical safety check as part of good practice.

Region: South West | ICB: NHS Dorset ICB | Trust: Dorset County Hospital NHS F... | Reset filters

Signal summary table

Signals over last 6 months		Signals over last 12 months	
Level 1	Level 2	Level 1	Level 2
0	0	0	0

MOSS summary of signals in last 12 months from 07 Jan 26 - 07 Jan 26

Trust name	Site name	Date of signal	Level of signal

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Performance and Safety Dashboard

Metric: Multiple selections

Group: All

Variation (V)

Assurance (A)

Select an icon to view matching metrics.

Metric ID	Metric	Chart Type	Group	Latest Date	Value	Target	Variation	Assurance
1	No Of Bookings Made	XmR	Booking	30/04/26	142			
8	No Of Babies Born	XmR	Births	30/04/26	163			
23	% Of Babies Born By Elective Caesarean	XmR	Births	30/04/26	24.5%			
24	% Of Babies Born By Emergency Caesarean	XmR	Births	30/04/26	22.7%			
34	% Of Babies With 1st Feed Maternal	XmR	Births	30/04/26	78.4%			
57	No Of Hypoxic-Ischemic Encephalopathy (HIE) Incidents	XmR	Neonatal	30/04/26	0			
73	% Of Babies With FGR Born <3rd Centile Above 37+6 weeks	XmR	SBL - FGR	30/04/26	0%			
75	% Of Women With CO Measurement Recorded At Booking	XmR	SBL - Reducing smoking	30/04/26	99.3%	95%		
91	No Of Transfers From Neonatal Unit To Other Hospital	XmR	Neonatal	30/04/26	0			
102	Rate Per 1000 Of Still Births	XmR	Births	30/04/26	0	4		
103	Rate Per 1000 Of Neonatal Deaths < 28 Days	XmR	Births	30/04/26	0	2		
110	Rate Per 1000 Of Women With 3rd / 4th Degree Tears (MSDS - National Tear Definition)	XmR	Delivery	30/04/26	12.3	25		
134	% Of Women Smoking At Booking (MSDS - National Smoking At Booking)	XmR	SATOB	30/04/26	7.8%			
136	% Of Women Smoking At Delivery (MSDS - National Smoking At Delivery)	XmR	SATOB	30/04/26	5.6%	6%		
178	Rate Per 1000 Of Women With PPH 1500ml or More (MSDS - National PPH 1500ml or More - Previous 3 Months)	XmR	Delivery	30/04/26	33.5	30		
194	Rate Per 1000 Of Babies With APGAR Score < 7 At 5 Mins - Term Singletons (MSDS - National APGAR Definition - Current 3 Months)	XmR	Delivery	30/04/26	31.3			

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Special cause variation of a concerning nature

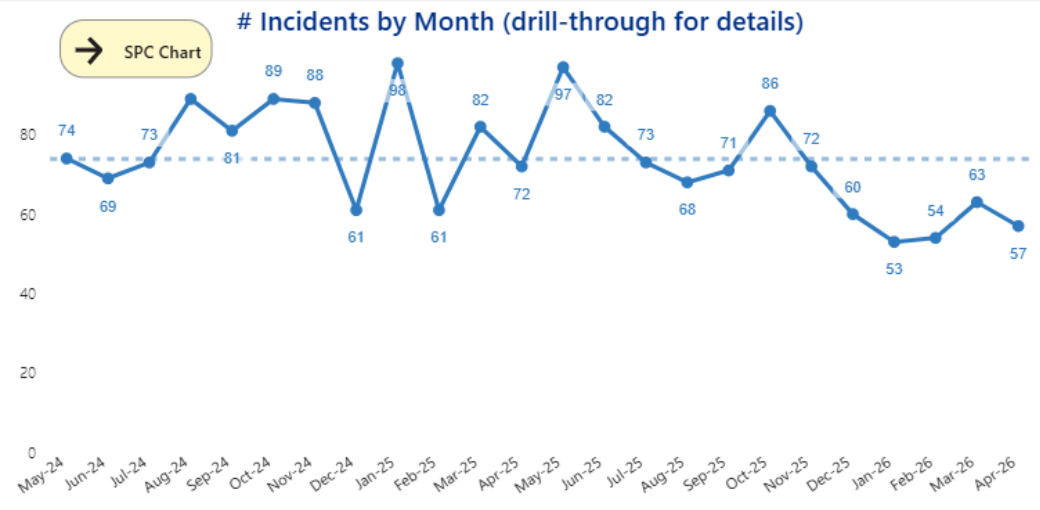
Metric ID	Metric	Chart Type	Group	Latest Date	Value	Target	Variation	Assurance
182	Rate Per 1000 Of Women With 3rd / 4th Degree Tears (MSDS - National Tear Definition - Current 3 Months)	XmR	Delivery	30/04/26	24.6	25		

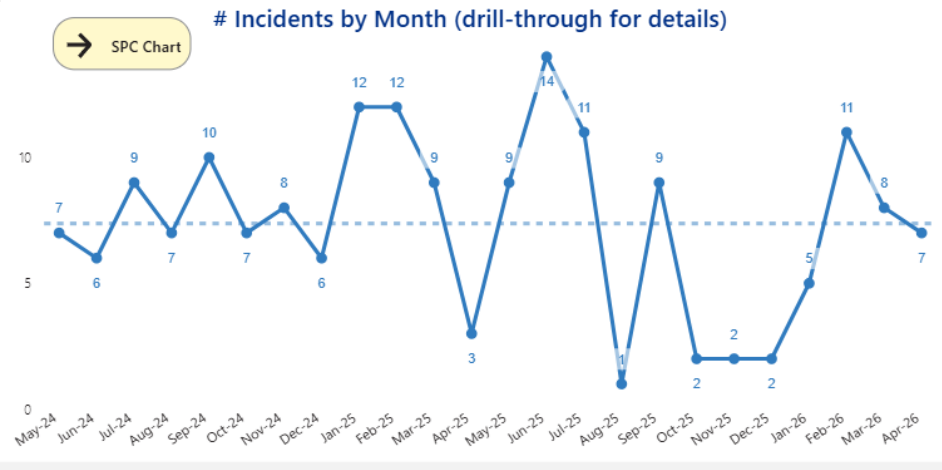
Special cause variation of an improving nature

Metric ID	Metric	Chart Type	Group	Latest Date	Value	Target	Variation	Assurance
59	% Of Women With A FGR Status Recorded At Booking	XmR	SBL - FGR	30/04/26	99.3%	80%		
75	% Of Women With CO Measurement Recorded At Booking	XmR	SBL - Reducing smoking	30/04/26	99.3%	95%		
80	% Women Given Leaflet About Fetal Movements By 28 Weeks	XmR	SBL - RFM	30/04/26	98.8%	95%		
140	No. Of BAME Women Active On Maternity Pathway At 29 Weeks Gestation	XmR	CoC	30/04/26	18			
169	% Of Women Who Reach 36 Weeks Gestation With A CO Measurement	XmR	Delivery	30/04/26	88.7%			

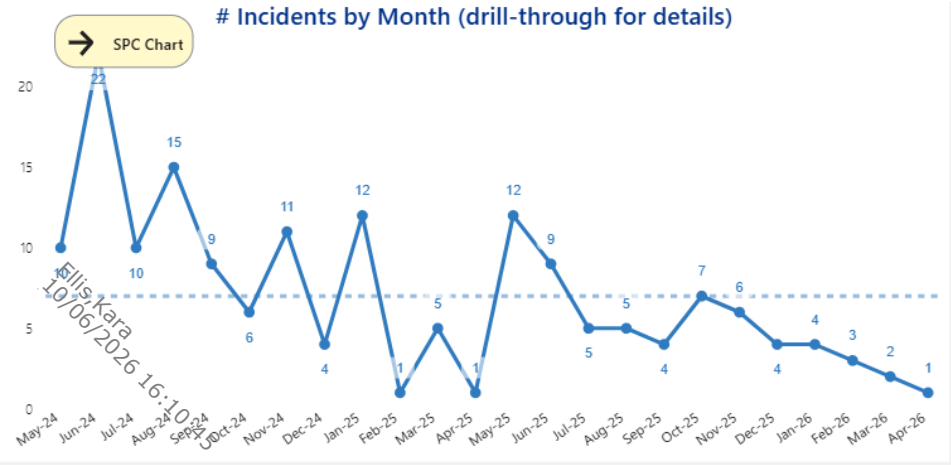
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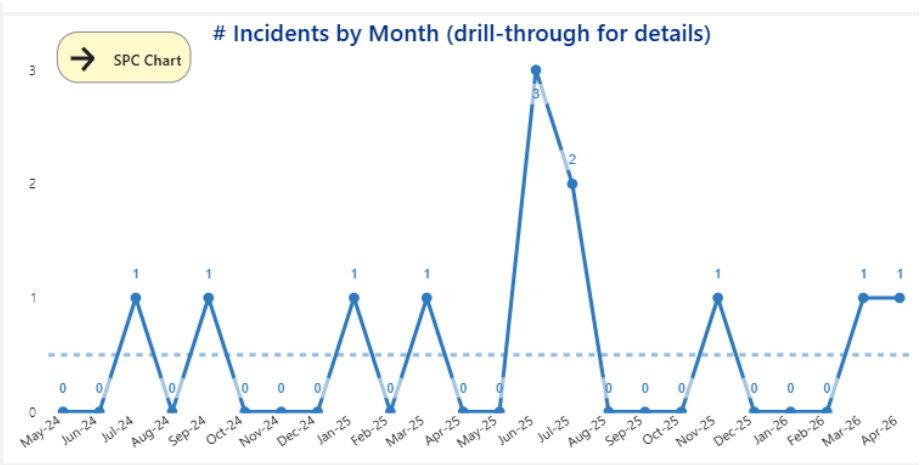
Total Number of Incidents submitted for March and April under Maternity and SCBU





Total number of incidents causing harm for maternity and scbu





Total incidents relative to maternity, obstetrics & SCBU – 174 (manual count)

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

Red flag	Descriptor	Incidents for march and April
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	1 x OPEL 3 1 x SCBU staffing
RF2	Missed medication	0
RF3	Delay in providing or reviewing an epidural in labour	0
RF5	Full examination not carried out when presenting in labour	0
RF6	Delay of ≥2 hours between admission for induction of labour & starting process	11 x delayed IOL 1 x delayed LSCS
RF7	Delay in continuing the process of induction of labour	
RF8	Unable to provide 1 to 1 care in labour	0
RF9	Unable to facilitate homebirth	sickness has resulted in many oncalls being covered by homebirth midwives picking up extra shifts
RF10	Delay of time critical activity	0

In-utero transfers – UHD is default level 2 NICU for DCH pregnancy <32 weeks	
In utero transfer of patient due to only 1 emergency cot in SCBU and a further admission would send the unit into Opel 4 and closure. Cot and maternity bed secured at UHD - attempted to arrange ambulance for transfer but wouldn't dispatch ambulance due to not meeting criteria.	Escalated to senior call handler, informed manager on call and consultant as have never had refusal to send ambulance. Discussed with consultant who was agreed transfer via taxi with midwife escort

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

IUD – intrauterine death/stillbirth - NND – nenonatal death

Incident	Gestation/Age at Incident	Date of Incident/deat	Case IDs	Investigator	External Owner	Update	PMRT Grading	Reasons for Grading	Open and Honest Conversation	Duty of Candour Letter	Open/Closed
Cooling	39+2	April 24 2026	58108	MNSI	No	MNSI contacting family	N/A	N/A	No-UHS gained consent for MNSI	Awaiting outcome	**open**
Maternal Death	37+3	March 23 2026	T026/055967	MBRRACE/MNSI	No	MNSI contacting family	N/A	N/A	Yes	Awaiting outcome	**open**
HIE	41+1	February 9 2026	MAT 002-170	MNSI review	No	MNSI rejected case, for internal review and M&M	N/A	N/A	Yes	Awaiting outcome	**open**
Maternal Death	22 days P/N	January 27 2026	MBRRACE ID unknown	MBRRACE	Yes/UHS	Family declined MNSI, review panel to be organised by UHS	N/A	N/A	N/A	Awaiting outcome	**open**
IUD	38+6	January 7 2026	101966/1	PMRT	No		B, A	**B**-no f/u MSU, ED attendance with no obstetric input	Yes	Awaiting outcome	**open**
Cooling	37+2	November 17 2025	49434	MNSI/EN	No	Draft MNSI report received	N/A	N/A	Yes	Awaiting outcome	**open**
NND	40+6 NND less than 6 hours of age	August 17 2025	99869/1, MI45424	PMRT/MNSI/CDRM	No	Final MNSI report published	C, B, A not for grading until all investigations completed.	**C** recognition of delay in labour and transition to 2nd stage, delay in FH auscultation, no written info SROM or ambulance t/f times No safety recommendations, awaiting PM before tripartite	Yes	Required	**open**
NND	41 weeks NND 2 days old	May 22 2025	98704/1, MI42426	PMRT/MNSI/CDRM	Yes/UHS	Final MNSI report published			Yes	Awaiting outcome	**open**

Incidents of moderate harm and above not reported eleswhere		
harm	**incident**	**Action**
None noted		

Ellis Kay 11/05/2026 16:30:45

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

Four 3rd degree tears, no 4th. All referred for endo-anal scan

Saving Babies'Lives (version 3.2) Board Report. Q4 2026

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Executive summary

Following release of the MIS Year 8 Core Standards and Supplementary Guidance, and with the agreement of the Cluster ICB Chief Nursing Officer, the LMNS-led SBLCBv3.2 quarterly review meetings will be stood down across all Trusts.

Expectations for delivery of SBLCBv3.2 remain unchanged. Trusts remain responsible for:

- Continued implementation of SBLCBv3.2 in line with MIS Year 8 requirements, including quarterly reporting to Trust Board.
- Retaining evidence for assurance purposes, including to support any potential MIS spot checks undertaken by NHS Resolution.

	Q1	Q2	Q3	Q4
Element 1 Smoking in pregnancy	100%	90%	100%	**75%**
Element 2 Fetal growth restriction	100%	100%	95%	**100%**
Element 3 Reduced fetal movements	100%	100%	100%	**100%**
Element 4 Fetal monitoring in labour	100%	100%	100%	**100%**
Element 5 Preterm birth	100%	100%	88%	**100%**
Element 6 Diabetes	67%	83%	100%	**100%**
Total implementation (all elements):	97%	97%	94%	**96%**

Element 1	• Recruitment into the team will support to increase compliance • Launching an inpatient NRT grab bag to increase exposure of smoke stop service.
Element 2	• High levels of compliance across this element • Increase in appropriate uterine artery scans • Good MDT review of audit & learning, including the sonography team
Element 3	• All interventions fully implemented.
Element 4	• All interventions are fully implemented • Mandatory training continues
Element 5	• Compliance remains high across this element. • Preterm birth MDT team have made good progress on audit/QI work surrounding Cervical length and in-utero transfer out
Element 6	• All interventions remain fully implemented

Ellie Kara 16/06/2026 16:10:45

Healthier lives Empowered citizens Thriving communities

Scorecard Q4 Jan – March 26

Scorecard Q4 Jan-Mar 2026

Trust Claims(obstetric) 2013-2023

Top injuries by volume:	Top injuries by value:
• Psychological damage (6) • Unnecessary pain (3) • Bowel damage/dysfunction (2) • Brain damage (2) • Hypoglycaemia (1)	• Brain damage (2) • Chromosomal abnormality (1) • Bowel damage/dysfunction (2) • Psychiatric/psychological damage (6) • Hypoxia (1)
Top causes by volume:	**Top 5 causes by value:**
• Fail to warn – informed consent (3) • Not specified (2) • Assault, Etc by hospital staff (2) • Perineal Tear 1st, 2nd, 3rd Deg (2) • Fail to recog. complication of (2) • Foreign body left in situ (1)	• Fail to warn – informed consent (3) • Fail AN screening (1) • Perineal tear 1st, 2nd, 3rd Deg (2) • Assault, Etc by Hospital staff (2) • Fail / Delay treatment (1)

Complaints Q4 2026

- X3 Early resolution complaints.

Themes

- Communication
- Information sharing and expectations
- Kindness & compassion
- Responsiveness & environment (answering main door at reception)

Incidents Q4 2026

2 cases of opening a second theatre ↓
3 Escalations to divert↓
10 reported incidents of delay of Induction
8 in-utero transfers ↓
1 in-utero transfer declined by SWAST
1 Maternal death reported to MBRRACE by DCH

Kirsty Kara
10/06/2026 16:10:45

Maternity Incentive Scheme - SA9
Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

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Themes Q4 2026

- Communication and information sharing
- Barriers that may prevent local and regional process

Learning Q4 2026

- Continue to review threatened Pre-term birth (Saving Babies lives)
- Review delay in in-utero transfers out.
- Work within regional process for Maternity Mortality
- Support for staff arranged

Action Plan Q4 2026

Discuss and highlight complaints at staff meeting	
Liaise with SWAST regarding transfers out	
Update progress on Mortality through Hospital mortality group & board	

Not started | In progress | Completed

Risk Register

ID	Title	Risk Statement	Open	Risk	responsibility
2312	Neonatal CPAP devices reached end-of-life with no service contracts available	4 CPAP devices (SLE1000) have now reached End of Support status and will no longer have renewing service contracts or supplying service kits. Of the 4 devices, one is already unavailable needing repair. No other CPAP devices available to use with neonatal patients. If the remaining 3 working devices stop working we will have no means of providing CPAP therapy, meaning patients will need to be transferred to other units.	18/03/2026 Débora Pascoal-Horta, Neonatal Matron, quarterly review	Moderate 9	Service specific
2292	YDH Reopening	YDH due to reopen April 22. Currently the plan is that YDH staff return to YDH for the reopening leaving DCH without the extra staffing, on the assumption women will immediately return to YDH. This may not happen, exposing DCH to the risk of inadequate staffing. This poses a risk to safety and quality **Update** Staffing maternity to 7-8 midwives plus the coordinator (prior to reopening, staffed to 8-9 plus coordinator). Number of LSCSs and IOLs has not noticeably changed	03/02/2026, Jo Hartley, DoMN, Monthly review	Moderate 9	Division
2306	Local, service specific induction process for obstetric trainees and new starters	Currently, the induction process for trainees and locally employed doctors in obstetrics and gynaecology fails to ensure all the required information is shared in a timely manner. Start dates and names are not confirmed and Outlook contact groups are not updated, invitations to essential meetings and training opportunities are not sent, required training is not completed, access to digital systems is not completed and doctors report being unprepared for their role. **Update** No identified progress with this risk. Dissatisfaction anticipated in GMC survey	09/03/2026, James Male, Service Manager, monthly review	Moderate 9	Care group

Ellis Kara
10/06/2026 16:10:45

2224	Potential inadequate capacity and staffing for antenatal ultrasound	The new maternity unit at UHD opened in March 25 and this has resulted in some women from East Dorset transferring their care to DCH and an increase in new bookings. In addition to this YDH maternity unit closed with no notice in May and a significant number of women have transferred their care to DCH. This is putting the Ultrasound Department under considerable pressure for the following reasons: **Update** Update requested but unavailable	29/09/25, Julia Morris, Radiology Manager, monthly review	Moderate 12	Division
2260	Evacuation plan for SCBU	at the present time, there is no finalised evacuation policy for the neonatal unit, in the event of a fire **Update** Fire Safety cards written and meeting with Fire Officer 18/03/2026 to discuss. when improvement work is due to commence.	04/12/25 Sarah True, Neonatal Risk Lead, quarterly review	Moderate 8	Division
2180	Lack of psychological support service for neonatal service	Lack of funding for specialist psychological professionals to support parents, in line with staffing recommendations for the Neonatal Units. Discrepancy in care across the region, as some units have psychological support in place (level 2 and 3 around us). When infants step down in care and move to DCH this support is nonexistent. **Update** SCBU is now piloting a psychological support service for parents and staff. Will take the form of a "drop in" service for referral and signposting and intervention if required immediately. Initially for one morning per week. To remain on Risk Register at present until established to BLISS standards and future funding ascertained. The service is provided by the Perinatal Mental Health Team with no long-term funding identified.	25/06/2025, Débora Pascoal-Horta, Neonatal Matron, quarterly review	Moderate 12	Service specific

Ellis,Kara
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2159	Patient and governance confidentiality	Layout of neonatal units results in daily breaches of confidentiality. Notes trolley in corridor. Phone conversations in the middle of the ward. Multidisciplinary conversations with external agencies in the middle of the ward. Inability of staff to leave the area for private conversations. Mitigation: Covers created for patient observations clipboards. Staff reminded about confidentiality and the need to move to a different area for private conversations, when possible. Staff asked to Datix when they witness incidents related to confidentiality. Daily observation and reminder by Matron and Governance Lead to the Team about open folders and iPads and logging out PCs after use.	09/05/2025, Débora Pascoal-Horta, Neonatal Matron, quarterly review	Moderate 8	Division
2183	YDH closure impact on obstetric workforce	**Update** No further update. However, with YDH poised to open in April, a workforce review will be required for DCH in response to the changing workload following the reopening	30/06/2025, James Male, Service Manager. Quarterly review	moderate 9	division
2139	Risk to the maternity advice line provided by UHD for all of Dorset	the maternity advice line provides a dedicated maternity triage service for all pregnant women in Dorset. A request has now been submitted by UHD that DCH pay a proportion of running costs – approx. £80k per annum. UHD may serve notice on the service if an agreement is not made. Without UHD providing this dedicated service, DCH would have to provide a 24/7 service for DCH women **Update** progressing at pace to the use of the Healthier Together app. Evidence from other Trusts indicates this reduces calls to the MAL. Staffing remains good on the advice line	07/04/2025, Jo Hartley, DoMN Services, monthly review	Moderate 12	Division
1980	EPAC restricted service	**Update** Currently EPAC remains open for most Mondays-Fridays. However, this comes at a cost pressure to maternity as a midwife has been reallocated to EPAC and vacant shifts are being covered by bank staff Business case has been submitted and awaiting amendments **Update** The service continues to be reduced with an increase in complaints received. The business case is not progressing due to funding. The risk rating has been raised as the rate of closure of the service is increasing	20/09/2024, Jo Hartley, DoMN Services, quarterly review	Moderate 12	Division

Ellis Kara 10/06/2026 16:10:45

1881	Neonatal Nursing	**Update** Business case approved and CoE actioned, increasing the establishment for the unit and allowing recruitment in the next few weeks. RNs with QIS also joined the bank and are now doing regular shifts on the unit, reducing drastically the use of agency. Risk still present but reduced. YDH neonatal nurse also working all her hours at DCH. Recruitment ongoing. Consultation with some staff to change band 3 to band 6 nurse on nights - allowing for 3 RNs and therefore a supernumerary lead nurse **Update** Interviews conducted in March. Several jobs offered to cover vacancies at Band 5 and 6.	01/05/2024 Débora Pascoal-Horta, Neonatal Matron, monthly review	High 16	Division
2044	Risk to sustainability of Maternity & Neonatal Digital Service	Currently the maternity digital team is 1 WTE midwife only. The admin support has left due to her secondment ending. The band 6 is on secondment (essential role within the Trust Digital Team) Education lead midwife for digital on maternity leave with no replacement identified. **Update** Interim arrangement continues	14/01/2025, Jo Hartley, DOMN, quarterly	low 6	Division
1689	Opening a second theatre in an emergency &the elective pathway	**Update** A second theatre was required three times in Sept and Oct. There were also several incidents where elective activity was significantly delayed, sometimes for more than 24hrs, because the maternity theatre was being used for emergencies and elective work cannot continue past 1700 **Update** No progress towards an elective pathway using a second theatre and team. Case demand under review	29/06/2023 managed by Jo Hartley DoM, quarterly review	moderate 12	Division
876	Maternity Staffing	**Update** whilst incidents of escalation to OPEL 3 and 4 continue to occur regularly and IOLs and LSCSs are regularly delayed, there has been progress in relation to recruitment. 6.4wte NQM appointed for 12 months fixed term. 2 WTE additional band 6 midwives recruited for fixed term 12 months. Agency now used regularly, and ward staffing increased to 8 plus the coordinator. However, the manager on-call frequently called in to bolster numbers and incentives used regularly. There isn't enough coordinators to ensure a 24/7 on-call for homebirths and senior cover. Sickness in the senior team often has to be covered by matrons. Given the challenges with ensuring a coordinator is available for every shift, the significant reliance on agency and the frequency of rotas not being fully staffed, the risk remains high **Update**	21/09/2021 Managed by Jo Hartley, Director of Midwifery, monthly reviews	High 15	Division

Ellis Kara
10/06/2026 16:10:45

		YDH staff no longer available. Notable increase in shifts not fully staffed. Significant reliance on agency and incentives used daily. Some night shifts approaching 50% of staff are agency. Manager on call covered 3 shifts in her week on-call. Staff with fixed term contracts have started looking for substantive jobs elsewhere. Increase in delayed inductions noted. 11wte midwives on maternity leave/LTS	

Neonatal transfer out data for March and April

Gestation	Weight	Reason	Transferred to
39+2	2794g	Transferred to Southampton for cooling for HIE grade 3	Will transfer back to YDH

Complaints and birth debrief feedback for maternity and SCBU

Total informal and formal

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

Themes
Poor communication in relation to moving to a room in SCBU
Lack of an obstetric review after caesarean
Medication error – two doses given (no harm to patient)
Poor communication during a complex pregnancy and then afterwards, when baby was in the neonatal unit
Management of preterm labour, including the need to transfer to a tertiary unit
Management of pain during pregnancy fell short of expectations
basic standards of cleanliness and patient care after birth including clean linen, refreshments etc.

Swiftkey 10/01/2023 16:10:45

Training Figures as of February 2026

MIS Year 8 Reportable Training	Staff Group	Compliance (%) Mar 2026	Compliance (%) April 2026	MIS Year 8: what good looks like in Safey Action B – includes narrative
SA6 SBLv3 Element 1.8	Carbon Monoxide Monitoring Midwives and MSWs giving Antenatal Care	82%	91%	Expected maintained
SA6 SBLv3 Element 1.9	Very Brief Advice All staff	87%	91%	Expected maintained
SA6 SBLv3 Element 2.11	Practical SFH assessment	92%	93%	Expected maintained
Fetal Monitoring and Surveillance in the AN and Intrapartum period	Obstetric Consultants	100%	100%	Expected maintained.
	Obstetric doctors (Registrars)	100%	100%	Expected maintained.
	Midwives	93%	95%	Expected maintained.
PROMPT * obstetric registrars and drs on obstetric sho rota who are rotational commencing after 1st July 2025 can have a lower compliance accepted, this will be included in the Q3 report moving forwards	Obstetric consultants	70%	50%	4 staff booked to attend May and June, expected 90% compliance in June 2026.
	Obstetric Registrars*	60%	50%	Staff booked to attend in June, expected compliance June 2026.

Ellis,Kara
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and is included in the action plan in Appendix 3 of this report.	Drs on obs SHO rota*	75%	75%	Staff booked to attend May and June, compliance expected June 2026.
	Midwives	90%	91%	Expected maintained
	MSWs	76%	91%	Expected maintained
	Obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	85%	77%	83% if include 1 new staff not required to be compliant until July 2026 (within 3 months as per technical guidance), 2 others out of date, escalated to Obstetric Anaesthetic Lead
	All other obstetric anaesthetic doctors contributing to the obstetric rota	92%	89%	Escalated to Obstetric Anaesthetic Lead
	8.12 Rotational Anaesthetic Staff commencing after 1st July (lower compliance accepted providing Trust Board agreed action to attend within 6 months	93%	90%	Issue of maintained compliance, escalated to Obstetric Anaesthetic Lead

Ellis,Kara
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	of start date from Trust)			
Neonatal Basic Life support (NBLS) Yearly	Paediatric consultants	78%	78%	BAPM airway framework/NLS update day cancelled as facilitator unwell March 2026. Arranging individual sessions. Individuals have been emailed. There is another BAPM airway framework study day planned for September.
	Paediatric registrars	78%	78%	2 staff arranging for individual update with NLS instructor, will be managed by SCBU educator.
	Neonatal nurses	100%	82%	2 out of date, booked on July study as back but planned for individual capture before then.
	MSWs and HCAs who require this training as per local policy	100%	100%	Expected maintained.
	ANNP	100%	100%	Expected maintained.
	Midwives	92%	93%	Expected maintained.
RCUK NLS Certification	Senior midwives and homebirth midwives	100%	100%	Expected maintained.
	Paediatric Consultants	100%	100%	Expected maintained.

Ellis,Kara
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	Paediatric Registrars	75%	89%	1 out of date end of March had been booked UHD 13th February – this was cancelled by provider – this has now been rebooked for June.
	Neonatal Nurses	91%	90%	
CCFv2 Training Saving Babies Lives Study Day – not Trust mandated, mandated within CCFv2, agreed by quadrumvirate in November 2023.	Midwives	87%	86%	
	Obstetric Consultants	50%	50%	Obstetric staff no longer routinely rostered for SBLv3.2 update day.
	Obstetric Registrars	80%	60%	
	Drs on SHO rota	25%	25%	
Safeguarding Level 3 Children **Trust Mandated**	Midwives	95%	88%	
	MSWs	75%	82%	Expected compliance May 2026
Basic Life Support – Adult **Trust Mandated**	Midwives	86%	79%	*Unsure ref accuracy, now called clinical emergency recognition, awaiting data update on esr.
	MSWs	82%	88%	*as above
	Obstetric Consultants	80%	60%	*as above
	Obstetric Registrars	100%	60%	*as above
	Drs on Obstetric SHO rota	75%	75%	*as above

Ellis Kara
10/06/2026 16:10:45

Ellis Kara
10/06/2026 16:10:45

Dorset HealthCare University
NHS Foundation Trust

Report to	Board in Common (DHC)	
Date of Meeting	17th June 2026	
Report Title	Community Hospital Inpatient Biannual Staffing Review	
Prepared By	Cara Southgate, Director of Nursing, Therapies & Quality, Alex Matutino, Safer Staffing Lead and Katie Powell, Data Analyst and Support	
Approved by Accountable Executive	Dawn Dawson, Joint Chief Nursing Officer	
Previously Considered By	Quality Governance Group, 7th April 2026 Quality Committee in Common, 26th May 2026	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1: Quality and Safety SR2: Culture SR3: Workforce Capacity SR4: Capacity and Demand SR6: Finance	
Financial	The report includes details on staffing shortfalls and, where applicable, the associated temporary staffing costs.	
Statutory & Regulatory	The report meets the national requirements for safer staffing reporting as guided by the National Quality Board (2016) and Developing Workforce Safeguards (2018).	
Equality, Diversity & Inclusion	The data in this report is drawn from a range of partners, including management accounts, business, and performance, eRoster, and feedback received from local managers, service leads, and the safer staffing forum.	
Co-production & Partnership	As above	

Executive Summary

This report provides an overview of safer nursing staffing as part of the biannual review requirements, triangulating data between May 2025 – January 2026 . It focuses on ensuring that the right staff, with the right skills, are in the right place at the right time. The report outlines the organisation's approach to monitoring and reviewing staffing establishments and safer staffing levels across our inpatient services. This work aligns with the expectations of the National Quality Board (2016) and the guidance set out in Developing Workforce Safeguards (2018).

This report provides an overview of the staffing position and associated workforce metrics for the reporting period. The narrative summarises key findings at the service level. A comprehensive report setting out the detailed breakdown of staffing data for each ward was taken to the Quality Governance Group (this is available to committee members if required).

Enclosure 10/2026/26 - 17/06/2026 10:45

The National Quality Board (2016) guidance Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time sets out a framework to support organisations and staff in

making staffing decisions that put patients first. These expectations guide provider boards in making informed local decisions that ensure high-quality patient care within available staffing resources.

NHS provider boards are accountable for ensuring that their organisation has the culture, leadership, and skills required to deliver safe, sustainable, and productive staffing (National Quality Board, 2016).

This paper follows the 2025 annual establishment review report for Community Hospital inpatient services. It incorporates a focus on acuity and dependency data collected using the evidence-based and nationally endorsed establishment tool - Safer Nursing Care Tool (SNCT) to support establishment setting.

EXPECTATION 1- RIGHT STAFF

Overall, staffing was well managed throughout the reporting period. The actual Care Hours per Patient Day (CHPPD) across the service aligned with total planned hours throughout the reporting period. Fill rates were largely maintained within KPI thresholds, with some variation attributable to reduced bed capacity on Jersey and Guernsey wards, a pilot reduction in Health Care Support Worker (HCSW) night staffing on Colmers Ward, and fluctuations in acuity, dependency and bed occupancy. Staffing shortfalls remained where duties could not be filled through temporary staffing solutions.

Staff are flexibly deployed across the community hospitals to mitigate shortfalls, informed by assessments of acuity and dependency, and by staff expertise. This approach is monitored through Directorate Management Groups and Safer Staffing reporting to ensure there is no detriment to patient safety or staff wellbeing. Approval has been given to proceed with the SafeCare evidence-based deployment tool to support safe and consistent decision-making.

Reliance on temporary staffing continued, primarily driven by vacancies and sickness. Community Hospitals, particularly in Mid, West and North Dorset, continue to experience recruitment challenges due to their rural locations and limited public transport links, which reduce the pool of staff able or willing to travel. In addition, competition from local care providers and other industries offering pay rates comparable to or above Agenda for Change can further impact recruitment and retention, creating additional pressure on staffing levels. Bespoke recruitment programmes are currently being explored with Trust Bank.

Peaks in agency usage coincided with increased incident reporting; however, no direct causal link to staffing levels was identified.

When compared against the 22% headroom allowance, average unavailability was also 22%. This figure excludes other forms of leave not accounted for in headroom, such as parental leave. When these additional leave types are included, the overall average unavailability rises to 29%, exceeding the allocated headroom and increasing the likelihood of staffing gaps and reliance on the temporary workforce.

Sickness absence remained persistently above 5%. While average annual leave across wards consistently met the KPI, analysis shows variability at ward level, with some wards exceeding the upper threshold of 17%—most commonly during school holiday periods.

SNCT data shows rising patient acuity and dependency, with the overall establishment for Community Hospitals sitting below SNCT recommended levels. This position will be closely monitored in the next census to determine whether a consistent trend is emerging ahead of the annual establishment-setting process. The use of enhanced therapeutic observations of care has been reduced and is now authorised on a case-by-case basis. This will continue to be kept under review to determine whether any changes to the staffing establishment are required.

Ella Kara
20/06/2026 10:10:45

The recommendation from the 2025 annual establishment review to increase night staffing on Tarrant Ward by one HCSW has now been approved.

Recruitment challenges persist, particularly in rural areas. As of January 2026, vacancies stood at 4.71 WTE for RNs and 26.55 WTE for HCSWs (including headroom) Colmers Ward held an HCSW vacancy as part of its night-duty pilot.

Workforce age profiling shows a stable mid-career cohort but limited recruitment of younger staff and increasing retirement risk, particularly at Colmers and Tarrant, highlighting the need for ongoing workforce planning and targeted recruitment strategies.

Expectation 2: Right Skills

Mandatory training, clinical supervision, and appraisal compliance remain key workforce priorities, with monitoring through Directorate Management Groups and reporting to the Trust Board. Clinical supervision requirements have been strengthened, moving to bi-monthly monitoring from September 2025, though current recorded compliance remains low and may reflect recording rather than delivery.

Although no incidents were reported as resulting from cancelled training, continued monitoring is needed to understand any impact on workforce competence. Additional BLS training capacity has been commissioned to support improvements. Appraisal compliance averaged 76%, though system changes impacting recording may mean the true figure is higher.

Incident reporting remains under routine monitoring, with no evidence that staffing levels directly contributed to patient harm. National and local red flags are currently being reviewed to ensure they reflect all relevant indicators associated with staffing shortfalls. This work will strengthen our ability to understand and evidence the impact of workforce gaps on patient safety, quality of care, and staff experience, enabling more informed decision-making and earlier identification of emerging risks.

Expectation 3: Right Place and Time

Contracted hours were effectively utilised during the period, with only a small variance between funded and assigned hours, though ongoing monitoring is required to ensure all available staffing capacity continues to support patient care.

33 complaints were received, with no themes identifying staffing levels as a contributory factor, providing assurance that workforce capacity is not impacting patient dissatisfaction.

One risk remains open on the risk register, relating to clinical cover across all sites, with other previously identified risks closed during the year.

Recommendation

- Receive the report for assurance that Dorset HealthCare is adhering to national safer staffing guidance.

Ellis,Kara
10/06/2026 16:10:45

1.0 Introduction

1.1 This report provides an overview of safer nursing staffing as part of the biannual review requirements, triangulating data and professional judgement between May 2025 and January 2026. It focuses on ensuring that the right staff, with the right skills, are in the right place at the right time. The report outlines the organisation's approach to monitoring and reviewing staffing establishments and safer staffing levels across our inpatient services. This work aligns with the expectations of the National Quality Board (2016) and the guidance set out in Developing Workforce Safeguards (2018).

1.2 This report provides an overview of the staffing position and associated workforce metrics for the reporting period. The narrative summarises key findings at the service level, while the accompanying appendices present a detailed breakdown of staffing data for each ward.

1.3 The National Quality Board (2016) guidance *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time* sets out a framework to support organisations and staff in making staffing decisions that put patients first. These expectations guide provider boards in making informed local decisions that ensure high-quality patient care within available staffing resources.

1.4 NHS provider boards are accountable for ensuring that their organisation has the culture, leadership, and skills required to deliver safe, sustainable, and productive staffing (National Quality Board, 2016).

1.5 This paper follows the 2025 annual establishment review report for Community Hospital inpatient services, consolidating the monthly reports from May 2025 to January 2026. It also incorporates a focus on acuity and dependency data collected using the evidence-based and nationally endorsed establishment tool - Safer Nursing Care Tool (SNCT) to support establishment setting.

2.0 Dorset HealthCare Governance

2.1 Dorset HealthCare demonstrates compliance with the principles of safer staffing by embedding evidence-based tools, professional judgement, and outcome measures into its staffing processes, in line with the Developing Workforce Safeguards (2018)

2.2 The appendices include an assessment of the organisation's position against the requirements outlined in Developing Workforce Safeguards (2018), undertaken by the Regional Safer Staffing Team (South West). This provides assurance on compliance and highlights any areas where further action may be required.

2.3 In addition, the organisation invited the National Safer Staffing Faculty to review current policies and procedures. Following this review, an action plan has been developed to address the recommendations and support ongoing improvement in safer staffing governance processes.

2.4 A comprehensive monthly safer staffing report is presented to the Safer Staffing Forum and the Quality Governance Group. Areas of concern are escalated to the Joint Quality Committee, a Board subcommittee, to ensure the Board remains informed and that action plans are in place.

2.5 The Safer Staffing Forum meets monthly to review staffing levels and associated challenges. Risks and emerging concerns are discussed and documented in the monthly Safer Staffing Report and, where appropriate, escalated to the Quality Governance Group. When an area of risk is identified, targeted support meetings are convened to monitor emerging themes, strengthen oversight, and track progress against agreed actions

2.6 Daily operational touchpoint meetings are held to review staffing levels, assess safety, and address temporary staffing requirements. Any concerns or escalations, such as the need for temporary staffing or the need to delay admissions, are discussed and actioned. Where it is safe to do so, substantive staff are redeployed to support other wards experiencing staffing pressures.

Ellis, Karen
10/06/2026 10:45

Community Hospital Dashboard

Patient Flow

91%
Average Bed Occupancy

1486
Admissions

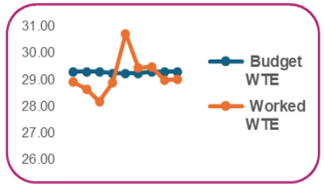
1495
Discharges

eRoster KPIs

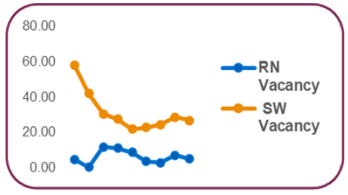
6%	13%	3%	3%	3%	1%	2004	443
Average Sickness Absence %	Average Annual Leave %	Average Parent Leave %	Average Study Leave %	Average Working Day %	Average Other Leave%	Additional Hours	Excess/Overtime Hours

Funded Establishment and Vacancies

Funded Establishment vs Worked *(including headroom/temporary staffing)*



RN and HCSW Vacancies (WTE) *(including headroom)*



Fill Rates

103%
Average RN Day Fill Rate

92%
Average HCSW Day Fill Rate

99%
Average RN Night Fill Rate

96%
Average HCSW Night Fill Rate

Top 3 Reasons for Additional Hours (Hours)

782	388	374
Training	High Patient Acuity	Shadowing

Mandatory Training

93%	76%	22%	0%
Mandatory Training Average	Appraisal Average	Qualified Clinical Supervision Average	Unqualified Clinical Supervision Average

Temporary Staffing

£1,747,687.96
Bank Spend

£116,557.54
Agency Spend

Substantive Worked 80%

Temporary Worked 20%

3775	2857	318	600	84%
RN Shifts Requested Total	RN Filled Shifts (Bank) Total	RN Filled Shifts (Agency) Total	RN Unfilled Shifts Total	RN Temp Fill Rate Total

5369	4255	9	1105	79%
HCSW Shifts Requested Total	HCSW Filled Shifts (Bank) Total	HCSW Filled Shifts (Agency)	HCSW Unfilled Shifts Total	HCSW Temp Fill Rate Total

Top 3 Reasons for Temporary Staffing Requests (Duties)

570
Estab Vacancies

192
Sickness (short

647
Sickness (Longterm)

Nurse Sensitive Indicators (Total)

All Falls	Unexpected Death Of A Patient	Pressure Ulcers	Medication Errors	Physical Abuse Pt/Pt (Injury)	Staffing
368	9	217	85	1	28

Falls Resulting in Harm	Pressure Ulcers Cat 3 and Above	Physical Abuse Pt/St (Injury)
182	30	26

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Supporting Narrative

EXPECTATION 1: RIGHT STAFF

3.0 Update on the Annual Establishment Review

3.1 Following the 2025 Annual Inpatient Staffing Establishment Review, the implementation of an additional night-duty HCSW on Tarrant Ward has been approved to mitigate fire evacuation risk. Funding is in place, and recruitment to the post is underway.

4.0 Planned vs Unplanned Nursing Hours (Fill Rates):

4.1 Fill rates are reported in the monthly Safer Staffing Report and the Integrated Corporate Dashboard data in the Board report. Wards where fill rates fall outside the Trust's agreed parameters of 90–120% are flagged as exceptions. The monthly report provides additional details, including the substantive-to-temporary staffing ratio, professional judgement and supporting workforce data to assess quality and safety.

4.2 Accurate fill-rate reporting requires timely updates to staff deployment in eRoster, including when staff move from supernumerary or supervisory roles into safer-staffing numbers or are redeployed across inpatient areas. Prompt and consistent updates are essential to maintain reliable staffing data and clear oversight of actual staffing levels.

4.3 Professional judgement is used to review staffing levels, taking into account acuity, dependency, skill mix, and bed occupancy. As a result, planned hours may at times be deemed not required—for example, during periods of low bed occupancy.

4.4 Current fill rates for Jersey and Guernsey reflect the previous staffing model, prior to the reduction in bed capacity, and include Registered Nursing Associates (RNAs) who formed part of that earlier establishment. Under the revised staffing model, RNAs are not included, as their retention within the skill mix would not provide the level of clinical cover required for the new establishment. Once the demand template is updated to reflect the revised bed base and skill-mix requirements, planned staffing levels will more accurately align with service demand. During this transition period, planned hours and planned Care Hours per Patient Day may therefore appear higher than the actual requirement.

4.5 Similarly, Colmers' planned and actual staffing levels will show some variation. An Equality and Quality Impact Assessment (EQIA) submitted by the Integrated Community Service in January 2026 recommended reducing the night-shift requirement to two HCSWs, and this change is currently being piloted with close monitoring of its impact. As the establishment has been temporarily adjusted to support this trial, planned hours may not fully align with the actual deployed staffing during the pilot period

4.6 Despite individual ward instances where fill rates fell below or rose above the threshold, overall average RN and HCSW fill rates remained within the 90%–120% KPI range throughout the reporting period.

5.0 Temporary Staffing:

5.1 Substantive staff covered 80% of duties, with temporary staff covering 20%. Temporary workforce utilisation included requests for 3775 RN duties and 5369 HCSW duties. This shows continued reliance on temporary staffing to maintain safer staffing levels. However, caution should be applied when reviewing temporary staffing skill-mix data, as substantive staff who pick up additional duties through the Trust bank are recorded as temporary hours. This includes staff already familiar with the clinical environment, which supports continuity, safety, and quality of care despite appearing in temporary staffing figures.

Ellis Fisher
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5.2 The top three recorded reasons for temporary staffing requests were established vacancies, short-term and long-term sickness absence.

5.3 Agency use was required throughout the reporting period, with peak activity in July, August, and September. This aligns with school holidays, when both substantive and bank staff may be unavailable, resulting in a greater dependency on agency workforce to maintain safer staffing levels. There was an increase in overall incidents reported during this time, especially in August, when falls, pressure ulcers, physical abuse of patient/staff, and staffing were at their highest.

5.4 While no clear link was identified between staffing levels and incidents, this should be interpreted with caution, as multiple factors may influence incident occurrence. Incidents will continue to be monitored closely, with any changes reported through established governance processes. The Safer Staffing Team is also working with the Patient Safety Team to strengthen collaboration, enabling improved incident review and earlier identification of emerging themes.

5.5 The Trust recognises the need to reduce temporary staffing utilisation in order to lower agency and bank expenditure, while also improving the quality, safety, and continuity of patient care. Historically, shifts requiring temporary staffing were released in advance—often more than eight weeks before the shift date—once rosters were finalised. In October 2025, as part of a quality improvement initiative within the ICS Directorate, a pilot was introduced in Community Hospitals to reduce this lead time to two weeks. The quality impact of this change is being monitored through both the Safer Staffing Forum and the EQIA Panel.

5.6 From a Trust-wide perspective, a dedicated working group has been convened to develop proactive approaches to optimising the deployment of substantive staff. This work focuses on strengthening roster planning and ensuring our workforce is utilised as effectively and efficiently as possible.

5.7 In parallel, the Trust is revisiting the potential implementation of the Allocate SafeCare module to enhance real-time visibility of staffing requirements and patient acuity. Adoption of this system may support safer and more efficient workforce management across services.

6.0 Substantive/Temporary % Split:

6.1 Substantive staff can work additional shifts via trust bank, and these hours are recorded as temporary within the system. As a result, headline temporary staffing figures may not fully represent the true level of substantive cover.

6.2 A substantive-to-temporary ratio falling below the 60/40 threshold triggers an exception in the monthly staffing report. This is reviewed through the Safer Staffing Forum and escalated through the relevant governance groups to ensure appropriate scrutiny and follow-up actions.

6.3 All wards consistently remained above the 60%/40% substantive-to-temporary staffing mix KPI, with the lowest proportion of substantive staff reported in August (76%).

7.0 Unavaliability:

7.1 During the reporting period, a total of 106,547 nursing hours were recorded as staff unavailability. This was split evenly between Registered Nurses (50%) and Health Care Support Workers (50%)

7.2 The funded establishment includes a 22% headroom allowance to cover time out requirements - annual leave (14%), sickness absence (4%), and training (4%). Any unavailability beyond this 22% allowance is not routinely funded, which creates additional pressure on staffing capacity and may lead to increased temporary staffing. The exception to this is Band 6 supervisory management time, which is standardised across the wards.

7.3 Headroom is calculated using whole-time equivalents rather than headcount, which means that services with a higher proportion of part-time staff may experience reduced actual hours available on the roster.

Ellis Kane 10/06/2026 16:10:45

7.4 When compared against the 22% headroom allowance, average unavailability was also 22%. This figure excludes other forms of leave not accounted for in headroom, such as parental leave. When these additional leave types are included, the overall average unavailability rises to 29%, exceeding

the allocated headroom and increasing the likelihood of staffing gaps and reliance on the temporary workforce.

7.5 Average sickness absence exceeded 5% for the majority of the reporting period, except for June (5%). The following table shows the top three reasons for sickness absence for the reporting period: *Source: Workforce Reporting*

Reason for Sickness Absence	Total Hours Lost
Cold, Cough, Flu - Influenza	4140
Anxiety/stress/depression/other psychiatric	3958
Other Musculoskeletal Problems	3800

7.6 The trust's agreed KPI for ensuring efficient rostering is between 11% and 17% (Nursing and Midwifery e-Rostering: A Good Practice guide, 2019). Maintaining this at any one time is important because it ensures that annual leave is taken consistently and evenly throughout the year, preventing large peaks in leave that could compromise safer staffing.

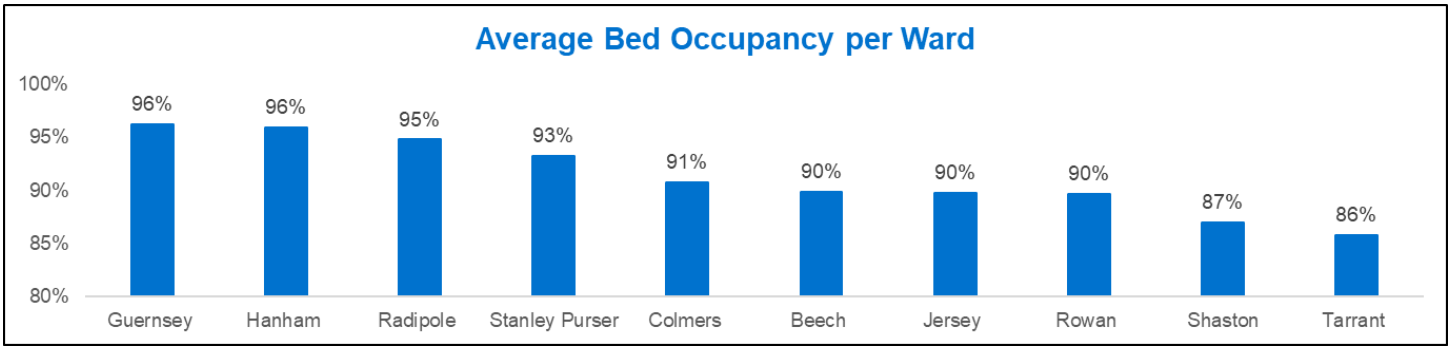
7.7 Average annual leave across the wards met the KPI throughout the reporting period. However, the data identifies several months where individual wards exceeded 17%—typically during school holiday periods—or fell below the 11% threshold.

8.0 Bed Occupancy:

8.1 Professional judgement considers acuity, dependency and bed occupancy, and staffing may be adjusted when these are low.

8.2 Average bed occupancy for the reporting period was 91%, comparable with the same period in 2024/25 (92%)

8.3 The following graph shows the average bed occupancy per ward.



9.0 Care Hours Per Patient Day (CHPPD):

9.1 CHPPD is a workforce measure used in inpatient care. It is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by 24 hours of inpatient admissions (approximating 24 patient hours by the number of patients at midnight).

9.2 CHPPD is most useful at the ward level to compare workforce deployment over time with similar wards in the trust or at other trusts. This measure should be used alongside clinical quality and safety outcome measures to reduce unwarranted variation and support the delivery of high-quality, efficient patient care.

9.3 All trusts with inpatient wards must report CHPPD data monthly to NHS England to support benchmarking across England. This is recorded on the Model Health System platform and made available to the public via a public-facing website.

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9.4 CHPPD is monitored and reported in the monthly Safer Staffing Report. Any unexpected or unwarranted variance between planned and actual CHPPD is reviewed.

9.5 The table below shows the *average* CHPPD for RNs and HCSWs for the reporting period. Overall, the actual CHPPD was comparable to the planned.

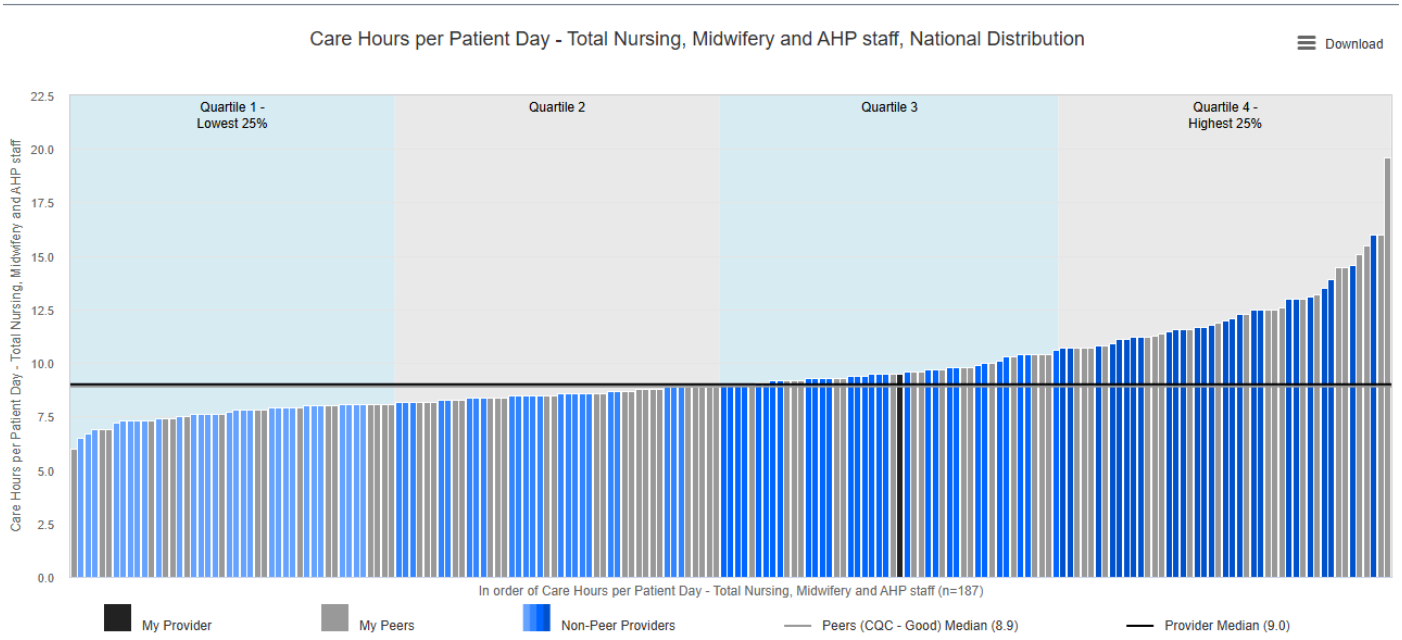
Planned CHPPD RN	Actual CHPPD RN	Planned CHPPD SW	Actual CHPPD SW	Planned CHPPD Total	Actual CHPPD Total
3.1	3.1	3.3	3.1	6.5	6.3

10.0 Benchmarking Against Peers:

10.1 The graph below illustrates Dorset HealthCare's total CHPPD position in comparison with the national average (inclusive of Registered Nurses, Registered Nursing Associates and HealthCare Support Workers). As an integrated provider of specialist mental health and community hospital services, our clinical model and bed base differ significantly from those of acute hospital trusts, which make up much of the national dataset.

10.2 For meaningful benchmarking, our CHPPD should be compared with organisations offering a similar mix of mental health and community hospital services, rather than with acute trusts, as comparisons with acute trusts do not reflect differences in patient acuity, service design, or workforce models.

10.3 It should be noted that the figures presented reflect all inpatient services across the Trust, rather than Community Hospitals specifically. The data should therefore be interpreted with this broader scope in mind. *Source: Model Health System (January 2026)*

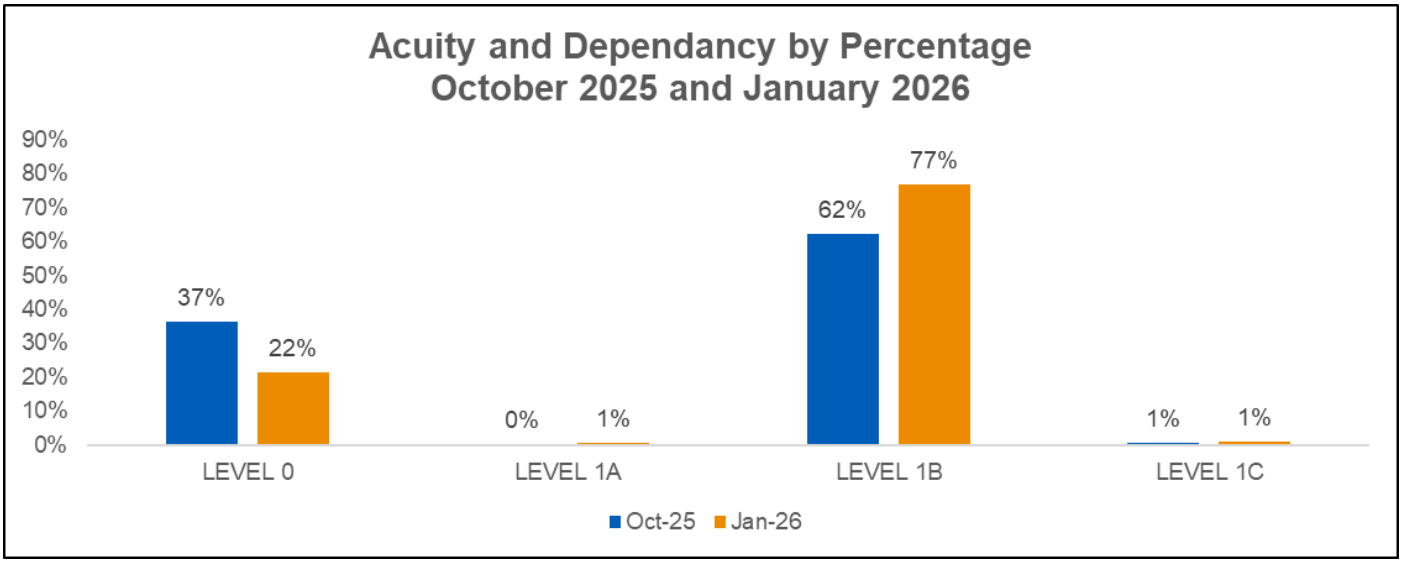


11.0 Evidence-based Tools: Safer Nursing Care Tool (SNCT):

11.1 The nationally endorsed evidence-based tools for establishment setting must be completed at least twice a year to monitor that funded establishments and demand templates are appropriate for the acuity and dependency of the patients in each ward. Three censuses are conducted each year in Dorset HealthCare to mitigate seasonal bias.

11.2 It is recognised that the recommended establishment provided by the SNCT cannot solely be used to set staffing establishments. Professional judgement and data triangulation are crucial elements of the process in forming conclusions and outcomes.

Ellis,Kara
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11.3 SNCT census data indicates a continued rise in patient acuity and dependency, with the most significant increase seen in dependency levels. Level 1b—*those who are clinically stable but require nursing support for all or most of their daily care needs.* This reflects a growing proportion of patients who require the assistance of two or more healthcare staff to safely meet their care needs, placing additional pressure on staffing capacity and care delivery.

11.4 The table below compares the SNCT recommended staffing WTE, ***excluding 1c and 1d provision***, with the funded establishment WTE and shows whether the current funded establishment is above or below the recommended SNCT recommendations. Both funded establishment and SNCT recommendations include headroom.

Funded Beds	SNCT Recommendations		SNCT Average (Two Cycle)	Nursing Funded Establishment *(Jan 25)*	WTE Variance (+/-)
	October 2025	January 2026			
207	304.03	314.32	309.18	287.93	-21.25

11.5 Radipole was the only ward to report patient acuity at a 1c level. This adds an additional 6.79 WTE to SNCT recommendations, making the two-cycle average 312.57 WTE and WTE variance -24.64. The increase relates to the care of a specific gentleman who required continuous observation and enhanced support. This does not reflect typical ward activity.

11.6 Community Hospitals continue to assess the need for enhanced therapeutic observations on an individual, case-by-case basis. Where additional staffing is required to maintain patient safety, approval is provided by the Service Manager.

EXPECTATION 2: RIGHT SKILLS

12.0 Mandatory Training:

12.1 All staff must undertake mandatory training, clinical supervision, and annual appraisal to meet national and local requirements. Compliance is monitored via Directorate Management Groups and reported to the Trust Board.

12.2 During the review period, and in line with the recent Clinical Supervision review, all staff are required to record a minimum of one supervision session every two months. From 30 September 2025, compliance will be monitored within each bi-monthly period rather than cumulatively across the financial year, ensuring a more accurate reflection of ongoing supervisory practice. At the time of reporting, the average across the service was 22% for Registered Staff and 0% for Unregistered.

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12.3 Continued monitoring is essential to understand whether staffing pressures are contributing to training gaps and to ensure that workforce development and patient safety are not adversely affected. During the review period, no incidents were reported citing cancelled training due to staffing shortfalls.

12.4 Average appraisal compliance for the period was 76%. It should be noted, however, that the system used to record appraisals changed during the reporting period, creating some initial challenges in recording. Therefore, the actual figure may be higher.

12.5 Additional training places for Basic Life Support (BLS) have been commissioned through a private provider to increase capacity and reduce waiting times. This enhanced provision is expected to improve overall compliance rates over the coming months as more staff can access the required training.

12.6 The following table illustrates the average mandatory training concordance across the reporting period.

Course	Compliance (Reporting Period Average)
Basic Life Support Taught	86%
Conflict Resolution	89%
Equality & Diversity	91%
Fire	99%
Health & Safety	97%
Infection Control Clinical	86%
Infection Control No Repeat	100%
Information Governance	95%
Moving & Handling Level 1	86%
Moving & Handling Level 2,3	96%
Oliver McGowan	99%
Patient Safety Level 1	98%
Safeguarding Adults Level 1	88%
Safeguarding Adults Level 2	95%
Safeguarding Adults Level 3	89%
Safeguarding Children Level 1	88%
Safeguarding Children Level 2	92%
Safeguarding Children Level 3	88%

13.0 Registered Nurse and Unregistered Vacancies:

13.1 Community Hospitals, particularly in Mid, West and North Dorset, continue to experience recruitment challenges due to their rural locations and limited public transport links, which reduce the pool of staff able or willing to travel. In addition, competition from local care providers and other industries offering pay rates comparable to or above Agenda for Change can further impact recruitment and retention, creating additional pressure on staffing levels.

13.2 As of January 2026, the vacancy position was 4.71 WTE for RNs and 26.55 WTE HCSWs (including headroom).

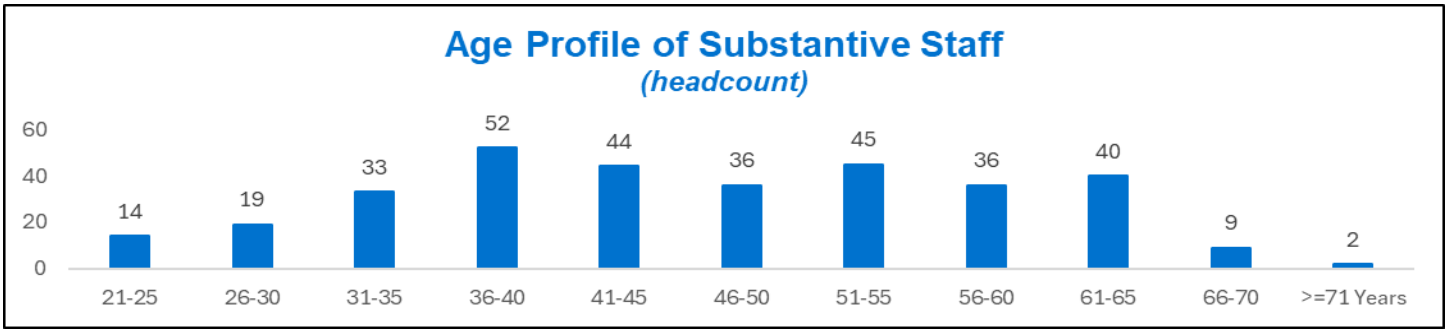
13.3 It is important to note that Colmers Ward has retained a vacancy while they trial a reduction of one HCSW on night duty. This trial was formally approved by the EQIA panel, and the vacancy has been held intentionally to support the evaluation period.

14.0 Age Profile Position by WTE (as of January 2026):

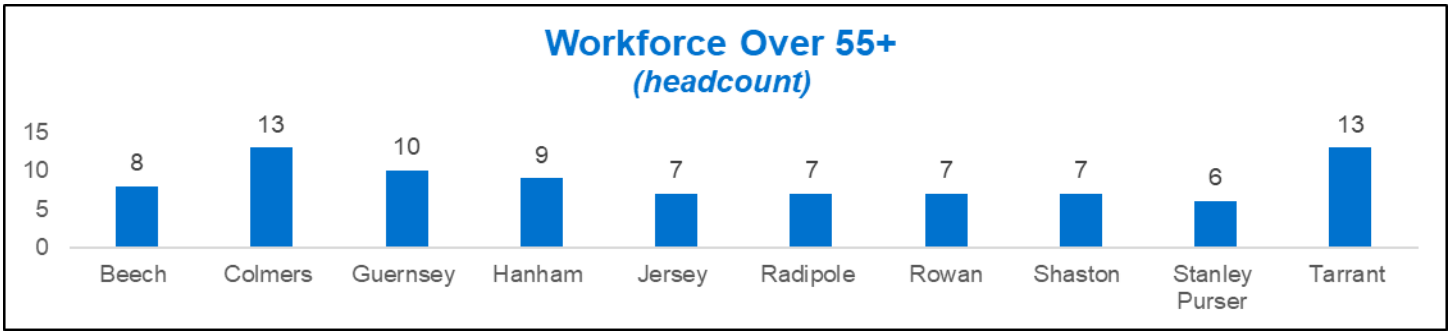
14.1 Overall, the data shows a stable mid-career workforce, but recruitment of younger staff remains low, and retirement risk is increasing. As of January 2026, Colmers and Tarrant had the highest number of staff aged 55 or older.

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14.2 The following graph shows the age profile of substantive staff across all Community Hospitals as of January 2026. *Source: Workforce Reporting*



14.3 The following table shows the workforce over the age of 55:



EXPECTATION 3: RIGHT PLACE AND TIME

15.0 Unused Contracted Hours:

15.1 It is important that contracted hours are fully utilised because unused hours represent staffing capacity that has been funded but not deployed to support patient care. Persistent unused hours may also indicate inefficiencies in duty allocation or roster planning and should be reviewed to ensure that the funded establishment is being used to its full potential.

15.2 The table below shows the total contracted hours for the ward compared with the total hours assigned during the reporting period, rounded to the nearest whole number. *Source: eRoster*

Contracted Hours	Assigned Hours	Variance
388,163	387,590	-573

16.0 Nurse Sensitive Indicators and Red flags:

16.1 The National Institute for Health and Care Excellence (NICE) guidance outlines key quality metrics/red flags that should be included in data triangulation. The safety metrics relevant to Dorset HealthCare are patient falls, pressure ulcers, and medication administration errors.

16.2 We are currently reviewing both national and internal red flags to ensure they comprehensively reflect all relevant indicators associated with staffing shortfalls. This work will strengthen our ability to understand and evidence the impact of workforce gaps on patient safety, quality of care, and staff experience, enabling more informed decision-making and earlier identification of emerging risks.

16.3 Written guidance is currently available on the Safer Staffing intranet page to support staff in escalating staffing concerns. This guidance is currently being rewritten and will form part of an overarching Safer Staffing Policy. We are awaiting a standardised policy template from the Regional Nursing Directorate (NHS England South West), which will inform the final structure and format. In the meantime, an extension to the existing internal guidance has been approved until the 31st July 2026.

Ellis, Kate
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16.4 30 Pressure Ulcers categorised as 3+ were reported during the reporting period. It is important to note that 14 of those reported were unstageable. All wards have developed and implemented local action plans to support the reduction of pressure ulcers, providing assurance that targeted improvement activity is in place across all areas.

16.5 Local monitoring arrangements are in place to oversee the incidence of falls and understand the contributory factors behind them. Falls data and thematic learning are reviewed both locally within

wards and through the Trust's PSIRF governance processes. Current analysis provides assurance that there has been no escalation in staffing levels identified as a direct factor in patient falls.

16.6 The following table shows nurse sensitive indicators reports per month per 1000 occupied bed days: *Source: Business and Performance Reporting.*

Month	All Falls	Falls Resulting in Harm	Unexpected Death Of A Patient	Pressure Ulcers	Pressue Ulcer Cat 3 or above	Med Error	Physical - Abuse (Injury) Pt On Pt	Physical - Abuse (Injury) Pt On St	Staffing
May	6	3	0	3	0	1	0	0	0
June	5	3	0	4	1	2	0	0	1
July	7	3	0	5	1	4	0	0	1
Aug	9	6	0	7	0	1	0	1	1
Sept	8	4	1	4	0	1	0	0	0
Oct	7	3	0	4	0	1	0	0	1
Nov	8	5	0	3	1	2	0	0	1
Dec	6	2	0	4	1	1	0	0	0
Jan	8	4	0	4	0	1	0	2	1

17.0 Patient Feedback and Complaints:

17.1 Thirty-three complaints were received during the reporting period, with Colmers, Jersey and Radipole each recording six. No complaints cited staffing levels as a contributory factor, offering assurance regarding current workforce capacity.

17.2 The following table shows complaint themes for community hospitals:

Complaint Category	Number of Complaints Recieved
Admission/Discharge	7
Clinical Treatment	2
Communications	4
End Of Life Care	1
Other	3
Patient Care	9
Trust Admin/Policies/Procedures	2
Values And Behaviours	5
Total	33

17.3 Three compliments were received, one for Jersey and two for Shaston. Themes include caring staff, good care and clinical outcomes.

17.4 Staff Experience and Satisfaction: The NHS Annual Staff Survey ran from 1st October 2025 to 28th November 2025. At the time of writing, the results were not available.

18.0 Risk Register:

18.1 At the time of the report, one risk was open.

Service	Risk Number	Date Entered	Date Closed	Description
Community Hospitals	1986 v4	14/01/2025	Ongoing	Lack of clinical cover across all CoHos .
Guernsey and Jersey	1823 v3	08/11/2023	24/10/2025	Medical workforce, including medical and ACP staffing levels for Guernsey and Jersey Wards.
Community Hospitals	1983 v5	24/01/2025	10/07/2025	Risk of identity fraud in temporary workforce and potential impact on patient safety, patient experience, the workforce, financial implications, and reputation of the Trust.

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19.0 Summary:

Expectation 1: Right Staff

19.1 Overall, staffing was well managed throughout the reporting period. Service Care Hours per Patient Day (CHPPD) aligned with total planned hours throughout the reporting period. Fill rates were largely maintained within KPI thresholds, with some variation attributable to reduced bed capacity on Jersey and Guernsey wards, a pilot reduction in Health Care Support Worker (HCSW) night staffing on Colmers Ward, and fluctuations in acuity, dependency and bed occupancy. Staffing shortfalls remained where duties could not be filled through temporary staffing solutions.

19.2 Staff are flexibly deployed across the community hospitals to mitigate shortfalls, informed by assessments of acuity and dependency, and by staff expertise. This approach is monitored through Directorate Management Groups and Safer Staffing reporting to ensure there is no detriment to patient safety or staff wellbeing. Approval has been given to proceed with the SafeCare evidence-based deployment tool to support safe and consistent decision-making.

19.3 Reliance on temporary staffing continued, primarily driven by vacancies and sickness. Community Hospitals, particularly in Mid, West and North Dorset, continue to experience recruitment challenges due to their rural locations and limited public transport links, which reduce the pool of staff able or willing to travel. In addition, competition from local care providers and other industries offering pay rates comparable to or above Agenda for Change can further impact recruitment and retention, creating additional pressure on staffing levels. Bespoke recruitment programmes are currently being explored with Trust Bank.

19.4 Seasonal peaks in agency usage coincided with increased incident reporting; however, no direct causal link to staffing levels was identified.

19.5 When compared against the 22% headroom allowance, average unavailability was also 22%. This figure excludes other forms of leave not accounted for in headroom, such as parental leave. When these additional leave types are included, the overall average unavailability rises to 29%, exceeding the allocated headroom and increasing the likelihood of staffing gaps and reliance on the temporary workforce.

19.6 Sickness absence remained persistently above 5% for most of the year. While average annual leave across wards consistently met the KPI, analysis shows variability at ward level, with some wards exceeding the upper threshold of 17%—most commonly during school holiday periods.

19.7 SNCT data shows rising patient acuity and dependency, with the overall establishment for Community Hospitals sitting below SNCT recommended levels. This position will be closely monitored in the next census to determine whether a consistent trend is emerging ahead of the annual establishment-setting process.

19.8 The use of enhanced therapeutic observations of care has been reduced and is now authorised on a case-by-case basis. This will continue to be kept under review to determine whether any changes to the staffing establishment are required. Ongoing SNCT census will continue in preparation for this year's annual establishment review setting process.

19.9 The recommendation from the 2025 annual establishment review to increase night staffing on Tarrant Ward by one HCSW has now been approved.

19.10 As of January 2026, vacancies stood at 4.71 WTE for RNs and 26.55 WTE for HCSWs (including headroom) Colmers Ward held an HCSW vacancy as part of its night-duty pilot.

19.11 Unavailability averaged at the headroom allowance (22%) but rose to 29% when including non-headroom leave. Sickness remained above 5% for most of the year. CHPPD aligned with plans, with no unexplained variances.

Ellis Fairbairn 10/06/2026 14:10:43

19.12 Workforce age profiling shows a stable mid-career cohort but limited recruitment of younger staff and increasing retirement risk, particularly at Colmers and Tarrant, highlighting the need for ongoing workforce planning and targeted recruitment strategies.

Expectation 2: Right Skills

19.13 Mandatory training, clinical supervision, and appraisal compliance remain key workforce priorities, with monitoring through Directorate Management Groups and reporting to the Trust Board. Clinical supervision requirements have been strengthened, moving to bi-monthly monitoring from September 2025, though current recorded compliance remains low and may reflect recording rather than delivery.

19.14 Although no incidents were reported as resulting from cancelled training, continued monitoring is needed to understand any impact on workforce competence. Additional BLS training capacity has been commissioned to support improvements. Appraisal compliance averaged 76%, though system changes impacting recording may mean the true figure is higher.

19.15 Incident reporting remains under routine monitoring, with no evidence that staffing levels directly contributed to increased incidents. We are currently reviewing both national and internal red flags to ensure they comprehensively reflect all relevant indicators associated with staffing shortfalls. This work will strengthen our ability to understand and evidence the impact of workforce gaps on patient safety, quality of care, and staff experience, enabling more informed decision-making and earlier identification of emerging risks.

Expectation 3: Right Place and Time

19.16 Contracted hours were effectively utilised during the period, with only a small variance between funded and assigned hours, though ongoing monitoring is required to ensure all available staffing capacity continues to support patient care.

19.17 33 complaints were received, with no themes identifying staffing levels as a contributory factor, providing assurance that workforce capacity is not impacting patient dissatisfaction.

19.18 One risk remains open on the risk register, relating to clinical cover across all sites, with other previously identified risks closed during the year.

Ellis Kara
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Appendix A: The Southwest (SW) Safer Staffing Team Gap Analysis:

No.	Safer Staffing Topic	Initial Gap Analysis Comment	Compliance	Evidence Provided Pre Initial Meeting	Compliance After Initial Meeting
1	NQB Guidance	The Trust provided a good description of their safer staffing process which follows the NQB guidance	Compliant	The Trust provided a good description of their safer staffing process which follows the NQB guidance	Compliant
2	Triangulation	The Trust provided a detailed explanation of how they apply the principles of safer staffing	Compliant	The Trust provided a detailed explanation of how they apply the principles of safer staffing	Compliant
3	Evidence Based Tools Utilisation	The Trust are using SNCT and MHOST, CNSST II still being rolled out.	Partial Compliance	The Trust are using SNCT, MHOST and CNSST II which has been deployed in line with national guidance	Compliant
4	No Tool Manipulation	The Trust confirm no data manipulation	Compliant	The Trust confirm no data manipulation	Compliant
5	Monthly Actual vs Planned Staff Reporting	The Trust supplied their August NHSE return and August staffing report. The public facing safer staffing page has a link to the national CHPPD data.	Compliant	The Trust supplied their August NHSE return and August staffing report. The public facing safer staffing page has a link to the national CHPPD data	Compliant
6	Annual Statement	The Trusts annual statement is available online	Compliant	The Trusts annual statement is available online	Compliant
7	Workforce Plan	The Trust states that their workforce plan exists but it is not seen online and had not been supplied	Partial Compliance	The Trust supplied their workforce plan	Compliant
8	Bi-Annual Establishment Review	The Trusts bi-annual establishment reviews are seen in board reports online	Compliant	The Trusts bi-annual establishment reviews are seen in board reports online	Compliant
9	Quality Dashboards	The Trust stated that they have a dashboard system in place and monthly reviews with appropriate committee	Compliant	The Trust are in the process of developing their dashboard, they have no completion date at present but will send a sample.	Partial Compliance
10	Quality Impact Assessments	The Trust supplied the minutes and action log from 28/8/25 Quality Impact Assessment Panel meeting	Compliant	The Trust supplied the minutes and action log from 28/8/25 Quality Impact Assessment Panel meeting	Compliant
11	Risk Management & Escalation	The Trust supplied guidance to support the management of staffing shortfalls in inpatients (written Jan 24, expires Jan 26)	Compliant	The Trust supplied guidance to support the management of staffing shortfalls in inpatients (written Jan 24, expires Jan 26)	Compliant
12	Board Awareness	The Trust provided their Board report (2/10/25) and safer staffing is reviewed	Compliant	The Trust provided their Board report (2/10/25) and safer staffing is reviewed	Compliant

Ellis,Kara
10/06/2026 16:10:45

Dorset HealthCare University
NHS Foundation Trust

Report to	Board in Common (DHC)	
Date of Meeting	17th June 2026	
Report Title	Mental Health Inpatient Biannual Staffing Review	
Prepared By	Cara Southgate, Director of Nursing, Therapies & Quality, Alex Matutino, Safer Staffing Lead and Katie Powell, Data Analyst and Support	
Approved by Accountable Executive	Dawn Dawson, Joint Chief Nursing Officer	
Previously Considered By	Quality Governance Group 7th April 2026 Quality Committee in Common, 26th May 2026	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1: Quality and Safety SR2: Culture SR3: Workforce Capacity SR4: Capacity and Demand SR6: Finance	
Financial	The report includes details on staffing shortfalls and, where applicable, the associated temporary staffing costs.	
Statutory & Regulatory	The report meets the national requirements for safer staffing reporting as guided by the National Quality Board (2016) and Developing Workforce Safeguards (2018).	
Equality, Diversity & Inclusion	The data in this report is drawn from a range of partners, including management accounts, business, and performance, eRoster, and feedback received from local managers, service leads, and the safer staffing forum.	
Co-production & Partnership	As above	

Executive Summary

This report provides an overview of safer nursing staffing as part of the biannual review requirements, triangulating data between May 2025 – January 2026. It focuses on ensuring that the right staff, with the right skills, are in the right place at the right time. The report outlines the organisation's approach to monitoring and reviewing staffing establishments and safer staffing levels across our inpatient services. This work aligns with the expectations of the National Quality Board (2016) and the guidance set out in Developing Workforce Safeguards (2018).

This report provides an overview of the staffing position and associated workforce metrics for the reporting period. The narrative summarises key findings at service level. A comprehensive report setting out the detailed breakdown of staffing data for each ward was taken to the Quality Governance Group (this is available to committee members if required).

The National Quality Board (2016) guidance Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time sets out a framework to support organisations and staff in

Public Meeting Pack 17/06/2026 10:00:45

making staffing decisions that put patients first. These expectations guide provider boards in making informed local decisions that ensure high-quality patient care within available staffing resources.

NHS provider boards are accountable for ensuring that their organisation has the culture, leadership, and skills required to deliver safe, sustainable, and productive staffing (National Quality Board, 2016).

This paper follows the 2025 annual establishment review report for Mental Health inpatient services. It incorporates a focus on acuity and dependency data collected using the evidence-based and nationally endorsed establishment tool - Mental Health Optimal Staffing Tool (MHOST) to support establishment setting.

EXPECTATION 1: RIGHT STAFF

During the reporting period, staffing pressures continued, largely attributable to vacancies, sickness absence, and additional staffing required to support enhanced therapeutic observations of care.

Average fill rates across the service remained within agreed parameters; however, Mental Health Support Worker (MHSW) fill rates on night duty consistently exceeded the upper KPI threshold. This was primarily due to occasions when a second Registered Nurse (RN) could not be filled and was therefore substituted with an MHSW, increased staffing to safely meet enhanced therapeutic observation of care needs and agreed to uplift staffing to maintain environmental safety.

The actual Care Hours per Patient Day (CHPPD) across the service remained aligned to total planned hours throughout the reporting period; however, actual Registered Nurse CHPPD was marginally lower than planned.

Reliance on temporary staffing to maintain patient safety continued throughout the reporting period. Caution should be applied when reviewing temporary staffing skill-mix data, as substantive staff who pick up additional duties through the Trust bank are recorded as temporary hours. This includes staff already familiar with the clinical environment, which supports continuity, safety, and quality of care despite appearing in temporary staffing figures.

Approval has been given to establish a substantive peripatetic staffing team to respond flexibly to staffing shortfalls arising from absence and enhanced care needs and to reduce reliance on temporary staffing. The safety and quality impacts of this pilot will be reported and monitored through the Directorate Management Group, Safer Staffing Forum and the relevant Quality Governance groups.

When compared against a 23.2% headroom allowance, the average unavailability was 23%. This figure excludes other types of leave, such as parental leave, which are not accounted for within headroom. When these additional leave types are included, the overall average unavailability rises to 31%, exceeding the allocated headroom and increasing the likelihood of staffing gaps and reliance on the temporary workforce.

Average sickness absence remained persistently above 5%. While average annual leave across wards consistently met the KPI, analysis shows variability at ward level, with some wards exceeding the upper threshold of 17%—most commonly during school holiday periods.

While the Mental Health Optimal Staffing Tool census outputs show a lower recommended WTE than the currently funded establishment, this does not indicate overstaffing. The tool is based on average acuity and dependency, not the environment in which care is being delivered, and can underestimate staffing requirements where a minimum safe staffing presence is required to deliver safe and effective care. As a result, MHOST outputs are used as a supporting indicator rather than a sole determinant, with professional judgement and patient outcomes continuing to inform establishment decisions.

Rita Kara
20/06/2026 09:14:45

As part of the 2025 Annual Inpatient Staffing Establishment Reviews, the recommendation to fund the ongoing cost pressure associated with the additional MHSW rostered on Waterston Ward to ensure safe and effective care has been approved. The associated funding has now been transferred to the ward's budget, and recruitment for the additional posts is underway.

The recommendation to increase Registered Nurse staffing levels at Glendinning Unit remains under review. This is due to the ongoing Rehabilitation Service Review, which is exploring potential opportunities to deliver care differently and optimise the skill mix across the service. The outcomes of this review may influence future workforce requirements; therefore, a final recommendation will be presented once the review is complete and any service redesign options have been fully considered.

As of January 2026, the vacancy position was 47.67 WTE Registered Nurses and 70.12 WTE Mental Health Support Workers, including headroom. Recruitment and retention continue to be influenced by wider socioeconomic factors, including the rising cost of living, limited availability of accessible and affordable housing, and local industries offering pay rates comparable to or above Agenda for Change. These external pressures reduce the applicant pool and increase turnover risk, creating additional challenges in maintaining sustainable staffing levels across our services.

The age profile shows a broadly even distribution of substantive staff across the 26–60 age range, with the largest group aged 26–30. Representation drops sharply at the youngest and oldest ends of the workforce, with very few staff under 20 or over 66. While the strong mid-career presence supports service stability, the declining numbers in older age bands indicate a future retirement risk, and the very small early-career cohort highlights the need to strengthen entry-level and developmental recruitment pathways.

EXPECTATION 2: RIGHT SKILLS

Mandatory training, clinical supervision, and appraisal compliance remain key workforce priorities, with monitoring through Directorate Management Groups and reporting to the Trust Board. Clinical supervision requirements have been strengthened, moving to bi-monthly monitoring from September 2025, though current recorded compliance remains low and may reflect recording rather than delivery.

Although no incidents were reported as resulting from cancelled training, continued monitoring is needed to understand any impact on workforce competence. Additional Basic Life Support training capacity has been commissioned to reduce waiting times. Appraisal compliance averaged 75%, though system changes impacting recording may mean the true figure is higher.

Incident reporting remains under routine monitoring, with no evidence from this review that staffing levels directly contributed to patient harm. National and local red flags are currently being reviewed to ensure they reflect all relevant indicators associated with staffing shortfalls. This work will strengthen our ability to understand and evidence the impact of workforce gaps on patient safety, quality of care, and staff experience, enabling more informed decision-making and earlier identification of emerging risks.

EXPECTATION 3: RIGHT PLACE AND TIME

Unused contracted hours were high in some areas, and variation between wards highlights the need for ongoing focus on effective roster planning to ensure the funded workforce is fully utilised.

Approval has been granted to implement the Allocate SafeCare module to enhance real-time oversight of staffing requirements and patient acuity, supporting safer and more efficient workforce management.

Patient feedback included one compliment for Florence House. 59 complaints were received, with the highest numbers in Waterston, Kimmeridge Court and AAU Seaview; none of these complaints cited staffing levels as a contributory factor.

Two staffing risks remain open on the risk register for Harbour and Waterston.

Ellis Kay
10/03/2026 14:10:45

Recommendation

- Receive the report for assurance that Dorset HealthCare is adhering to national safer staffing guidance.

1.0 Introduction

1.1 This report provides an overview of safer nursing staffing as part of the biannual review requirements, triangulating data between May 2025 and January 2026. It focuses on ensuring that the right staff, with the right skills, are in the right place at the right time. The report outlines the organisation's approach to monitoring and reviewing staffing establishments and safer staffing levels across our inpatient services. This work aligns with the expectations of the National Quality Board (2016) and the guidance set out in Developing Workforce Safeguards (2018).

1.2 This report provides an overview of the staffing position and associated workforce metrics for the reporting period. The narrative summarises key findings at service level, while the accompanying appendices present a detailed breakdown of staffing data for each ward.

1.3 The National Quality Board (2016) guidance Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time sets out a framework to support organisations and staff in making staffing decisions that put patients first. These expectations guide provider boards in making informed local decisions that ensure high-quality patient care within available staffing resources.

1.4 NHS provider boards are accountable for ensuring that their organisation has the culture, leadership, and skills required to deliver safe, sustainable, and productive staffing (National Quality Board, 2016).

1.5 This paper follows the 2025 annual establishment review report for Mental Health inpatient services consolidating the monthly reports from May 2025 to January 2026. It also incorporates a focus on acuity and dependency data collected using the evidence-based and nationally endorsed establishment tool - Mental Health Optimal Staffing Tool (MHOST) to support establishment setting.

1.6 **Dorset HealthCare Governance**

1.7 Dorset HealthCare demonstrates compliance with the principles of safer staffing by embedding evidence-based tools, professional judgement, and outcome measures into its staffing processes, in line with the Developing Workforce Safeguards (2018)

1.8 The appendices include an assessment of the organisation's position against the requirements outlined in Developing Workforce Safeguards (2018), undertaken by the Regional Safer Staffing Team (Southwest). This provides assurance on compliance and highlights any areas where further action may be required.

1.9 In addition, the organisation invited the National Safer Staffing Faculty to review current policies and procedures. Following this review, an action plan has been developed to address the recommendations and support ongoing improvement in safer staffing governance.

1.10 A comprehensive monthly safer staffing report is presented to the Safer Staffing Forum and the Quality Governance Group. Areas of concern are escalated to the Joint Quality Governance Committee, a Board subcommittee, to ensure the Board remains informed and that action plans are in place.

1.11 The Safer Staffing Forum meets monthly to review staffing levels and associated challenges. Risks and emerging concerns are discussed and documented in the monthly Safer Staffing Report and, where appropriate, escalated to the Quality Governance Group. When an area of risk is identified, targeted support meetings are convened to monitor emerging themes, strengthen oversight, and track progress against agreed actions

Ellis Karen
10/06/2026 16:10:45

1.12 Daily operational touchpoint meetings are held to review staffing levels and address temporary staffing requirements.

Mental Health Inpatient Summary

Patient Flow

87%
Average Bed Occupancy

745
Admissions

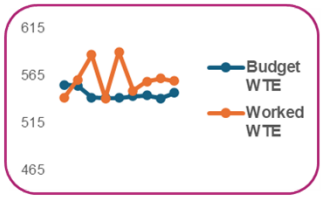
723
Discharges

eRoster KPIs

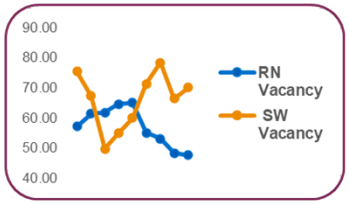
6%	13%	3%	4%	3%	2%	63939	5358
Average Sickness Absence %	Average Annual Leave %	Average Parent Leave %	Average Study Leave %	Average Working Day %	Average Other Leave%	Additional Hours	Excess/Overtime Hours

Funded Establishment and Vacancies

Funded Establishment vs Worked *(including headroom/temporary staffing)*



RN and HCSW Vacancies (WTE) *(including headroom)*



Fill Rates

96%
Average RN Day Fill Rate

106%
Average HCSW Day Fill Rate

96%
Average RN Night Fill Rate

127%
Average HCSW Night Fill Rate

Top 3 Reasons for Additional Hours (Hours)

29202	10060	9545
Level 3 Close Obs	Level 1 General Obs	High Patient Acuity MH

Mandatory Training

94%	75%	34%	0%
Mandatory Training Average	Appraisal Average	Qualified Clinical Supervision Average	Unqualified Clinical Supervision Average

Temporary Staffing

£4,502,779.7
Bank Spend

£1,079,407.
Agency Spend

Substantive Worked 67%

Temporary Worked 33%

7430	4107	2062	1261	83%
RN Shifts Requested Total	RN Filled Shifts (Bank) Total	RN Filled Shifts (Agency) Total	RN Unfilled Shifts Total	RN Temp Fill Rate Total

17119	12985	2071	2063	88%
MHSW Shifts Requested Total	MHSW Filled Shifts (Bank)	MHSW Filled Shifts (Agency)	MHSW Unfilled Shifts Total	MHSW Temp Fill Rate Total

Top 3 Reasons for Temporary Staffing Requests (Duties)

17627
Estab Vacancies

1413
Level 3 Close Obs

779
Annual Leave Cover

Nurse Sensitive Indicators (Total)

All Fall	Unexpected Death Of A Patient	Pressure Ulcers	Medication Errors	Physical Abuse Pt/Pt (Injury)	Staffing
278	6	11	11	15	1

Falls Resulting in Harm	Pressure Ulcers Cat 3 and Above	Physical Abuse Pt/St (Injury)
15	1	53

Ellis 2016 16:10:03

Supporting Narrative

EXPECTATION 1: RIGHT STAFF

2.0 Update on the Annual Establishment Review

2.1 As part of the 2025 Annual Inpatient Staffing Establishment Reviews, the recommendation to fund the ongoing cost pressure associated with the additional MHSW rostered on Waterston Ward to ensure safe and effective care has been approved. The associated funding has now been transferred to the ward's budget, and recruitment for the additional posts is underway.

2.2 The recommendation to increase Registered Nurse staffing levels on day duty at Glendinning remains under review. This is due to the ongoing Rehabilitation Service Review, which is exploring potential opportunities to deliver care differently and optimise the skill mix across the service. The outcomes of this review may influence future workforce requirements; therefore, a final recommendation will be presented once the review is complete and any service redesign options have been fully considered.

3.0 Planned vs Unplanned Nursing Hours (Fill Rates):

3.1 Fill rates are reported in the monthly Safer Staffing Report and the Integrated Corporate Dashboard data in the Board report. Wards where fill rates fall outside the Trust's agreed parameters of 90–120% are flagged as exceptions. The monthly report provides additional details, including the substantive-to-temporary staffing ratio, professional judgement and supporting workforce data to assess quality and safety.

3.2 Accurate fill-rate reporting requires timely updates to staff deployment in eRoster, including when staff move from supernumerary or supervisory roles into safer-staffing numbers, are working on an 'allocate on arrival' basis or are redeployed across inpatient areas. Prompt and consistent updates are essential to maintain reliable staffing data and clear oversight of actual staffing levels.

3.3 Despite individual ward instances where fill rates fell below or rose above the threshold, overall average RN (day and night) and MHSW fill rates (day) remained within the 90%–120% KPI range throughout the reporting period.

3.4 The MHSW night-shift fill rate has consistently exceeded 120%, with an overall average of 127%. This reflects the substitution of the second registered nurse on night duty, increased demand for enhanced care, and previously agreed enhanced night-time staffing levels required to maintain safety on Waterston, Haven Female and Chine.

4.0 Temporary Staffing:

4.1 Substantive staff covered 67% of duties, with temporary staff covering 33%. Temporary workforce utilisation included requests for 7430 RN duties and 17119 MHSW duties. This shows continued reliance on temporary staffing to maintain safer staffing levels. However, caution should be applied when reviewing temporary staffing skill-mix data, as substantive staff who pick up additional duties through the Trust bank are recorded as temporary hours. This includes staff already familiar with the clinical environment, which supports continuity, safety, and quality of care despite appearing in temporary staffing figures.

4.2 The top three recorded reasons for temporary staffing requests were established vacancies, Level 3 enhanced care needs and annual leave cover.

4.3 Additional hours are predominantly filled by temporary staffing. It is worth noting that the coding used to record additional hours is not currently reliable. Staff do not always select the most accurate reason, which compromises data quality. For example, Level 1 General Observations appears in the top 3 reasons for additional hours, even though this activity should not require extra staffing, indicating inconsistent use of the current coding options. Work is underway to strengthen this process.

Ellis Fabian 10/06/2025 16:10:43

4.4 Temporary staffing usage was required throughout the reporting period, with notable peaks in August, October, and December, which align with school holiday periods. Sickness absence also contributed to

the demand for temporary staffing, exceeding 5% in October and December. Agency use peaked in August, November and September.

4.5 While no clear link was identified between staffing levels and incidents, this should be interpreted with caution, as multiple factors may influence incident occurrence. Incidents will continue to be monitored closely, with any changes reported through established governance processes. The Safer Staffing Team is also working with the Patient Safety Team to strengthen collaboration, enabling improved incident review and earlier identification of emerging themes.

4.6 The Trust acknowledges the need to reduce temporary staffing to lower agency and bank expenditure and strengthen the quality, safety, and continuity of patient care. A Trust-wide working group is developing proactive approaches to optimise the deployment of substantive staff, with a focus on improving roster planning and maximising workforce efficiency.

4.7 In parallel, approval has been granted to implement the Allocate SafeCare module to enhance real-time oversight of staffing requirements and patient acuity, supporting safer and more efficient workforce management.

5.0 Substantive/Temporary % Split:

5.1 Across the reporting period, the *average* substantive/temporary split remained within the KPI across services, with the lowest levels recorded between July and September. As noted previously, substantive staff frequently work additional bank shifts, meaning the actual proportion of substantive staffing is likely higher than the rostered split reflects.

5.2 A substantive-to-temporary ratio falling below the 60/40 threshold triggers an exception in the monthly staffing report. This is reviewed through the Safer Staffing Forum and escalated through the relevant governance groups to ensure appropriate scrutiny and follow-up actions.

6.0 Unavailability:

6.1 During the reporting period, a total of 196,358 nursing hours were recorded as staff unavailability. Of these hours, 56% were attributable to MHSWs and 44% to RNs.

6.2 The funded establishment includes a 23% headroom allowance to cover time-out requirements, annual leave (14%), sickness absence (4%), and training (5%). Florence House and Twynham have a higher headroom - 26.6% and 27.9% respectively – due to a historical assessment of higher training requirements.

6.3 Any unavailability beyond this allowance is not routinely funded, which places additional pressure on staffing capacity and may increase reliance on temporary staffing. The exception to this is Band 6 supervisory management time; however, this provision is not standardised across wards, and not all wards have allocated funding for this purpose.

6.4 Headroom is calculated using whole-time equivalents rather than headcount, which means that services with a higher proportion of part-time staff experience reduced actual hours available on the roster.

6.5 When compared against a 23.2% headroom allowance, the average unavailability was 23%. This figure excludes other types of leave, such as parental leave, which are not accounted for within headroom. When these additional leave types are included, the overall average unavailability rises to 31%, exceeding the allocated headroom.

6.1 Average sickness absence was 6%, slightly above the 5% KPI threshold. Sickness absence average was highest in December (7%). The following table shows the top three reasons for sickness absence for the reporting period: *Source: Workforce Reporting*

Ellis Kara
10/06/2026 11:00:53

Reason for Sickness Absence	Total Hours Lost
Anxiety/stress/depression/other psychiatric	9267
Cold, Cough, Flu - Influenza	7742
Gastrointestinal Problems	6186

6.2 The trust's agreed KPI for ensuring efficient rostering is between 11% and 17% (Nursing and Midwifery e-Rostering: A Good Practice guide, 2019). Maintaining this at any one time is important because it ensures that annual leave is taken consistently and evenly throughout the year, preventing large peaks in leave that could compromise safer staffing.

6.3 While the Trust-wide average was within the KPI, individual wards exceeded the upper threshold during peak periods, such as school holidays, and fell below it during non-peak periods.

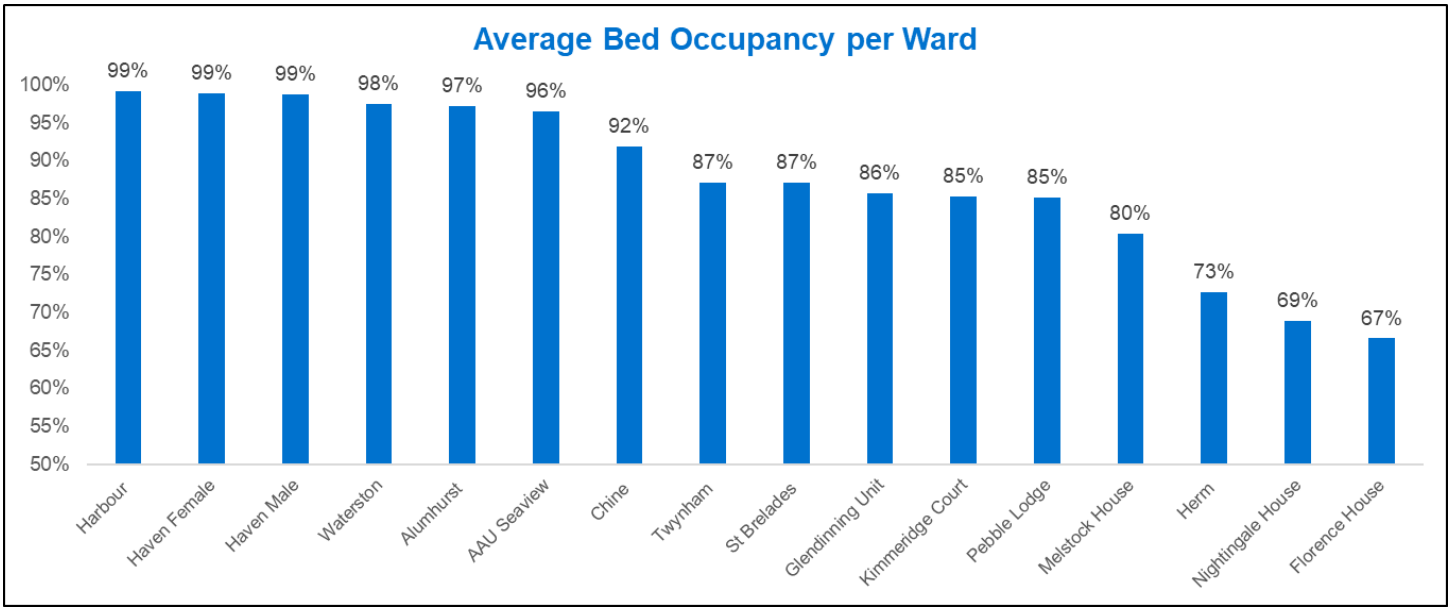
7.0 Bed Occupancy:

7.1 Professional judgement considers acuity, dependency and bed occupancy, and staffing may be adjusted when these are low.

7.2 Average bed occupancy for the reporting period was 87%. For the same period in 2024/25, average bed occupancy was 84%.

7.3 While average occupancy figures do not fully reflect variation across the range of inpatient specialities, high-acuity areas consistently maintained occupancy between 90% and 100%, indicating sustained demand.

7.4 The following graph shows the average bed occupancy per ward arranged from highest to lowest.



8.0 Care Hours Per Patient Day (CHPPD):

8.1 CHPPD is a workforce measure used in inpatient care. It is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by 24 hours of inpatient admissions (approximating 24 patient hours by the number of patients at midnight).

8.2 CHPPD is most useful at the ward level to compare workforce deployment over time with similar wards in the trust or at other trusts. This measure should be used alongside clinical quality and safety outcome measures to reduce unwarranted variation and support the delivery of high-quality, efficient patient care.

8.3 All trusts with inpatient wards must report CHPPD data monthly to NHS England to support benchmarking across England. This is recorded on the Model Health System platform and made available to the public via a public-facing website.

Ellis Kelly
10/06/2026 16:14:41

8.4 CHPPD is monitored and reported in the monthly Safer Staffing Report. Any unexpected or unknown variance between planned and actual CHPPD is reviewed and explored.

8.5 The table below shows the *average* CHPPD for RNs and MHSWs for the reporting period. Overall, the actual CHPPD was comparable to the planned, although the slightly lower actual RN against planned requires monitoring.

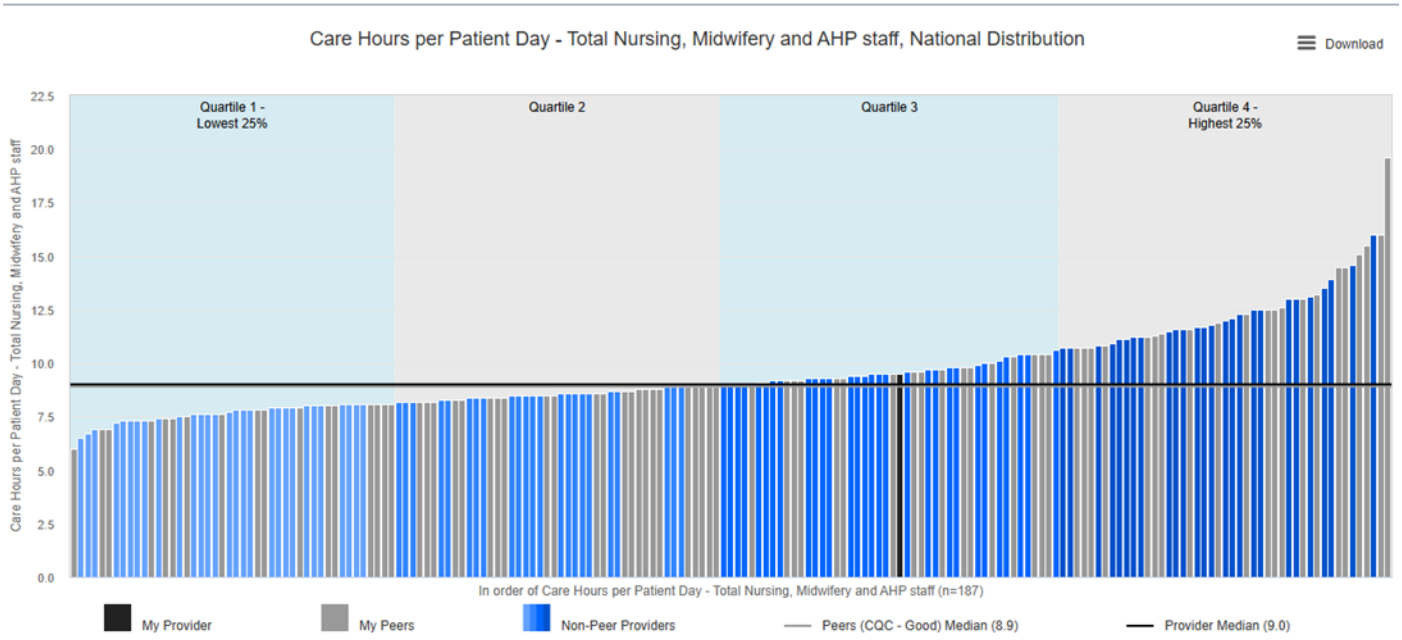
Planned CHPPD RN	Actual CHPPD RN	Planned CHPPD MHSW	Actual CHPPD MHSW	Planned CHPPD Total	Actual CHPPD Total
5.8	5.4	8.8	9.0	14.6	14.4

9.0 Benchmarking Against Peers:

9.1 The graph below illustrates Dorset HealthCare's total CHPPD position in comparison with the national average (inclusive of Registered Nurses, Registered Nursing Associates and HealthCare Support Workers). As an integrated provider of specialist mental health and community hospital services, our clinical model and bed base differ significantly from those of acute hospital trusts, which make up much of the national dataset.

9.2 For meaningful benchmarking, our CHPPD should be compared with organisations offering a similar mix of mental health and community hospital services, rather than with acute trusts, as comparisons with acute trusts do not reflect differences in patient acuity, service design, or workforce models.

9.3 It should be noted that the figures presented reflect all inpatient services across the Trust, rather than Mental Health inpatient services specifically. The data should therefore be interpreted with this broader scope in mind. *Source: Model Health System (January 2026)*



10.0 Evidence-based Tools: Mental Health Optimal Staffing Tool (MHOST

10.1 MHOST is a nationally endorsed, multi-disciplinary, evidence-based system that enables ward-based clinicians to assess patient acuity, incorporating a staffing multiplier to ensure that funded baseline ward establishments reflect patient needs. It is acknowledged that the tool does not consider the ward environment, geographical location, or competency of the workforce, all of which may affect staffing levels.

10.2 MHOST is conducted twice a year, in Spring and Autumn, to mitigate seasonal bias. If a data collection cycle falls within a month that does not reflect typical practice (for example, if acuity or bed occupancy is significantly higher or lower than expected), it is recommended that the data collection cycle be extended or repeated.

10.3 It is recognised that the recommended establishment provided by the MHOST cannot solely be used to set staffing establishments. Professional judgement and data triangulation are crucial to the process of forming conclusions and outcomes.

Ellis Kay
10/06/2026 16:10:36

10.4 A review and refresh of the MHOST is currently underway, led by the Shelford Group of Chief Nurses. Dorset HealthCare is a key contributor to this national programme of work, ensuring that local insight and operational experience inform the redesign.

10.5 The MHOST acuity and dependency census was undertaken in April 2025 and October 2025. The following table shows the average number of patients in each MHOST care level:

Patient Care Level Indicators	Average Patient Numbers	Percentage
Level 1	33.38	18%
Level 2	59.47	32%
Level 3	49.70	27%
Level 4	23.86	13%
Level 5	17.90	10%
Total Occupied Beds	186.29	

10.6 The graph below compares the MHOST-recommended staffing WTE with the funded establishment WTE and indicates whether the current establishment sits above or below the recommendation. Both figures include headroom.

Funded Beds	MHOST Recommendations		MHOST Average (Two Cycle)	Nursing Funded Establishment *(Oct 25)*	WTE Variance (+/-)
	April 2025	October 2025			
198	276.00	329.62	302.81	507.96	+205.15

10.7 While the Mental Health Optimal Staffing Tool census outputs show a lower recommended WTE than the currently funded establishment, this does not indicate overstaffing, and caution is advised when interpreting the data in isolation.

10.8 In several areas, there are significant gaps between MHOST-recommended WTE and the funded establishment. Because MHOST calculations are based on average acuity and dependency, smaller wards (15 beds or fewer) can generate recommendations that do not reflect the staffing required for safe and effective care. In these cases, professional judgement—supported by patient outcomes—remains the primary decision-making factor.

10.9 The MHOST licence does not permit organisations to capture the acuity and dependency needs of individuals assessed under Section 136 in the Health-Based Place of Safety (HBPoS). As a result, Seaview's funded establishment is higher than the MHOST recommendation because the ward supplies the Mental Health Support Workers who provide continuous 1:1 observation in the HBPoS suite.

10.10 The HBPoS is due to relocate on the St Ann's site in 2027, and the WTE currently held in Seaview's budget for HBPoS MHSW staffing will transfer with the service. The next annual establishment review will determine Seaview's future staffing requirements to ensure it retains the appropriate number and skill mix to continue delivering safe and effective care.

10.11 Current MHOST analysis indicates that enhanced care requirements can generally be met within the existing staffing establishments across most wards. However, this is not always reflected in operational practice, where enhanced care demands can create short-term staffing pressures. To support a more consistent approach, a pilot substantive peripatetic team has been agreed through the EQIA process, with the aim of mitigating staffing shortfalls associated with fluctuations in enhanced care needs.

10.12 It is recognised that some wards are under-assessing patient dependency, particularly where cases involve complex discharge planning, and further training and support will be required to strengthen the accuracy of these assessments. We have also identified a gap in our external validation processes. To address this, we will be piloting a new validation model using the Practice Development Nurse for Mental Health inpatients to enhance oversight, consistency, and assurance.

EXPECTATION 2: RIGHT SKILLS

11.0 Mandatory Training and Appraisal:

11.1 All staff must undertake mandatory training, clinical supervision, and annual appraisal to meet national and local requirements. Compliance is monitored via Directorate Management Groups and reported to the Trust Board.

Ellie Kara 09/06/2026 16:04:43

11.2 During the review period, and in line with the recent Clinical Supervision review, all staff are required to record a minimum of one supervision session every two months. From 30 September 2025, compliance will be monitored within each bi-monthly period rather than cumulatively across the financial year, ensuring a more accurate reflection of ongoing supervisory practice. At the time of reporting, the average across the service was 34% for Registered Staff and 0% for Unregistered.

11.3 Continued monitoring is essential to understand whether staffing pressures are contributing to training gaps and to ensure that workforce development and patient safety are not adversely affected. During the review period, no incidents were reported citing cancelled training due to staffing shortfalls.

11.4 Average appraisal compliance for the period was 75%. It should be noted, however, that the system used to record appraisals changed during the reporting period, creating some initial challenges in recording. Therefore, the actual figure may be higher.

11.5 Additional training places for Basic Life Support (BLS) have been commissioned through a private provider to increase capacity and reduce waiting times. This enhanced provision is expected to improve overall compliance rates over the coming months as more staff can access the required training.

11.6 The following table illustrates the average mandatory training concordance across the reporting period.

Course	Compliance (Reporting Period Average)
Basic Life Support Taught	86%
Conflict Resolution	91%
Equality & Diversity	92%
Fire	99%
Health & Safety	98%
Infection Control Clinical	88%
Infection Control No Repeat	53%
Information Governance	97%
Moving & Handling Theory Level 1	98%
Moving & Handling Practical Level 2,3	23%
Oliver McGowan	99%
Patient Safety Level 1	99%
PMVA	87%
Safeguarding Adults Level 1	60%
Safeguarding Adults Level 2	94%
Safeguarding Adults Level 3	87%
Safeguarding Children Level 1	60%
Safeguarding Children Level 2	88%
Safeguarding Children Level 3	88%

12.0 Registered Nurse and Unregistered Vacancies:

12.1 Recruitment and retention continue to be influenced by wider socioeconomic factors, including the rising cost of living, limited availability of accessible and affordable housing, and local industries offering pay rates comparable to or above Agenda for Change. These external pressures reduce the pool of applicants and increase turnover risk, creating additional challenges in maintaining stable and sustainable staffing levels across our services.

12.2 As of January 2026, the vacancy position was 47.67 WTE Registered Nurses and 70.12 WTE Mental Health Support Workers, including headroom. A pilot substantive peripatetic 'allocate-on-arrival' staffing model has been agreed following completion of an EQIA and will be funded through headroom. The safety and quality impacts of this pilot will be reported and monitored through the Directorate Management Group, Safer Staffing Forum and the relevant Quality Governance groups.

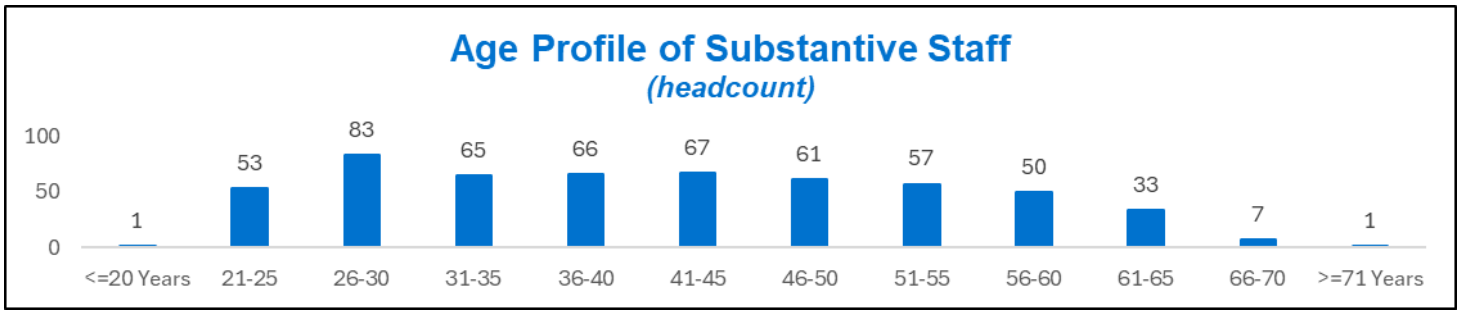
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13.0 Age Profile Position by WTE (as of January 2026):

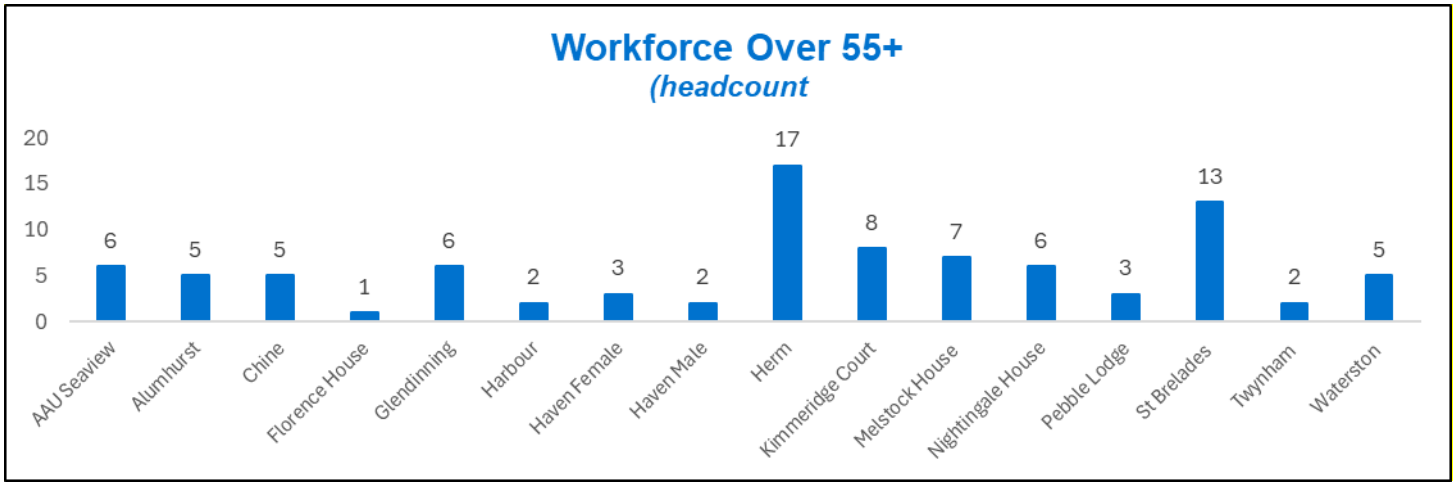
13.1 The age profile shows a broadly even distribution of substantive staff across the 26–60 age range, with the largest group aged 26–30. Representation drops sharply at the youngest and oldest ends of

the workforce, with very few staff under 20 or over 66. While the strong mid-career presence supports service stability, the declining numbers in older age bands indicate a future retirement risk, and the very small early-career cohort highlights the need to strengthen entry-level and developmental recruitment pathways.

13.2 The following graph shows the age profile of substantive staff as of January 2026. *Source: Workforce Reporting*



13.3 The data indicates that the highest number of staff aged 55 and over are working in Herm and St Brelades, which are among the most physically demanding clinical areas. This highlights a potential future workforce risk, as these roles place greater physical strain on an ageing workforce.



EXPECTATION 3: RIGHT PLACE AND TIME

14.0 Unused Contracted Hours:

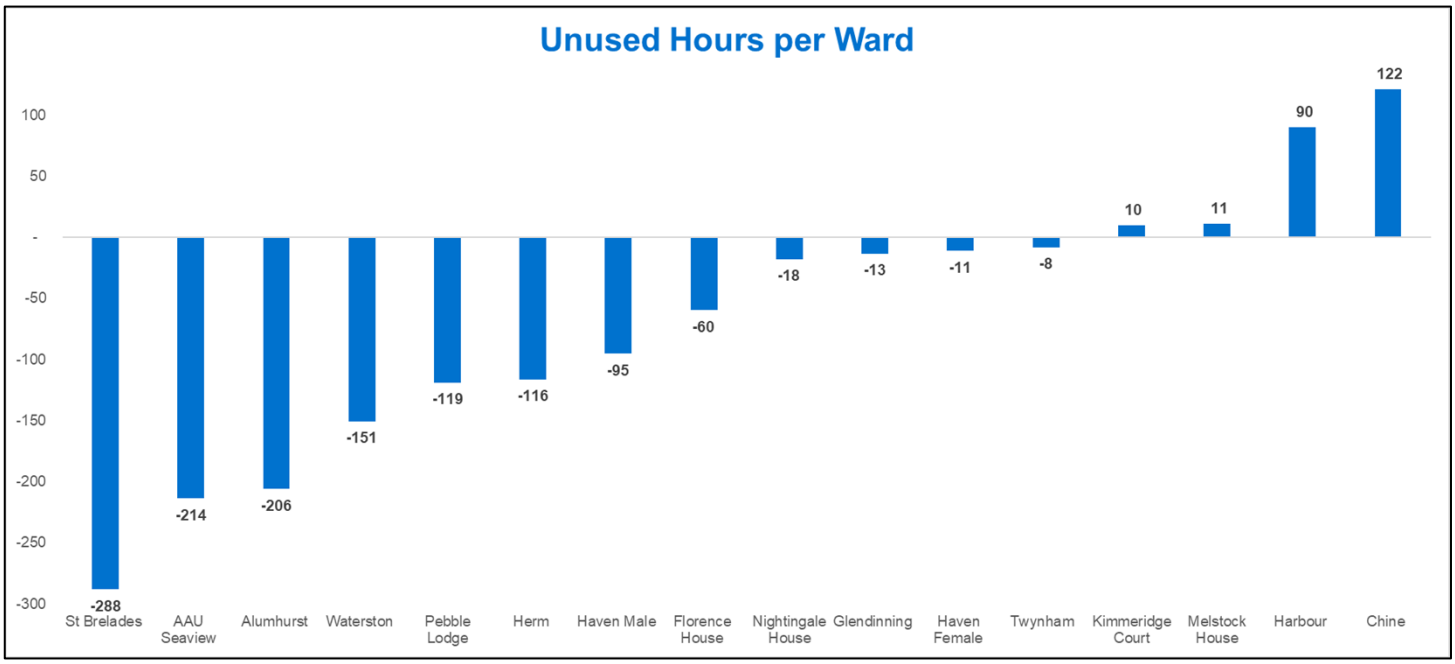
14.1 It is important that contracted hours are fully utilised because unused hours represent staffing capacity that has been funded but not deployed to support patient care. Persistent unused hours may also indicate inefficiencies in duty allocation or roster planning and should be reviewed to ensure that the funded establishment is being used to its full potential.

14.2 The table below shows the total contracted hours for the ward compared with the total hours assigned during the reporting period, rounded to the nearest whole number. *Source: eRoster*

Contracted Hours	Assigned Hours	Variance
615,302	614,236	-1,066

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14.3 The graph below displays unused hours by ward, ordered from the highest number of unused hours to those exceeding contracted hours.



15.0 Nurse Sensitive Indicators and Red flags:

15.1 We are currently reviewing both national and internal red flags to ensure they comprehensively reflect all relevant indicators associated with staffing shortfalls. This work will strengthen our ability to understand and evidence the impact of workforce gaps on patient safety, quality of care, and staff experience, enabling more informed decision-making and earlier identification of emerging risks.

15.2 Written guidance is currently available on the Safer Staffing intranet page to support staff in escalating staffing concerns. This guidance is currently being rewritten and will form part of an overarching Safer Staffing Policy. We are awaiting a standardised policy template from the Regional Nursing Directorate (NHS England Southwest), which will inform the final structure and format. In the meantime, an extension to the existing internal guidance has been approved until the 31st of July 2026.

15.3 The quality and comprehensiveness of staffing related incident reports varied across services. A Quality Improvement project is currently underway to strengthen the identification and reporting of staffing red flags, as well as to improve the capture and articulation of escalation, mitigation and impacts arising from suboptimal staffing.

15.4 The following table shows nurse sensitive indicators reports per month per 1000 occupied bed days: *Source: Business and Performance Reporting*

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Month	All Falls	Falls Resulting in Harm	Unexpected Death Of A Patient	Pressure Ulcers	Pressue Ulcer Cat 3 or above	Med Error	Physical - Abuse (Injury) Pt On Pt	Physical - Abuse (Injury) Pt On St	Staffing
May	6	4	0	0	0	2	3	7	2
June	3	2	0	0	0	2	2	8	3
July	7	4	0	1	0	2	5	10	6
Aug	5	3	0	0	0	3	3	14	7
Sept	7	5	1	0	0	3	4	12	7
Oct	5	3	0	0	0	3	3	11	5
Nov	6	4	0	0	0	3	2	12	2
Dec	6	3	0	0	0	3	3	14	2
Jan	5	3	0	0	0	2	3	12	2

16.0 Patient Feedback and Complaints:

16.1 One compliment was received for Florence House relating to *'Good Care Provided to the Patient'*.

16.2 A total of 59 complaints were received during the reporting period. Waterston (18), Kimmeridge Court (10), and AAU Seaview (8) recorded the most complaints. Importantly, none of the complaints cited staffing levels as a contributory factor, providing assurance that current workforce capacity has not been raised as a concern through the complaints process.

16.3 The following table shows complaint themes across the mental health inpatient service:

Complaint Category	Number of Complaints Received
Admission/Discharge	3
Clinical Treatment	4
Communications	13
Facilities	4
Patient Care	16
Prescribing	1
Privacy, Dignity, Wellbeing	1
Trust Admin/Policies/Procedures	12
Values And Behaviours	4
Total	59

17.0 Risk Register:

17.1 The following risk for the mental health inpatient service was on the risk register during the reporting period:

Service	Risk Number	Date Entered	Date Closed	Description
Mental Health Inpatient Services	1983 v6	24/01/2025	10/07/2025	Risk of identity fraud in temporary workforce and potential impact on patient safety, patient experience, the workforce, financial implications, and reputation of the Trust.
Harbour	1816 v4	13/10/2023	Open	Unable to provide full safe staffing nursing with substantive staffing levels due to nursing vacancies leading to a high reliance on band and agency staff including block booked agency.
Waterston	1806 v5	14/09/2023	05/12/2025	Inability to provide occupational therapy to patients due to OT staff currently on long term sick or leaving.
	1970 v2	31/12/2024	Open	Risk of being unable to provide safe staffing with substantive staff on the ward due to extensive vacancies leading to a high reliance on bank and agency workers including the use of block booked agency.

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18.0 Summary:

EXPECTATION 1: RIGHT STAFF

18.1 Across the reporting period, inpatient services continued to experience variable staffing pressures, influenced by vacancies, sickness absence, enhanced care demands, and fluctuating temporary staffing use. During the reporting period, staffing pressures continued, largely attributable to vacancies, sickness absence, and additional staffing required to support enhanced therapeutic observations.

18.2 Average fill rates across the service remained within agreed parameters; however, Mental Health Support Worker (MHSW) fill rates on night duty consistently exceeded the upper KPI threshold. This was primarily due to occasions where a second Registered Nurse (RN) could not be filled and was therefore substituted with an MHSW, increased staffing to safely meet enhanced therapeutic observation of care needs and agreed uplifts to staffing to maintain environmental safety.

18.3 The actual Care Hours per Patient Day (CHPPD) across the service remained aligned to total planned hours throughout the reporting period; however, actual Registered Nurse CHPPD was marginally lower than planned.

18.4 Reliance on temporary staffing to maintain patient safety continued throughout the reporting period. Caution should be applied when reviewing temporary staffing skill-mix data, as substantive staff who pick up additional duties through the Trust bank are recorded as temporary hours. This includes staff already familiar with the clinical environment, which supports continuity, safety, and quality of care despite appearing in temporary staffing figures.

18.5 Approval has been given to establish a substantive peripatetic staffing team to respond flexibly to staffing shortfalls arising from absence and enhanced care needs and to reduce reliance on temporary staffing. The safety and quality impacts of this pilot will be reported and monitored through the Directorate Management Group, Safer Staffing Forum and the relevant Quality Governance groups.

18.6 When compared against a 23.2% headroom allowance, the average unavailability was 23%. This figure excludes other types of leave, such as parental leave, which are not accounted for within headroom. When these additional leave types are included, the overall average unavailability rises to 31%, exceeding the allocated headroom and increasing the likelihood of staffing gaps and reliance on the temporary workforce.

18.7 Work is ongoing to strengthen workforce planning, improve data quality, enhance MHOST assessment accuracy, and advance Trust wide initiatives to reduce temporary staffing, optimise rostering, and improve overall workforce sustainability.

18.8 Sickness absence remained persistently above 5%. While average annual leave across wards consistently met the KPI, analysis shows variability at ward level, with some wards exceeding the upper threshold of 17%—most commonly during school holiday periods.

18.9 While the Mental Health Optimal Staffing Tool census outputs show a lower recommended WTE than the currently funded establishment, this does not indicate overstaffing. The tool is based on average acuity and dependency and can underestimate staffing requirements where a minimum safe staffing presence is required to deliver safe and effective care. As a result, MHOST outputs are used as a supporting indicator rather than a sole determinant, with professional judgement and patient outcomes continuing to inform establishment decisions.

18.10 As part of the 2025 Annual Inpatient Staffing Establishment Reviews, the recommendation to fund the ongoing cost pressure associated with the additional MHSW rostered on Waterston Ward to ensure safe and effective care has been approved. The associated funding has now been transferred to the ward's budget, and recruitment for the additional posts is underway.

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18.11 The recommendation to increase Registered Nurse staffing levels at Glendinning Unit remains under review. This is due to the ongoing Rehabilitation Service Review, which is exploring potential opportunities to deliver care differently and optimise the skill mix across the service. The outcomes

of this review may influence future workforce requirements; therefore, a final recommendation will be presented once the review is complete and any service redesign options have been fully considered.

18.12 As of January 2026, the vacancy position was 47.67 WTE Registered Nurses and 70.12 WTE Mental Health Support Workers, including headroom. Recruitment and retention continue to be influenced by wider socioeconomic factors, including the rising cost of living, limited access to affordable housing, and local industries offering pay rates comparable to or above Agenda for Change. These external pressures reduce the applicant pool and increase turnover risk, creating additional challenges in maintaining stable, sustainable staffing levels across our services.

18.13 The age profile shows a broadly even distribution of substantive staff across the 26–60 age range, with the largest group aged 26–30. Representation drops sharply at the youngest and oldest ends of the workforce, with very few staff under 20 or over 66. While the strong mid-career presence supports service stability, the declining numbers in older age bands indicate a future retirement risk, and the very small early-career cohort highlights the need to strengthen entry-level and developmental recruitment pathways.

EXPECTATION 2: RIGHT SKILLS

18.14 Mandatory training, clinical supervision, and appraisal compliance remain key workforce priorities, with monitoring through Directorate Management Groups and reporting to the Trust Board. Clinical supervision requirements have been strengthened, moving to bi-monthly monitoring from September 2025, though current recorded compliance remains low and may reflect recording rather than delivery.

18.15 Although no incidents were reported as resulting from cancelled training, continued monitoring is needed to understand any impact on workforce competence. Additional BLS training capacity has been commissioned to support improvements. Appraisal compliance averaged 75%, though system changes impacting recording may mean the true figure is higher.

18.16 Incident reporting remains under routine monitoring, with no evidence that staffing levels directly contributed to patient harm. National and local red flags are currently being reviewed to ensure they reflect all relevant indicators associated with staffing shortfalls. This work will strengthen our ability to understand and evidence the impact of workforce gaps on patient safety, quality of care, and staff experience, enabling more informed decision-making and earlier identification of emerging risks.

EXPECTATION 3: RIGHT PLACE AND TIME

18.17 Unused contracted hours were high in some areas, and variation between wards highlights the need for ongoing focus on effective roster planning to ensure the funded workforce is fully utilised.

18.18 Approval has been granted to implement the Allocate SafeCare module to enhance real-time oversight of staffing requirements and patient acuity, supporting safer and more efficient workforce management.

18.19 Patient feedback included one compliment for Florence House. 59 complaints were received, with the highest numbers in Waterston, Kimmeridge Court and AAU Seaview; none of these complaints cited staffing levels as a contributory factor.

18.20 Two staffing risks remain open on the risk register for Harbour and Waterston.

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Appendix A: The Southwest (SW) Safer Staffing Team Gap Analysis:

Below is the heat map for DHC with details for their initial submission and how their compliance has been updated post initial meeting which was held on 19 January 2026.

No.	Safer Staffing Topic	Initial Gap Analysis Comment	Compliance	Evidence Provided Pre Initial Meeting	Compliance After Initial Meeting
1	NQB Guidance	The Trust provided a good description of their safer staffing process which follows the NQB guidance	Compliant	The Trust provided a good description of their safer staffing process which follows the NQB guidance	Compliant
2	Triangulation	The Trust provided a detailed explanation of how they apply the principles of safer staffing	Compliant	The Trust provided a detailed explanation of how they apply the principles of safer staffing	Compliant
3	Evidence Based Tools Utilisation	The Trust are using SNCT and MHOST, CNSST II still being rolled out.	Partial Compliance	The Trust are using SNCT, MHOST and CNSST II which has been deployed in line with national guidance	Compliant
4	No Tool Manipulation	The Trust confirm no data manipulation	Compliant	The Trust confirm no data manipulation	Compliant
5	Monthly Actual vs Planned Staff Reporting	The Trust supplied their August NHSE return and August staffing report. The public facing safer staffing page has a link to the national CHPPD data.	Compliant	The Trust supplied their August NHSE return and August staffing report. The public facing safer staffing page has a link to the national CHPPD data	Compliant
6	Annual Statement	The Trusts annual statement is available online	Compliant	The Trusts annual statement is available online	Compliant
7	Workforce Plan	The Trust states that their workforce plan exists but it is not seen online and had not been supplied	Partial Compliance	The Trust supplied their workforce plan	Compliant
8	Bi-Annual Establishment Review	The Trusts bi-annual establishment reviews are seen in board reports online	Compliant	The Trusts bi-annual establishment reviews are seen in board reports online	Compliant
9	Quality Dashboards	The Trust stated that they have a dashboard system in place and monthly reviews with appropriate committee	Compliant	The Trust are in the process of developing their dashboard, they have no completion date at present but will send a sample.	Partial Compliance
10	Quality Impact Assessments	The Trust supplied the minutes and action log from 28/8/25 Quality Impact Assessment Panel meeting	Compliant	The Trust supplied the minutes and action log from 28/8/25 Quality Impact Assessment Panel meeting	Compliant
11	Risk Management & Escalation	The Trust supplied guidance to support the management of staffing shortfalls in inpatients (written Jan 24, expires Jan 26)	Compliant	The Trust supplied guidance to support the management of staffing shortfalls in inpatients (written Jan 24, expires Jan 26)	Compliant
12	Board Awareness	The Trust provided their Board report (2/10/25) and safer staffing is reviewed	Compliant	The Trust provided their Board report (2/10/25) and safer staffing is reviewed	Compliant

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Report to	Board in Common (DCH)	
Date of Meeting	17th June 2026	
Report Title	Inpatient Wards Biannual Staffing Review	
Prepared By	Trudi Goode, Lead Nurse Workforce and Safe Staffing	
Approved by Accountable Executive	Dawn Dawson, Joint Chief Nursing Officer	
Previously Considered By	Quality Governance Group, 15th May 2026 Quality Committee in Common, 26th May 2026	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1: Quality and Safety SR2: Culture SR3: Workforce Capacity SR4: Capacity and Demand SR6: Finance	
Financial	The report includes details on staffing shortfalls and, where applicable, the associated temporary staffing costs.	
Statutory & Regulatory	The report meets the national requirements for safer staffing reporting as guided by the National Quality Board (2016) and Developing Workforce Safeguards (2018).	
Equality, Diversity & Inclusion	The data in this report is drawn from a range of partners, including management accounts, business, and performance, eRoster, and feedback received from local managers, service leads, and the safer staffing forum.	
Co-production & Partnership	As above	

Executive Summary

This report provides assurance in relation to Safer Staffing for acute ward-based nursing following the acuity and dependency audit completed January 2026 for a period of 30 days (5/1/2026 – 3/2/2026). The last audit was completed in July 2025, and the report presented to Trust Board in November 2025. It is acknowledged that the audit is completed twice yearly, and is included in the planned audit programme for 2026/27.

Maternity staffing was subject to review using professional judgement and review of activity and complexity in Quarter 3 2023/24 and the Better Births 3 yearly staffing review undertaken in September 2024. The results and recommendations were included in the Annual Safe Staffing report November 2024 and is not due to be further reported until Quarter 3 2027. Establishment was increased during 2025/26 because of the closure of the Yeovil Maternity Unit and supported by the redeployment of Yeovil Midwives to DCH. A further review will be undertaken before the end of Quarter 1, 26/27 following the reopening of the Yeovil Unit and a rebase of activity.

The Neonatal Staffing audits continue to be completed quarterly and submitted to the Wessex Neonatal Network. The audit tool has not yet been amended to reflect the changes in staffing requirements to support transitional care. This is monitored and managed locally based on professional judgement and

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acuity and dependency at unit level. Recruitment of Qualified in Specialty (QIS) Neonatal and Band 5 Registered Nurses, in line with BAPM standards, is complete with successful candidates expected to start in post during Q1 and Q2.

As this is the bi-annual report there are no financial requests and any recommendations will be managed in budget by the Divisional Heads of Nursing, however consideration needs to be given to the use of in-extremis beds and the requirement for extra staff currently a temporary staffing cost pressure. It should also be noted that the SNCT audit tool and results are based on 22% uplift whilst the National Quality Board recommends 22.2%. The DCH uplift is being increased in line with national recommendations and as a consequence of prior agreements to convert temporary staffing spend to substantive to avoid cost pressure. This implementation is being monitored by the Financial Recovery Board to ensure that there is no additional cost pressure, and that staffing metrics and quality of care are not adversely affected.

Recommendation

- Receive the report for assurance that Dorset County Hospital is adhering to national safer staffing guidance.

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DCH Bi - Annual Safe Staffing Review 2025/2026

Inpatient Wards

Executive Summary

1. Introduction

1.1 The National Quality Board (2016) and Developing Workforce Safeguards (2018) set out mandatory requirements of Trust Boards to ensure that staffing levels are based on patients' needs, acuity, and risks, which are monitored from 'ward to board' and will enable NHS provider boards to ensure that the right staff with the right skills are in the right place at the right time.

- Trust Boards must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their board every month.
- An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.
- As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes, must have a full quality impact assessment (QIA) review.
- Given day-to-day operational challenges, we expect Trusts to carry out business-as usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance, and staff experience must be clearly described in these risk assessments.
- Should risks associated with staffing continue or increase and mitigations prove insufficient, Trusts must escalate the issue (and where appropriate, implement business continuity plans) to the board to maintain safety and care quality. Actions may include part or full closure of a service or reduced provision: for example, wards, beds and teams, realignment, or a return to the original skill mix.

1.2 As part of the establishment review, the Chief Nursing Officer must confirm in a statement to the Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable. This is evidenced annually in the Annual Report Governance Statement.

1.3 This review has included all inpatient wards at Dorset County Hospital.

1.4 Critical Care, Maternity, Special Care Baby Unit (SCBU) audit results have not been included in this report. A separate review of Critical Care staffing is being conducted in recognition of the New Hospitals Build and remains in progress. Senior staff in ED refreshed their training on the use of the SNCT toolkit during May 2025. The ED audit was subsequently completed during November 2025 for a period of 12 days, as determined by SNCT, the results of which are included in this report.

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1.5 Following the approval of the Trust Headroom and Temporary Staffing paper (November 2025), the following wards are compliant at 22% headroom: Stroke, Moreton, Portesham, Fortuneswell and the Mary Anning Unit.

1.6 Subsequent roll out is underway for Abbotsbury, Lulworth and Purbeck to 22%, with the Emergency Department increasing to 25%.

1.7 Following monitoring and evaluation of impact in the initial cohorts, adjustments will be applied to:

- Prince of Wales Ward, Cardiac Care Ward, Ridgeway Ward, Evershot Ward and Ilchester Ward.

1.8 This will also be subject to review based on any changes to bed base or patient cohorts in year.

1.9 Additionally, the Temporary Staffing and Headroom paper recommended removal of the Registered Nurse Degree Apprentices (RNDA) from ward vacancies and to centralise the budget and management oversight to reduce bank and agency dependencies for backfill. This was actioned from April 2026 with RNDA rostering and management now being held by the Education Centre. This will allow wards/departments to recruit into these vacancies thus stabilising the available workforce and avoiding temporary staffing usage.

1.10 The Trust commissioned an independent review, against the Developing Workforce Safeguards guidance, by the National SNCT team and the Trust is working through the recommendations. Assurance was gained for inpatient areas, and work is underway to strengthen the approach to annual staffing reviews for non-ward based teams e.g. clinical nurse specialists and a roll out of job planning. The action plan will be monitored by the Safe Staffing Group and Terms of Reference are being revised accordingly.

1.11 This year the Trust has been successful in its' application to join a National Exemplar Programme to advance the implementation of Enhanced Therapeutic Observations Care (ETOC). The programme aims to reduce reliance on high-cost staffing models and use of additional staff groups, such as Security, to ensure a patient centric, holistic and therapeutic plan of care. As part of a wider cohort, there the opportunity for sharing of best practice, data collection methods and reporting via the Provider Workforce Return. This programme aligns with the ambition for creative health and wellbeing activities and de-escalation of behaviours through the use of activity and distraction boxes, music therapy, dayroom activities which have also been supported by the Trusts' Charity. The Regional team gave good feedback around the work we are doing in this area including our ETOC policy, training plans and support to our staff.

1.12 Red flag reporting is collected monthly from Wards, ED, SCBU, Maternity and Paediatrics and mitigated or reported accordingly. At the twice daily recorded safe staffing meetings any ward red flag shifts are mitigated using assessment of Allocate SafeCare dependency and acuity reviews, availability of additional roles and the redeployment of staff to maintain patient care and safety.

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2. Methodology

2.1 The methodology for determining safer staffing has previously been approved by the Trust Board. This incorporates the use of an acuity and dependency evidence-based

tool (Safer Nursing Care Tool (SNCT), The Shelford Group (2023), alongside any relevant benchmarking (such as Model Hospital or Royal College of Nursing recommendations), and Professional Judgement.

2.2 Safer staffing reviews are expected as part of the regulatory framework to ensure the organisation is meeting the needs of the patients that use our services. Lesson learnt from national reviews underpinned the need for staffing levels, and the outputs of regular safe staffing reviews, are overseen by Trust Boards (Francis Report, 2013 and Keogh Review, 2013).

2.3. The assessment of safe staffing includes skill mix, leadership, and availability of any supporting roles in the form of professional judgement applied to the audit. Having the right number of nurses, with the right mix of skills and experience, is essential to support safe, high-quality care for patients. National Institute for Health Research (NICE 2019) notes that determining the right number of staff on the wards and mix of education and skills is not a precise science and depends on a risk assessment based on the best available evidence.

2.4 The Royal College of Nursing (RCN) has set out detailed expectations for employers, national organisations, and regulators to support patient safety and enable the UK's nursing workforce to deliver safe and effective care. The 14 workforce standards, launched by the College in May 2021 are intended to bring the entire nursing community in the UK, under one set of standards for the benefit of staff and patient safety. The RCN have recently announced a review of guidance and consideration of best methodologies and benchmarking including nurse to patient ratios and Care Hours per Patient Day. The outputs of this review are outstanding but will form a revision of approaches at Dorset County Hospital to ensure audit against best evidence-based practice.

Care Hours per Patient Day DCH comparison with other acute Trusts (the average number of actual Registered Nursing care hours spent with each patient per day)

Name of Acute Trust	**2026**	2025	2024
DCH	**5.88**	**5.2**	**4.8**
UHD	4.65	4.5	4.5
Salisbury	5.06	5.1	5.3
Somerset	5.14	4.6	4.6
R D & Exeter	4.96	5.0	No data
Royal Cornwall	4.71	4.5	4.3
North Bristol	4.53	5.4	5.0
RUH Bath	5.85	5.8	5.6

2.5 It should be noted that this data can be adversely affected by budgeted establishment (see SNCT thresholds), size of organisation and ability to flex staffing resource, fluctuations in available staff, use of temporary escalation areas and patients with enhanced levels of care need e.g. mental health, dementia or complex needs.

2.6 Full engagement of the ward leaders was achieved to ensure the audit was complete and accurate, with the Matrons holding responsibility for ensuring that the data was collected and that the tool was being applied effectively and consistently across their inpatient wards.

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2.7 All inpatient wards were required to collect data using the SNCT during the same period, to ensure consistency and allow benchmarking across the Trust. The audit took place in January 2026.

2.8 Triangulation was applied to ensure validation of information from the following sources.

- Patient Acuity and dependency
- Professional Judgement
- Quality indicators

2.9 Nurse to Patient ratios were also applied considering the national recommendations by NICE. The ratio of 1:8 has broadly been applied and some areas, with recognised higher acuity or smaller footprint, are demonstrating a ratio of 1:5/6 e.g. Evershot Acute Assessment Unit, Maud Alex, Portesham. It is anticipated that the correction of ward establishments will improve the accuracy of CHPPD in line with the SNCT methodologies (e.g. uplift at 22%).

2.10 Information regarding staffing vacancies, turnover and sickness rates were also used to inform the recommendations made within this paper.

2.11 Divisional analysis and additional information regarding the financial implications were applied.

2.12 Current uplift for ward establishments is 20.5% (for training, annual leave etc), of which 2% is kept centrally for sickness absence cover using temporary staffing. This uplift is currently below nationally recommended levels and Safe Staffing toolkits (including SCNT) are unable to accurately calculate below 22% uplift. The current uplift for the Critical Care and Emergency Departments is the same as the inpatient wards and below national benchmarks. The recommendations are to align budgeted establishments with the national recommendations (see below).

	NQB - Jan 18 Wards		NQB - Jun 18 ED & CC		RCEM & RCN Type 1 ED	
	days	%	days	%	days	%
Annual Leave	29.9	11.6%	29.9	11.6%	29.9	11.6%
Bank Holidays	8.0	3.1%	8.0	3.1%	8.0	3.1%
Sickness	7.7	3.0%	10.3	4.0%	10.3	4.0%
Training/ study	7.7	3.0%	11.6	4.5%	16.8	6.5%
Parenting	2.6	1.0%	2.6	1.0%	2.6	1.0%
Other	1.3	0.5%	2.1	0.8%	2.1	0.8%
TOTAL	**57.3**	**22.2%**	**64.5**	**25.0%**	**69.7**	**27.0%**

[1] The National Quality Board, Safe, sustainable and productive staffing, An improvement resource for adult inpatient wards in acute hospitals, January 2018.
[2] The National Quality Board, Safe, sustainable and productive staffing, An improvement resource for urgent and emergency care, June 2018.
[3] The Royal College of Emergency Medicine together with the Royal College of Nursing, *Nursing Workforce Standards for Type 1 Emergency Departments*, October 2020.

2.13 Business planning 2024/2025 included a business case to request investment to align to national recommendations and thereby significantly reduce reliance on short-term agency use to cover planned leave and absences.

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2.14 Since the annual review in July 2024 and reported November 2024, alternative roles in the clinical area have been explored and a pilot project for Ward Housekeepers was

undertaken on 2 wards. Early indications were that this has been successful with improvement demonstrated during a PLACE assessment during the project. This has particularly been evident with bed area preparation, management of allergens and the support given to patients to remain on their wards and de-escalate anxiety. Food service and food safety is now a priority with food being seen as medicine (NHS 2023 National Standards for Healthcare Food and Drink) which support delivery of quality indicators such pressure ulcer management and patient experience. This should be a phased roll out recommendation in partnership with our Catering and Domestic Facilities teams. Given the financial constraints since July 2024, this project has not achieved roll out but there is potential opportunity for joint work with the EFM team for a service review in line with any changes to meal provision and to achieve further workforce efficiencies.

2.15 Since November 2025, a new policy for the provision of Enhanced Therapeutic Observation Care (ETOC) has been developed to support safer staffing for those requiring more enhanced, engaged and meaningful care to those patients more vulnerable such as those with Dementia, Mental Health needs and those with Learning Disability. A project for ETOC is in place on Purbeck ward with staff undertaking extra training and support in collaboration with our colleagues in Dorset Healthcare. Additionally, DCH was accepted onto the National Programme for ETOC development and who are supporting us with developing our provision of ETOC at DCH. Training roll out will commence across high use wards to address further opportunities for agency reductions and a more collaborative approach with both clinical and security teams.

3. Additional In-Extremis Beds

3.1 Over 2024/2025 additional in-extremis beds were open by exception to support additional admission demand. This fluctuated but presents an ongoing pressure to staff the wards to ensure patient safety. The February 2025 acuity and dependency audit reflected all these beds being open and the below chart reflects the requirement to support this pressure. Action was taken to de-escalate the in-extremis beds as soon as possible. Over the course of 2025/2026 action was taken to reduce these extra beds with the Mary Anning Unit managing and nursing patients over a split site of Mary Anning and Maud Alexander ward, with the overall bed base being now 26. This was as part of the bed reconfiguration, a Quality Improvement programme and to support the development of the Hyper Acute Stroke Unit.

3.2 Since the last audit June 2025 Moreton and Fortuneswell wards have had their unfunded beds funded. Moreton continues to ad hoc increase their funded bed base from 26 to 27.

3.3 The Day Surgery Unit at Dorset County Hospital is continuously open to extra in-patient beds overnight ranging from 3 – 12 patients at a time and is dependent of the theatre activity lists being able to support inpatient stays. Inpatient stays however can and do impact at times on waiting list activity. Your Future Hospital collaborative to improve patient flow, enable earlier discharge and reduce reliance on temporary escalation areas, including corridors, aims to address these risks.

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3.4 Portesham Unit was opened initially to 10 beds to support the streaming of patients from ED and included 4 Frailty Same Day Emergency Care spaces. During the audit the SDEC spaces were often opened to inpatients which affected the functionality of the unit and consequently patient flow. Additionally, Portesham further expanded into

the Discharge Lounge (DL) cubicles and main floor area adding a maximum of 9 temporary escalation beds.

Ward	Escalation Beds	Additional Staff Required
Moreton Ward	1	Nil
Day Surgery Unit	1 - 12	2 RN's 24/7 including weekends
Portesham Unit	1 – 11 (x4 FSDEC & 9 DL)	1 RN and 1 HCA 24/7

3.5 As a consequence of usage, restrictions on flow and publication of national guidance on eliminating corridor care, the FSDEC was moved to provide 2 permanent spaces and increase the bedded number on Portesham from 10 to 13. This has proved a more efficient model.

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4. Results

4.1 Several areas were identified as under established. This was identified following completion of the SNCT and professional judgement review with Divisional leads. It is noted that the ability to recruit into current vacancies and subsequently reduce the need for temporary staffing remains the highest challenge in current management of safer staffing.

Ward	Current WTE Establishment (Excluding Band 7 & Admin Roles)	SNCT Results with 22% uplift	Current Vacancies (WTE) **as at 12.5.25**	Recommendations
Abbotsbury Ward (29 Beds)	43.83	46.89	Vacancies: HCA 2.00 but have RNDA 4.0 in post at time of audit	No change to current establishment but it is recommended that to improve the nurse-to-patient ratio there remains a need for an off-duty review to achieve 4RN's both day and night. Acuity remains consistently high with ETOC provision also required. **Recommend increase headroom to 22% as per headroom paper. In progress**
Lulworth Ward (31 beds)	41.64	44.31	Vacancies: RN 0.55 HCA's 2.0 RNDA 2.00 in post at time of audit	No change to current establishment but it is recommended that to improve the nurse-to-patient ratio there remains a need for an off-duty review to achieve 4 RN's for both day and night. Currently 1:6 day and variable 1:10/1:7 night depending on professional judgement demands a higher ratio due to acuity and provision of ETOC also required. **Recommend increase headroom to 22% as per headroom paper. In progress**
Purbeck Ward (27 beds)	44.83	43.48	Vacancies: RN 6.0 HCA 5.0 RNDA 2.0 in post at time of audit	Over the last year there has been an increased need to provide Enhanced Therapeutic Observation Care (ETOC) to several patients including a long-term, complex patient requiring additional, specialist staff to a ratio of 3:1. This has subsequently affected CHPPD and directly contributed to high spend on agency. **Recommend increase headroom to 22% as per Headroom paper. In progress**

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Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22% uplift	Current Vacancies (WTE)	Recommendations
Portesham (10 beds + 4 frailty SDEC beds) Currently being used to support Frailty SDEC patients streamlined from the ED. An additional 9 patients were also added utilising the DL during the audit.	26.85	10.67 for 10+4 extra beds 18.91 for 14+9 extra beds	Vacancies: HCA 6.76 Over RN's 2.0	Ward was audited both on its' 10 funded beds with 4 FSDEC bed opened and audited to include the extra 9 patients housed in the DL. Small ward principles applied in addition to covering across a geographically spread area. **Compliant with Headroom at 22% but not budgeted for additional beds.**
Ridgeway Ward (20 beds) Planned Orthopaedic patients only	40.34	35.38	Vacancies: HCA 7.0 but have RNDA 3.00 in post at time of audit	No change recommended, the ward also manages its' Surgical Admission lounge within the footprint of staff. **During the period of the audit, in order to maximise the bed availability a SOP was developed to enable MRSA screened patients from Purbeck to transfer to Ridgeway. This influenced the dependency of the ward which is used to high turnover of well patients. During the period of the audit there were multiple high falls risk patients, confused wanderers, End of Life, high NEWS scored patients as well as the theatre activity to manage through admission and discharges. Recommend increase Headroom to 22%.**
Kingfisher Ward (14 beds + PAU)	27.33	17.7	Vacancies: RN 2.0	No change to current establishment – Smaller unit principles applied. Occupancy of the ward can vary with the average for January 2026 being 9 occupied beds. Additionally, an average of 6.87 referrals daily and 4 ward attenders daily across a geographic spread.
Fortuneswell Ward (17 beds) + 3 additional beds open for the duration of the audit	30.37	32.30 17 beds would equal 23.33	Vacancies: RN 3.74 HCA 2.79 but RNDA 2.0 in post at time of audit	Recommended increase to establishment of 2 RN's and 3 HCA's if beds are to remain open. **It is noted that 5 days of data were missing in this audit period.** **Compliant with Headroom at 22%**

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Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22% uplift	Current Vacancies (WTE)	Recommendations
Moreton Ward (23 beds) + 3 and sometimes 4 additional beds open for the duration of the audit and historically since Covid-19 pandemic began.	39.95	30.34 based on 23 days data only	Vacancies: RN 3.29 HCA 6.84	If 3/4 extra beds remain open, an additional 3 RN's and 3 HCAs are required to manage the geographical spread of the ward, the acuity of patients and to meet the nurse-to-patient ratio. Beds may be reviewed as part of bed reconfiguration plans. **The ward is currently working on a Quality Improvement Programme and reducing the bed base would form part of this and the Quality Nursing Indicators.** **7 days of audit data were not submitted, therefore only 23 days audited (SNCT recommends 30 days).** **Compliant with Headroom at 22%**
Evershot Ward (14 beds)	19.30	14.33	No vacancies	Small ward principles applied. Ward functions as a high turnover of medical patients with a "pull" approach from ED many days recycling at least half the ward number of patients thus supporting patient flow. **Recommend increase Headroom to 22%.**
Emergency Department	138.65		Vacancies RN 2.26, HCA 4.92 currently at time of audit RN band 7 off set by over band 6 plus 2.67 RSCN and 6.34 HCA	ED has seen an increase of all patients to the department with areas being overcrowded and "corridor care" being instigated. Additionally there has been spill into other areas to manage patients leading to high agency expenditure. The ED has also been required to comply with Timely Handover targets with SWAST requiring additional staff. **Recommend increase headroom to 25% in line with Headroom paper. Note RCEM recommends 27%.**

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Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22% uplift	Current Vacancies (WTE)	Recommendations
Cardiac Care Ward (18 beds)	32.33	26.71	No vacancies	No change to current establishment – smaller unit principles applied – the area functions as both a ward and, CCU providing 1:2 patient care. **Recommend increase Headroom to 22%.**
Ilchester Ward (33 beds)	51.18	53.18	Vacancies: RN 1.26 HCA 1.4	No changes to establishment required nurse: patient ratio currently 1:8 plus a NIC. Functionality restored to general medical ward. **Recommend increase Headroom to 22%.**
Mary Anning Unit 16 beds across Mary Anning and 10 Maud Alexander Ward area	49.23	38.47 (note 1c not included but if was, would require an extra 18.95)	Vacancies: HCA 3.30 but have 1.0 RNDA in post at time of audit	**During the audit period there were between 9-12 patients on DoLS, MH Section patients, 21 falls risk patients with also 4 wandering and challenging behaviour. No changes recommended as the Unit is currently split across 2 ward areas. Compliant with Headroom at 22%**

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Ward	Current WTE Establishment (Excluding Band 7 and Admin Roles)	SNCT Results with 22% uplift	Current Vacancies (WTE)	Recommendations
Maud Alexander Ward (10 beds)				Included with Mary Anning
Stroke Unit (22 beds)	67.93 + ACP 9-5 Mon-Fri, Outreach B6 08:00-20:00 Daily Nurse Consultant M-F	40.51	Vacancies: RN 12.3 HCA 11.0 but have 4.00 RNDA in post at time of audit	Unit is in process of developing HASU model and to meet national stroke standards and increasing bed base. Ward establishment will be adjusted accordingly, and any shortfalls identified. The Somerset developments will further inform staffing recommendations. The HASU will provide 1:2 patient care in the acute phase. **Compliant with Headroom at 22%**
Prince of Wales Ward (13 beds)	30.81	17.66	Vacancies: HCA 3.50	No change to current establishment – smaller unit principles applied and noting regional emergency dialysis unit status. 6 days of audit data were not submitted, therefore only 24 days audited (SNCT recommends 30 days). **Recommend increase Headroom to 22%**

4.2 Summary of Recommendations:

- Further investments required to increase budget uplift at 22% headroom particularly in high agency usage (Moreton, Lulworth, Purbeck) and to 25% for ED, increase substantive posts and offset agency use and spend to manage planned and predicted absence (Annual leave and Mandatory training) as well as those areas identified as Tranche 3 in the Headroom paper November 2025.
- Review of redeployment opportunities to right size bed and staffing capacity and in line with planned bed reconfigurations.
- Ongoing review and investment of Stroke staffing considering planned increased in HASU and Acute Stroke capacity, and in line with national Stroke Standards as measured by SSNAP Sentinel audit.

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- Review of e-roster to ensure nighttime staffing levels are strengthened.
- Completion of reviews for Critical Care and ED for assurance and noting the investment requirements for the New Hospitals Programme and to acknowledge NQB recommendations for CRCU & ED uplift of 25%, whilst RCEM recommends 27% for ED to support agency reduction, use of incentive payments and ensure “corridor care” is safe when used.
- SCBU business plan approved to meet the supervisory requirements in line with BAPM standards to support further reduction in off framework agency expenditure and the use of incentive payments. Currently being implemented.
- AH@H is not included as part of the SNCT Audit, however the recommendations of the Headroom paper also suggest increasing the Headroom to 22% and this will support staffing to increase and further manage patients in their own homes virtual to the Trust.

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5. Conclusion

5.1 There is a requirement by NHS England to submit information relating to Ward based Nursing Acuity and Dependency audits, recommended twice yearly. DCHFT nursing leads now have a clear and robust process in place to achieve this.

5.2 The Safer Nursing Care Toolkit is the recognised method for reviewing safe staffing at ward level and uses a triangulation of metrics to assist decision making and recommendations. The tool is not prescriptive and should be applied alongside the application of professional clinical judgement, which acknowledges ward type, number of single rooms and ward layout, skills and experience of staff, and enhanced care requirements.

5.3 In addition to the formal review, staffing levels, patient acuity and dependency, and effective utilisation of resources is discussed twice daily at the internal bed/operational flow meetings. Twice daily Safe Staffing meetings are in place to support the Divisions with immediate staffing requirements. Staff are requested to move area of work to ensure safe and effective care of our patients. This review is undertaken in conjunction with the Ward Sister, Matron and Divisional Head of Nursing and Quality responsible for that area.

5.4 The Trust has reviewed the acuity and dependency audits results for the adult inpatient ward areas and there are no recommendations for increase to establishments in this report. The Trust also remains within the expected limits of the Model Hospital data in relation to nursing and midwifery staffing.

5.5 The 2025/2026 scheme to embed safe staffing methodology was as follows:

- Embed Allocate ‘Safe Care’ to complete twice daily acuity and dependency utilising digital software to support and evidence movement of staff around the Trust and to support areas of greatest need, alongside care hours per patient day. Safe Staffing Lead implemented Safe Care project with all adult wards trained in the use of the tool and now needs to become business as usual.
- Ward dashboards continue to be developed
- To manage safe staffing via allocate and scrutiny of rosters.
- Encourage Safe Staffing Fellowship access by senior nurses – Deputy Director of Nursing substantive post holder has completed.
- Joint Head of Nursing, Professional Practice and Workforce with Dorset Healthcare appointed.

6. Recommendations

6.1 To acknowledge and accept the outcome of the Bi-Annual Safe Staffing Review 2025/26.

6.2 To acknowledge the uplift business case in headroom from **20.5 % to 22%** in inpatient areas and 25% for ED

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Trudy Goode, Lead Nurse Workforce and Safe Staffing, May 2026.

Dorset County Hospital
Dorset HealthCare

Finance and Performance Committee in Common Assurance Report for the meeting held on Wednesday 27 May 2026

Chair	Dave Underwood
Executive Lead	Chris Hearn – Joint Chief Financial Officer Rachel Small – Chief Operating Officer, DHC Anita Thomas – Chief Operating Officer, DCH
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Board Cross-referral for FPCiC to consider the constituent components of Better Payment Practice Performance and areas of non-compliance deferred to July 2026 due to system wide changes in procurement teams. • DHC Performance – continued challenge of LoS > 60 Days impacted by a cohort of complex long stay patients. CRFD running at 19% vs target of 7.5%. CYP Access exceeded plan at 104% and Urgent Community Response consistently exceeding activity and timeliness standards. • DCH Performance – Continued focus on improving flow and timely patient movement from ED. Ambulance handovers perform comparatively well regionally. RTT waiting list has reduced. • Medium Term Plan – NHSE Feedback received for both organisations – contract remain to be signed but are nearing finalisation. • Finance reports: challenge of significant unidentified CIP (£9M DHC & 29% DCH) to be fully identified by end Q1. • Corporate Risk Register – committee noted that several of the mitigations in the DCH register were, as presented, either out of date or restatements of the challenge rather than mitigations. The committee chair expressed a desire to find a work around that would provide a more robust basis for gaining assurance recognising the current limitations of the recording system that is due to be replaced later this year.
Key issues / matters discussed at the meeting	An informal committee meeting took place 29th April 2026 covering the following topics for discussion: • Productivity Overview – A summary of the 2025/26 NHS implied productivity metric, methodology, data limitations, performance to date and next step recommendations was received. While the methodology is well established, data limitations remain, particularly in community and mental health activity, SDEC coding variations, and the challenge of capturing quality of care improvements in output measures.

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- Discussion on the challenges of measuring the implied productivity in Mental Health & Community Trusts which is required for the first time under the 26/27 National Oversight Framework. Plans were considered to model current and future National Oversight measures (including any future productivity measure) for visibility of this performance in future.

DHC Performance Report

The committee accepted the report for assurance noting the following:

- 2025/26 outturn noted with 9 of 17 operating metrics achieved.
- Length of Stay remains a significant concern, particularly >60 days, with performance adversely impacted by a cohort of complex long-stay patients; clinically ready for discharge at 19% against a 7.5% target.
- NHS Talking Therapies delivery exceeded plan; however, reliable recovery rate remains challenged due to waiting times. Recovery planning is underway with NHS England and the ICB.
- Individual Placement Support performance has deteriorated due to funding, flow and recruitment challenges, impacting delivery.
- CYP Eating Disorders performance impacted by patient choice, Recovery plan in place with expected improvement over three months.
- CYP Access exceeded plan at 104%, noted as positive.
- Mental Health 2+ contacts show a declining trend reflecting ongoing service transformation, including caseload realignment.
- Diagnostic (DM01) performance below standard due to sustained demand and workforce pressures in Audiology; recovery plan in development, with resource requirements under review.
- Virtual Wards marginally below target, reflecting service variation and recent consultant vacancy; new appointment commencing June and system integration work underway.
- Community Hospital Average Length of Stay above target, driven by long-stay cohort; improvement activity ongoing with transition from Future Care Programme to internal oversight.
- Community waiting lists continue to grow, primarily in Audiology and MSK, with recovery actions managed through directorate processes.
- Community RTT transition from April noted, with performance expected to exceed the 78% standard.
- Urgent Community Response consistently exceeding activity and timeliness standards, noted as positive.

DCH Performance Report

The committee accepted the report for assurance with the following highlights:

- Strong year-end delivery against significant demand and winter pressures, including achievement of the 78% RTT and Type 1 ED standard.

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- Length of Stay improved pre-winter but remains above target following seasonal pressures. Recovery actions remain in place to restore trajectory.
- April performance impacted by industrial action and bank holidays; recovery achieved by month-end.
- 12-hour waits remain high, with some improvement noted. Continued focus on improving flow and timely patient movement from ED.
- RTT waiting list reduced; impact on 52+ week performance recognised due to denominator effects.
- Follow-up backlog remains below pre-COVID levels.
- Cancer: 31-day standard achieved; 62-day below target, with backlog reduction noted.
- Diagnostic performance improved, supporting recovery plans.
- ED flow remains challenged; ambulance handovers perform comparatively well regionally.
- Elective growth requirement for 2026/27 identified as a key risk; mitigation plans in place.
- Productivity stable overall; outpatient data subject to further validation.
- Non-elective Length of Stay elevated; recovery actions progressing.

Medium Term Plan NHSE Feedback

- NHS England feedback letters have been received for both organisations, with largely consistent themes across the system.
- CIP delivery and risk profile highlighted, with robust internal oversight arrangements in place.
- 2026/27 contracts remain unsigned across the system, but nearing finalisation.
- Financial controls strengthened, with further review of investment control processes underway.
- Dorset HealthCare: focus on NHS Talking Therapies trajectories, with discussions ongoing to agree an affordable plan.
- Dorset County Hospital: additional focus on productivity, with regional support for further analysis.
- Plans accepted subject to conditions, with oversight via regional and internal governance arrangements.

DHC Finance Report

- Month 1 position in line with plan, reporting a £366k surplus (£6k favourable).
- CIP delivery slightly below plan (£1.7m vs £2.0m), with improvement expected from Month 2.
- £9m unidentified CIP, with plans for full identification by end of Q1.
- Cost pressures in out-of-area placements offset by underspends and additional income.
- Financial Recovery Board oversight in place to manage delivery and risk.

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DCH Finance Report

- Month 1 deficit with £216k adverse to plan, driven by industrial action and bank holidays, with no confirmed mitigation funding.
- Budget phasing adjustments underway following zero-based review; stability expected from Month 2. Agency spend reduced but above plan; bank remains a pressure.
- CIP delivery broadly on track; 29% unidentified with Q1 resolution required. Focus on recurrent delivery continues.
- Cash ahead of plan due to timing benefits; close monitoring required.
- Capital broadly on plan, with variances reflecting timing only

Security (LSMS) Annual Report (Joint)

- Comprehensive update provided on compliance with national security response standards with a framework in place to support delivery.
- Violence and aggression reduction strategy progressing,
- Executive-led governance structure established, with senior leadership oversight and initial meetings commenced.
- Engagement underway with staff networks and partners to inform understanding of training effectiveness and support arrangements, particularly for higher-risk groups.
- Strategy to be further progressed through People and Culture Committee, ensuring alignment between operational standards and staff experience.
- Further detailed conversations amongst committee members about staff training rates and the targeting of staff groups with assurance provided on approach to training provision relating to security, violence and aggression. Additional detailed discussion on illicit substances brought onto NHS premises and the associated challenges.

Green/Net Zero Progress Report & Joint Green Annual Plan

- Sustainability progress is broadly on track, with Dorset HealthCare demonstrating stronger performance reflecting prior investment in solar and estate rationalisation; DCH position impacted by estate growth, with improvement expected as investment programmes progress.
- Waste and recycling targets achieved, supported by strong operational delivery and staff engagement.
- Joint working across both organisations strengthened, with increased multidisciplinary participation and system-wide initiatives progressing.
- Approximately 70% of planned actions delivered, with remaining activity focused on larger infrastructure schemes including EV transition, charging infrastructure, and solar/battery investment.
- Green Plan 2026–2029 developed with strong stakeholder engagement and aligned to NHS net zero targets (2040/2045)
- Key priorities in the plan include embedding sustainability in clinical practice and procurement and advancing staff engagement.

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- Notable progress since 2022 includes estate decarbonisation, digital transformation, clinical sustainability initiatives, and externally funded solar investment.
- Ambitious carbon reduction targets noted (80% by 2032), with delivery dependent on securing required capital investment.

Post Meeting Note: In addition to approving the Joint Green Plan based on the detailed summary paper and helpful discussion, committee members were sent the full plan post-meeting for comment which had not been included in the original committee paper pack. No further comments or objections to the approval of the plan were received.

Joint Estates Compliance Report

The committee received the report for assurance, noting that variation in compliance reflects differing reporting systems, with transition to a shared platform planned to improve consistency. DHC compliance is reported at 95% and DCH compliance at 71% which reflects challenges primarily within fire safety and emergency lighting, driven by estate complexity and ongoing asset validation. Fire risk assessment and fire door programmes are progressing on a risk-prioritised basis in partnership with the fire service, alongside wider asset verification and remedial activity, including window restrictors and emergency lighting. The PAM improvement programme continues to progress under strengthened joint governance arrangements.

Health & Safety (including fire and water) Compliance Report
DHC

The committee received the report for assurance, noting that it has been prepared in line with statutory requirements and reflects a structured "plan, do, check, act" framework covering monitoring, incident reporting, inspections and training; a strong reporting culture is evidenced with the majority of incidents classified as no or low harm, alongside low external reporting and non-clinical litigation levels. An increase in ligature incidents was noted and assurance provided on continued focus on ligature risk management and suicide prevention across services. Training compliance remains in place with additional emphasis on strengthening management capability, and fire safety governance has been enhanced in line with updated national guidance.

DCH

The committee received the report for assurance, noting that overall compliance remains strong with no red-rated areas and a small number of amber items reflecting ongoing validation activity under the newly appointed Health and Safety Manager. Continued progress noted across divisions in strengthening compliance. Targeted work is underway on COSHH arrangements, including training, support and external specialist

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input. Increased focus on staff safety incidents, particularly within security functions, with a review of training and support arrangements underway. A recent waste management incident has been fully reviewed, with remedial actions undertaken.

DCH SubCo Escalation and Performance report including Terms of Reference
The committee received the report for assurance, noting the transition to an expanded service with a broader outpatient remit and increased estate footprint. Workforce constraints, including recruitment and locum reliance, continue to limit the pace of expansion; Governance arrangements, including refreshed Terms of Reference and KPIs, have been strengthened to reflect the wider remit, Chair succession arrangements were also noted.

National Cost Collection Pre-Submission Report
The committee noted and supported the approach to preparing the 2025/26 national cost collection submission, which underpins key national benchmarks including the model hospital and reference cost index. A structured process and timeline are in place ahead of the July submission deadline.

Board Assurance Framework Assigned Risks
Committee members received the report for assurance. There is one score reduction for SR6 Finance at both DHC and DCH from 16 to 12 reflecting the 25/26 year end position and planning assumptions for year ahead. A full explanation and assurances were provided on overdue actions. A broader refresh of strategic risk wording and introduction of risk appetite statements has been undertaken.

Corporate Risk Register Assigned Risks
The DCH and DHC reports were summarised highlighting the high-risk areas, and assurance was provided on the mitigating actions as follows:

- Bed availability in mental health services (DHC)
- New Build Project (CAMHS HIE) poor subcontractor performance on delivery of mechanical, electrical and plumbing (DHC)
- ED Crowding (DCH)
- Prolonged Wait time in community Padeatircs

The following escalation reports from subgroups were received for assurance by the committee members:
The following were received for assurance without discussion:

- Joint:
  Financial Recovery Board
  DHC & DCH Sustainability Working Groups
- DHC:
  Capital Investment Meeting
  Efficiency Delivery Group

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	Emergency Planning & Resilience Group Health & Safety Group • DCH: Capital Planning and Space Utilisation Group Emergency Planning & Resilience Group Health & Safety Group Value Delivery Board
Decisions made at the meeting	Approvals by DCH and DHC committees: • Joint 2026/27 Green Annual Plan • DCH SubCo Terms of Reference • National Cost Collection Submission Approach (to complete in July 26)
Issues / actions referred to other committees / groups	• None

Quoracy and Attendance						
	27/05/2025					
Quorate?	**Y**					
Dave Underwood	Y					
Claire Lehman	Y					
Andreas Haimbock-Tichy	N					
Chris Hearn	Y					
Lucy Knight	Y					
Rachel Wharton	Y					
Anita Thomas	Y					
Rachel Small	N					

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Dorset HealthCare University
NHS Foundation Trust

Report to	Board in Common	
Date of Meeting	17th June 2026	
Report Title	Integrated Corporate Dashboard – April 2026	
Prepared By	Daniel Cunningham Corporate Performance Business Partner	
Approved by Accountable Executive	Chris Hearn Chief Finance Officer Rachel Small Chief Operating Officer	
Previously Considered By	Senior Leadership Group (draft) 20 May 2026	
Action Required	**Approval**	
	Assurance	Y
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand SR6: Finance	
Financial	Finance metrics for assurance.	
Statutory & Regulatory	Many of the metrics within the report are statutory or regulatory and so these are provided for assurance.	
Equality, Diversity & Inclusion	Completeness of Patient Ethnicity Data for assurance.	
Co-production & Partnership	No implication	

Executive Summary

This paper is to provide the Board with insight and foresight concerning Trust performance. It summarises key messages and the current position against the Trust strategic priorities. It aims to support effective decision making, highlighting key areas of exception and good practice.

This report marks the launch of a new approach to Board performance reporting from April 2026, aligned to NHS England's Insightful Provider Board guidance. The aim is to provide a clearer, more focused view of organisational performance, risk and improvement activity, with greater emphasis on the areas requiring Board oversight and assurance. The report has been a result of significant coproduction between clinical, corporate and operational areas in the Trust.

This revised Integrated Corporate Dashboard (ICD) will also use the Trust's strategic aims icons to make the link between performance, risk and strategy more explicit. This will help the Board to see how individual measures support delivery of safe, person-centred care; healthier communities; an empowered and thriving workforce; and sustainable use of environmental, financial and physical resources.

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16/06/2026 16:10:45

The report adopts a reporting by exception approach. Appendix A sets out the wider agreed metric set within scope of the ICD Board report, while the main body of the report focuses on the areas selected for exception reporting this month. Where a metric is shown as failing in the appendix but is not included as an individual exception report, this reflects that there has been no material change in performance or risk during the period. These metrics will continue to be monitored and will be reviewed through the rolling reporting cycle during the year, ensuring all areas of potential underperformance receive appropriate Board focus without repeating unchanged narrative each report. This will help highlight areas requiring more urgent oversight, the actions being taken, and how associated risks are being managed or mitigated. This approach has been planned and agreed via the appropriate governance forums internally and allows a more dynamic approach to board scrutiny and oversight, supported by real time data.

The transformation to the ICD goes beyond the physical board report itself. The monthly report included in the Board agenda will continue to provide the position as of the reporting month for the metrics in scope, however in addition to this underpinning and feeding the board report is a newly built ICD Power BI dashboard which will provide real time data for Board metrics in one place. The dashboard allows direct filtering of key Board metrics to enable more detailed live analysis e.g. of particular time periods or service areas, without a reliance on Business Intelligence Teams to produce information via new one off reports. **The key aim of this dashboard is to ensure connection between Board and front line teams around data,** as part of moving the trust from analogue to digital. Analysis of key data as a live concept to inform our day to day work within the organisation as well as the oversight and assurance of the board via the same source will support strong alignment between delivery and governance in the organisation. The same reporting logic, strategic alignment and exception-based view can be accessed more widely across the Trust by services and operational teams. This will support more timely review, ownership and action at all levels of the organisation.

The launch of the new approach in 2026 / 2027 has been agreed in two planned phases. Phase one, from April 2026, is the launch of the revised reporting format, the exception focused approach, and the Power BI dashboard for a number of key existing Board metrics. Phase two, aimed for launch from October 2026, will include additional capability such as the introduction of a live summary heat map in the Power BI dashboard, which will also be included at the start of the report. This will provide the Board with an at-a-glance view of areas requiring attention, mapped across the relevant reporting domains and strategic aims. The heat map will support the reporting by exception approach by helping to identify where performance, variation or risk requires further scrutiny, while also signposting the Board to the more detailed analysis provided later in the report. Phase two will also see some new metrics included which are currently under technical development (for example, predictive reporting for NOF metrics to allow for corrective action where required, as NOF metrics are currently published in retrospect by NHSE).

Fundamentally, the ICD has been transformed to ensure Board oversight continues to be firmly focused on what matters most for residents of Dorset using DHC services, but also further enables the board to understand and take action regarding exceptions, link data to the wider Trust strategy and regulatory environment, and strengthen the use of real time data as part of the Trust's digital journey.

Ellis Cara 10/06/2026 16:19:45

This report includes 19 metrics reported as an exception in April 2026 out of a total of 71 reportable performance metrics in scope of the ICD.

Recommendation
Members are requested to: • Receive the report for **assurance** • Note the areas where recovery plans are being developed.

Ellis,Kara
10/06/2026 16:10:45

Dorset HealthCare University
NHS Foundation Trust



Integrated Corporate Dashboard

April 2026

Ellis,Kara
10/06/2026 16:10:45

Introduction

Dorset HealthCare University
NHS Foundation Trust

Why we have transformed how we do Board reporting

This report marks the launch of a new approach to Board performance reporting from April 2026, aligned to NHS England's Insightful Provider Board guidance. The aim is to provide a clearer, more focused view of organisational performance, risk and improvement activity, with greater emphasis on the areas requiring Board oversight and assurance. The report has been a result of significant coproduction between clinical, corporate and operational areas in the Trust.

This revised Integrated Corporate Dashboard (ICD) will also use the Trust's strategic aims icons to make the link between performance, risk and strategy more explicit. Where relevant, reported areas will be mapped to one or more of the four strategic aims: Care, Communities, Colleagues and Sustainability, using the below symbols. This will help the Board to see how individual measures support delivery of safe, person-centred care; healthier communities; an empowered and thriving workforce; and sustainable use of environmental, financial and physical resources.



Ellis,Kara
10/06/2026 21:10:43

It is important to note that the ICD primarily reflects operational delivery, performance, risk and improvement activity. A separate organisational strategy dashboard is currently under development and will provide dedicated oversight of progress against delivery of the Trust strategy. The ICD should therefore be seen as complementary to this work, helping the Board understand how operational performance supports delivery of the Trust's strategic aims.

Introduction

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NHS Foundation Trust

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The report adopts a reporting by exception approach. Appendix A sets out the wider agreed metric set within scope of the ICD Board report, while the main body of the report focuses on the areas selected for exception reporting this month. Where a metric is shown as failing in the appendix but is not included as an individual exception report, this reflects that there has been no material change in performance or risk during the period. These metrics will continue to be monitored and will be reviewed through the rolling reporting cycle during the year, ensuring all areas of potential underperformance receive appropriate Board focus without repeating unchanged narrative each report. This will help highlight areas requiring more urgent oversight, the actions being taken, and how associated risks are being managed or mitigated. This approach has been planned and agreed via the appropriate governance forums internally and allows a more dynamic approach to board scrutiny and oversight, supported by real time data.

Some high-profile metrics will continue to be included in every Board report, particularly where they are nationally mandated, reflect key organisational risks, or require regular oversight. Other metrics will be reported on a cyclical basis, enabling the Board to maintain visibility across a wider range of subjects over time without making the report overly lengthy or repetitive. The report section headers are as per the NHSE Insightful Board guidance suggestion and have also been linked to the Care Quality Commission five key questions. In addition, where a metric forms part of the NHSE Medium Term Operational Plan (2026 – 2029), or the National Oversight Framework, this is noted in the metric summary box. At the time of writing, the NOF metrics for 2026 / 2027 are being finalised by NHSE therefore any reference to NOF performance is Q3 25 / 26 in this report. This will be refreshed following national publication of metrics for 26 / 27.

The transformation to the ICD goes beyond the physical board report itself. The monthly report included in the Board agenda will continue to provide the position as of the reporting month for the metrics in scope, however in addition to this underpinning and feeding the board report is a newly built ICD Power BI dashboard which will provide real time data for Board metrics in one place. The dashboard allows direct filtering of key Board metrics to enable more detailed live analysis e.g. of particular time periods or service areas, without a reliance on Business Intelligence Teams to produce information via new one off reports. **The key aim of this dashboard is to ensure connection between Board and front line teams around data,** as part of moving the trust from analogue to digital. Analysis of key data as a live concept to inform our day to day work within the organisation as well as the oversight and assurance of the board via the same source will support strong alignment between delivery and governance in the organisation. The same reporting logic, strategic alignment and exception-based view can be accessed more widely across the Trust by services and operational teams. This will support more timely review, ownership and action at all levels of the organisation.

Ellie.Jay 10/06/2026 16:20:13

Introduction

Dorset HealthCare University
NHS Foundation Trust

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The following pages outline how to use Statistical Process Control charts, and then includes the exceptions for the Board to consider for April 2026 reporting. Included at Appendix A is the full list of Board metrics that are within the scope of the ICD and included / being developed within the Power BI dashboard for reference. Appendix B includes the Safer Staffing summary report.

To note, in April 2026 falls assessments and VTE risk assessment timeliness metrics have fallen slightly short of the target in month, but an exception report is not included as this represents common cause variation. In respect of metrics on seclusion, restrain and rapid tranquilisation, all are reporting common cause variation and an exception report is not due in this month. The number of incidents has reduced in all restraint and seclusion metrics from March 2026 with the exception of rapid tranquilisation (0 to1) and supine restraint (3 to 5) which therefore remain within common cause variation.

Sylvia.kara 30/06/2026 13:10:45

Fundamentally, the ICD has been transformed to ensure Board oversight continues to be firmly focused on what matters most for residents of Dorset using DHC services, but also further enables the board to understand and take action regarding exceptions, link data to the wider Trust strategy and regulatory environment, and strengthen the use of real time data as part of the Trust's digital journey.

Understanding SPC Charts

Dorset HealthCare University
NHS Foundation Trust

Statistical Process Control (SPC) charts help distinguish between normal variation and meaningful change so the Board can focus on the issues that need attention.

What an SPC chart tells you

- The centre line shows the average level of performance
- The control limits show the range within which normal variation is expected
- A stable process will vary, but usually within those limits
- Special cause variation suggests something has changed and may need review, escalation or learning
- SPC is more useful than looking at one month in isolation because it shows the pattern over time

How to interpret the signals

Blue dots	Improvement or better-than-expected performance.
Orange dots	Potential concern or worse-than-expected performance.
Assurance icon	Whether the current process is capable of achieving the required standard consistently.

Assurance			Variation						
									
Consistently **Passes** target	Pass and fail target subject to random variation	Consistently **Fails** target	**Special Cause** Concerning variation either **Higher** or **Lower**		**Special Cause** Improving variation either **Higher** or **Lower**		**Special Cause** Neither improving nor concerning variation		**Common Cause**

Ellis Kate
10/06/2026 16:10:45

Why this matters for the Board: SPC supports better assurance by showing whether changes reflect expected fluctuation, a genuine deterioration, or sustained improvement.

Patient Safety Alerts Outstanding

Description of metric

Number of NHS England patient safety alerts outstanding in most recent monthly snapshot.

In Month: 1 **Threshold:** 0

The Trust was one day late responding to the national patient safety alert (NatPSA/2026/003/DHSC) relating to medication provided to induce labour in expectant mothers.

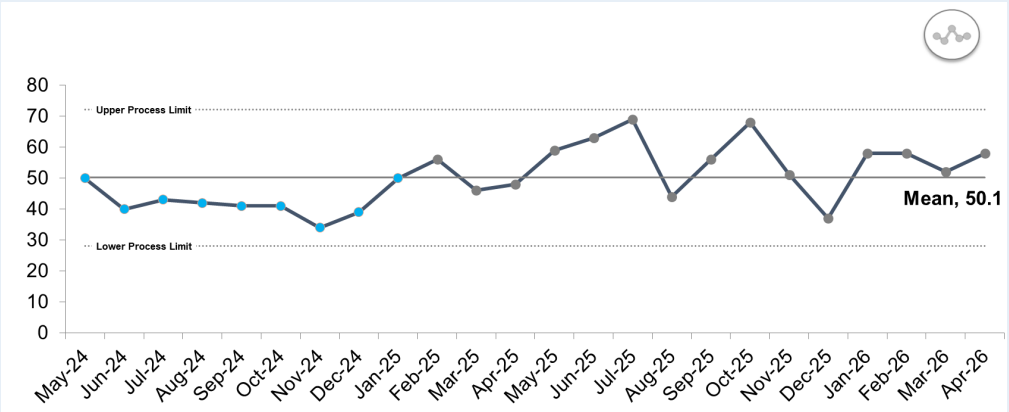
The Central Alerting System (CAS) is a database which notifies organisations of national patient safety alerts. Trusts are required to acknowledge these alerts, within 24 hours of issue, ascertain whether they are applicable to the Trust and if so to undertake the actions contained within the alert. Each alert provides a deadline by which the Trust must confirm whether the alert was not applicable, or where it was, that all actions have been completed. On this occasion, an alert was issued, however, the email notification to the Trust was not received. A member of staff was providing training to a colleague when the alert was identified, 24 hours after the deadline. The alert was immediately reviewed and a response submitted to CAS the same day.

The alert was reviewed and identified as not applicable to the Trust as it does not provide maternity services and the CAS system updated. Contact was made with the CAS provider to advise of missed email. The Trust has been advised to complete daily checks of the CAS system as a back up in the event of further issues receiving alert notifications.

Specific to this alert, there were no patient safety issues as the Trust does not deliver the service that the alert related to. New daily monitoring of the CAS system should prevent risk of reoccurrence. This has been included as an exception due to the threshold for missed / late alerts being 0.

Ellis Hall
10/06/2026 16:10:16

Complaints



Description of metric (in month figure)

Number of complaints received, both written and verbal, including any themes identified. (58)

The number of complaints that, the Parliamentary and Health Service Ombudsman has notified the Trust, have been referred to the Ombudsman. (1)

The number of complaints, both written and verbal, that have been reopened during the month. (4)

Thresholds: None

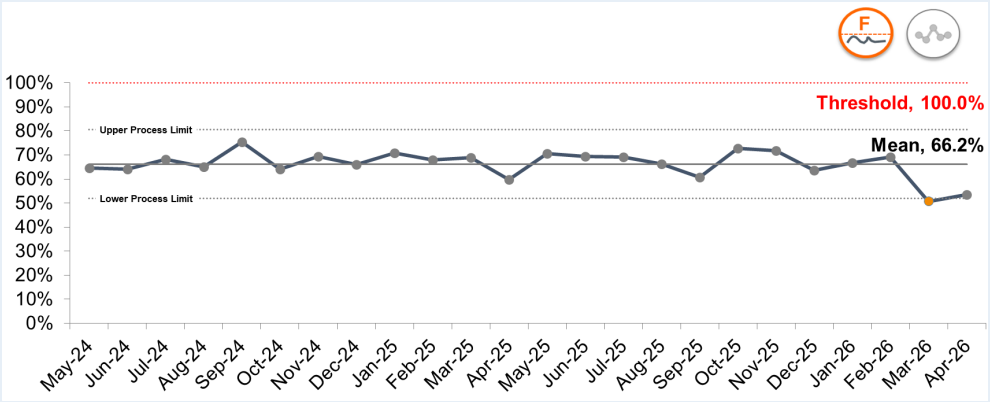
Complaint handling timeliness remains strong overall, with most cases completed within expected timeframes and performance remaining within the expected limits based on previous performance; however, it appears that increasing operational pressures are beginning to place strain on response times in some areas. Mental Health Services and the Integrated Urgent Care Service (IUCS) generated the highest volume of complaints, escalations, and reopened matters, highlighting the sustained operational pressures across urgent and community-based services. Recurring themes across these services included patient care, access to treatment, communication, appointment delays/cancellations, values and behaviours, admission/discharge processes, and clinical treatment.

An example of service learning highlighted the need to clearly obtain and document consent, communicate confidentiality limits from the outset, and ensure transparent information-sharing with young people and their parents. The service aims to improve communication with families and has shared the learning across teams to strengthen practice and prevent recurrence.

Currently, a threshold for complaints is being developed in order to define what constitutes an exception to performance, to inform future reporting. Until the threshold is set, the exception summary for complaints continues to be included.

Ellis-Jane
10/06/2026 16:10:45

Duty of Candour



Description of metric (in month figure)

Number of times duty of candour disclosure was initiated following incidents resulting in moderate, major or catastrophic harm.

In Month: 53.5% **Threshold:** 100%

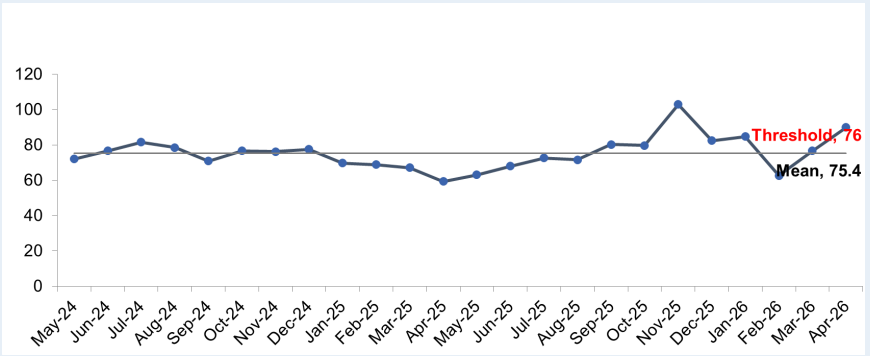
Reported compliance with Statutory Duty of Candour (DoC) is currently 52.6% against a target of 100%; as reported previously, this does not accurately reflect compliance with Statutory DoC due to limitations in Ulysses and the way the forms are designed for completion. This indicator is therefore flagging a data quality risk. The key issue was to improve the accuracy and transparency of Duty of Candour reporting, ensuring clear differentiation between Professional and Statutory requirements and full visibility of compliance with Regulation 20.

In recognition of the concerns regarding ability to accurately extract data previously, we have previously undertaken a randomised audit and for assurance for incidents that trigger moderate and above, there is a prompt to consider if Statutory DoC applies within the learning response templates. A further audit is currently in progress which will be submitted to Quality Governance Group on completion.

A system change to Ulysses, the Trust's risk system, was implemented on 21.05.26 which now enables clear differentiation between Professional and Statutory Duty of Candour, and the capturing of compliance across all four stages of the statutory process. Therefore, we will be in a position to report our accurate compliance on Statutory DoC for all patient safety incidents reported/submitted after the 21.05.26. Staff have been made aware of the changes with updated guidance and reminders regarding consideration of Statutory DoC.

Ellie Tara 10/06/2026 16:10:43

Length of Stay



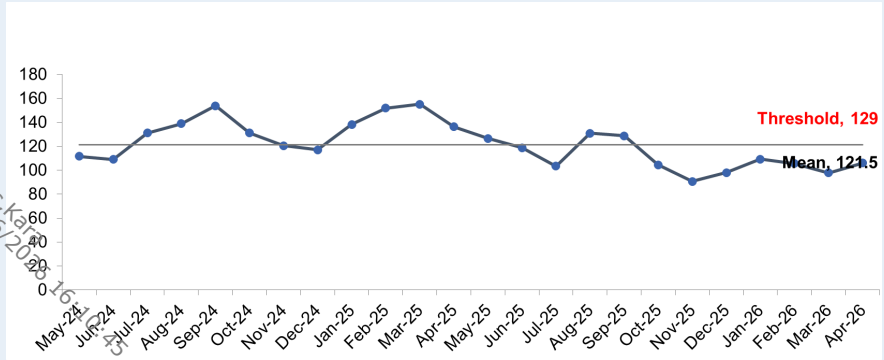
Average length of stay for patients in Adult Acute and Psychiatric Intensive Care Unit (PICU) Mental Health Beds

Medium Term Operational Planning & National Oversight Framework metrics

Description of Metric

The mean length of stay for anyone discharged in the reporting period. Three month rolling period.

In Month: 90 **Threshold:** 76



Ellis Kate
10/06/2026 16:14:43

Average Length of Stay for Patients in Older Adult Acute Mental Health Beds

Medium Term Operational Planning & National Oversight Framework metrics

Description of Metric

The mean length of stay for anyone discharged in the reporting period. Three month rolling period.

In Month: 106 **Threshold:** 129

Length of Stay

Narrative

Length of stay across both adult Acute and PICU wards and older adult acute wards remains above target for the National Oversight Framework metric. In respect of the Medium Term Operational Planning return, a trajectory has been set (shown as the thresholds in this report) for reducing ALOS month on month. For Adult and PICU beds, this is not compliant with the trajectory currently (90 versus 76), however for Older Adults, the Trust is currently performing ahead of the required trajectory . However, as it is not performing for the NOF metric as at the Q3 NOF published position, it has been included as an ongoing Board exception.

Ongoing work through the Peri hospital / Mental Health Therapeutic admissions programme has identified that the length of stay metric is predominantly increased by a small number of individuals who have an exceptionally long length of stay. Extended length of stay is clinically appropriate for a small minority of this group, however, many of this group have an extended length of stay due to challenges around provision of an appropriate discharge pathway either due to complexity/risk associated with the individual, or the lack of suitable accommodation.

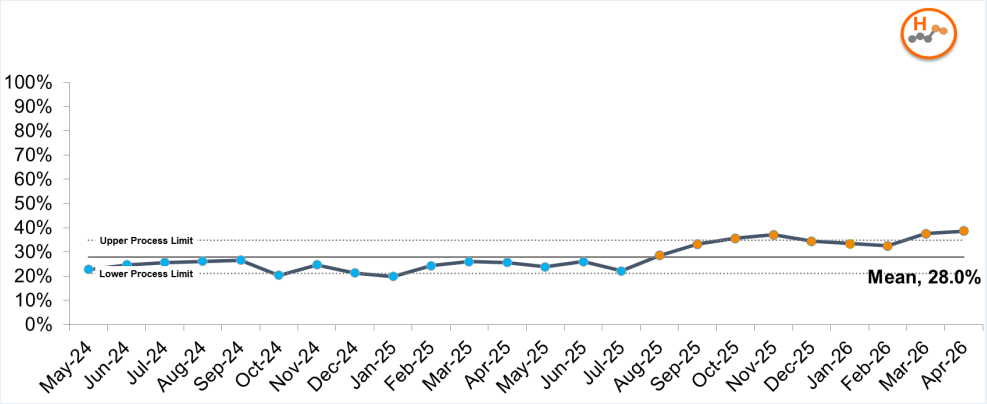
Reducing length of stay is a key outcome of the Perihospital / Mental Health Therapeutic Admissions programme which is one of the Trust's key transformation priorities this year. This is a system-wide programme addressing multiple elements related to patient flow. Dorset Healthcare is also part of the NHS England South West Mental Health Learning Improvement Network of which length of stay is a key focus.

All patients clinically ready for discharge are reviewed daily by senior leaders with a weekly system-wide Operational Flow group to address areas of delay that require escalation. Patients awaiting admission are reviewed daily and least restrictive options are prioritised wherever possible with the support of community teams.

There continues to be ongoing detailed assurance of the transformation programme delivery milestones reported to the Strategy, Transformation and Partnerships Committee in Common. The programme milestones due are on track and rated as green, however as delivery is mobilised of key pathway changes and processes these are not expected to take effect in respect of performance compliance until November 2026.

Ellis Kay
10/06/2026 16:40:53

Right to Reside



Medium Term Operational Planning Metric

Description of metric (in month figure)

Percentage of Occupied Bed Days where patients in Community Hospitals are marked as fit for discharge during the month.

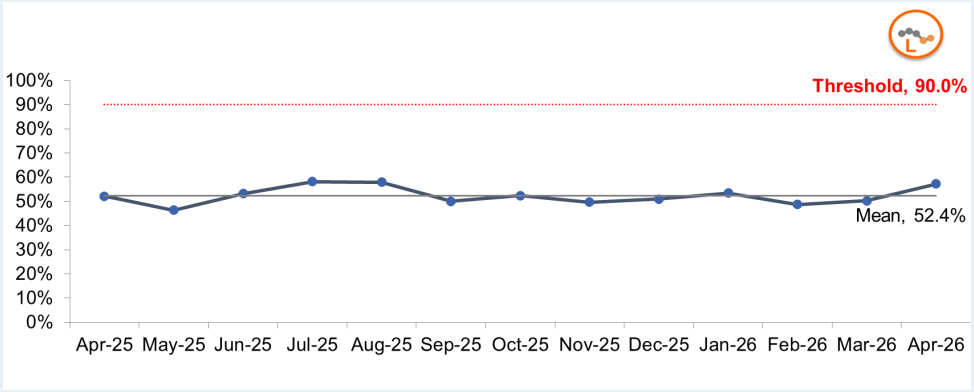
In Month: 38.6% **Threshold:** none

During April, the percentage of Occupied Bed where there was no Right to Reside was 38.6% with 75 inpatients having no right to reside at the end of the month. System escalation processes are in place to address inpatients with long No Criteria to Reside. Transfer of Care Hubs supporting and working with Social Care partners are in place with clear escalation triggers agreed amongst partners. East and West Weekly System Improvement Groups are also in place monitoring performance and implementing actions. In addition, an executive oversight escalation group has been introduced on a fortnightly basis between partners to review patients with complex barriers to discharge and longest length of stay. Currently, NCTR fluctuates on a day to day basis with some days within performance thresholds, but the overall monthly position is not and therefore further work is required on sustainable solutions with key partners including social care and housing.

Elissara 10/06/2026 16:10:43

Reduced patient flow through the Community Hospital beds leads to longer waits in acute hospitals. This is being actively managed within the system Transfer Of Care and Futurecare workstreams. Patients with longer No Criteria to Reside length of stay are at risk of healthcare-associated infections, falls and deconditioning whilst waiting discharge. This is mitigated by usual ward care practice and work is being implemented to monitor this.

Integrated Urgent Care Service (IUCS) Proportion of Clinical Call backs within agreed timeframe



Description of metric

Percentage of patients called back within agreed timeframe by the 111 Clinical Assessment Service (CAS).

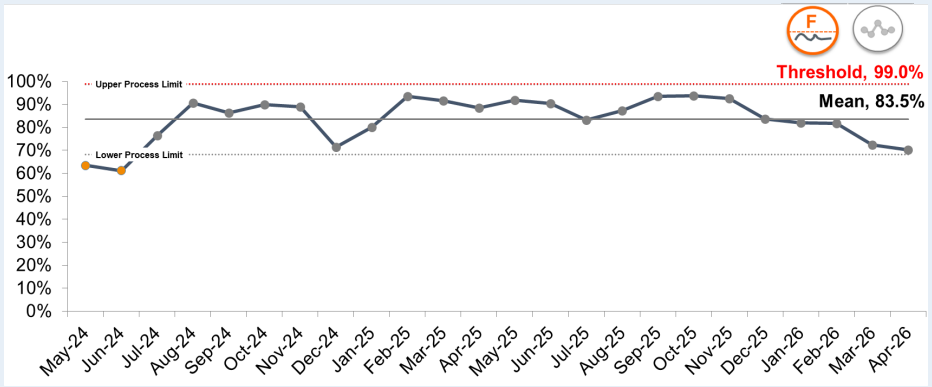
In Month: 54.2% **Threshold:** 90%

Performance increased to 57.2% in April. This is against the backdrop of a busy Easter period, two bank holidays and an urgent response to meningitis cases being identified in Dorset causing an increase in demand on 111. Whilst the Service continually benchmarks within the top quartile of national IUCS providers for this metric, akin with other providers it is not meeting the 90% target for call backs within the required timescale. This metric covers call backs of all urgency ratings as well as to online enquiries.

An ongoing programme of work is underway to improve performance, with options including reconfiguring the clinical workforce between NHS 111 and CAS and a proposed pilot initiative which aims to reduce the number of 20 minute cases reaching the call back queue due to be considered at Quality Governance Group shortly. The proposal includes modelling to underpin a recovery plan. In the meantime, risks to patient safety are actively mitigated through close live monitoring of delays by IUCS Clinical Shift Leaders, data analysis, performance reviews, a culture of learning and development across the service (including audits and After Action Reviews) and partner engagement to improve patient flow. This ensures clinical risk informs call back prioritisation in a dynamic way. The service have also been in discussion with the digital team, and a change request is being developed for a potential new IT system which will be better suited to 111, as the service is unlikely to be moving onto EPIC with the wider Trust.

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Maximum 6 week wait for diagnostic procedures



Medium Term Operational Planning Metric

Description of metric

Percentage waiting less than 6 weeks at the end of the month for specific diagnostic tests.

In Month: 70.3% **Threshold:** 99%

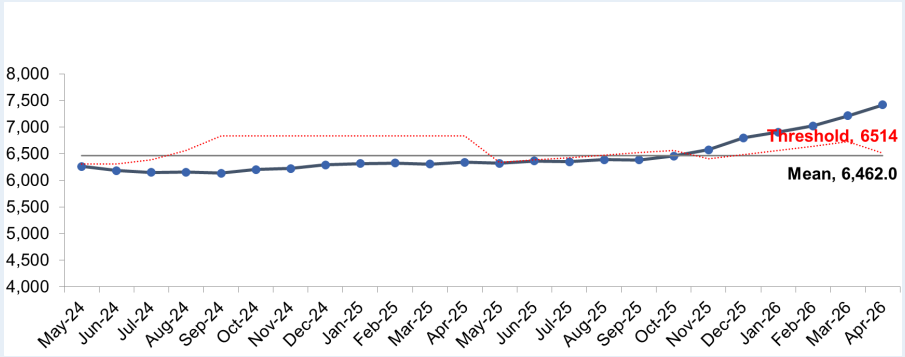
Performance has declined due to staffing availability. Audiology Compliance: 65.2%, 801/2,302 breaches (March 71.6%, 655/2,306 breaches). The Longest Waiter was 24 weeks (March longest waiter 20 weeks) this was due to an admin error; the referral was on the system but had not been added to the waiting list. One patient waited 13+ weeks in April (March 6 waiting 13+ weeks).

There is a growing backlog of patients, circa 200 per month added, waiting over six weeks for diagnostics, due to staff sickness, maternity leave, increase in referrals and some lost capacity due to the resources required for the Improving Quality in Physiological Services (IQIPS) accreditation process which recently took place. A recovery action plan has been developed proposing a range of costed options for recovery as well as a review of data taking place to ensure validity. This proposal is due to be reviewed at the Senior Leadership Group meeting in June 2026 for consideration and subsequent confirmation of associated recovery timescales.

Locum cover is in place although experience of available temporary staffing means that some internal training and development of those locums is required to meet service need. Clinical bank cover is supported through engagement with Southampton University students joining the bank once appropriately skilled and part-time staff undertaking additional hours. Clinical risk to patients is minimised through triage processes. There remains a risk to delay in patient care but no evidence of harm has been identified to date.

Ellie Kemp
10/06/2026 16:15:43

Children & Young People Access



Children & Young People (CYP) Access 1+ Contact, DHC Under 18s rolling 12 months

Medium Term Operational Planning and National Oversight Framework Metrics

Description of Metric

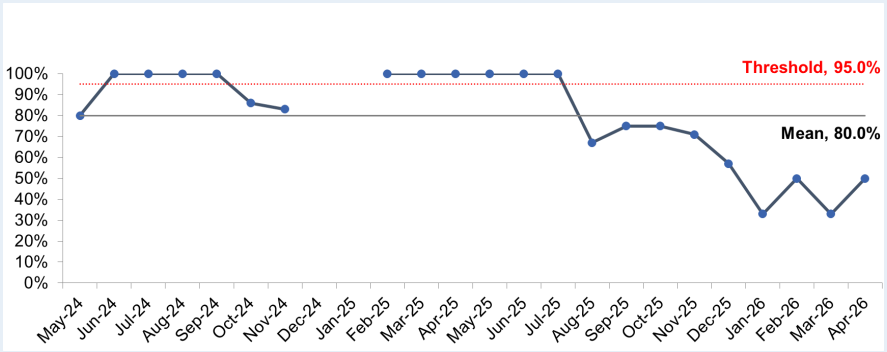
Number of CYP aged under 18 supported through NHS funded mental health with at least one contact (either direct or indirect) in the previous 12 months. 12 month rolling period.

In Month: 7,417 **Threshold:** 6,514

Performance for CYP access to mental health services remains above the overall threshold for 12-month rolling access, the service continues to meet national expectations for coverage and has significantly exceeded the recovery target and is therefore included to note the positive performance outside of previous process controls. This evidences the success of the recovery plan initiated in October 2025.

Ellis,Kara
10/06/2026 16:10:45

Children & Young People Eating Disorders (CYPED)

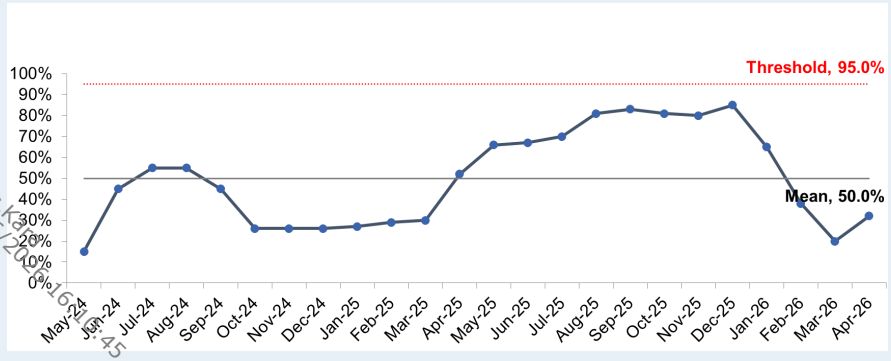


Urgent Referrals

Description of Metric

Proportion of referrals with eating disorders categorised as urgent cases entering treatment within one week in the reporting period, aged 0-18.

In Month: 50% **Threshold:** 95%



Routine Referrals

Description of Metric

Proportion of referrals with eating disorders categorised as routine cases entering treatment within four weeks in the reporting period, aged 0-18.

In Month: 32% **Threshold:** 95%

Ellis Kay
10/06/2026 16:45

Children & Young People Eating Disorders (CYPED)

Narrative

Performance is significantly below target across urgent and routine pathways: The CYP Eating Disorders has faced challenges in relation to staffing when attempting to meet the referral demand. A recovery plan is in development and will be presented to the Senior Leaders Group (SLG) in July 2026. The urgent pathway is affected when no urgent referrals are received in month as the metric is calculated based on a rolling 3-month period. In April there was one urgent referral which was seen within the seven day threshold for 100% compliance, resulting in 50% rolling period.

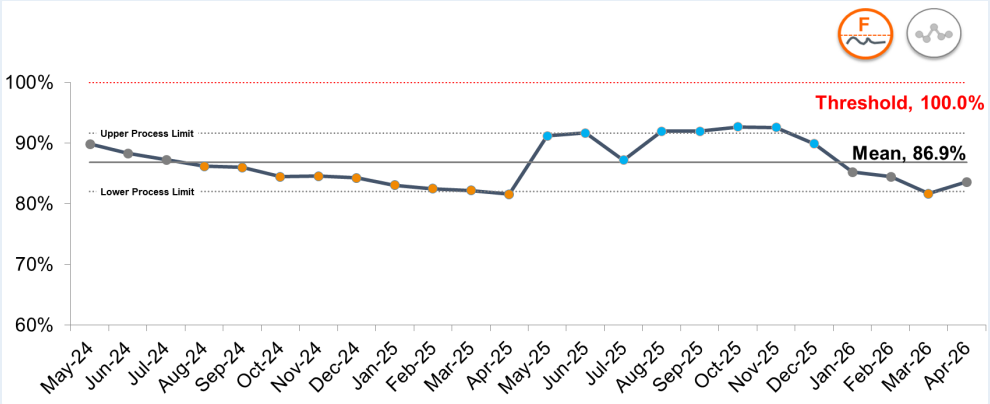
It is recognised that the routine compliance has declined, work is underway to improve the metric, without having to stop the clinically effective multi-family assessments. The multi-family assessment clinic runs once a week and two additional days for individual assessment appointments for both routine and urgent referrals. A significant number of patients opt for the multi-family assessment clinic resulting in patient choice impacting on the referral to treatment metric as some choose dates outside of the target time. Last minute cancellations by family to attend has impacted on capacity. A review of the frequency of the assessment clinics has been completed. The service has experienced an increase in referrals by 20% based on the same time period in 25/26, resulting in assessment clinic capacity not meeting the current demand.

The service has taken the following actions to address this:
- Additional clinic capacity implemented to support performance recovery, with a specific focus on increasing capacity in Dorchester
- Paediatrician input into duty twice weekly to strengthen screening and early signposting where appropriate
- All 18-year-olds referrals are now routed directly into the adult pathway for assessment, reflecting increased capacity within this pathway and seen within 28 days
- Admin team call patients on a Friday and prompt for Tuesdays Assessment Clinic reducing the risk of families cancelling at last minute

When clarity is needed relating to a new referral the Duty Team will contact the young person/family directly. The waiting list is being closely managed, a small proportion of longer waits are regularly contacted by phone and/or letter however are not engaging or responding to an offer of an assessment.

Ellis, Kara
10/06/2026 16:10:45

Completeness of Patient Ethnicity Data



Description of metric

The percentage of service users who have their ethnic category recorded on a source system and which can be used for reporting purposes.

In Month: 83.6% **Threshold:** 100%

Completeness of patient ethnicity data remains below the local target of 100%, creating a data quality risk and limiting full analysis of performance, access, experience and outcomes by ethnicity.

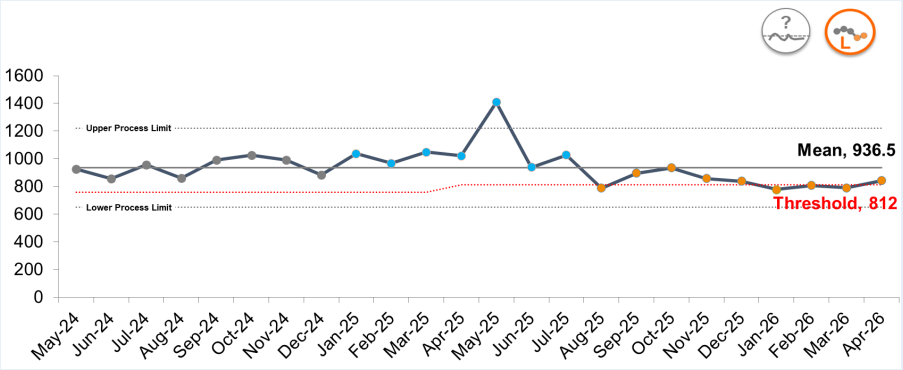
A specific issue has been identified within Health Visiting, where ethnicity for new-born babies may be recorded at source but is not flowing through extracts as expected. This may relate to an approximate six-week delay through GP, national and DiiS systems, although further investigation is required.

Work is underway to confirm the cause, including whether data is being captured in clinical system templates but not coded or extracted into reportable fields. A confirmed recovery timescale cannot yet be provided; this will be updated once the primary cause and corrective actions are confirmed.

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10/12/2025 16:18:45

This work supports future analysis by protected and other characteristics. In the interim, Trust priorities continue to be guided by national, regional and system intelligence, including the Patient and Carer Race Equality Framework and a focus on Gypsy, Roma and Traveller communities.

Talking Therapies



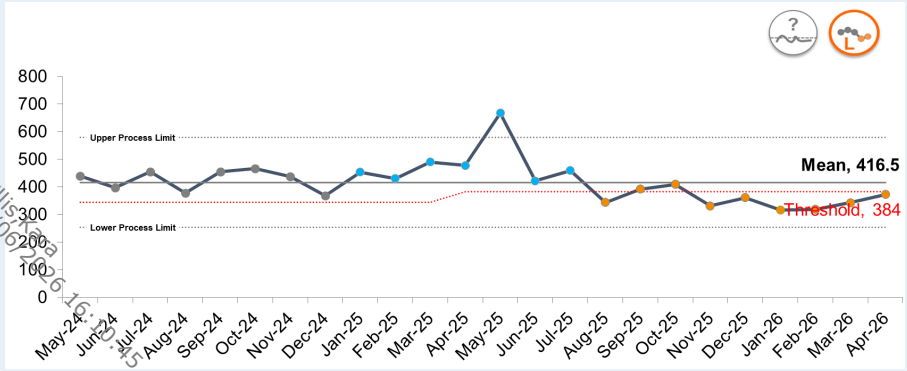
Courses of Completed Treatment

Medium Term Operational Planning Metric

Description of Metric

The number of people who have a course of treatment (2+ contacts).

In Month: 843 **Threshold:** 812



Reliable Recovery

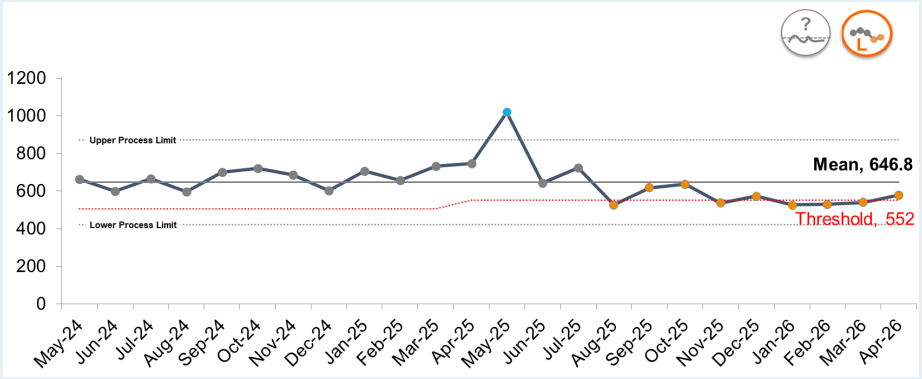
Medium Term Operational Planning Metric

Description of Metric

Number of patients that achieved reliable recovery.

In Month: 373 **Threshold:** 384

Talking Therapies



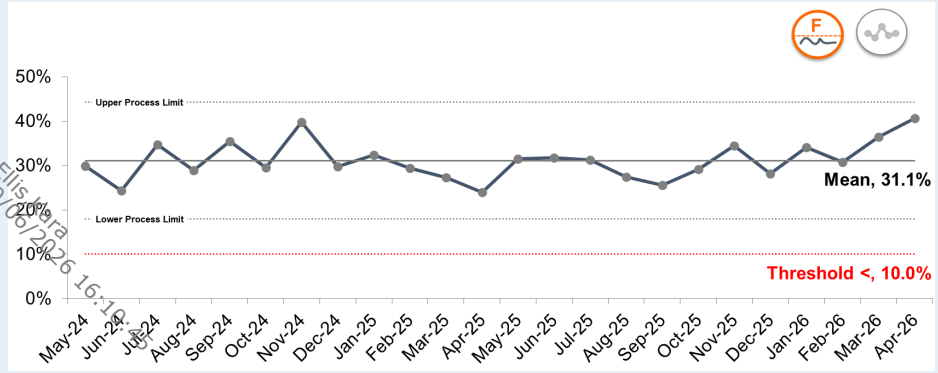
Reliable Improvement

Medium Term Operational Planning Metric

Description of Metric

Number of patients that achieved reliable improvement.

In Month: 579 **Threshold:** 552



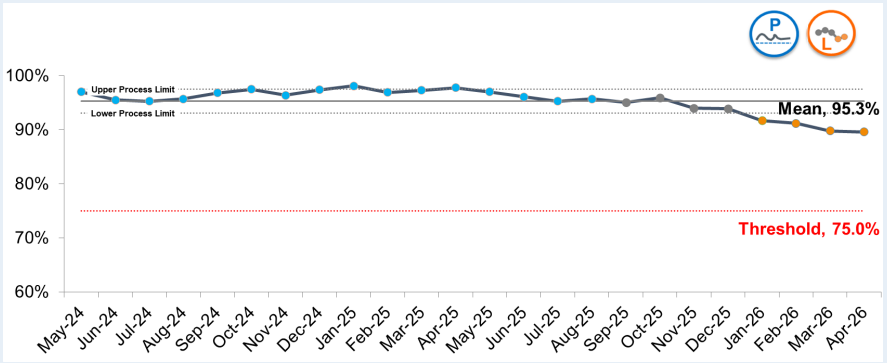
Talking Therapies 1st to 2nd Treatment

Description of Metric

The proportion of people who waited over 90 days between first and second treatment appointment (where the second treatment appointment occurred within the month) in the reporting period.

In Month: 40.6% **Threshold:** 10%

Talking Therapies



Talking Therapies Waiting Times - 6 weeks

Description of Metric

Proportion of referrals that finished a course of treatment in the reporting period that waited 42 days or less for first treatment.

In Month: 89.6% **Threshold:** 75%

Narrative

Courses Of Treatment

The courses of treatment threshold continues to be exceeded; however, the chart is showing special cause variation due to sustained below mean performance over the last nine months and therefore future compliance is at risk. The service is continuing discussions with NHS England to review whether the target should be brought into line with national fair share expectations for 2026/27 as it was increased substantially last year due to previous high performance on this metric in 2024, but expansion resources were not matched in line with this. The discussions to finalise the target for 26 / 27 remain ongoing currently.

Ellis.Jane
10/06/2026 16:10:45

Talking Therapies

Narrative (cont.)

Reliable Recovery

Reliable Recovery remains a concern and is showing special cause variation, with sustained below mean performance over the last nine months. This indicates a deteriorating position. The impact of the lack of expansion for 2025/26 has previously been outlined through the Board report and quality impact assessment. A recovery plan is therefore currently being developed for consideration at the Senior Leadership Group in June 2026.

The key issue is the interaction between current waiting lists, investment and the known relationship between longer waits and outcome measures. The service is reviewing improvement options within current resources. There remains a significant risk that the target will not be achieved if access targets remain the same. The intention is to increase dosage and reduce wait times with relevant funding and modelling has been shared with commissioners on the required resources.

Reliable Improvement

Reliable Improvement is meeting target, but performance is showing special cause variation due to sustained below mean performance over the last nine months. This should be treated as an emerging risk, as waiting times are correlated with both Reliable Recovery and Reliable Improvement outcomes. Conversations with NHS England and the Dorset system are ongoing as outlined above.

Ewa Kara
10/06/2026 16:10:45

Talking Therapies

Narrative (cont.)

1st to 2nd Treatment

This indicator remains above the 10% target. Performance has deteriorated over the last two months and is now above the mean, indicating increased pressure on access. Waiting list improvement is variable, with some interventions and localities reducing waits over the last six months while others have increased. The main pressure remains within High Intensity (HI) individual interventions, where demand and workforce capacity continue to affect waiting times. The focus on offering least intrusive interventions is currently being revisited following a significant increase in the percentage of patients entering HI individual interventions (those with the longest waiting times). Service finances has meant that support from external providers have been reduced, impacting on wait times. Additional funding for this is currently being explored.

Other initiatives such as adherence to the new attendance policy and reviewing treatment in supervision is ongoing. NHS England funding for trainees was received in 2025/26; however, it will be Q3 and Q4 of 2026/27 before these staff are at full clinical capacity. With a 13.7 WTE vacancy for High Intensity and 6.3 WTE Low Intensity vacancy that cannot be recruited to due to the temporary nature of these vacancies (maternity, secondments, career breaks etc). A lack of HI CBT bank staff availability and agency controls mean that this is a risk to reducing the HI CBT waiting list. Recovery of this metric would need to follow the recovery modelling underway for the core operational planning metrics (completed treatments, reliable recovery and reliable improvement).

Ellis Kirk
10/06/2026 16:10:43

6 week wait

The 6 week wait target continues to be achieved; however with performance reducing, dipping below the lower process limit. This is not a target failure, but it indicates an emerging risk if demand, capacity and workforce pressures continue. The service has identified the localities where performance has dipped, this is related to staffing and capacity being below what is required to run the services. This is being discussed with NHS England and the ICB.

Finance

Metrics	In Month	YTD	YTD Threshold
Cash Balance	41,035	41,035	46,100
Capital Expenditure	1,059	1,059	6,300
Financial efficiency : variance from efficiency plan	315	315	2,001
Financial stability : variance from NHSE plan	-6	-6	-360
Better payment practice code	97.6%	97.6%	95.0%

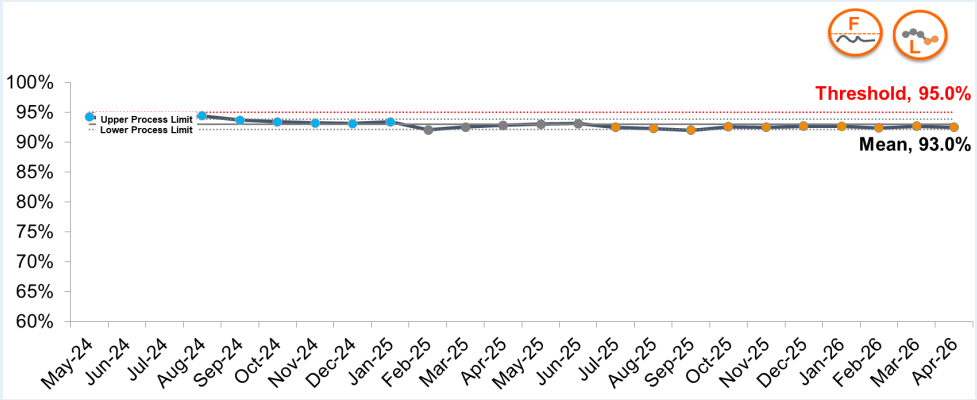
National Oversight Framework

The cash balance is below plan by £5,100k due to the repayment of £2.9m to NHSE in respect of the New Hospital Programme slippage and the reduced payment of 2024/25 outstanding Dorset County Hospital (DCH) debt. Due to the level of cash held any risk is minimal, but constant monitoring of the position will identify any issues.

The capital expenditure is below plan by £5,241k due to slippage of the New Hospital Programme, as handover of St Ann's and the CAMHS unit are both delayed until June 2026. All risks are managed at programme level and the programme remains on financial target.

Ellis.Kay 10/06/2026 10:45

Mandatory Training Completed



Description of metric

Percentage of staff at month end having completed the Mandatory training requirements, as set nationally by the UK Core Skills Training Framework (2013). The required level of training is dependant on profession and workplace, and staff group requirements are decided locally.

In Month: 92.5% **Threshold:** 95%

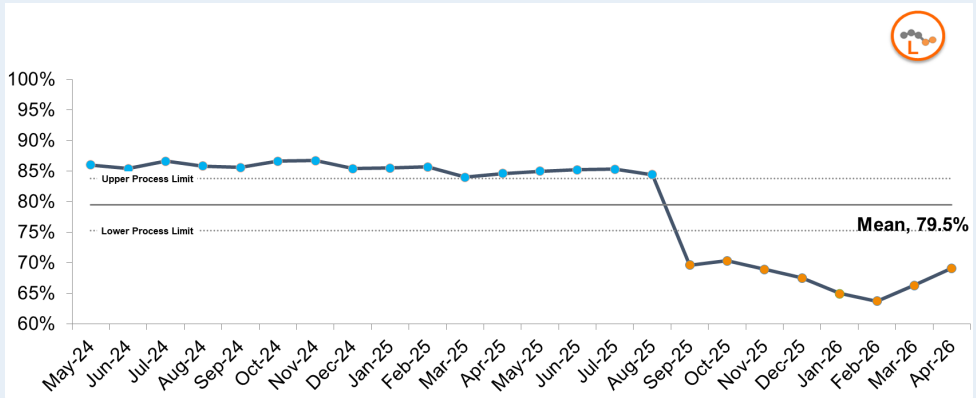
Mandatory training compliance saw a minimal decrease of 0.2% this month to 92.5%. This remains beneath the current compliance target of 95% and slightly lower than this time last year. There are many potential contributing factors for this including reduced access to essential training such as Basic Life Support/Emergency Life Support due to trainer absence, annual leave and annual leave cover, increased workload due to other compliance activity and the response to the meningitis outbreak major incident.

Access to managers dashboards, director reports and individual reminders are all in place to assist with increasing compliance. Planned training sessions and booked attendance are all indicative that there will be an increase in the next quarter. Sustained below target compliance could suggest a reduced assurance the staff have required understanding of statutory subjects which could present a risk to patients; however, it is important to note the national statutory mandatory review and new mandatory training framework are moving away from compliance targets and focusing more on patient outcomes.

A co-ordinated approach to include patient incidents against patient outcomes should be considered alongside compliance for a full picture in future.

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Completed Appraisals last year



Description of metric

Percentage of Staff having recorded an appraisal conversation within the past 13 months.

In Month: 69.1% **Threshold:** None

Since the introduction of the new appraisal recording process and platform we had seen a steady decline of completion rates across the trust. The March data showed the first increase of 2.5% in completions with compliance at 66.3%. The latest data for end of April shows a further increase of 2.9% from last month to give a current compliance of 69.12%. To achieve the Trust's target of ≥85% appraisal completion a Recovery Plan has been developed, a stakeholder workshop (23 March) took place was informed by a pre-circulated questionnaire. Feedback led to a focused action plan monitored at the Senior Leadership Group meeting. Key system improvements implemented include clearer sign-off process, defined mandatory vs. optional form elements, simplified, less text-heavy forms, and reduced and streamlined system screens.

Further activity to support recovery of compliance rates includes: guidance available via short video and interactive materials; MS Teams drop-in sessions; fortnightly reports to Service Directors highlight outstanding appraisals enabling targeted oversight; eHub manager dashboard provides real-time appraisal status across teams; ongoing multi-channel communications emphasising the need to complete all outstanding appraisals; and regular monitoring through Directorate Management Groups via HR Business Partners.

Ellis.Kane 10/06/2026 16:09:36

Quality

Metrics	In Month	Target	Assurance	Variation
Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infections (blood stream infection)	0			
Clostridioides difficile infections	1			
E. coli bloodstream infections	0			
Other significant HCAI – number of patients affected	0			
NHS England Patient Safety Alerts Outstanding	1	0		
Patient Safety Events (excludes falls & all no/low harm)	71			
Falls on inpatient wards per 1,000 OBD	6.2			
Medication incidents	82			
Violent incidents - patient on patient in hospital	43			
Falls Assessment within 24 hours	93.0%	95.0%		
Venous Thromboembolism (VTE) risk assessment within 24 hours	92.6%	95.0%		
Pressure ulcer risk assessments (Purpose T) within 6 hours	97.5%	95.0%		
MUST risk assessment within 24 hours	95.6%	95.0%		
ICS in-patients not feeling safe	0.0%			
MH in-patients not feeling safe	9.1%			
Friends & Family Test - positive experience feedback	91.8%	95.0%		
Number of complaints	58			
Number of complaints with Ombudsman involvement	1			
Reopened complaints	4			
Duty of Candour	53.5%	100.0%		
Patients reporting being involved in their care	94.4%			
Category 4 pressure ulcers acquired in our care (DHC)	0			
Admissions to adult facilities of patients who are under 16 years old	0			
Average length of stay for patients in Adult Acute and PICU Mental Health Beds	90	76		
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds	106	129		
Right to reside (CHS)	38.6%			
Prone Restraint (Adult)	2			
Supine Restraint (Adult)	15			
Seclusion (Adult)	0			
Rapid Tranquilisation (Adult)	6			
Prone Restraint (<18 y.o.)	0			
Supine Restraint (<18 y.o.)	5			
Seclusion (<18 y.o.)	0			
Rapid Tranquilisation (<18 y.o.)	1			

Ellis,Kara
10/06/2026 16:10:45

Access and Targets (performance)

Metrics	In Month	Target	Assurance	Variation
IUCS Proportion of Clinical Call backs within agreed timeframe	57.2%	90.0%		
Community Waiting List sitrep - numbers waiting over 52 weeks	0	0		
Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	80.4%	70.0%		
Maximum 6-week wait for diagnostic procedures	70.3%	99.0%		
Children & Young People (CYP) Access 1+ Contact, DHC Under 18s rolling 12 months	7,417	6,514		
Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact with an MHST	1,783	1,797		
CYP MH Waits over 104 Weeks	756	1,055		
Children & Young People Eating Disorders (CYPED) Urgent - 1 week rolling 3 month	50.0%	95.0%		
Children & Young People Eating Disorders (CYPED) Routine - 4 weeks rolling 3 months	32.0%	95.0%		
Completeness of Patient Ethnicity Data	83.6%	100.0%		
Dementia Diagnosis Rate	57.6%	66.7%		
Serious Mental Illness (SMI) Physical Health Checks	73.0%	75.0%		
Number of women accessing (1+ contact) specialist community PMH and MMHS services in the previous 12 months	684	687		
Meet the existing commitments to expand Individual Placement Support	542	699		
Health Visiting - 6 to 8 Weeks visit	93.4%	95.0%		
Health Visiting - 10 to 12 Months Visit	94.0%	95.0%		
Health Visiting - 24 to 28 Months Visit	91.2%	95.0%		
Health Visiting - Antenatal Visits	96.0%	95.0%		
Health Visiting - New Birth Visits within 14 Days	85.7%	95.0%		
Health Visiting - New Birth Visits within 30 Days	99.1%	98.0%		
CiC Review Health Assessments	76.5%	90.0%		
CYP SALT - 18 Week RTT	97.4%	95.0%		
Health Visiting - Data quality percentage of infants feeding status at 6-8wks	61.9%	50.0%		
Percentage of children who received a 2-2½ year review using Ages and Stages Questionnaire (ASQ-3) who were at or above the expected level of development in all five domains	76.9%	95.0%		
Talking Therapies Courses of Treatment	843	812		
Talking Therapies Reliable Recovery	373	384		
Talking Therapies Reliable Improvement	579	552		
Talking Therapies 1st to 2nd treatment	40.6%	10.0%		
Talking Therapies Waiting Times - 6 weeks	89.6%	75.0%		
Virtual wards bed occupancy rate	71.3%	80.0%		
Community Mental Health (CMH) 2+ Contacts, Local Provider Data rolling 12 months	9,016	9,526		
Southampton Priory Placements - Appropriate Out of Area Placements (number of active placements at end of month)	7			
Out of Area Placements - Inappropriate Placements (active placements at end of month)	2			

Ellis,Kara
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Finance

Metrics	In Month	YTD	YTD Threshold
Cash Balance	41,035	41,035	46,100
Capital Expenditure	1,059	1,059	6,300
Financial efficiency : variance from efficiency plan	315	315	2,001
Financial stability : variance from NHSE plan	-6	-6	-360
Better payment practice code	97.6%	97.6%	95.0%

People

Metrics	In Month	Target	Assurance	Variation
Mandatory training completed	92.5%	95.0%		
Completed Appraisals last year	69.1%			
Employee Relations cases (current live cases)	58			
Staff turnover (monthly)	0.4%			
Leaver rate	6.6%			
Vacancy rate	8.3%			
Sickness absence rate (monthly)	4.7%			

Strategy - Overall Delivery

Metrics	In Month	Target	Assurance	Variation
NHSE System Oversight Framework - Segment	2			
Overall CQC Rating	Outstanding			
CQC Well Led rating	Outstanding			

Please note that Staff Pulse Survey results are reported to the Board separately via a dedicated report on a quarterly basis and are therefore not included within this appendix. Temporary workforce reporting and clinical supervision rates reporting is currently in development and will be incorporated in a future iteration once available.

For any metrics that do not currently have a commissioned, contractual, national or local target, an internal review is underway to consider whether identifying a specific target would add value to the board assurance process for metrics in question.

Ellis,Kara
10/06/2026 16:10:45

Safer Staffing Summary

This information is reported to the monthly Safer Staffing Forum and Quality Governance Group, with escalation to the Quality Committee in Common, as required. Detailed staffing data is provided in the monthly *Right Staffing Report.*

Staffing Challenges

Workforce data and staff feedback indicate that safer staffing levels continue to be impacted by vacancies and sickness absence for reported teams. 'Anxiety/stress/depression/other psychiatric' continues to be the leading cause of sickness absence.

Staffing Incidents

Staffing-Related Incidents: A total of 37 staffing incidents were reported across all clinical teams. There were 32 categorised as no Harm, four as minor non-permanent harm, and one prevented. Based on the information available, the identified red flags and impacts on patient and staff experience have been grouped into themes:

Impacts on patient care and experience/Red Flags

- Delays in meeting patients' needs, including medication management
- Delays to assessment by an Allied Health professional impacting engagement and meaningful activity
- Reduced services, limiting the capacity to deliver the full range of operational hours

Impacts on staff experience included

- Inability to take rest breaks and increased workloads due to higher patient acuity and complex dependency needs
- Redeployment against the professional judgement of the nurse in charge
- Working excess hours
- Cancelled training

Ellis,Kara
10/06/2026 16:10:45

Fill Rate Analysis

Hospital Site Details		Ward Name	Specialty 1	Day				Night			
Site code	Hospital Site name			Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nursing associates (%)	Average fill rate - non-registered nursing associates (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nursing associates (%)	Average fill rate - non-registered nursing associates (%)
RDYEY	WESTMINSTER MEMORIAL HOSPITAL	Ashmore/Shaston Ward	314 - REHABILITATION	100.6%	94.8%	-	N/A	100.0%	100.0%	-	-
RDYFC	YEATMAN HOSPITAL	Beech Ward	314 - REHABILITATION	92.0%	89.4%	-	-	97.1%	90.0%	-	-
RDYEJ	BRIDPORT COMMUNITY HOSPITAL	Colmers Ward	314 - REHABILITATION	98.4%	93.9%	-	N/A	100.6%	71.3%	-	-
RDY22	ALDERNEY HOSPITAL	Guernsey Ward	314 - REHABILITATION	74.5%	94.3%	N/A	-	100.0%	123.3%	-	-
RDYFE	VICTORIA HOSPITAL W'BORNE	Hanham Ward	314 - REHABILITATION	100.4%	95.9%	N/A	-	100.0%	96.7%	-	-
RDY22	ALDERNEY HOSPITAL	Jersey Ward	314 - REHABILITATION	85.9%	77.1%	-	-	98.3%	100.0%	-	-
RDYEG	WESTHAVEN HOSPITAL	Radipole Ward	314 - REHABILITATION	111.1%	86.9%	N/A	N/A	94.4%	94.8%	-	-
RDYFC	YEATMAN HOSPITAL	Rowan Ward	314 - REHABILITATION	95.5%	89.1%	N/A	N/A	96.7%	87.4%	-	-
RDYFD	SWANAGE COMMUNTIY HOSPITAL	Stanley Purser Ward	314 - REHABILITATION	106.2%	89.2%	-	-	100.4%	100.3%	-	-
RDYFF	BLANDFORD COMMUNITY HOSPITAL	Tarrant Ward	314 - REHABILITATION	102.6%	96.4%	-	N/A	100.0%	101.7%	-	-
RDYFC	ST ANN'S HOSPITAL	AAU Seaview	710 - ADULT MENTAL ILLNESS	89.8%	99.8%	-	-	87.4%	109.6%	-	-
RDY10	ST ANN'S HOSPITAL	Alumhurst Ward	710 - ADULT MENTAL ILLNESS	96.7%	101.1%	-	N/A	95.1%	103.6%	-	N/A
RDY10	ST ANN'S HOSPITAL	Chine Ward	710 - ADULT MENTAL ILLNESS	86.1%	109.6%	-	N/A	97.1%	125.0%	-	N/A
RDY10	NIGHTINGALE HOUSE	Florence House	710 - ADULT MENTAL ILLNESS	81.7%	124.2%	-	-	103.3%	103.3%	-	-
RDYFX	MAIDEN CASTLE HOUSE	Glendinning Unit	710 - ADULT MENTAL ILLNESS	104.8%	123.9%	-	-	106.7%	107.0%	-	-
RDYFT	ST ANN'S HOSPITAL	Harbour Ward	710 - ADULT MENTAL ILLNESS	93.1%	171.9%	-	N/A	100.0%	198.5%	-	-
RDY10	ST ANN'S HOSPITAL	Haven Ward Female	928 - MENTAL HEALTH REHABILITATION	102.9%	107.4%	-	N/A	100.0%	148.4%	-	-
RDY10	ST ANN'S HOSPITAL	Haven Ward Male	928 - MENTAL HEALTH REHABILITATION	127.9%	89.0%	-	N/A	103.3%	99.8%	-	-
RDY10	ALDERNEY HOSPITAL	Herm Ward	715 - OLD AGE PSYCHIATRY	98.1%	94.6%	-	-	100.0%	110.4%	-	-
RDY22	KIMMERIDGE COURT	Kimmeridge Court	710 - ADULT MENTAL ILLNESS	67.6%	90.2%	-	N/A	62.2%	176.6%	-	-
RDYEG	FORSTON CLINIC	Melstock House	710 - ADULT MENTAL ILLNESS	103.9%	95.6%	-	N/A	193.3%	96.7%	-	-
RDYFX	NIGHTINGALE HOUSE	Nightingale House	710 - ADULT MENTAL ILLNESS	121.8%	95.3%	N/A	-	100.0%	113.4%	-	-
RDYFX	PEBBLE LODGE	Pebble Lodge	711 - CHILD AND ADOLESCENT PSYCHIATRY	87.3%	97.1%	-	N/A	101.7%	99.1%	-	-
RDYMR	ALDERNEY HOSPITAL	St Brelades Ward	715 - OLD AGE PSYCHIATRY	95.4%	121.1%	N/A	-	100.0%	153.7%	-	-
RDY22	ST ANN'S HOSPITAL	Twynham Ward	712 - FORENSIC PSYCHIATRY	72.5%	94.3%	N/A	N/A	78.8%	115.0%	-	-
RDY10	FORSTON CLINIC	Waterston AAU	710 - ADULT MENTAL ILLNESS	83.1%	112.1%	-	N/A	95.1%	155.0%	-	N/A

Overall Position

Analysis of planned versus actual nursing hours across community hospital and mental health inpatient wards shows that average Registered Nurse fill rates remain within the KPI range of 90–120% for both day and night shifts. Mental Health Support Worker fill rates exceeded the upper KPI threshold during night shifts, reflecting the need for enhanced care and the substitution of second Registered Nurse duties with Support Workers

Fill rates exceeding 120% reflect:

- Increased care needs requiring additional staff
- Backfilling of the second RN role with a MHSW
- Agreed adjustments to demand templates to ensure safer staffing in specific environments (Waterston, Haven Female, Chine).

Ellie Ayara
10/06/2026 16:17:45

Community Hospital Wards - Exceptions Wards - Exceptions

- Beech: The HCSW fill rate fell below 90% on day duty (89%). 54% of temporary staffing requests were filled.
- Radipole: The HCSW fill rate fell below 90% on day duty (87%) due to ongoing vacancies and sickness absence. 71% of temporary staffing requests were filled.

- Rowan: The HCSW fill rate fell below 90% on day (89%) and night duty (87%) due to sickness absence. 55% of temporary staffing requests were filled.
- Stanley Purser: The HCSW fill rate fell below 90% on day duty (89%) due to sickness absence. 78% of temporary staffing requests were filled.

The overall fill rate for RNs was 97% on day duty and 99% on night duty. For HCSWs 91% on day duty and 95% on night duty.
No incidents were reported in which staffing levels adversely affected patient safety.
Jersey and Guernsey show RN fill rates below 90%. The wards have recently reduced their bed numbers and are now working to a lower planned staffing model. eRoster is still reporting against the previous planned staffing levels, and work is underway to update the system to reflect the revised establishment.

Mental Health Inpatient Wards – Exceptions

- AAU Seaview: RN fill rates were below 90% on night duty (87%). There is maternity leave and long-term sickness absence. The ward manager has also provided professional judgement that there are several nursing staff who for various reasons including flexible working and occupational health advice, cannot work night shifts.
- Chine: RN fill rates were below 90% on day duty (86%). Sickness absence was high and there are vacancies for RNs and MHSWs.
- Florence House: RN fill rates were below 90% on day duty (82%) due to sickness absence.
- Haven Male: MHSW fill rates were below 90% on day duty (89%) due to overall unavailability of SWs (sickness absence, annual leave, study leave, maternity leave etc).
- Kimmeridge Court: RN fill rates fell below 90% on both day (68%) and night duty (62%), primarily due to sickness absence and vacancies.
- Pebble Lodge: RN day-duty fill rates fell below 90% (87%), primarily due to sickness absence and vacancies.
- St Brelades: Currently in safer staffing measures. Fill rates were within KPI parameters for RNs and exceeded 120% for MHSW on days (121%) and nights (154%).
- Twynham: RN fill rates were below 90% on both day (72%) and night duty (79%) due to vacancies and maternity leave.
- Waterston: RN day-duty fill rates fell below 90% (83%), due to vacancies and sickness absence.

The overall fill rate for RNs was 91% on day duty and 96% on night duty. For MHSWs, 105% on day duty and 125% on night duty.
No incidents were reported in which staffing levels adversely affected patient safety.
Registered Nurse block bookings are currently in place at Harbour, Haven Male, St Brelades and Waterston. These bookings are regularly reviewed in the Vacancy Control Panel to ensure they remain appropriate.

Ellis Jarvis
10/06/2026 08:10:45

Escalations

- St Brelades is currently operating under the Safest Staffing Protocol. Kimmeridge Court remain under Watchful Waiting due to ongoing staffing shortfalls, this is primarily impacted by RN vacancies.

Hospital Site Details		Ward Name	Specialty 1	CHPPD				
Site code	Hospital Site name			Registered nurses/midwives	Care Staff	Registered nursing associates	Non-registered nursing associates	Overall
RDYEY	WESTMINSTER MEMORIAL HOSPITAL	Ashmore/Shaston Ward	314 - REHABILITATION	3.9	3.4	0.0	0.1	7.3
RDYFC	YEATMAN HOSPITAL	Beech Ward	314 - REHABILITATION	4.3	3.1	0.0	0.0	7.4
RDYEJ	BRIDPORT COMMUNITY HOSPITAL	Colmers Ward	314 - REHABILITATION	2.7	3.0	0.0	0.3	6.0
RDY22	ALDERNEY HOSPITAL	Guernsey Ward	314 - REHABILITATION	3.1	4.3	0.3	0.0	7.6
RDYFE	VICTORIA HOSPITAL W'BORNE	Hanham Ward	314 - REHABILITATION	2.9	3.1	0.2	0.0	6.2
RDY22	ALDERNEY HOSPITAL	Jersey Ward	314 - REHABILITATION	3.4	3.6	0.0	0.0	7.0
RDYEG	WESTHAVEN HOSPITAL	Radipole Ward	314 - REHABILITATION	2.7	2.8	0.1	0.1	5.7
RDYFC	YEATMAN HOSPITAL	Rowan Ward	314 - REHABILITATION	4.1	3.7	0.4	0.0	8.3
RDYFD	SWANAGE COMMUNTIY HOSPITAL	Stanley Purser Ward	314 - REHABILITATION	3.4	2.8	0.0	0.0	6.1
RDYFF	BLANDFORD COMMUNITY HOSPITAL	Tarrant Ward	314 - REHABILITATION	2.5	2.7	0.0	0.2	5.4
RDYFC	ST ANN'S HOSPITAL	AAU Seaview	710 - ADULT MENTAL ILLNESS	4.9	7.9	0.0	0.0	12.8
RDY10	ST ANN'S HOSPITAL	Alumhurst Ward	710 - ADULT MENTAL ILLNESS	2.6	3.7	0.0	0.5	6.9
RDY10	ST ANN'S HOSPITAL	Chine Ward	710 - ADULT MENTAL ILLNESS	4.8	7.2	0.0	0.2	12.2
RDY10	NIGHTINGALE HOUSE	Florence House	710 - ADULT MENTAL ILLNESS	9.9	8.4	0.0	0.0	18.3
RDYFX	MAIDEN CASTLE HOUSE	Glendinning Unit	710 - ADULT MENTAL ILLNESS	4.0	4.3	0.0	0.0	8.3
RDYFT	ST ANN'S HOSPITAL	Harbour Ward	710 - ADULT MENTAL ILLNESS	3.9	7.5	0.0	0.5	11.9
RDY10	ST ANN'S HOSPITAL	Haven Ward Female	928 - MENTAL HEALTH REHABILITATION	7.6	16.4	0.0	0.9	24.9
RDY10	ST ANN'S HOSPITAL	Haven Ward Male	928 - MENTAL HEALTH REHABILITATION	6.5	12.9	0.0	0.2	19.6
RDY10	ALDERNEY HOSPITAL	Herm Ward	715 - OLD AGE PSYCHIATRY	3.2	8.3	0.0	0.0	11.6
RDY22	KIMMERIDGE COURT	Kimmeridge Court	710 - ADULT MENTAL ILLNESS	9.3	12.3	0.0	0.5	22.1
RDYEG	FORSTON CLINIC	Melstock House	710 - ADULT MENTAL ILLNESS	4.3	4.7	0.0	0.1	9.2
RDYFX	NIGHTINGALE HOUSE	Nightingale House	710 - ADULT MENTAL ILLNESS	3.6	5.3	0.4	0.0	9.3
RDYFX	PEBBLE LODGE	Pebble Lodge	711 - CHILD AND ADOLESCENT PSYCHIATRY	6.6	11.6	0.0	0.0	18.2
RDYMR	ALDERNEY HOSPITAL	St Brelades Ward	715 - OLD AGE PSYCHIATRY	4.1	12.9	0.2	0.0	17.2
RDY22	ST ANN'S HOSPITAL	Twynham Ward	712 - FORENSIC PSYCHIATRY	4.5	7.2	0.2	0.1	12.1
RDY10	FORSTON CLINIC	Waterston AAU	710 - ADULT MENTAL ILLNESS	3.0	4.8	0.0	0.5	8.3

The above table show care hours per patient day (CHPPD). This is calculated by dividing actual staff hours by number of patients on the ward at 23.59.

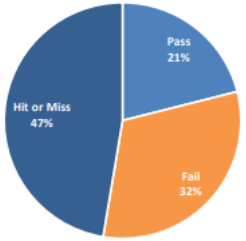
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CYP, All Age Mental Health & Learning Disability Services – Operational Performance Summary April 2026 (M1)

Dorset HealthCare University NHS Foundation Trust

Overview of Operational Performance/KPI Metric Summary

There are 134 local & contractual metrics across All Age MH&LD, CYP and NHSTT Services plus 43 National metrics (MTP & NoF) of which 19 have reportable targets. In April 26 (M1) 53% of the national metrics were on track 10/19.

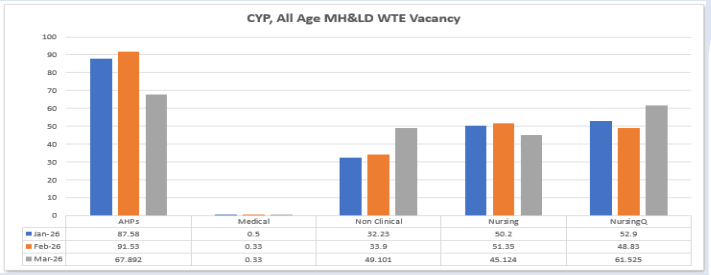


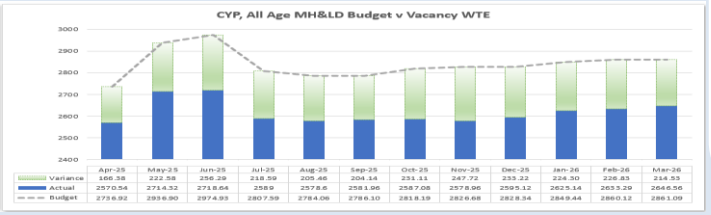
Performance at year end 25/26 – key metrics:
CYP 1+ Access: Exceeded Target
IPS Access: did not meet target: recovery plan in place for 26/27
Adult Acute, PICU & OPMH LOS: met target
NHSTT Reliable Recovery: met target, 26/27 targets awaiting sign off
Perinatal & MHS Access Rate: did not meet target, on track as at M1 26/27
Out of Area Placements: met target

The local & contractual metrics are monitored monthly as agreed Operational priorities by the DMG/ICB. These are a mixture of activity based and non-targeted metrics.

Exception summaries and action plans are in place for those off track some of which are part of longer-term transformation /development plans.

Workforce





As at M12 March 26: The vacancy rate is 8.1% based on a budgeted 2507.4 WTE.

CYP 0-19 PHS:	10.24 WTE
CYP SaLT:	-0.2 WTE
CiC:	0.41 WTE
NHSP:	0.14 WTE
CAMHS:	42.84 WTE
MH Other:	5.82 WTE
Prim & Psych:	38.15 WTE
LD & Pro Collab:	78.83 WTE
Secondary Comm:	58.86 WTE
High Acuity:	126.8 WTE

Caseload Summary

DIRECTORATE COMBINED CASELOAD	25/26 YTD	26/27 YTD	Growth	% Growth
	183,403	175,378	-8,025	-4%

There are on average 43,517 people (excluding school aged children) on caseload each month, this is approx. 5.2% of the Dorset Population (827,116; DiiS).

Eligible Cohort & Open Caseload

CYP&F	25/26 YTD	26/27 YTD	Growth	% Growth
Health Visiting	30,891	26,714	-4,177	-14%
School Nursing	117,588	114,257	-3,331	-3%
Paed SaLT	5,706	5,463	-243	-4%
Children in Care Health Team	1,024	1,109	85	8%
Total Caseload	155,209	147,543	-7,666	-4.94%

Activity Summary

DIRECTORATE COMBINED REFERRALS	25/26 YTD	26/27 YTD	Growth	% Growth
	6,243	5,733	-510	-8%

DIRECTORATE COMBINED CONTACTS	25/26 YTD	26/27 YTD	Growth	% Growth
	51,590	44,980	-6,610	-13%

Activity is slightly off track compared to the same period last year. This is no cause for concern at M1 reporting.

Finance: (Brackets) = favourable variance

Financial Summary £m		
Annual Budget	YTD Actual	YTD Variance
132.0	11.2	0.2

The finance summary provides a combined overview of CYP, MH&LD. Forecasting commences from M3.

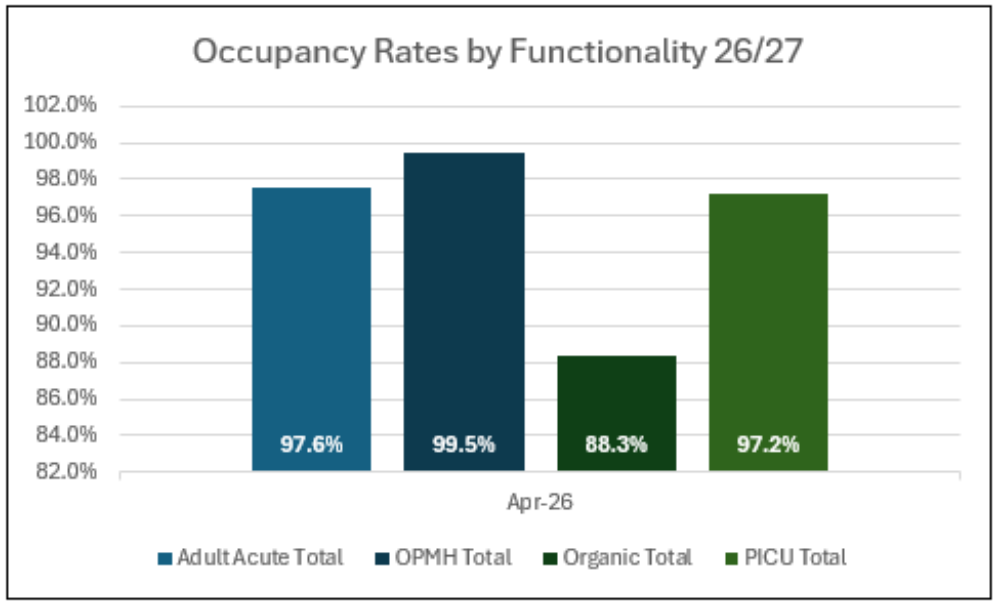
The YTD variance is attributable to

- 0.2 MH Services
- 0.0 CYP Services

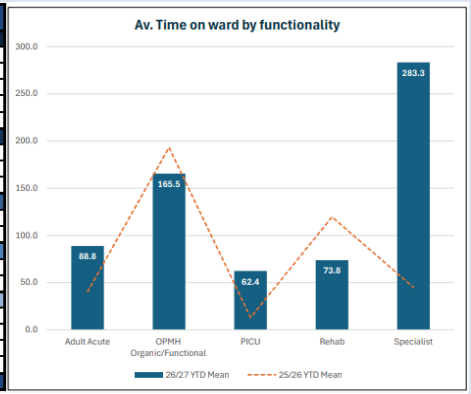
Service Director Commentary

- Overall Demand remains high (~43.5k caseload); activity slightly below last year but expected at M1
- Performance 53% of national metrics on track (10/19), Strong delivery in CYP access, LOS targets, OAPs, and Talking Therapies. Improvement needed in IPS and perinatal/MH access – SDIPS and plans in place.
- Inpatient Flow - High occupancy (94.5%; Adult Acute 98.6%) driving pressure. LOS above target in Adult Acute/PICU; discharge flow remains a constraint.
- Out of Area Placements - Appropriate use well managed; low inappropriate placements. Reduction trajectory on track; block beds fully utilised.
- Workforce & Finance - Vacancy rate 8.1%; pressures in key areas remain. Financial position stable at M1.
- Key Priorities - Improve flow and reduce LOS. Continue to recover access standards (IPS, IPS, perinatal). Sustain OAP reduction and continue to improve community offers through the perihospital programme. .

Operational Performance Inpatient Flow



Av. Time On Ward (Days)	25/26 YTD Mean	26/27 YTD Mean	Growth (Days)	% Growth	26/27 YTD Median	26/27 YTD Mode
Adult Acute	**40.5**	**88.8**	**48.3**	**119%**	**-60.0**	**#N/A**
AAU Seaview	15.9	24.8	8.9	56%	-21.0	23.0
Chine Ward	28.8	75.0	46.2	160%	-77.0	34.0
Harbour Ward	44.3	173.2	128.9	291%	-60.0	15.0
Melstock House	88.6	111.4	22.8	26%	-80.0	39.0
Waterston Acute Assessment Unit	25.0	59.8	34.8	139%	-51.5	5.0
OPMH Organic/Functional	**193.1**	**165.5**	**-27.6**	**-14%**	**-78.0**	**#N/A**
Alumhurst Ward	193.1	165.5	-27.6	-14%	-162.5	69.0
Herm	82.5	68.0	-14.5	-18%	-74.0	1.0
St Brelades	58.3	68.8	10.5	18%	-78.0	0.0
PICU	**13.1**	**62.4**	**49.3**	**376%**	**-25.5**	**#N/A**
Psychiatric Intensive Care Unit – F	8.3	94.3	86.0	1036%	-29.0	5.0
Psychiatric Intensive Care Unit - M	17.9	30.5	12.6	70%	-22.0	11.0
Rehab	**119.5**	**73.8**	**-45.8**	**-38%**	**-73.8**	**#N/A**
Glendinning Unit	0.0	37.0	37.0	#DIV/0!	-37.0	30.0
Nightingale House	239.0	110.5	-128.5	-54%	-110.5	0.0
Specialist	**44.9**	**283.3**	**238.5**	**531%**	**-2.5**	**0.0**
Kimmeridge Court	45.5	0.0	-45.5	-100%	0.0	0.0
Pebble Lodge	73.0	1122.0	1049.0	1437%	-1122.0	1122.0
Perinatal In-Patient Mother's Ward	61.0	11.3	-49.7	-81%	-5.0	2.0
Twynham Ward	0.0	0.0	0.0	#DIV/0!	0.0	0.0
Total	**61.3**	**134.5**	**73.2**	**119%**	**-55.8**	**0.0**



Average Time Spent on a Ward:

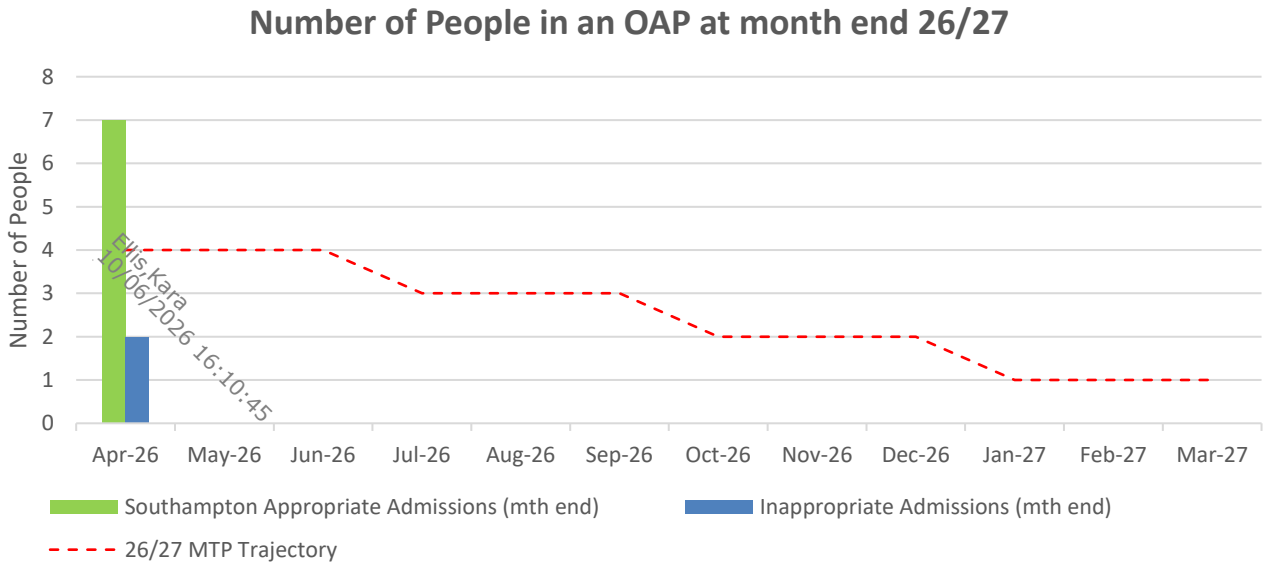
- This differs to Length of Stay which is based on Hospital Episode (total time from admission to discharge irrespective of internal movement/ transfers) compared to the same period in 25/26).

26/27 Operational Planning (MTP): Av. Length of Stay: M1

- Adult Acute & PICU Average LOS (3-mth rolling period) 92 days (target 73 days)
- OPMHS Average LOS (3-mth rolling period) 106 days (target 128)

43% of Adults had a LOS >60 days in April

Out of Area Placements (OAP) No. of Patients Admitted



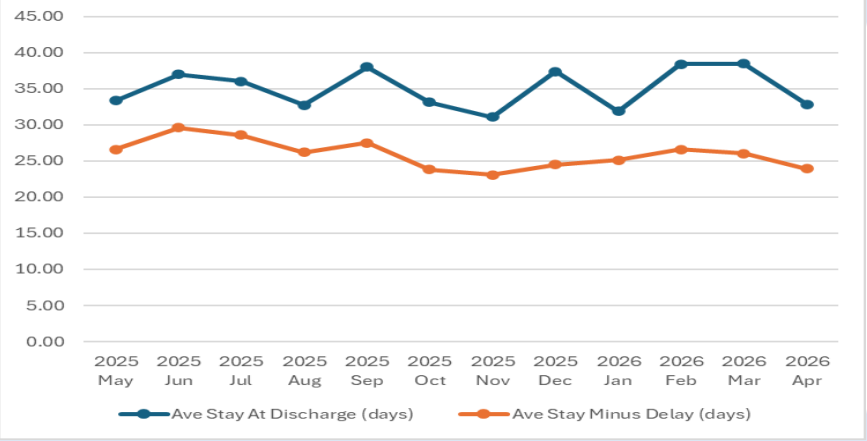
Supporting Commentary

Out of Area Placements:

- **Appropriate Placements**: As of 30 April, there were seven patients admitted to the Priory. There were seven admissions in month and eight discharges. A total of 248 Occupied Bed Days were utilised.
- **Inappropriate Placements**: As of 30 April, there were two patients admitted to other OAP providers. There were three admissions in month and three discharges for 84 OBDs.
- The 8 block purchased beds at Southampton Priory are being appropriately and fully utilised.

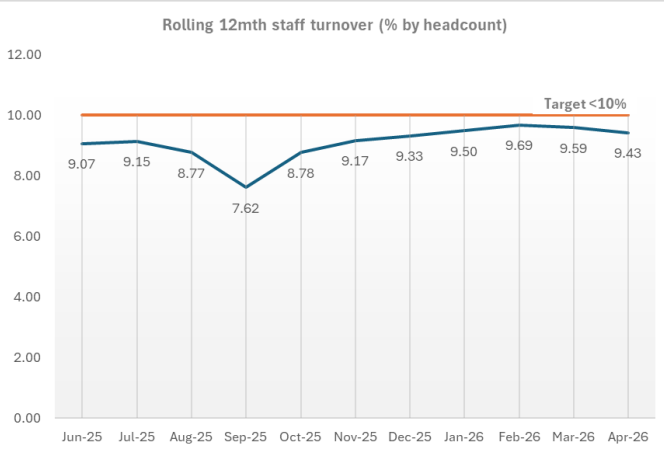
Integrated Community Services–Operational Performance Board Summary – April 2026 (1)

Community Hospitals Average Length of Stay



In Apr '26 average LoS at discharge was 32.86 days. If average delays of 8.96 days had not occurred, average LoS would have been 23.9 days.

Staff Turnover Rate



The 12 month turnover rate (headcount) for Community Services was 9.43% in Apr '26 against a Trust total of 9.31%. This is within the target of <10%.

Highlight on a Service

Meningitis B Outbreak response

Following a third case of Meningitis B in the Weymouth area identified in April 2026, Dorset healthcare led on mobilising a response to the outbreak, at the request of UKHSA. The response required administration of antibiotics and Men B vaccinations to children and young people who live in Weymouth, Portland or Chickerell, and are in school years 7 to 13.

The response was set up within 48 hours to commence antibiotic delivery at the weekend starting at Budmouth Academy followed by a rapid rollout of vaccinations during the day and evening sessions. A range of teams and services from DHC and DCH stepped up at pace to support this, including the

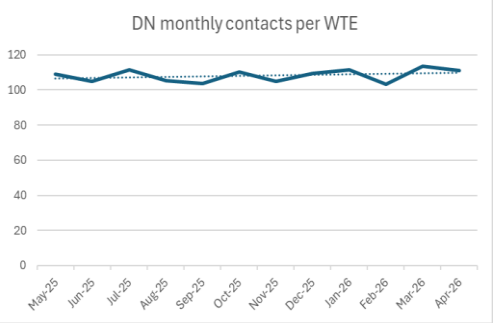
- Integrated vaccination service
- CYP 0-19 services
- DCH Pharmacy
- Communications
- Trust Bank
- Estates
- EPRR/Health and Safety
- Digital services
- DCH children's team

As well as support from Highways to assist the initial very busy weekend at Budmouth, DHC leads have closely worked with UKHSA, Public Health Dorset and DC Education and Learning to ensure correct indentation of the cohorts and monitoring of uptake for daily reporting to the SCC/TCG. As a result of the efforts, to date 73% of the cohort received the antibiotics and 72% received Vaccine 1. Preparation is underway to repeat the exercise for rollout of Vaccine 2 which, whilst there is more time to plan, has been carefully coordinated to work around school exam schedules requiring collaborative working with school leaders.

Many involved in the response commented on how refreshing it was to work with new colleagues and services within DHC and to work to support the incident response.

Ellis Jarvis 10/06/2026 16:14:44

Contacts FTE in community nursing



In Apr 26 there was an average of 111 contacts per WTE for District Nursing Staff, compared to 103.4 in Apr 25. There has been an increase in contacts per wte over the last year. Many factors are contributing to the increase in contacts including the move towards more community-centred care, earlier discharges and patients requiring administration of medication at home with an increasing number of patients requiring insulin

Service Director Commentary

DHC performance against the diagnostic standard has remained challenged due to capacity challenges driven by staffing in both clinical and supporting admin teams. The Audiology service underwent assessment for accreditation by UKAS (IQIPS) and has been provided with positive feedback and a three month period to address findings with ambitions to progress to accredited status.

DHC has seen a plateau in the total number of patients waiting for a community appointment. Work progresses to ensure no patients wait longer than 52 weeks. Reporting community services against 18-week Referral to Treatment (RTT) standards from April 2026 indicates that at aggregate level the MTP target of >78% of patients waiting less than 18 weeks was achieved. Our 111 and Urgent Care teams have continued to see high demand, both in terms of call numbers and required clinical intervention, especially over the Easter period, and in response to the meningitis outbreak, which also required emergency support from Weymouth UTC.

Dorset County Hospital
NHS Foundation Trust

Report to	Board in Common (DCH)	
Date of Meeting	17th June 2026	
Report Title	Integrated Board performance report	
Prepared By	Tyrell Bowcher, Head of Financial Management Emma Hallett, Deputy Chief People Officer Emma Hoyle, Deputy Director of Nursing Adam Savin, Director of Operations and Performance	
Approved by Accountable Executive	Anita Thomas, Chief Operating Officer	
Previously Considered By	Anita Thomas, Chief Operating Officer Jo Howarth, Director of Nursing Claire Abraham, Deputy Chief Finance Officer	
Action Required	**Approval**	-
	Assurance	X
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality SR4 Capacity and demand	
Financial	Reporting against financial key indicators	
Statutory & Regulatory	Reporting against, constitutional and contractual standards	
Equality, Diversity & Inclusion	N/A	
Co-production & Partnership	N/A	

Executive Summary

The Trusts Integrated performance report pulls together each of the domains within the NHS Oversight Framework and provides tend data, analysis and actions for each of the metrics the trust is measured on, within the framework.

All indicators are covered in detail in the respective sub-board committees and therefore, this paper does not attempt to duplicate the committees work or the deep dives, but rather provider an oversight of them combined. The pack of Board papers include the sub-board committee escalation reports, which have been written by each Chair and in conjunction with this report, provides the opportunity for triangulation.

To note, the NoF data has not been updated. The main body of the report uses monthly data, where this exists, to provide the Board with an indication of the direction of travel.

Key Highlights:

- **Patient Safety:**
  - Staff survey scores for raising concerns remain above average, supported by Freedom to Speak Up initiatives.
  - Infection rates for C. difficile and MRSA are at multi-year lows, though Klebsiella cases exceed thresholds and are under active review against a very low threshold for 25/26.
- **Effectiveness and Experience:**

Ellis,Kara
10/06/2026 16:10:19

- Flow improvements have been tested due to winter pressures and continued increase in demand at the front door. Process mapping of current discharge arrangements and identification of Quality Improvements is in progress, and in response to patient feedback via the National Inpatient Survey.
- Patient experience scores remain stable and largely in line with sector benchmarks, with targeted quality improvement plans in place. Quality Improvement work is underway in relation to inequalities and experience of access for inclusion health groups and in accordance with EDS2 priorities.
- SHMI mortality indicator is at an all time low of 0.9818

- **Access to Services:**
  - Cancer care metrics show a drop in the 28-day diagnosis standard (84.74% in Feb to 77.98% in April) and small fluctuation in the 62-day treatment standard. The 62 day trajectory was not met in March or April.
  - Elective care performance has not met trajectory in March or April and is at risk for Q1. Activity levels are below plan, which is the root cause. Nationally, a 7% improvement is required in 2026/27, which is a significant step up in activity volumes from month 1.
  - Urgent and Emergency Care met the 4-hour standard trajectory in March but not for April. The12-hour breaches remain a concern, primarily due to bed availability.

- **People and Workforce:**
  - Staff engagement scores remain above average, supported by initiatives from the People Promise Exemplar Programme.
  - Sickness absence has increased to 5% in January but has come back to 4.1% in April. This below national average, with mental health-related absence as the leading cause.

- **Finance and Productivity:**
  - Combined financial score is 2 (above average), reflecting alignment to plan despite a planned £9.8m deficit. No further data is available for this metric.
  - NHSE has completed a data gathering exercise to establish if there are under and over funded Trust's. The results indicated that DCH is underfunded and while planning guidance has started to address this, the Trust remains underfunded in 2026/27.
  - Productivity performance has fallen due to increasing costs and is under investigation.

Recommendation

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

Ellis,Kara
10/06/2026 16:10:45

Dorset County Hospital
NHS Foundation Trust

Integrated Board performance report June 2026

Operational Support

Ellis K
10/06/2026 16:10:45

Healthier lives Empowered citizens Thriving communities

Introduction and the NHS Oversight Framework (NoF)

Dorset County Hospital
NHS Foundation Trust

1. Introduction

This paper pulls together each of the domains within the NHS Oversight Framework (NOF) and provides trend data, analysis and actions for each of the metrics the trust is measured on within the framework.

The first iteration of this paper went to the October 2025 Board meeting, where it was approved that the integrated board performance report would focus on the metrics in the NHS Oversight Framework. The order of this paper, follows the metric order of the NOF. Where other metrics are off track, these are included in the sub-board committee escalation reports.

The NOF is updated each quarter. Where this paper falls in between updates, the latest monthly data is provided to give an indication of what to expect at the next published quarter. This means that during the in between months, the data on the slides for each domain, may be different to that of the slides relating to the last quarter results.

2. The NHS Oversight Framework 2025/26- quarter 3 results (NO CHANGE since the last Board)

The NHS Oversight Framework 2025/26 sets out NHS England's approach to assessing and supporting Integrated Care Boards (ICBs) and NHS trusts/foundation trusts. It aims to ensure transparency, accountability, and improvement across the system, aligning with the 10 Year Health Plan and the 2025/26 NHS priorities and operational planning guidance.

The published league table and domain results can be found here, which now includes quarter 3 results: https://data.england.nhs.uk/dashboard/nofacute. Future pages details performance against each of the metrics and the movement from Q2.

2.1 Summary of Q3 performance against the NoF (NO CHANGE since the last Board)

DCH ranked 68 out of 134 acute providers, this is a fall from 48 in Q1 and 51 in Q2. There are 6 acute types within the league table, DCH is group in the "small acute" type. Of the 134 providers, 19 have been designated a small acute provider. In Q3, DCH ranked 10th out of 19, this a fall from 7th in Q2 and 5th in Q1. There is only 1 other provider designated as small in the South West which is Salisbury, who ranked 67 out of 134 and 9th out of the 19 small providers in Q3. The table overpage details each metric within the framework, performance against it, the ranking and the committee through which that the metric is scrutinised.

Ellie.Kate 02/10/2025 16:10:45

Q3 results and movement from Q2 (NO CHANGE since the last Board)

NHS
Dorset County Hospital
NHS Foundation Trust

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Access to services	Cancer care	Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Q3 2025/26	75.61	%	7.12	3.06	82 out of 118	77.61	80
Access to services	Cancer care	Percentage of patients treated for cancer within 62 days of referral	Q3 2025/26	69.32	%	1.70	2.75	70 out of 118	71.48	75
Access to services	Elective care	Percentage of cases where a patient is waiting more than 52 weeks for elective treatment	Dec-25	1.30	%	-0.12	2.32	51 out of 131	1.56	1
Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	Dec-25	65.76	%	6.14	3.90	74 out of 79	0.96	
Access to services	Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Dec-25	60.90	%	0.66	2.50	66 out of 131	60.90	
Access to services	Elective care	Difference between planned and actual 18 week performance	Dec-25	-0.47	percentage points	-0.35	2.20	48 out of 131	-1.82	0
Access to services	Urgent and emergency care	Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q3 2025/26	80.07	%	-3.03	1	18 out of 123	73.05	78
Access to services	Urgent and emergency care	Percentage of emergency department attendances spending over 12 hours in the department	Q3 2025/26	11.20	%	2.59	3.34	96 out of 119	8.17	
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Dec-25	1.12	days	0.26	3.17	92 out of 125	0.83	
Effectiveness and experience	Patient experience	Summary Hospital-level Mortality Indicator	Oct 24-Sept 25		score		2			
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2024		score		2			
Finance and productivity	Finance	Planned surplus/deficit	2025/26	-3.18	%	0	4	92 out of 134	-1.54	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 9 2025	0.52	%	0.52	1	5 out of 134	-0.13	
Finance and productivity	Finance	Combined finance	Q3 2025/26		Score		2			
Finance and productivity	Productivity	Implied productivity level	Q2 2025/26 vs Q2 2024/25	1.2	%	-3.09	3.12	95 out of 134	2.60	
Patient safety	Patient safety	Number of MRSA bacteraemia cases	Jan 25-Dec 25	3	count	2.00	2.66		3	0
Patient safety	Patient safety	Proportion of E. coli bacteraemia	Jan 25-Dec 25	1.11	rate	0.20	2.39		1.17	1
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2024	6.54	out of 10	0	1.99	45 out of 134	6.42	
Patient safety	Patient safety	Proportion of C. difficile infections	Jan 25-Dec 25	0.80	rate	-0.18	1		1.12	1
People and workforce	Retention and culture	Sickness absence rate	Q2 2025/26	4.39	%	0.32	1.44	29 out of 134	5.03	
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2024	7.03	out of 10	0	1.83	38 out of 134	6.88	

Ellis,Kara 16/06/2026 16:10:35

NoF areas of declining metrics for Q3 (NO CHANGE since the last Board)

Dorset County Hospital
NHS Foundation Trust

2.2 Areas of reduced performance

The percentage of patients waiting over 52 weeks for a community service has increased, to 65.76%, from 59.62% in Q2, which ranks the trust 74 out of 79. In Q2, DCH ranked 75/79 for this metric. Dorset is an outlier, with UHD ranked 75 out of 79, improved from 77 in Q2. This related to the Neuro-disability waiting list (ADHD and Autism assessment). For 2026/27, the ICB have invested in a new provider, which will enable both UHD and DCH to transfer a proportion of the waiting list to the independent sector. In addition to this, a waiting well inciative has been funded, which will support patients and their family while on the waiting list.

The percentage of emergency department attendances spending 12 hours in the department increased in Q3 to 11.20%, this was a 2.59% increase from Q2. For this metric, the trust ranks 96/123 in Q3 Vs 60. This follows a 10.60% growth in attendances year to date and an 7.62% increase in admissions. Patients are tracked at the 3 time a day bed meeting, to mitigate 12 hour breaches where possible. Patients are triaged and cared for during the wait and patients prioritised beds based on clinical need, as well as total waiting time.

The percentage of emergency department patients, transferred or discharged within four hours decreased by 3.03% to 80.07%. Whilst one of the largest changes in the metrics (value), the trust was nonetheless ranked 18/123 for Q3 (where closer to 1 is the preferred ranking). This demonstrates strong performance despite the sustained increase in pressures both from presentations and as seen in the metric for delayed discharges that the Trust continues to have compromised flow out to other care settings.

Implied productivity fell by 3.09% in the reporting period, which moves the trust to a rank of 95/134. Year-to-date implied productivity growth stands at 0.4% at month 8, which is 1.6% below the 2% national ambition. Expenditure has grown by 0.9%, driven largely by increased substantive staffing costs offset by reduced temporary staffing. Cost-weighted activity has grown by 1.3%, with increases in non-elective pathways and outpatient follow-ups, though elective activity is 0.7% below the previous year due to reduced inpatient theatre throughput.

Page Kept 10/12/2025 16:10:13

There was an increase in the number of MRSA cases and an increase in staff sickness rate, but there is no significant concern noted for either.

Introduction and NHS Oversight Framework continued

Dorset County Hospital
NHS Foundation Trust

2.3 Areas of improved performance

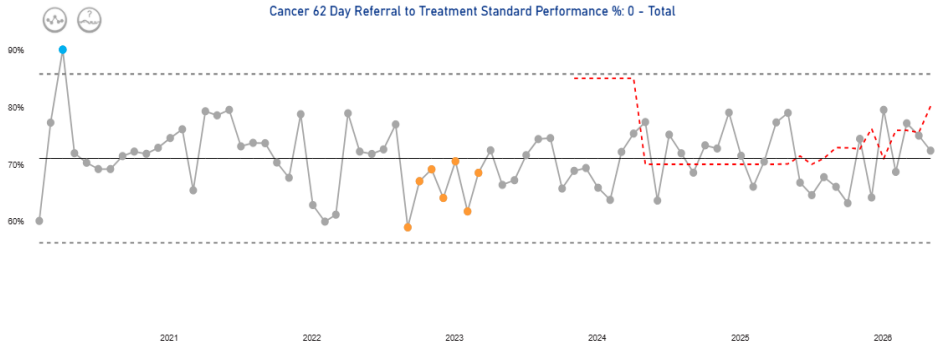
The greatest area of improvement was within Cancer care. Performance against the 28-day standard improved by 7.12% in Q3, moving the trust to rank 82/118, compared to 99/118 in Q2. Performance against the 62 day treatment standard improved by 1.70%, with a ranking of 70/118. Although performance improved, DCH had a higher ranking for the 62 day metric in Q2, 69/118, which means most providers improved in this metric n the same timeframe.

Performance against the 18 week standard improved by 0.66% and the Trust's ranking position improved from 75/131 in Q2 to 66/131 in Q3. Performance of the percentage of patients waiting over 52 weeks for elective treatment improved by 0.27%, with ranking at 51/131 but this is a reduction from 41/131 in Q2, suggesting others had a larger gain in this metric in the same period.

Ellis,Kara
10/06/2026 16:10:45

Domain: Access to Services. Sub domain: Cancer care. Measure: Percentage of patients treated for cancer within 62 days of referral.

Dorset County Hospital
NHS Foundation Trust



Cancer Site	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Brain								100.00%	100.00%	100.00%		100.00%
Breast	90.00%	69.57%	66.67%	64.58%	72.50%	80.00%	79.41%	77.78%	78.43%	87.80%	84.78%	80.85%
Colorectal	62.50%	52.94%	41.03%	56.10%	45.16%	35.29%	62.50%	9.09%	70.00%	37.84%	62.50%	41.67%
CUP		100.00%	50.00%	100.00%		100.00%		100.00%		100.00%	100.00%	
Gynaecology	42.86%	21.43%	0.00%	46.67%	0.00%	7.69%	80.00%	25.00%	12.50%	33.33%	50.00%	0.00%
Haematology	53.85%	70.00%	38.10%	66.67%	69.23%	41.18%	45.45%	84.62%	80.00%	71.43%	100.00%	76.92%
Head and Neck	50.00%	8.33%	33.33%	53.85%	40.00%	37.50%	40.00%	20.00%	60.00%	0.00%	16.67%	40.00%
Lung	81.82%	53.85%	77.27%	48.48%	54.84%	55.00%	68.00%	35.71%	50.00%	43.48%	65.22%	63.64%
Other												
Paediatric												
Sarcoma	100.00%			0.00%								
Skin	92.96%	93.33%	93.33%	84.21%	95.08%	83.33%	87.63%	92.19%	93.44%	87.80%	96.67%	98.85%
Upper GI	60.00%	88.24%	52.63%	82.35%	60.71%	76.92%	88.89%	80.00%	80.95%	85.71%	78.57%	69.70%
Urology	80.52%	69.57%	80.70%	75.56%	78.00%	70.18%	68.85%	65.45%	79.07%	60.87%	77.36%	69.23%
Total	**78.97%**	**66.80%**	**64.62%**	**67.97%**	**66.07%**	**63.22%**	**74.44%**	**64.68%**	**79.50%**	**68.68%**	**77.15%**	**75.08%**

Description of metric

Percentage of patients treated for cancer within 62 days of referral.

Contractual target 85%, but 2025/26 planning guidance trajectory is 75% by March 2026.

Analysis

Performance of the 62-day combined standard did not achieve the trajectory in March or April. Delays at tertiary centres are a contributing factor.

The total waiting list size has increased by 99 patients since January. The backlog (62-103 days) has increased by 13 patients to 47, and the backstop (over 104 days) has increased by 1 patient to 13.. As noted on the next page there continues to be an increase in referrals in comparison with previous years, adding pressure throughout the pathway depending on conversions to treatment.

Total treatments have been on an upwards trajectory, with the last financial year delivering the highest number of treatments ever. This is in response to the continued increase in demand for cancer services. . April volumes can be found in the bottom right of the analysis box.

Metric	Opsplan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Cancer: 62 RTT (combined)	Plan	70.08%	71.43%	70.00%	71.03%	72.90%	72.88%	72.66%	76.22%	70.97%	75.91%	75.91%	75.54%
	actual	78.97%	66.80%	64.87%	67.11%	65.60%	63.50%	74.60%	64.21%	79.50%	69.93%	76.49%	75.00%
	variance	8.89%	-4.63%	-5.13%	-3.92%	-7.30%	-9.38%	1.94%	-12.01%	8.53%	-5.98%	0.58%	-0.54%

Ellis Kara 10/06/2026 16:10:23

Metric	Opsplan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Cancer: 62 RTT (combined)	Plan	80.13%	80.00%	80.14%	80.13%	80.41%	80.43%	80.12%	80.58%	80.15%	80.54%	80.45%	80.65%
	actual	72.40%											
	variance	-7.73%											

Cancer Site	Total Seen	Achieve 62 Days	Breach 62 Days	% Meet 62 Days
Brain	2	1.00	0.50	66.67%
Breast	24	20.00	4.00	83.33%
Colorectal	12	6.00	5.50	52.17%
CUP				
Gynaecology	7	3.00	3.50	46.15%
Haematology	10	6.50	3.00	68.42%
Head and Neck	4	1.50	2.50	37.50%
Lung	12	8.00	4.00	66.67%
Other				
Paediatric				
Sarcoma				
Skin	28	28.00		100.00%
Upper GI	13	8.50	4.50	65.38%
Urology	34	21.00	12.50	62.69%
Total	**144**	**103.50**	**40.00**	**72.13%**

Actions

For patients that breach the 104-day backstop, on a 62-day pathway, a full route cause analysis is completed, which includes a harm review.

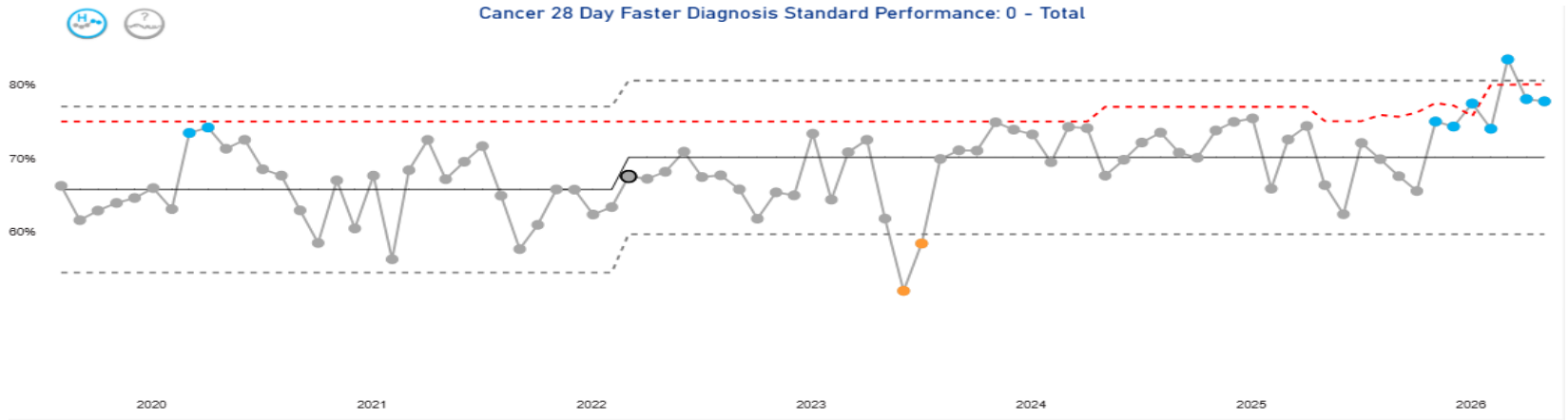
Tumour site pathway reviews underway, to identify barriers that are delaying getting to treatment.

Focus on the 28 day standard, to ensure patients are diagnosed in a timely way remains the key focus. Improvements have been made with endoscopy and imaging capacity in Q3, which continue into Q4 and is supporting cancer performance improvements. This is evident in an overall improvement in the DM01 standard.

Healthier lives Empowered citizens Thriving communities

Domain: Access to Services. Sub domain: Cancer care. Measure: Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks (28 days).

Dorset County Hospital
NHS Foundation Trust



Description of metric

Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks (28 day standard).

Contractual target 80%, but 2025/26 planning guidance trajectory is 80% by March 2026, rather than each month of the year.

Analysis

.Performance of the 28-day standard did not meet the trajectory in March and slightly fell in April to 77.98%. Performance in May is expected to achieve 80%. Performance has been on an improving nature for the last 7 data points.

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Cancer: 28 days FDS	Plan	75.07%	75.04%	75.06%	75.89%	76.65%	76.23%	77.51%	77.17%	75.74%	80.00%	80.00%	80.06%
	actual	66.33%	62.41%	72.11%	69.87%	67.51%	65.58%	74.98%	74.28%	77.45%	74.02%	83.51%	78.10%
	variance	-8.74%	-12.63%	-2.95%	-6.02%	-9.14%	-10.65%	-2.53%	-2.89%	1.71%	-5.98%	3.51%	-1.96%

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Cancer: 28 days FDS	Plan	80.03%	80.05%	80.06%	80.01%	80.00%	80.04%	80.03%	80.01%	80.08%	79.97%	80.06%	80.03%
	actual	77.98%											
	variance	-2.05%											

Ellis,Kate 10/06/2026 15:10:45

Cancer Site	Apr-2025	May-2025	Jun-2025	Jul-2025	Aug-2025	Sep-2025	Oct-2025	Nov-2025	Dec-2025	Jan-2026	Feb-2026	Mar-2026
Brain												
Breast	75.00%	66.15%	86.79%	84.97%	93.50%	95.43%	94.31%	91.93%	95.15%	76.17%	87.50%	92.83%
Colorectal	52.15%	43.08%	55.45%	50.99%	38.50%	44.40%	54.55%	48.58%	67.14%	69.76%	79.47%	52.43%
CUP	0.00%	100.00%	0.00%			0.00%			0.00%			
Gynaecology	59.46%	43.27%	48.80%	60.83%	60.42%	59.46%	53.41%	51.96%	53.15%	58.54%	68.32%	70.43%
Haematology	16.67%	40.00%	40.00%	55.56%	0.00%	44.44%	77.78%	57.14%	75.00%	60.00%	42.86%	37.50%
Head and Neck	63.25%	67.66%	65.66%	62.42%	59.40%	57.75%	66.20%	72.50%	80.45%	75.89%	86.03%	85.95%
Lung	74.47%	68.97%	74.19%	83.72%	73.47%	77.50%	63.16%	83.33%	70.73%	61.11%	68.00%	74.55%
Other	50.00%	0.00%										100.00%
Paediatric	100.00%	100.00%	100.00%	100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	75.00%
Sarcoma		100.00%										
Skin	83.85%	76.39%	83.68%	78.82%	72.38%	69.70%	83.92%	91.75%	92.25%	81.03%	93.39%	87.23%
Upper GI	52.00%	51.69%	67.31%	61.11%	59.52%	53.52%	73.11%	61.61%	75.33%	75.36%	82.43%	74.34%
Urology	63.84%	70.37%	76.58%	71.90%	68.52%	75.38%	76.30%	66.10%	70.71%	72.59%	79.49%	73.03%
Total	66.36%	62.41%	72.09%	69.95%	67.58%	65.56%	75.00%	74.30%	77.45%	73.92%	83.45%	77.81%

Actions

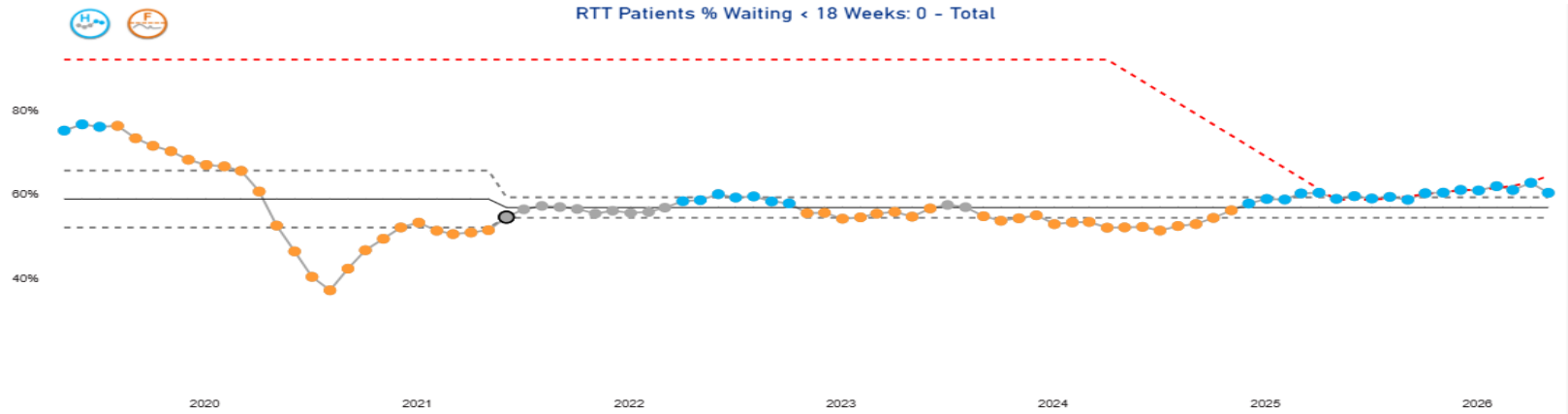
Insourcing where demand is outstripping capacity at the front of the pathway, with capacity now in place for the first 6 months of the new financial year.

Refreshed cancer PTL and performance review meetings at a Care Group level. These combine RTT, cancer and DM01, into one data pack and review session, which enables a full pathway review. Positive feedback for the first two sessions.

Healthier lives Empowered citizens Thriving communities

Domain: Access to Services. Sub domain: Elective Care. Measure: Difference between planned and actual 18 week performance and Percentage of cases where a patient is waiting 18 weeks or less for elective treatment

Dorset County Hospital
NHS Foundation Trust



Description of metric

Difference between planned and actual 18-week performance:

Hit or miss planning trajectory, as per the operating plan.

Percentage of cases where a patient is waiting 18 weeks or less for elective treatment:

Contractual target 92%

Planning guidance target, 63.89% by March 2026 and then a 7% further improvement in 2026/27.

Analysis

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At the end of March 2026, DCH achieved 62.70%. This was 1.19% off the trajectory set out in the Operating plan. Compared to November 2024, performance improved by 4.92%, only just missing the 5% national ask.

There were several unexpected issues in the year, impacting RTT performance. This included a national supply chain issue in Orthopaedics, which resulted in additional cancellations in quarter 4 and 3 rounds of Resident Doctor strike action in2025, each for 5 days.

For 2026/27, every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national performance target of 70%). For DCH, this means achieving 70.89% RTT 18-week performance and 77.69% for 1st activity, by March 2027. For April, both metrics did not hit the required standard.

Elli Kara 17/06/2026 16:16:35

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
RTT: % patients waiting <18wks	plan	58.70%	58.70%	58.70%	58.70%	59.00%	59.50%	60.37%	60.87%	61.37%	61.87%	62.72%	63.89%
	actual	58.90%	59.59%	58.98%	59.40%	58.69%	60.20%	60.38%	61.00%	60.90%	61.91%	61.00%	62.70%
	variance	0.20%	0.89%	0.28%	0.70%	-0.31%	0.70%	0.01%	0.13%	-0.47%	0.04%	-1.72%	-1.19%

Metric	Ops plan 26/27	Apr-26	May-26
RTT: % patients waiting <18wks	plan	64.38%	65.32%
	actual	60.30%	
	variance	-4.08%	
RTT: % patients waiting <18wks for 1st Activity	plan	71.65%	71.81%
	actual	65.90%	
	variance	-5.75%	

Actions

Care Groups are developing plans on how this is delivered, via improved efficiencies, using the insourcing fund differently, by developing business cases to invest in, in-house solutions (where this makes sense and is financial beneficial to the trust). It is expected activity levels will be behind plan for at least Q1, while these plans are developed. The inclusion of this level of activity growth was not confirmed and built into the operational plan until the final submission. Prior to this, non-delivery of the required improvement had been proposed, but this was not accepted. Activity levels need to increase significantly (table below) if the performance trajectory is to be delivered this year.

% growth required for 26/27	
Consultant-led first outpatient attendances (Spec acute)	5.15%
Consultant-led follow-up outpatient attendances (Spec acute)	4.34%
Consultant-led follow-up outpatient attendances - of which Outpatient Procedures	4.34%
Total outpatient attendances (All TFC, Consultant and Non consultant led)	4.00%
Total number of specific acute elective day case spells in the period	7.96%
Total number of specific acute elective ordinary spells in the period	6.26%
Total number of specific acute elective spells in the period	7.84%

Healthier lives Empowered citizens Thriving communities

Domain: Access to Services. Sub domain. Elective Care. Measure: Percentage of patients waiting over 52 weeks for elective treatment

Dorset County Hospital
NHS Foundation Trust

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
RTT: 52wk wait	plan	431	410	390	369	348	327	306	285	286	265	243	222
	actual	448	439	377	368	365	303	283	262	270	317	323	245
	variance	17	29	-13	-1	17	-24	-23	-23	-16	52	80	23
RTT: 52wk cohort % of Waiting List	plan	2.00%	1.90%	1.80%	1.70%	1.60%	1.50%	1.40%	1.30%	1.30%	1.20%	1.10%	1.00%
	actual	1.99%	1.94%	1.68%	1.64%	1.64%	1.42%	1.33%	1.24%	1.30%	1.49%	1.53%	1.14%
	variance	-0.01%	0.04%	-0.12%	-0.06%	0.04%	-0.08%	-0.07%	-0.06%	0.00%	0.29%	0.43%	0.14%
RTT: 52wk wait CYP	plan	50	45	40	20	10	0	0	0	0	0	0	0
	actual	57	48	44	20	34	24	21	16	20	17	25	32
	variance	7	3	4	0	24	24	21	16	20	17	25	32

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
RTT: 52wk wait	plan	208	189	170	151	137	118	99	80	66	47	28	0
	actual	296											
	variance	88											
RTT: 52wk cohort % of Waiting List	plan	0.99%	0.91%	0.82%	0.74%	0.67%	0.58%	0.49%	0.40%	0.33%	0.24%	0.14%	0.00%
	actual	1.35%											
	variance	0.36%											

Description of metric

Percentage of patients waiting over 52 weeks for elective treatment

Contractual standard is zero, 52+ week breaches

Planning guidance requests less than 1% of the waiting list waiting over 52+ weeks by March 2026. For 2027, DCH need to achieve zero 52+ week waits.

Analysis

From January DCH has not achieve the 52-week trajectories and although March was an improved position, it missed the trajectory by 0.14%. Factors impacting this metric are operational pressures in UEC pathways, which has resulted in elective cancellations. A total of 300 elective patients were cancelled in January and February across day surgery and main theatres. External factors impacting the NHS national supply chain, contributed to the level of cancellations and industrial action.

For April, the number of 52+ week waiters increased with activity levels not hitting plan, as covered above. There is no CYP, 52+ week trajectory for 2026/27.

To achieve a 7% improvement in RTT and to delivery zero, 52+ week waits, activity levels within the Operating plan increase.

Ellis, Sara
10/06/2026 16:10:45

Actions

Every patient in month, that is over 52 weeks, is reviewed (validated) weekly. This enables proactive pathway management.

Total cohort is modelled against activity plans and reviewed monthly via the Elective Performance Management Group.

All patients on the waiting list are contacted to confirm they what to remain on the waiting list, once every 12 weeks.

Patients with a confirmed date for surgery are contacted 7 days before to confirm nothing has changed i.e. fitness. This ensures capacity is maximised by avoiding some on-the-day cancellations.

Review of insourcing capacity, to ensure, where budget allows, activity is maximised and target to those waiting the longest.

Executive sign off ,of cancellations for winter pressure reasons to ensure proporitionate to the situation each day.

Domain: Access to Services. Sub domain: UEC. Measure: Percentage of emergency department attendances admitted, transferred or discharged within four hours

Dorset County Hospital
NHS Foundation Trust

2026/27

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
A&E: 4 hour wait %(all)	plan	82.00%	81.89%	81.99%	78.36%	78.34%	77.69%	78.87%	79.97%	80.52%	81.01%	81.43%	82.06%
	actual	78.70%											
	variance	-3.30%											
A&E: 4 hour wait %(DCH)	plan	66.25%	65.82%	66.14%	60.19%	60.41%	60.43%	63.61%	63.40%	64.40%	65.29%	66.16%	67.22%
	actual	60.90%											
	variance	-5.35%											
A&E: Children 4 hour wait %(all)	plan	95.41%	95.83%	95.30%	95.71%	95.49%	95.07%	95.43%	95.46%	95.60%	95.60%	95.15%	95.60%
	actual	93.30%											
	variance	-2.11%											

2025/26

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
A&E: 4 hour wait %(DCH)	plan	65.98%	61.04%	58.64%	56.74%	64.85%	66.89%	60.39%	61.05%	52.40%	52.62%	60.13%	60.14%
	actual	65.70%	68.46%	68.30%	74.50%	68.20%	63.70%	68.42%	66.04%	60.40%	61.50%	59.40%	62.40%
	variance	-0.28%	7.42%	9.66%	17.76%	3.35%	-3.19%	8.03%	4.99%	8.00%	8.88%	-0.73%	2.26%

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
A&E: 4 hour wait %(all)	plan	81.80%	79.64%	78.18%	76.89%	81.43%	82.22%	79.03%	79.12%	74.91%	75.17%	78.87%	78.88%
	actual	82.00%	83.7%	83.4%	86.3%	82.8%	79.9%	81.99%	80.72%	77.58%	77.7%	77.1%	79.1%
	variance	0.20%	4.05%	5.22%	9.41%	1.37%	-2.34%	2.96%	1.60%	2.67%	2.53%	-1.77%	0.22%

Description of metric

Percentage of emergency department attendances admitted, transferred or discharged within four hours.

Contractual target 95%

Planning guidance, For the 2026/27 financial year, NHS England has set a mandatory A&E target requiring every provider to treat, admit, or discharge 82% of A&E attendees within four hours, by March 2026.

Analysis

Performance against the 4-hour standard (including UTC's) has met the trajectory set out in the operational plan, for 10 out of 12 months. The national planning guidance required a minimum of 78% for 2025/26. DCH performance above the national aggregate performance for the 4-hour standard, for every month of 2025/26. The operating plan for 2025/26 also has a trajectory for type 1 (DCH only) performance. The trajectory has been met for 9 out of 12 months, achieving the trajectory For March.

For 2026/27, there are three KPIs in the operating plan, to monitor the 4-hour standard. As with 2025/26 these are the 4-hour standard (all activity), 4-hour standard for type 1 (DCH only) activity and the additional measure, is performance against the 4-hour standard for children.

Chris Karp 10/06/2026 16:10:45

For the reporting month of April 2026, DCH did not achieve the trajectory for all 3, 4-hour metrics. This was due to demand at the front door (5.5% above plan) and DCH had higher than plan length of stay, although this was lower than last year. There was also Resident Doctor strike action, for a 5-day period in April.

Actions

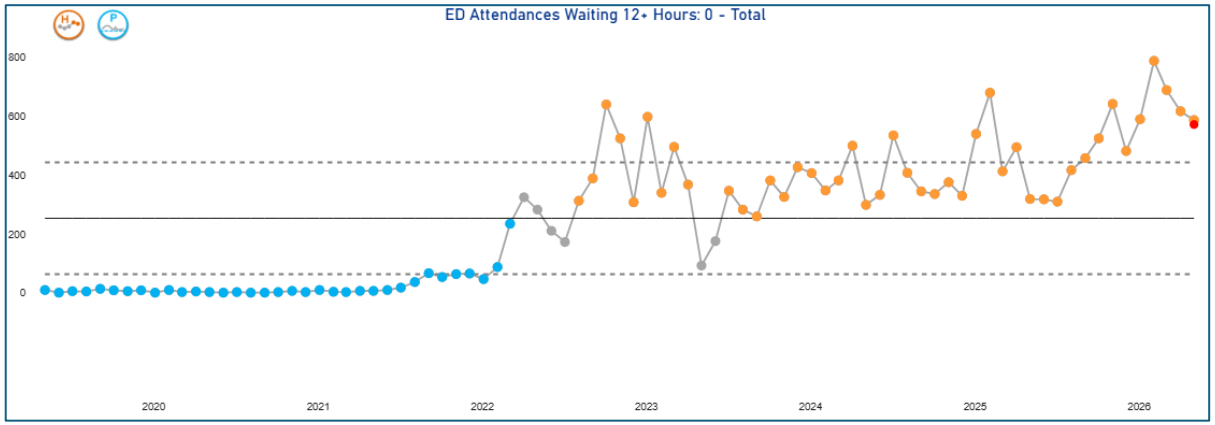
Demand has been escalated to all system partners and brought to the attention of NHSE, as part of the Regional Performance meetings. Postcode analysis has shown it is growth from all areas, rather demand drift. Weymouth and Portland, the subject of Neighbourhood intervention work, is the area with the highest demand growth by volume and therefore supporting the need for the local prevention work in this locale.

Additional staff have been put on to keep the department safe and all bedded escalation space is used flexibly, to facilitate flow.

Bed base reconfiguration work is underway. With the stroke building work due to complete in May, it provides an opportunity to reconfigure the bed base, to support reduced length of stay and maximise bed use (bed turnover).

Domain: Access to Services. Sub domain: UEC. Measure: Percentage of emergency department attendances spending over 12 hours in the department

Dorset County Hospital
NHS Foundation Trust



Description of metric

Percentage of emergency department attendances spending over 12 hours in the department.

Contractual target- the isn't one for 2025/26

Planning guidance: a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25

Analysis

The 2025/26 operating plan required a trajectory for patients waiting in A&E over 12 hours. Since July, the Trust has had more 12-hour breaches than the trajectory. Since January, the volume of 12-hour breaches has started to fall, however not by enough to hit the trajectory.

For April 2026, the number of 12-hour breaches fell further. The volume was higher than the operating plan, but due to the above plan demand (attendances), the percentage of A&E attendances that breached 12 hours was better than plan.

Ellis,Kara 10/06/2026 16:20:35

2025/26

Metric	Ops plan 25/26	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Number of A&E12 hour breaches	plan	305	344	546	415	351	342	383	336	551	694	392	434
	actual	320	318	310	417	458	525	642	482	590	788	689	616
	variance	15	-26	-236	2	107	183	259	146	39	94	297	182
Percentage of A&E attendances over 12 hours	plan	6.57%	6.96%	11.52%	8.30%	6.97%	7.38%	8.22%	7.58%	11.91%	16.28%	9.09%	9.09%
	actual	6.72%	6.45%	6.16%	7.53%	8.23%	10.46%	12.21%	10.00%	11.70%	15.70%	16.20%	12.20%
	variance	0.15%	-0.51%	-5.36%	-0.77%	1.26%	3.08%	3.99%	2.42%	-0.21%	-0.58%	7.11%	3.11%

2026/27

Metric	Ops plan 26/27	Apr-26
Number of A&E12 hour breaches	plan	572
	actual	587
	variance	15
Percentage of A&E attendances over 12 hours	plan	11.61%
	actual	11.30%
	variance	-0.31%

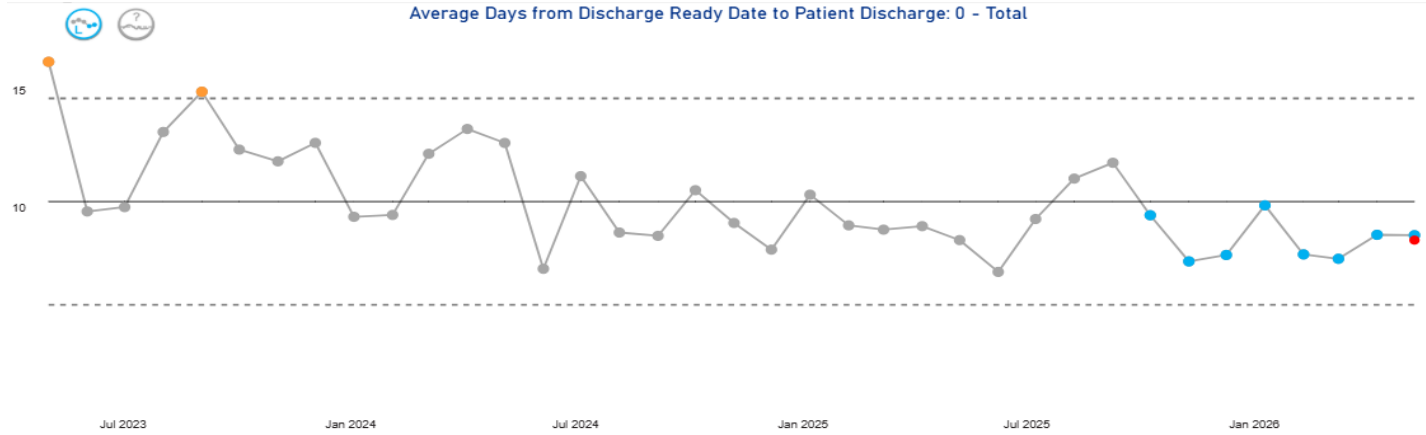
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Actions

- Performance against the headline metric of the 4-hour standard is meeting our provider trajectory and the national minimum requirement of 78%.
- 12-hour breaches are not meeting plan and an area of concern. The largest cause of these breaches is waiting for a bed, however, there are improvements that can be made where patients breach 12 hours but are not admitted.
- The trust will move to managing a cumulative score for the day on the bed reports and discuss more specifically actions we could take to prevent 12/24 hr waits in the 3 times a day bed meeting.
- National Guidance on reducing corridor care closely maps to the Trusts New Models of Care QI Programme which aims to reduce long stays in ED and wards

Domain: Effectiveness and experience. Sub domain: Flow. Measure: Average number of days from discharge ready date to actual discharge date (including zero days)

Dorset County Hospital
NHS Foundation Trust



Description of metric

This measures the extent of delays experienced by patients who are medically ready for discharge but are not able to be discharged from hospital.

The average delay to discharge, from when the patient is ready for discharge to the date of discharge.

Analysis

For the 2025/26 operating plan, no reason to reside has been omitted, but non-elective length of stay (LoS) included. This is the measure of how long non-elective patients remain in a bed, excluding patients with a zero length of stay and those being cared for by the Hospital at home team. Performance against this metric has not achieved trajectory all year. A higher than planed LoS limits the number of times a bed can be turned round and thus, increase the overall bed stock need. LoS has reduced compared to last year but remains higher than pre-COVID.

For 2026/27, the metrics in the Operational Plan relating to flow, are slightly different. The non-elective average length of stay is measured by taking total non-elective bed days (all) and divided by the number of total non-elective admissions. This therefore measures the effectiveness of all non-elective pathways, combined. For April, Non-elective LoS was 0.68 above plan, driven by 819 more bed days and 145 few discharges than plan.

Chris.Kane 10/06/2026 16:10:45

The higher than planned length of stay is being driven by continued above plan levels of no reason to reside. While a trajectory was not required for the operating plan, tracking this is key in understanding the drivers of LoS and bed occupancy. Locally, a target of 49, NRTR has been set as part of the FutureCare work.

The number of patients occupying a bed with no reason to reside was 14 above the locally agreed trajectory, but it should be noted, that 63, is the lowest number since September 2025 and a reduction of 10 compared to March 2026.

Actions

Escalation to all system partners, with Executive involvement for patients with extended length of stay.

FutureCare programme, with admission avoidance schemes and the introduction of the Transfer of Care Hub, which is now fully operational.

Roll out criteria led discharge and standardised board rounds.

Increase use of Acute Hospital at Home and Hospital at Home (DCH) to facilitate earlier discharge with continued support where applicable.

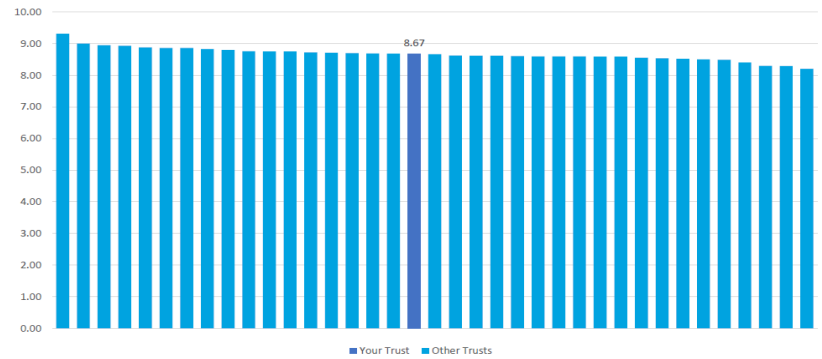
Executive led review of processes applied through the FutureCare programme this winter to provide further efficiency and productivity through collaborative solutions for community care.

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Domain: Effectiveness and experience. Sub domain: Patient experience. Measure: CQC inpatient survey satisfaction rate

Dorset County Hospital
NHS Foundation Trust

Overall Rating 8.67



Description of metric

2023 – 2024 Survey

The survey required a sample of 1,250 consecutively discharged inpatients, working back from the last day of November 2024, who had a stay of at least one night in hospital. There were a number of categories of patients excluded from the survey e.g. psychiatric and maternity patients.

2026 - Awaiting further CQC inpatient survey activity.

Analysis

473 completed questionnaires were returned from the sample of 1105. The final response rate for the Trust was 45%.

At Question level, 2 scores have improved significantly since 2023, 1 significantly declined. When compared to other sector organisations, 8 scores are in the top-20% range, 36 scores in the intermediate – 60% range and 5 in the bottom – 20% range.

The scores for the Trust are mostly in line with the sector scores and stable year on year. The findings highlight areas for recommendation, but it is noted that the Trust should also celebrate areas where scores are higher than the sector benchmark.

Ellis,Kara
10/06/2026 16:10:45

Actions

CARE – Inpatient Quality Improvements

Updated PALS boards with key patient info New Patient Experience leaflet (NHS complaints process) Carer's Pack for unpaid carers HIVE social prescribing hub (since May 2025) Volunteer Ward Reps to resolve quick ward issues

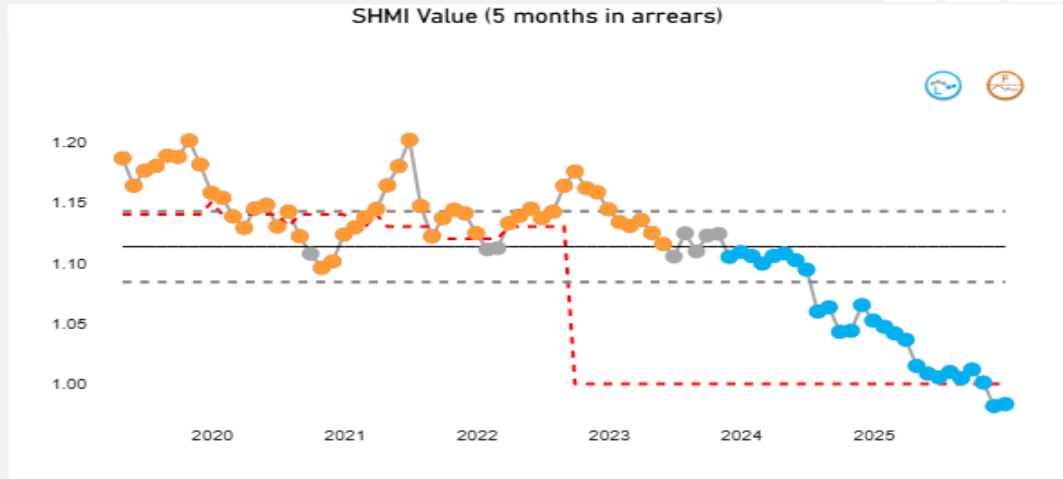
DISCHARGE - Improve patient & care information on discharge

Keyworker training on use of carer/self-funding packs; Self funding packs to support faster decision making; Carer packs with support info and key contacts; Carer's Café for peer support in complex discharges; Volunteer Centre Dorset for welfare calls and practical help; Networking with PCNs & Integrated Neighbourhood Teams for co-ordinated support.

Admission - improve communication around waiting times and admission alongside work going on to reduce waiting lists

Domain: Effectiveness and experience. Sub domain: Patient experience. Measure: Summary Hospital Level Mortality Indicator.

Dorset County Hospital
NHS Foundation Trust



Description of metric

SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period to the expected deaths (predicted from coding of all admissions).

Analysis

SHMI is published by NHS Digital for a 12-month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. It is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period to the expected deaths (predicted from coding of all admissions).

DCH current SHMI is 0.9818. This is the lowest it has been. DCH national ranking position is 27.

The Business Intelligence team have produced a dashboard which predicts our SHMI aiming to give assurance and the chance to act early if we see a predicted rise in SHMI. Our predicted SHMI gives assurance that we are not seeing excess deaths:

Louise Hara
10/06/2026 16:10:45

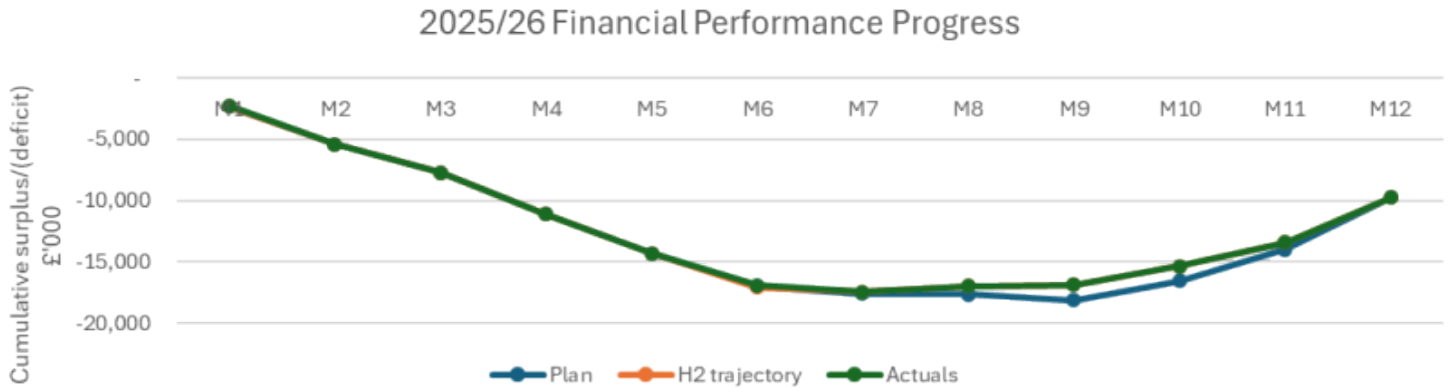
Actions

The Business Intelligence team have produced a dashboard which predicts DCH SHMI aiming to give assurance and the chance to act early if we see a predicted rise in SHMI.

DCH predicted SHMI gives assurance that we are not seeing excess deaths:

Domain: Finance and productivity. Sub domain: Finance. Measure: Combined finance

Dorset County Hospital
NHS Foundation Trust



Description of metric

The combined financial position of the organisation taking into account both planned and actual position metrics (these two individual metrics are detailed in slides below).

Resulting in a score between 1 – 4 (1 being high performing, 4 being low performing)

Updates on this score will only be provided quarterly, as the metric is only refreshed quarterly.

Analysis

In quarter 3 the planned deficit score was a 4 and the actual YTD position against plan was a score of 1, these metrics when considered together have given a combined overall finance score of 2 indicating above average. In summary while our planned deficit of £9.8m is not the break-even Trusts are aiming for, at this point in year we are where we planned to be which is positive.

The graph above details the Trust's 2025/26 actual performance in 2025/26 tracked against the original plan and the updated H2 trajectories required to evidence control and improvement on positions.

Ellis Kara
10/02/2026 16:10:45

No further data or ranking has been given against this metric.

Actions

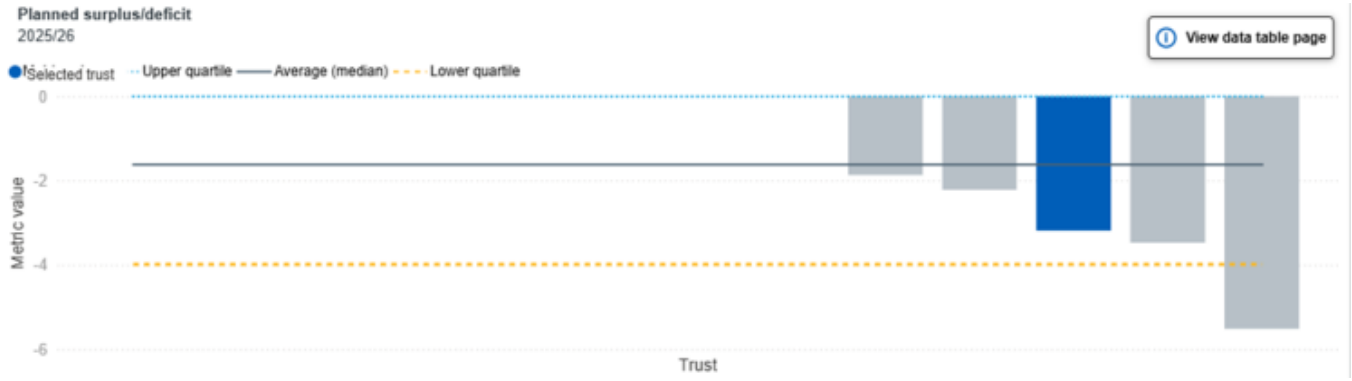
As this score is a combination of the following two Finance metrics, actions have been listed against their individual metrics.

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Domain: Finance and productivity. Sub domain: Finance. Measure: Planned surplus/deficit

Dorset County Hospital
NHS Foundation Trust

The Trust showing blue against other providers in the South West region.



Description of metric

The metric shows the overall level of planned surplus/deficit of the organization for the financial year once deficit support funding has been removed.

Metric calculates a score between 1-4 (1 being high performing and 4 being low performing).

This is an annual scoring metric based on the planned deficit, therefore no further updates will be given for this measure.

Analysis

Due to the planned £9.8 deficit the resulting score was a 4 for the Trust, indicating low performance. A score of 4 recognises a performance of -2% or below when compared against other Trust's surplus/deficit plans, the Trust plans stand at -3.18%. This was between the lower and average quartiles as detailed below:

Lower quartile	Average (median)	Upper quartile
-3.99	-1.62	0.00

Ellis,Kara
10/06/2026 16:10:45

The Trust placed 90th out of the 134 Trusts and 11th out of the 13 South West based Trusts, as the graph is showing above.

Actions

While this metric cannot be changed for the year as it is only calculated annually, work continues to identify areas of saving opportunity and address the underlying deficit.

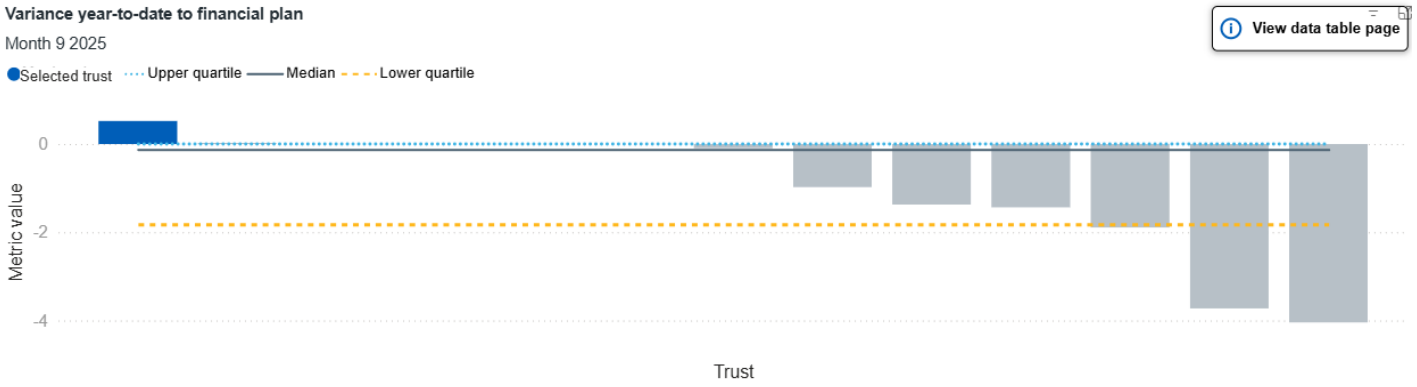
As we begin 2026/27, further attention is being given within DCH to address both nationally set target areas and those internally highlighted as an area of opportunity to bring the Trust back into financial balance.

In addition, NHSE has completed a data gathering exercise to establish if there are under and over funded Trust's. The results indicated that DCH is underfunded and while planning guidance has started to address this, the Trust remains underfunded in 2026/27.

Domain: Finance and productivity. Sub domain: Finance. Measure: Variance year-to-date to financial plan

Dorset County Hospital
NHS Foundation Trust

The Trust showing blue against other providers in the South West region.



Description of metric

Percentage of variance of the actual financial position year-to-date when compared to the planned position.

Metric calculates a score between 1-4 (1 being high performing and 4 being low performing) based on the % variance against plan.

While timing differences and unexpected activity may lead to monthly variation, Trust is required to meet financial plans by the end of the year.

Analysis

NOF data reflects a score of 1 as a month 9 (latest available information via Model Hospital) due to being ahead or in line with plan, and the Trust ended the year on plan so will have scored a 1 for the final Q4 of 2025/26, indicating high performance. A score of 1 recognises a Trust on plan or doing better, which is considered as anything higher than -0.5%, the Trust has a 0.52% variance to plan at month 3. This was between the average and upper quartiles as detailed below:

Lower quartile	Average (median)	Upper quartile
-1.83%	-0.13%	0.00%

Ellis.Kay
10/06/2026 16:10:45

Pending Q4 final results, at Q3 the Trust placed 5th out of the 134 Trusts and 1st out of the 13 South West based Trusts, as indicated in the graph above. While the Trust was ahead of original plan at this time, it was in line with updated H2 trajectory planning and finished the year in line with the £9.8m deficit plan.

Actions

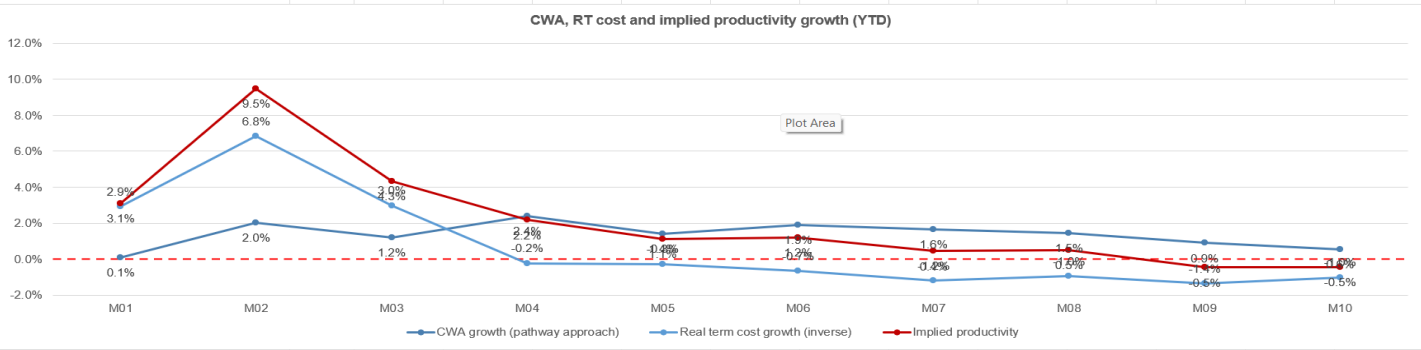
While the Trust was ahead of plan at the month 9, this was linked to achieving updated H2 trajectory forecasts and remained on plan. Following Q4 of 2025/26, the Trust achieved the £9.8m deficit plan by delivering a challenging CIP programme.

During the year, mitigations were identified to close unidentified efficiency gaps and the Recovery Group was in place to ensure progression and delivery of CIP projects. This included:
Property sales
Support services income
Enhanced workforce controls
Wider grip & control focus – with focus on controllable spend and addressing and mitigating overspending areas.

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Domain: Finance and productivity. Sub domain: Productivity. Measure: Implied productivity level

Dorset County Hospital
NHS Foundation Trust



	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10
CWA growth (pathway approach)	0.1%	2.0%	1.2%	2.4%	1.4%	1.9%	1.6%	1.5%	0.9%	0.6%
Real term cost growth	-2.9%	-6.8%	-3.0%	0.2%	0.3%	0.7%	1.2%	1.0%	1.4%	1.0%
Real term cost growth	*-2.9%*	*-6.8%*	*-3.0%*	*0.2%*	*0.3%*	*0.7%*	*1.2%*	*1.0%*	*1.4%*	*1.0%*
Actual cost growth	*3.5%*	*-0.7%*	*3.4%*	*7.6%*	*7.5%*	*7.9%*	*5.7%*	*5.5%*	*6.0%*	*5.7%*
Deflators	*6.6%*	*6.6%*	*6.6%*	*7.3%*	*7.2%*	*7.2%*	*4.5%*	*4.5%*	*4.6%*	*4.6%*
Implied productivity	3.1%	9.5%	4.3%	2.2%	1.1%	1.2%	0.4%	0.5%	-0.5%	-0.5%

Description of metric

As a core headline metric, improving this value means outputs (cost-weighted activity) relative to inputs (operating expenditure) are improving resulting in an improvement in Implied Productivity.

Analysis

For DCH, year-to-date implied productivity growth stands at -0.5% at month 9, which is 1.5% below the 2% national ambition. Real term cost growth has increased by 1%, driven largely by increased substantive staffing costs offset by reduced temporary staffing.

Cost-weighted activity has grown by 0.6%, with increases in non-elective pathways and outpatient follow-ups, though elective activity is 0.9% below the previous year due to reduced inpatient theatre throughput. Costs are disproportionality higher than the increase in activity.

Ellis,Kara
10/06/2026 16:10:45

Action

Proactive counting and coding exercise, working with clinical services to identify activity they are doing, which isn't being counted.

Benchmarking clinic template design, through the GIRFT outpatients work, with the aim of increasing clinic slots.

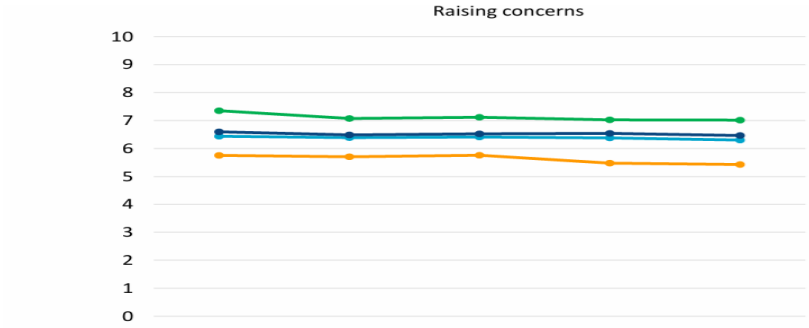
Delivery of identified CIP, drives improved implied productivity.

DCH has reached out to the national team for support. Following a kick off meeting, it has been identified that there is likely an issue with our activity capture. Early findings suggest this is linked to Radiology systems, but further work is needed to confirm this. A report will be going to the next FPC meet. NHSE are supporting the trust with both data analysis.

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Domain: Patient safety. Sub domain: Patient safety. Measure: NHS Staff survey - raising concerns sub-score

Dorset County Hospital
NHS Foundation Trust



	2021	2022	2023	2024	2025
Your org	6.60	6.49	6.53	6.54	6.46
Best result	7.35	7.07	7.12	7.02	7.02
Average result	6.44	6.39	6.41	6.38	6.30
Worst result	5.75	5.70	5.76	5.48	5.43

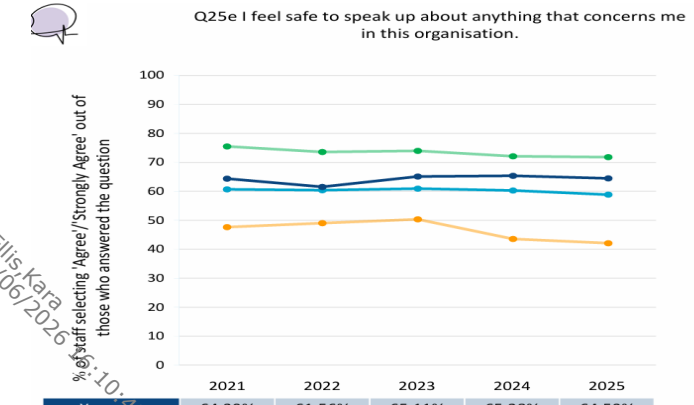
Description of metric

Raising concerns sub-score from 2024 NHS Staff Survey

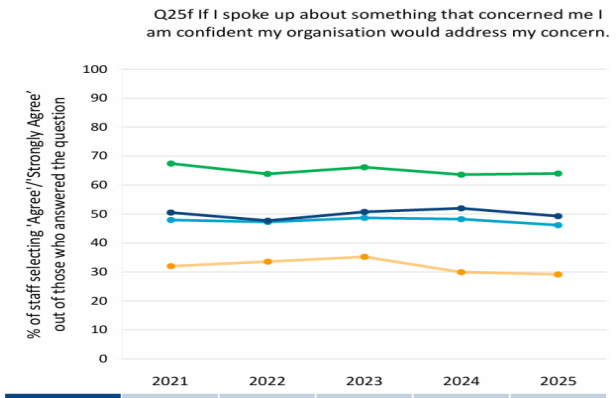
The DCH score (6.54) is above the average (6.38) and ranks us 45 out of 134.

The chart and narrative in this section has been updated to reflect the 2025 results.

Analysis



	2021	2022	2023	2024	2025
Your org	64.39%	61.56%	65.11%	65.38%	64.50%
Best result	75.53%	73.59%	73.99%	72.14%	71.81%
Average result	60.69%	60.38%	60.95%	60.31%	58.85%
Worst result	47.63%	49.02%	50.35%	43.57%	42.11%



	2021	2022	2023	2024	2025
Your org	50.50%	47.71%	50.76%	51.98%	49.30%
Best result	67.44%	63.83%	66.16%	63.62%	63.99%
Average result	47.96%	47.24%	48.68%	48.24%	46.18%
Worst result	32.01%	33.60%	35.23%	29.95%	29.15%

Ellis Kara 10/06/2026 16:10:

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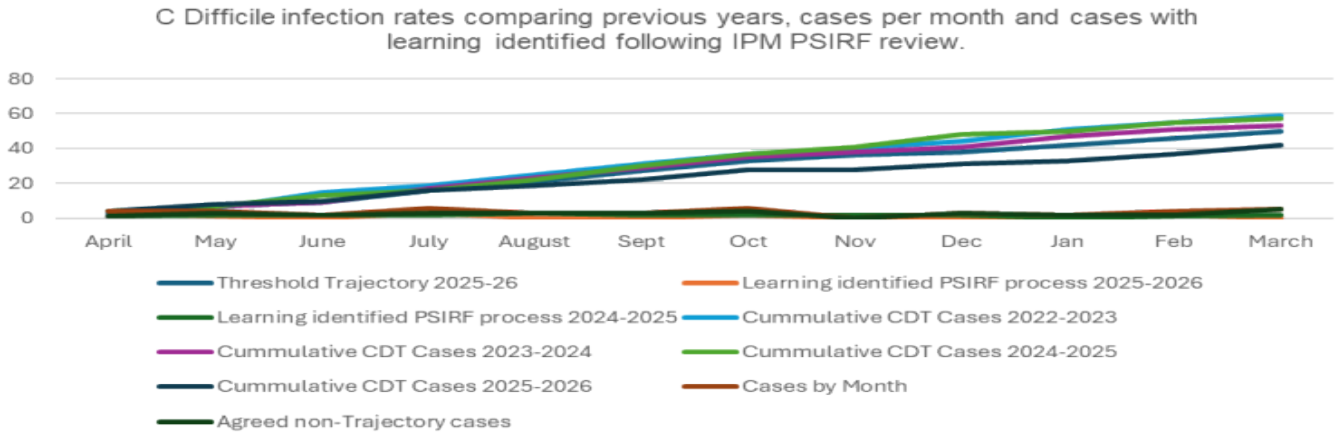
Actions

Since 2022 there have been improvements in both survey questions relating to raising concerns and these scores also remain above average. This improvement can be attributed to the introduction of the Freedom to Speak Up Guardian role and to the implementation of mandatory essential skills training relating to raising matters of concern.

More recently an online reporting tool has been implemented to facilitate anonymous reporting of FTSU and sexual safety issues. Once the tool is embedded within the Trust it will be expanded to capture any issue of concern.

Domain: Patient safety. Sub domain: Patient safety. Measure: Rate of C-Difficile infections

Dorset County Hospital
NHS Foundation Trust



Description of metric

Number of trust apportioned Clostridioides difficile (C. diff) cases to be below the national trajectory for 2026/2027. The trust apportioned trajectory figures are 50 for 2025/2026.

Analysis

Current Reporting as of 30 April 2026

Seven Hospital Onset Healthcare Associated (HOHA), and 4 Community Onset Healthcare Associated (COHA) C. difficile cases reported for March and April 2026. This brings the total of HOHA/COHA cases for 2026-2027 to 6. All the cases have followed the IPC PSIRF (Patient Safety Incident Response Framework) review process.

CDI cases for 25-26 have reduced compared to 24-25 case figures for the same time last year. Currently running at a 4-year low.

Ellis Kara
10/06/2026 16:10:45

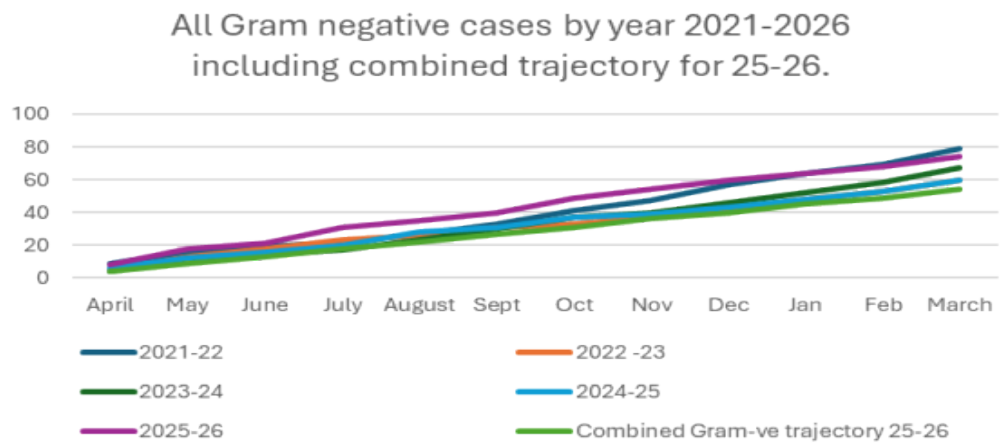
Actions

The IPC Education Framework sets out a vision for the design and delivery of IPC education that supports effective and safe care. Training has a strong Antimicrobial Stewardship focus. DCH is the first Trust in the ICS and most of the Southwest to implement this training using a tired approach.

IPM team are performing a scoping exercise to review the use of urine dipsticks across the trust, this will support our system priority to address a call to action from NHS England regarding our future to deliver the AMR National Action Plan. DCH target to ensure no UTI is diagnosed using a urine dipstick alone, with a formal report due March 2027.

Domain: Patient safety. Sub domain: Patient safety. Measure: Rate of E-Coli infections

Dorset County Hospital
NHS Foundation Trust



Description of metric

Number of Trust apportioned Gram-ve cases to be below the national trajectory for 2026/2027.

Threshold: The Trust apportioned trajectory figures are to be 54 as a total for Gram-ve BSI for 2025/2026.

Analysis

Current Reporting as of 30 April 2026.

Eight Hospital Onset Healthcare Associated (HOHA) & 3 COHA (Community Onset Healthcare Associated) cases gram -ve reportable BSI cases in March and April 2026.

The trajectory levels for 2026/2027 (to be set):

- *E. coli*
- *P. aeruginosa*
- *Klebsiella spp*

In total there were the following HOHA/COHA cases in March and April 2026:

- *E. coli 8 Running total for this year 3 (26-27).*
- *P. aeruginosa 1 Running total for this year 1 (26-27).*
- *Klebsiella spp 2 Running total for this year 1(26-27)*

Elizabeth Kay 21/05/2026 16:10:43

Actions

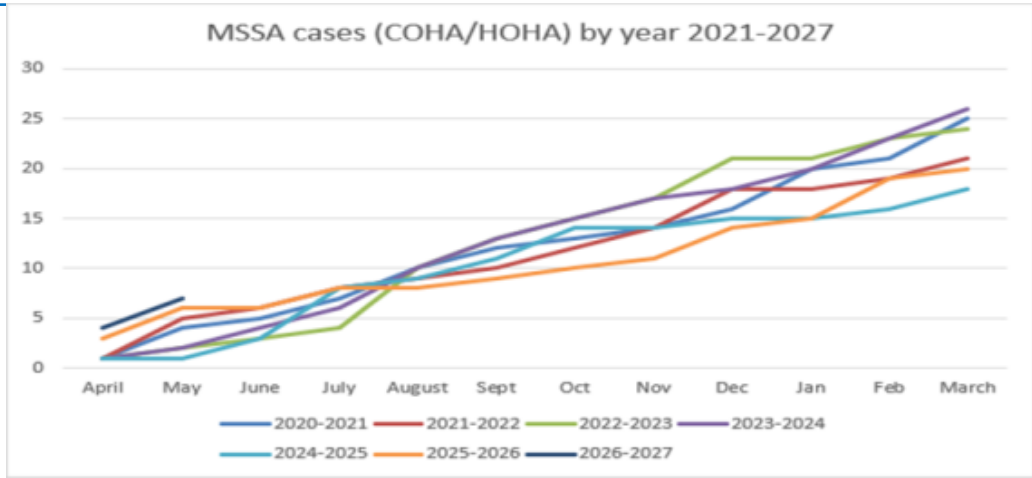
Gram –ve BSI cases are running above threshold level. DCH has a very low threshold figures for *Pseudomonas* and *Klebsiella* blood stream infections for 2025-2026. As mitigation for not remaining within these thresholds all Hospital Onset Healthcare Associated (HOHA) are investigated using the IPM PSIRF (Patient Safety Incident Response Framework) review process, and any learning is addressed, and quarterly reports are provided to the Patient Safety and IPM committees. There are plans to review IPM PSIRF process for 26-27.

Gram-ve reportable BSI running higher than last year.. However, data provides reassurance that DCH are not an outlier trust for *E. coli* or *Klebsiella* BSI rates. However, DCH is not an outlier trust for E coli or Klebsiella BSI rates.

The IPM Team continue face-to-face teaching which include ward based scenarios teaching, Dr induction and Housekeeping training.

Domain: Patient safety. Sub domain: Patient safety. Measure: Number of MRSA infections

Dorset County Hospital
NHS Foundation Trust



Description of metric

Number of Trust apportioned Gram +ve BSI cases to remain low for 2025/2026. There is no trajectory figures set for Gram +ve BSIs.

Analysis

Current Reporting as of 30 April 2026.

There were 3 Hospital Onset Healthcare Associated (HOHA) & 2 COHA (Community Onset Healthcare Associated) cases gram +ve reportable BSI cases in March and April 2026.

In total there were the following HOHA/COHA cases in March and April 2026:
MRSA 0 Running total for this year 0.
MSSA 5 Running total for this year 4.

Evis.Kara 10/06/2026 16:10:45

Actions

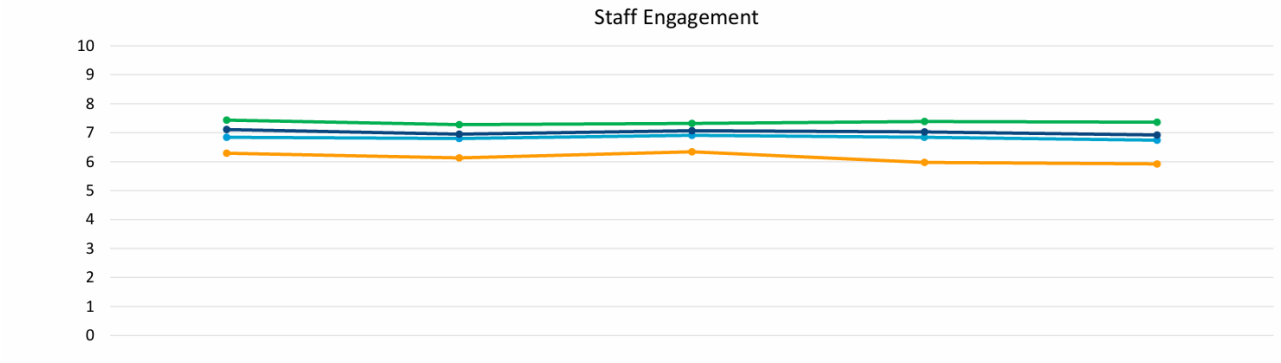
New emerging themes and actions:

- The IPM lead specialist nurse has joined the Southwest MSSA collaborative.
- The Dorset ICB IPC team are carrying out an in-depth case review of all the MRSA Blood stream infections.

Healthier lives Empowered citizens Thriving communities

Domain: People and workforce. Sub domain: Retention and culture. Measure: NHS staff survey engagement theme sub-score

Dorset County Hospital
NHS Foundation Trust



	2021	2022	2023	2024	2025
Your org	7.11	6.95	7.07	7.03	6.92
Best result	7.43	7.28	7.32	7.39	7.36
Average result	6.84	6.80	6.91	6.84	6.74
Worst result	6.29	6.13	6.34	5.98	5.92
Responses	1515	1402	1418	1746	1621

Description of metric

Engagement theme sub-score from 2024 NHS Staff Survey

The DCH score (7.03) is above the average (6.88) and ranks us 38 out of 134.

The chart and narrative in this section has been updated to reflect the 2025 results.

Analysis

The staff engagement score for DCH has remained stable since 2021 and remains above average.

Ellis,Kara
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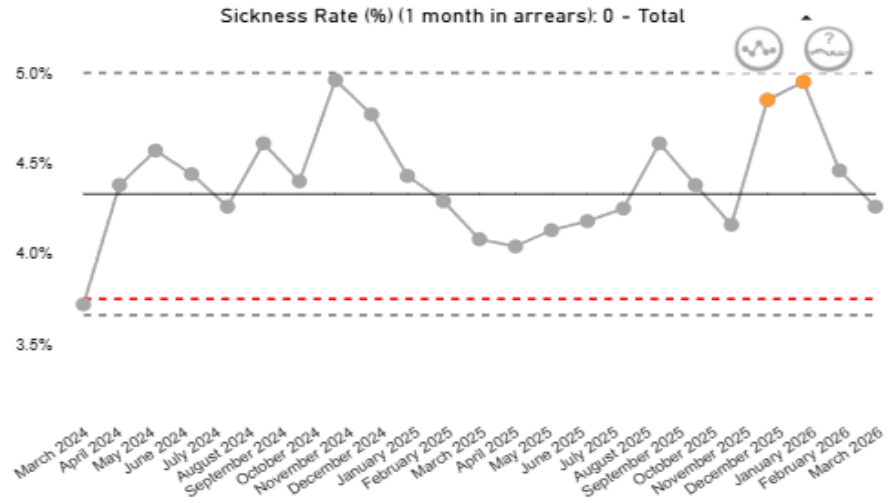
Actions

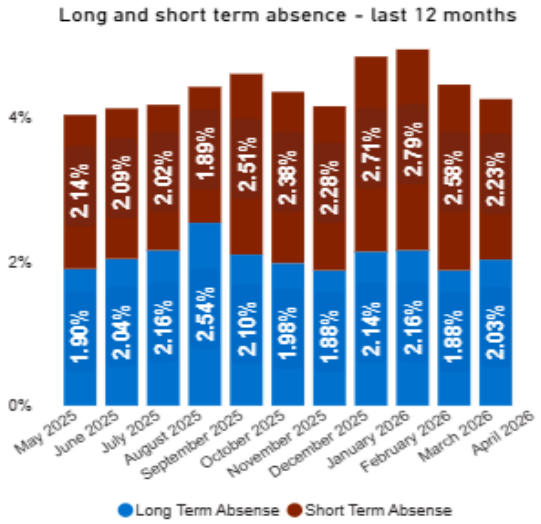
The full 2025 staff survey results were shared with the Board in April. Local results of the 2025 Staff Survey are being disseminated at present and action plans are being developed. 43.5% of staff participated in the 2025 survey.

Healthier lives Empowered citizens Thriving communities

Domain: People and workforce. Sub domain: Retention and culture. Measure: Sickness absence rate

Dorset County Hospital
NHS Foundation Trust





Description of metric

NOF Average Sickness Absence Percentage Q2 25-26

The DCH score (4.4%) is below the average (5%) and ranks us 29 out of 134.

Analysis

The overall sickness percentage increased in month nine and ten, reaching 5% in January. This spike was related mainly to short term sickness due to seasonal illness (coughs/colds). Sickness has reduced since then, to 4.3% in March and 4.1% in April. The rolling 12-month sickness average remains at 4.4%.

Five of the nine staff groups saw a decrease to their absence rates (Additional Clinical Services, Admin & Clerical, Estates & Ancillary, Healthcare Scientists and Nursing & Midwifery Registered). Additional Clinical Services remained as the staff group with the highest absence rate in month with a decrease of 0.2% to 6.7%. In Month 12 three staff groups (Healthcare Scientists, Medical & Dental and Students) recorded sickness below the target of 3.75%.

The top reason for absence remained as Anxiety/Stress/Depression. This accounted for 25.7% in month an increase of 2.5% and accounted for 1,317 days lost; an increase of 220 in month. Use of the on-site counselling service and OH referrals reduced in April due to the Easter period, but use of the Vivup Employee Assistance Programme and associated telephone counselling offer increased in-month.

Actions

HR support is provided in the ongoing management of absence.
A comprehensive health and wellbeing offer is in place for staff, including access to Occupational Health services, a 24/7 Employee Assistance Programme, expediated access to Physiotherapy and onsite counselling provision. Over 90 Health and Wellbeing Champions are in place across the organisation, supported by the OD Team.

The teams and DCH and DHC have been successful in obtaining funding of £40k from NHS Charities Together Workforce Wellbeing Fund. The successful bid will be used to upskill the staff networks for them to become more involved in staff wellbeing. This approach will help to target support for disproportionately affected staff groups.

Healthier lives Empowered citizens Thriving communities

Ellie Kay 10/06/2026 16:10:45

Report to	Board in Common (DHC) – Part 1	
Date of Meeting	17th June 2026	
Report Title	Trust Finance Report for Month 1, April 2026	
November	Michele King – Head of Management Accounts	
Approved by Accountable Executive	Chris Hearn, Joint Chief Finance Officer	
Previously Considered By	Senior Leaders' Group Finance and Performance Committee in Common	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR6: Finance	
Financial	Value for money and financial sustainability addressed in the report	
Statutory & Regulatory	Underpins long term financial sustainability and delivery of operational plan	
Equality, Diversity & Inclusion	No implications arising from the report	
Co-production & Partnership	System financial plan delivery	

Executive Summary

Key messages for the month ended April 2026 are as follows:

- The Trust delivered an adjusted year-to-date surplus of £366k at month 1. This equates to a surplus of £6k against the plan submitted to NHSE for 2026/27.
- With the exception of Corporate services and Finance and Strategic Development and Nurse Executive and quality, all other services are overspent.
- As at month 1, savings of £1.68m have been delivered against a plan of £2.0m, leading to a deficit against the target of £0.32m.

Actions:

- Collectively work together to agree the actions to resolve the financial position at month 1.
- Continue to identify recurrent savings.

Recommendation

The Board is requested to:

- Receive the report for assurance

Ellis,Kara
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Trust Financial Performance Report

Month 1 2026/27- April Summary

1. Summary

At the end of April three out of five of the KPIs are rated green.

KPI	RAG
Current Month Break Even	
Year to Date Variance to Plan	
Capital Spend against Plan	
Delivery of Savings Programme	
Better Payment Policy	

Key messages

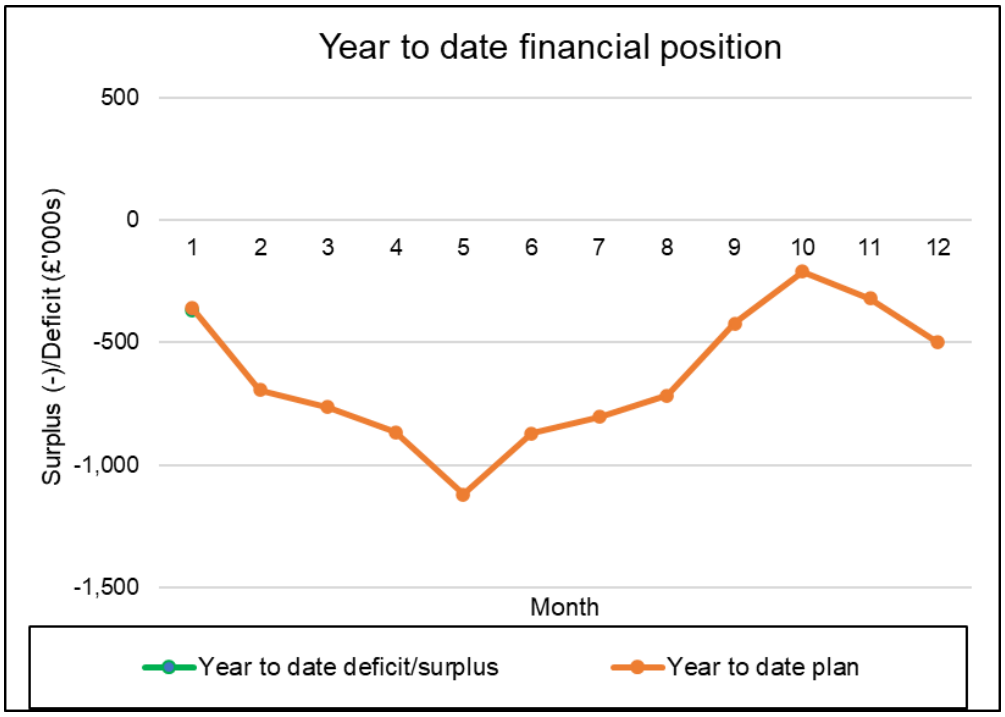
- The Trust has three measures of financial performance: Income over expenditure, performance against NHSE Plan and, due to phasing of budgets different from NHSE plan, the budget plan.
- The Trust delivered an adjusted year-to-date surplus of £366k at month 1. This equates to a surplus of £6k against the plan submitted to NHSE for 2026/27.
- With the exception of Corporate services and Finance and Strategic Development and Nurse Executive & Quality, all other services are overspent.
- As at month 1, savings of £1.68m have been delivered against a plan of £2.0m, leading to a deficit against the target of £0.32m.

Ellis,Kara
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2. Month 1 performance

2.1 Summary

- The graph below shows that the Trust delivered an adjusted year-to-date surplus of £366m at month 1. This equates to a surplus of £6k against the plan submitted to NHSE for 2026/27.
- Appendix 1 includes the full detail of the Trust's financial performance.



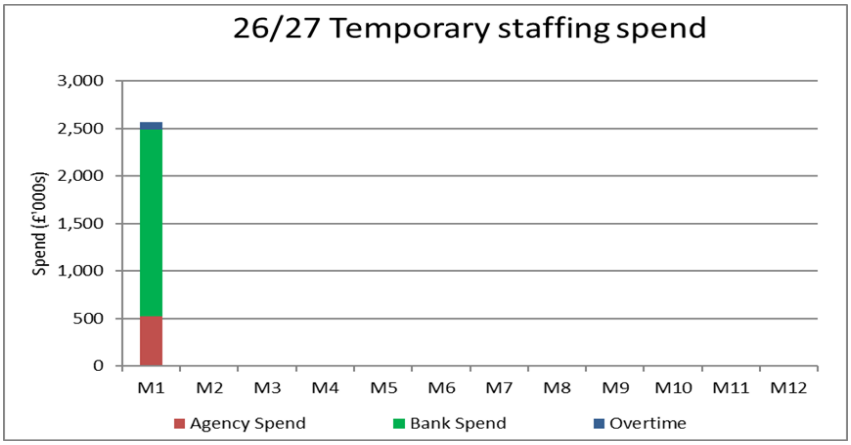
- The key drivers of the Trust's position are set out below.

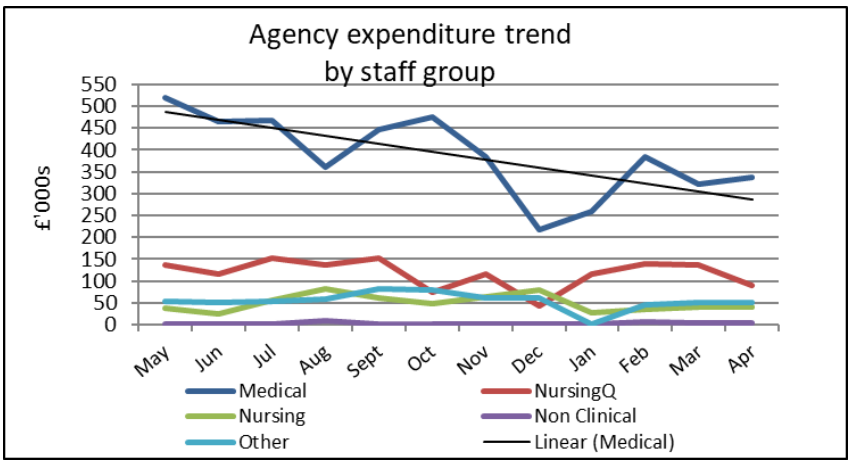
Drivers of Financial Performance	£'000s
MH Collaborative (Lead provider) purchase of healthcare	(387)
Clinical supplies and service	(249)
Staff related costs	(218)
Interest received	(96)
Temporary staffing	336
Efficiency savings	315
Out of area placements	293
Surplus against NHSE plan	**(6)**

Ellis Hall
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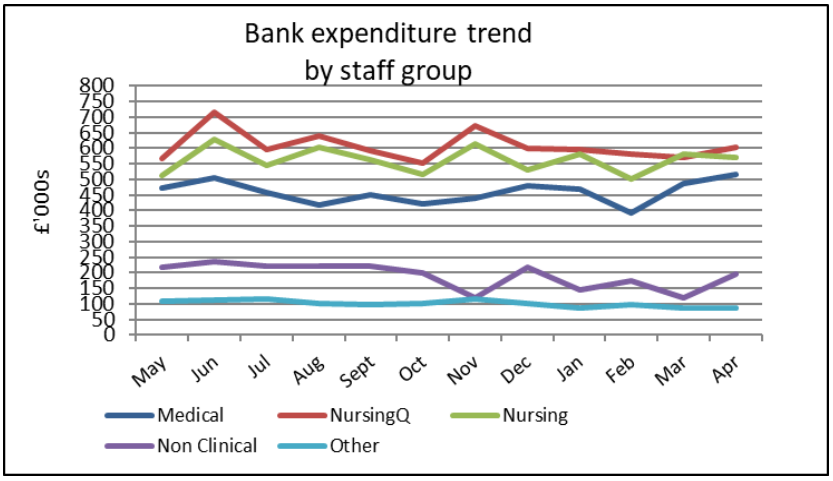
2.2 Agency expenditure

- Temporary staffing costs increased by £213k in month 1.
- Agency costs increased by £94k, from £428k to £522k, bank increased by £124k and overtime reduced by £5k.
- Agency expenditure is £220k lower than the same period last year, bank £44K higher and overtime costs £18k higher.
- The largest area of agency spend is currently in the Medical directorate, which is £186k lower than the same period in 25/26.
- Agency expenditure is above plan by £37k and 1.87% of total pay costs.
- Bank expenditure is above plan by £299k and is 7.06% of total pay costs.





Ellis,Kara
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2.3 Efficiency Programme

- The total target for 2026/27 is £28.9m. This is made up of £22.2m assigned to operational efficiencies and a central stretch target of £6.7m.
- The table below shows the position as at the end of April.
- As at month 1, savings of £1.68m have been delivered against a plan of £2.0m, leading to a deficit against the target of £0.32m.

						Of identified:				
						Risk level			R/NR	
Division	Core Target Allocations £'000	Temporary Workforce Allocation £'000	Core Identified £'000	Core (Unidentified) / over £'000	Core % Identified	Low £'000	Medium £'000	High £'000	Recurrent	Non Recurrent
Core - 5%										
MH & CYP	3,549	4,102	4,083	534	115.1%	1,232	2,601	250	36.8%	63.2%
ICS	2,713	2,295	2,040	(673)	75.2%	1,133	851	56	50.7%	49.3%
Medical		2,360	-	-			-	-		
Estates	2,437	96	2,742	305	112.5%	597	631	1,514	45.3%	54.7%
Finance	254	19	254	0	100.1%	159	95	-	37.4%	62.6%
Digital	1,083	26	636	(447)	58.7%	270	366	-	76.9%	23.1%
Business & Performance	362	-	282	(79)	78.0%	282	-	-	63.0%	37.0%
Transformation & QI	14	-	14	0	100.0%	14	-	-	100.0%	0.0%
Nursing & Quality	503	34	505	2	100.3%	279	178	49	64.8%	35.2%
People & Culture	831	19	507	(324)	61.0%	238	269	-	95.4%	4.6%
Corporate	63	1	79	16	125.0%	79	-	-	100.0%	0.0%
Central	1453		1,197	(256)	82.4%	1,197	-	-	73.6%	26.4%
Temporary Workforce Reduction	8,953	(8,953)	4,283	(4,670)	47.8%	1,600	-	2,683	161.0%	-61.0%
Subtotal	**22,215**	**-**	**16,622**	**(5,593)**	**74.8%**	**7,079**	**4,990**	**4,553**	**39.0%**	**61.0%**
Central Stretch - 1.5%	6,665		2,970	(3,695)	44.6%	2,970	-	-	50.5%	49.5%
Total	**28,880**		**19,592**	**(9,288)**	**67.8%**	**10,049**	**4,990**	**4,553**	**48.2%**	**51.8%**
						51%	25%	23%		

- Of the £28.9m target, £19.6m (68%) of efficiency schemes have been identified with 48.2% being recurrent.
- Of these:
  - £10.0m (51%) is low risk.
  - £5.0m (25%) is medium risk
  - £4.5m (23%) is high risk.

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2.4 Out of area placements

- The mental health bed capacity in Dorset is currently below the modelled requirements, meaning that out of area placements will continue to be necessary until the new St Ann's hospital opens.
- Beds have been block booked at the Priory in Southampton to compensate for the lack of capacity. 8 beds have been block booked until the end of March 2027.
- With 12 patients at the end of April, including 8 in block booked beds, the budget is overspent by £293k.

2.5 Directorate performance

- The table below sets out the financial performance by directorate, with the majority of directorates facing financial challenges.
- Note that the variance to budget is a key internal control measure only and is a key indicator of individual directorate performance. It is not reported as the Trust's deficit externally as the budget phasing does not align with the plan submitted to NHSE.
- Work is ongoing to re-align the pay budgets with the majority expected to be completed for month 2.

	Full year budget	Month 1 spend	YTD spend	Variance to budget at Month 11
	£'000s	£'000s	£'000s	£'000s
Trust Wide Income	(352,821)	(29,459)	(29,459)	(0)
Central budgets	43,543	90	90	807
Integrated Community Services	111,740	9,283	9,283	56
Mental Health & Children's Service	132,023	11,191	11,191	196
Medical Staffing	28,049	2,582	2,582	149
Nurse Executive and Quality	9,604	765	765	(31)
Finance and Strategic Development	42,434	3,291	3,291	(255)
People & Culture	5,852	353	353	28
Strategy, Transformation & Partnerships	14,533	1,246	1,246	39
Corporate Services	4,080	347	347	(11)
Total	39,037	(310)	(310)	978
Capital donations/grants/peppercorn lease	(39,537)	55	(55)	
Adjusted total	(500)	(255)	(366)	

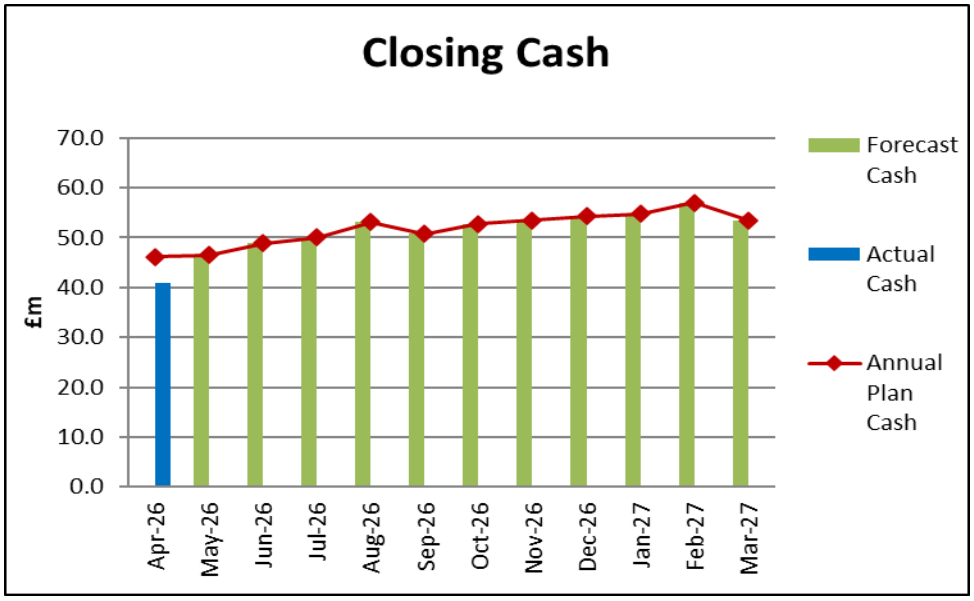
- The table above reflects the net position of each service.
- The drivers of the Medical Staffing directorate variance are:
  - Unachieved efficiency savings.
  - Agency expenditure.
- The drivers of the Mental Health and Children's Services directorate variance are :
  - Unachieved efficiency savings.
  - Out of area placements.

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- The drivers of the Finance & Strategic Development directorate variance are :
  - Facilities vacancies.
  - Low Adult Eating Disorders Provider Collaborative costs due to low activity.

3. Cashflow and payments

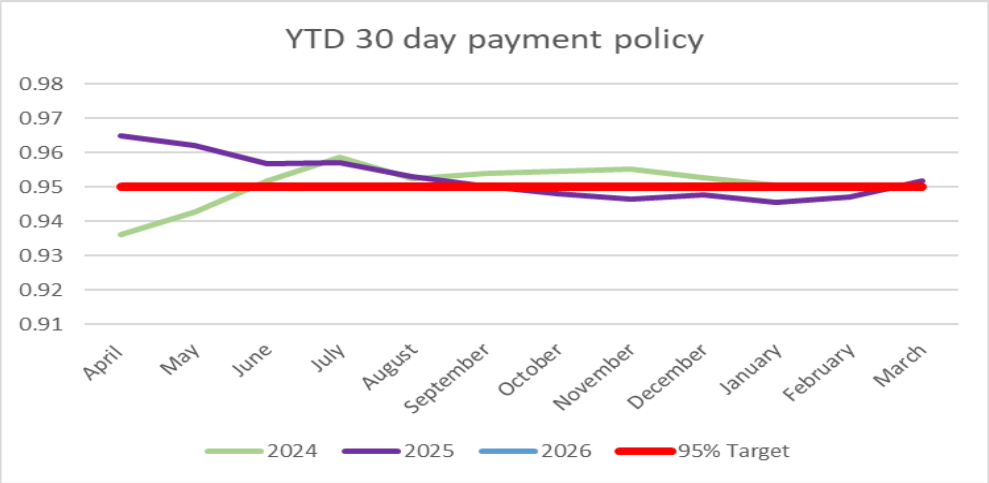
- The cash balance at M1 was £41.04m, a decrease of £0.25m from last month.
- Cash levels are below plan (£5,100k) due to £2.9m repaid to NHSE in respect of NHP slippage and reduced payment of outstanding DCH debt from 2024/25 than planned last year.
- Overall debtors remain high with £11.42m of LA and NHS debt which is over 90 days old. DCH represents 99.9% of this balance.



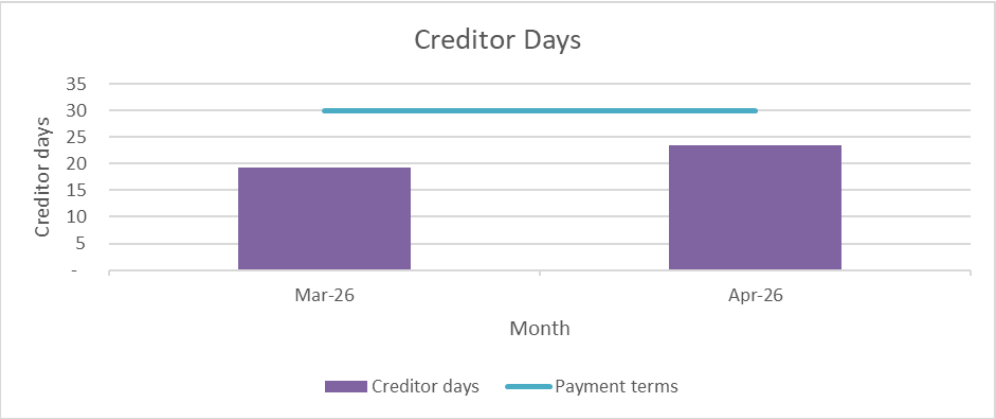
- The YTD Better Payment Practice Code performance is shown below. The target is 95% and has been achieved this month.
- Performance is up by 2.38% in month.

Month	1
BPPC performance	97.55%

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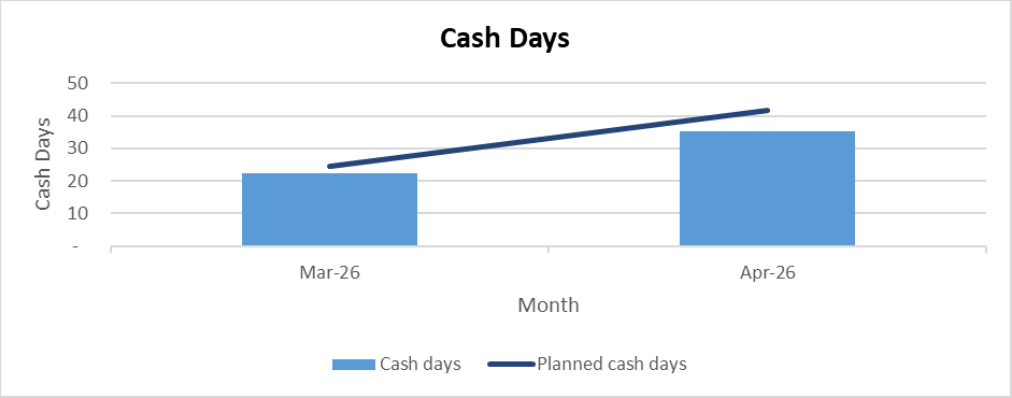


- Favourable creditor days based on trade payable only.



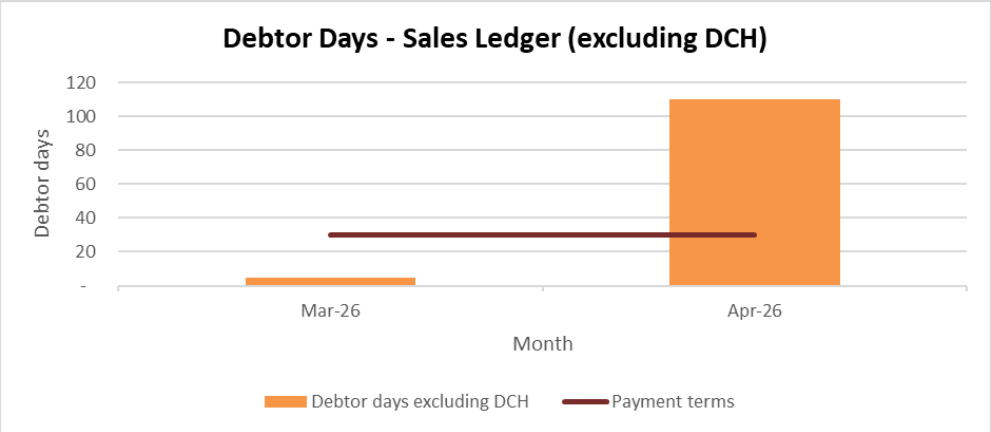
A standard 30-day payment term has been used for comparison.

- The cash days graph below shows the number of days that the Trust could sustain its current level of expenditure without any further income, giving a snapshot of our current cash position.



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- The debtors day graph below shows how long it takes the Trust to collect payment from its customers.
- Debtor days has increased as there has been minimal invoicing at the start of the year.



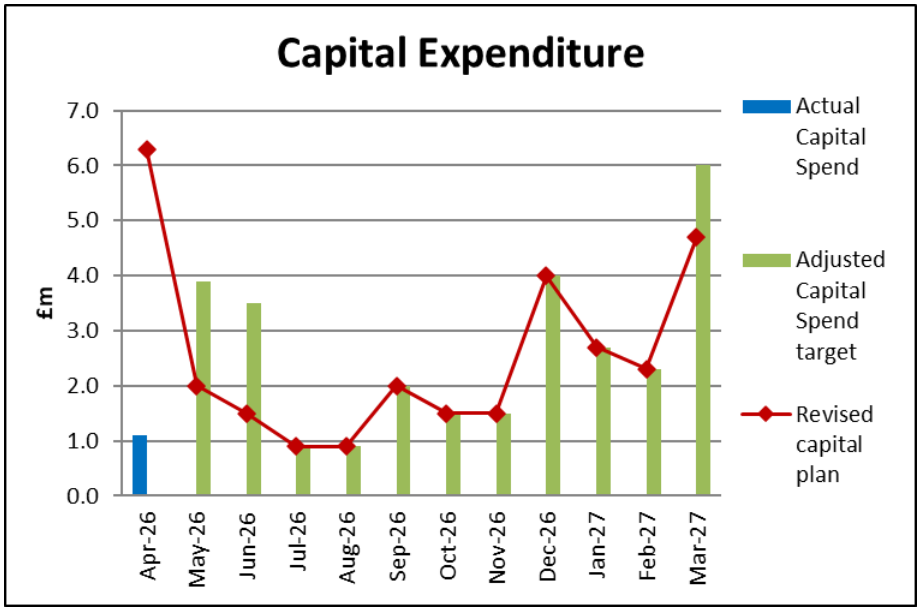
4. Capital programme

- Total capital expenditure target for 2026/27 is £30.27m.
- Month 1 spend was £1.06m of which £85k was on internally funded capital CDEL and £973k on externally funded programmes.
- 2026/27 forecast spend on the New Hospital Programme is £16.2m. This is the result of some slippage on the new builds completion into May/June 2026 and the further refurbishment works to be undertaken at St Ann's which is delayed by both new build completion and design work.
- Work is being undertaken to see if the underspend from zero rated VAT can be used for additional opportunities in line with the business case objectives.
- St Ann's NHP is under review for scope enhancements.
- The delivery of the capital programme will be achieved by:
    - Regular meetings between the capital finance team and key capital budget managers.
    - Line by line review of larger capital project lines, such as the NHP project, backlog maintenance and IT projects.
    - The investigation of variances between plan and actual spend.
    - The accurate accruing to completion at the quarter months.
    - The identifying of internally funded capital slippage, and the reallocation to additional spends in year brought forward from future years.
    - Regular monthly meetings of the Capital Investment Meetings (C.I.M.), where progress is reported, and adjustments agreed to the in-year programme to compensate for slippage.
- Key projects within the 2026/27 capital programme include:

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- St Ann's, CAMHS PICU, and HIP 2 – £16.2 million (externally funded)
- Backlog maintenance - £2.7m (internally funded)
- Herm ward extension - £1.8m (internally funded)
- St Leonard's repurpose - £1.5m (internally funded)
- Healthset - £1.0m (internally funded)

- Depreciation totalled £1.20m (plan £1.16m) for month 1, £0.04m above plan. This is due to the Trust mitigating capital slippage towards the end of 2025/26 with equipment purchases plus the securing of £600k of additional funding in that year which was largely used to purchase equipment which has a shorter life in use. This increases subsequent year depreciation.



5. Points to note.

- April non-pay expenditure is usually light, due to the process in place to capture costs at year-end.
- Not all pay budgets have been realigned to take account of staff in post as at 31ST March or been uplifted for the agenda for change pay award. It is expected this will be completed for month 2 reporting.
- Medical pay budgets will be uplifted for month 3 reporting in line with the payment of the award backdated to 1st April.

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6. Conclusion

- 2026/27 will be a challenging year for the NHS and Trust finances.
- Financial balance will only be achieved by individuals and directorates working hard to achieve a successful outcome.
- There are a number of risks to financial balance which are being monitored closely across all areas of the Trust.

Ellis,Kara
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Appendix 1 – Trust financial performance

INCOME & EXPENDITURE SUMMARY								
Month 1 2026/27		YTD			IN MONTH			
April	**ANNUAL BUDGET**	**YTD Budget**	**YTD Actuals**	**YTD Variance**	**Budget**	**Actual**	**Variance**	
	£'000	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	
INCOME								
Baseline Income	(351,204)	(29,237)	(29,237)	(0)	(29,237)	(29,237)	(0)	G
Integrated Community Services	(18,945)	(1,667)	(1,712)	(45)	(1,667)	(1,712)	(45)	G
Children, Y.P. & Family Services, All Age Mental Health & L.D. Services	(33,121)	(2,456)	(2,232)	224	(2,456)	(2,232)	224	R
Medical Staffing	(2,975)	(248)	(253)	(5)	(248)	(253)	(5)	G
Nurse Executive & Quality	(1,526)	(129)	(160)	(30)	(129)	(160)	(30)	G
Finance & Strategic Development	(7,661)	(638)	(569)	69	(638)	(569)	69	R
People & Culture	(6,031)	(606)	(605)	0	(606)	(605)	0	G
Strategy, Transformation & Partnerships	(23)	(2)	(6)	(4)	(2)	(6)	(4)	G
Corporate	(572)	(48)	(52)	(4)	(48)	(52)	(4)	G
Interest Received	(1,617)	(222)	(222)	(0)	(222)	(222)	(0)	G
Central Budgets	(1,235)	(278)	(326)	(48)	(278)	(326)	(48)	G
Total Trust Income	**(424,910)**	**(35,531)**	**(35,373)**	**158**	**(35,531)**	**(35,373)**	**158**	R
EXPENDITURE								
Integrated Community Services	130,685	10,894	10,995	101	10,894	10,995	101	R
Children, Y.P. & Family Services, All Age Mental Health & L.D. Services	165,144	13,451	13,423	(28)	13,451	13,423	(28)	G
Medical Staffing	31,024	2,681	2,835	154	2,681	2,835	154	R
Nurse Executive & Quality	11,131	926	925	(1)	926	925	(1)	G
Finance & Strategic Development	50,094	4,184	3,860	(324)	4,184	3,860	(324)	G
People & Culture	11,883	931	959	28	931	959	28	R
Strategy, Transformation & Partnerships	14,557	1,209	1,252	43	1,209	1,252	43	R
Corporate	4,652	405	399	(7)	405	399	(7)	G
Central Budgets	(128)	(935)	(81)	855	(935)	(81)	855	R
Impairments	38,942	0	0	0	0	0	0	G
Total Trust Expenditure	**457,982**	**33,746**	**34,566**	**820**	**33,746**	**34,566**	**820**	R
NET INCOME & EXPENDITURE	**33,073**	**(1,785)**	**(807)**	**978**	**(1,785)**	**(807)**	**978**	
PDCD	5,964	497	497	(0)	497	497	(0)	G
RETAINED (SURPLUS)/DEFICIT	**39,037**	**(1,288)**	**(310)**	**978**	**(1,288)**	**(310)**	**978**	R
EBITDA			**5.1%**					
Technical adjustments								
Capital donations/grants/peppercorn lease/PPE	(39,537)		(55)					
ADJUSTED (SURPLUS)/DEFICIT	**(500)**		**(366)**					

Ellis,Kara
10/06/2026 16:10:45

Dorset County Hospital
NHS Foundation Trust

Report to	Board in Common (DCH)	
Date of Meeting	17th June 2026	
Report Title	DCH Finance Report – Month 1 2026/27	
Prepared By	Claire Abraham, Deputy CFO DCH	
Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	Finance and Performance Committee in Common 27 June 2026	
Action Required	**Approval**	-
	Assurance	Y
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR6 Finance Identify risks and mitigations associated with plan delivery, financial sustainability	
Financial	Value for money and financial sustainability	
Statutory & Regulatory	Monitoring, active intervention to deliver operational plan	
Equality, Diversity & Inclusion	n/a	
Co-production & Partnership	Federation working and organisational financial plan delivery	

Executive Summary

Dorset County Hospital NHS Foundation Trust (DCHFT) submitted a break even plan to NHS England (NHSE) on 18th April 2026 for the financial year 2026/27, noting the inclusion of £2.6 million Deficit Support Funding to reach balance.

Key Messages

Month one delivered a deficit of £1.3 million after technical adjustments, being £0.216 million away from the planned deficit of £1.1 million. The driver of this position is largely due to the cost of supporting Industrial Action in month, which at this stage remains unfunded per NHSE advice.

Phasing adjustments reflecting ZBB exercise being completed for M2 across income, pay and non pay areas – no impact on bottom line phased plan per month or full year.

Temporary workforce agency costs incurred of c.£0.5m and whilst over April plan, this plan reflects expected reduced expectation of 30% reductions in temporary workforce spend. Actual in month demonstrates an improved run rate from March (£684k and Feb £660k). Month one Off framework usage of £16k has been incurred noting break glass limited usage in place.

Bank challenged area with increased usage noting month one challenges and plan caveat as mentioned above. In month actual spend of £1.351 million is currently higher than prior month run rate actual spend with March incurring £1.237 million and February £1.199 million. Industrial action (no offset currently), meningitis support (offset by income), bank holidays and increased operational pressures are key driving factors with active oversight in place to review and recover.

Efficiency delivery for the year is £23.3m at 6.5%, with in month delivery of £0.571 million against a plan of £0.598 million being £0.027 million away with 61% delivered recurrently (£0.348 million), noting essential focus in this area to support recovery of the Trust's underlying deficit.

Ellakara 29/06/2026 13:19:43

NHSE has requested that by end of quarter one, no unidentified scheme levels remain, and with no more than 20% of identified schemes classed as high risk. At month one, the Trust has 29% unidentified (£6.7m) and 20% of high risk schemes (£4.7m).

Cash is currently ahead of plan due to timing of income received, VAT recovery and timing of capital creditor payments which enhances the Trust's short term cash resilience however noting daily granular monitoring is in place for early indications of cashflow issues.

Capital expenditure is progressing with £3.4 million spend in month being £0.1 million ahead of plan largely due to net impact of internally funded schemes behind plan (£0.7m) and timing of New Hospital Programme (NHP) works ahead of plan (£0.8m).

Key Actions

There are a number of challenging risk areas which require significant focus and active mitigation to ensure the Trust delivers to plan for the financial year – these being efficiency delivery; pay variance control in particular agency and bank expenditure; continued risk of increased operational pressures; sickness, and the ongoing risk of costs supporting Industrial Action.

Careful cash monitoring remains a high priority with active system and NHSE discussions to address longer term mitigations ongoing.

The Trust's Finance Recovery Board chaired by the Chief Executive and supported by the Improvement Director has clear focus and oversight in these areas, with active engagement from all areas in place. Key focus on discretionary expenditure monitoring is in place. Continued emphasis on the efficiency programme including recurrent scheme delivery to support reducing the Trust's underlying deficit position is a key priority.

Recommendation

The Trust Board is recommended to:

1) Receive the month one financial position for the financial year 2026/27 for **assurance**.

Ellis,Kara
10/06/2026 16:10:45

Dorset County Hospital
NHS Foundation Trust

Financial Position Update 2026/27

April 2026 - Month 1

Chris Hearn
Chief Financial Officer

Healthier lives Empowered citizens Thriving communities

Ellis,Kara
10/06/2026 16:10:45

Financial Position Update April 2026 - Month 1

Executive Summary

Dorset County Hospital NHS Foundation Trust

A summary of progress for April 2026 is presented against the plan submitted to NHS England (NHSE) on 18 March 2026, which outlined a breakeven position including £2.6m of Deficit Support Funding.

In April 2026, Dorset County Hospital NHS Foundation Trust (DCH) has delivered a month 1 deficit of £0.216 million after technical adjustments, an adverse performance against a plan of £1.088 million deficit.

The adverse variance of £0.216 million is the direct result of costs incurred supporting Industrial Action in month 1, at this stage there is no funding to support the spend impact. The position also includes £0.184m of costs arising directly from the closure of and support provided to the Yeovil maternity service. This has been offset by assumed income, which remains subject to confirmation.

The Trust plan included a £0.6 million efficiency target for month 1, which was largely delivered with a small shortfall of £0.027 million in month. Savings were mainly the result of efficiencies in pay slippage, Bank Interest and some non pay savings with further traction needed to commence planned efficiency schemes. The total efficiency plan for the year is £23.3 million and 29% of this remains unidentified and a further 20% at high risk of delivery. Continued identification and development of schemes is needed to ensure the full year financial plan can be achieved. NHSE have stated Trusts must identify full efficiency schemes with only 20% rated high risk by the end of Quarter 1.

Agency expenditure in M1 is £0.2m away than planned levels, and while the spend in month 1 is an improvement to the average for the prior quarter, costs remain high across both nursing and medical categories, noting Easter period and supporting Industrial Action. Medical agency reduction is a strong focus for the Trust alongside continued work on Nursing agency. Bank expenditure remains a key focus area noting bank overspend of £0.7m in Month 1. The high spend in Temporary Staffing is due to supporting Industrial action; Yeovil maternity; ongoing demand, and at this stage includes offsets by vacancy levels. Reduction in agency and bank expenditure requires essential focus on enhanced controls across the Trust to manage spend and will continue to be an area of focus with NHSE throughout 2026/27 .

Non Pay is overspending at M1 which includes increased spend against the Trusts external security provision whilst recruitment to the new structure is ongoing. Backdated rates; autism assessments, and increased reporting services for out of hours external CT scanning reports due to vacancies within the team have been seen in M1, although mitigated through out of contract income.

The Management Accounts team are currently processing some outstanding budget adjustments linked to the zero based budgeting exercise recently undertaken which are expected to be completed for month 2. This will appropriately align budgets across income and expenditure lines with expected spend.

The Trust is progressing with the capital programme for 2026/27 with month 1 YTD spend totalling £3.4 million, which is ahead of plan by £0.1 million. Externally funded projects are £0.8 million ahead of plan due to timing of expenditure on the New Hospital Programme (NHP) construction works. Internally funded schemes, leased schemes and donated schemes are behind plan by £0.7 million due to timing of expenditure on generator, Digital Healthset (EHR) and replacement of Medical Equipment.

The cash position at the end of April is £23.7 million, which is £4.9 million ahead of submitted plan. This favourable variance is driven by the receipt of Q1 Health Education England income, of which £2.1 million relates to May and June, VAT recovery £0.7 million received in month and the timing of capital creditor payments, which provides a short-term cash-flow benefit £2.1 million. These factors collectively enhance the Trust's short-term cash resilience; however the a portion of the benefit is timing-related and will unwind in future periods.

Ellis,Kara
10/06/2026 16:10:45

Financial Position Update April 2026 - Month 1

Key Risks

Dorset County Hospital
NHS Foundation Trust

Efficiency Delivery Risk
Forecast delivery is currently highlighted as a risk, noting unidentified and high risks which remain at M1. NHSE requests that all organisations have a fully identified efficiency plan with no more than 20% schemes rated as high risk by the end of June 2026. The Trust continues to deploy targeted support towards this achievement with an Improvement Director across the Federation, led by the CEO as part of the Financial Recovery Board (FRB) and supported by the wider Executive team in order to mitigate the risk to financial balance.

Cash Position
There is a risk to cash levels throughout the year as a result of planned deficits in the first 9 months of the year and challenging efficiency targets, which if not delivered would have further negatively impact cash levels . Detailed cashflow workings are in place to provide granular monitoring of cash levels and to give early indication of cashflow problems.

Ongoing Risk of Cost Pressures re Yeovil Maternity support
On 19th May 2025 Yeovil District Hospital took the decision to close the Maternity and Special Care Baby Unit. Given approximately 20% of activity in these units was attributable to Dorset residents, and with some Somerset residents being more local to Dorchester than Taunton or Bath, a significant increase in the number of mothers and babies requiring care at DCH has been experienced. While Yeovil Maternity has now reopened, the Trust is not expecting a immediate cessation of the additional activity seen in 2025/26, as a result cost pressures continue to ensure safe levels of staffing are provided. At this stage there is an assumed funding in the position to offset the incurred costs, with discussions taking place to finalise the income.

Ellis Kara
10/06/2026 16:10:45

Financial Position Update April 2026 - Month 1

Key Risks

Dorset County Hospital NHS Foundation Trust

Red Risks:

The Trust has an efficiency delivery requirement of £23.3m to achieve the planned full year breakeven position. Of which c.£2.7m is planned efficiencies relating to reduction in Bank and Agency.

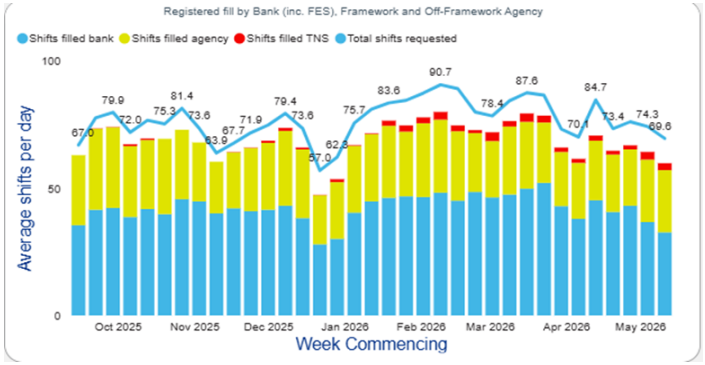
At Month 1, agency expenditure finished £0.24m overspent (£0.5m actual vs £0.26m plan). The overspend is primarily driven by Nursing (£0.27m adverse) and Medical (£0.05m adverse), partially offset by favourable positions within Other Clinical and Admin & Clerical. Total agency usage remains concentrated within Nursing, which accounts for the majority of spend (£0.28m in-month). Compared to plan, this reflects early year pressure on frontline staffing groups, noting support for Industrial Action not funded at this stage.

NHSE mandated that all off-framework agency spend ceased from July 2024. In Month 1, whilst off-framework usage remains minimal, this remains an area of high focus going in to 2026/27. Internal controls through the High Cost Agency Reduction Group remain in place, with a continued focus on reducing nursing agency usage and optimising bank utilisation where appropriate. Agency notice periods remain at 48 hours to support bank fill rates.

Bank expenditure in Month 1 finished £0.67m overspent (£1.35m actual vs £0.68m plan). The overspend is largely driven by Nursing (£0.33m adverse) and Medical (£0.20m adverse), with further pressure across Admin & Clerical (£0.11m adverse) and Other Clinical (£0.03m adverse). Bank usage continues to be deployed to support safe staffing across vacancies, sickness and operational pressures and the continued approach to utilise bank staffing ahead of agency.

Bank spend represents 6.9% of total pay, consistent with run-rate expectations but above plan, reflecting continued reliance on temporary staffing at the start of the year. Work continues to ensure bank usage is appropriate, with rosters aligned to demand and booking controls reinforced through standard operating procedures.

Looking ahead, the Month 1 position highlights early year pressure across both agency and bank, particularly within Nursing and Medical workforces. If sustained, this trajectory presents a financial risk against the 2026/27 plan. Reducing reliance on temporary staffing remains a key priority, with delivery of planned cost improvement programmes and strengthened workforce controls critical to mitigating cost pressures over the remainder of the year.



Ellis,Kara
10/06/2026 16:19:43

Key Risk Status
Red - Significant risk of non-delivery. Additional actions need to be identified urgently.
Amber - Medium risk of non-delivery which requires additional management effort to ensure success
Green -. Low risk of non-delivery – current actions should deliver.

Dorset County Hospital
NHS Foundation Trust

Key Risks

Amber Risk:

For 2026/27 NHS England has revised the Aligned Payment and Incentive (API) approach to all NHS standard contracts. This approach now splits the payment mechanism for the majority of NHS contracts into three envelopes, Fixed, Variable & UEC Blended.

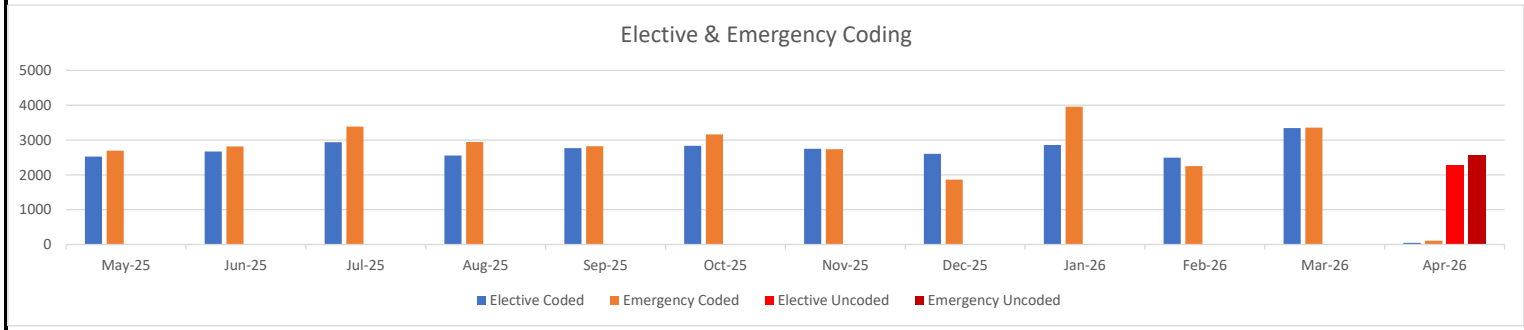
The fixed element of the contract will be agreed between NHS providers and commissioners for the provision of specified services, this will be paid on a block basis across the year regardless of activity delivery. The fixed element of the contract will pay for any activity not covered under the variable or UEC blended elements.

The variable element of the contract will cover most elective activity: Elective inpatients, Day cases, Outpatient first attendances, Outpatient procedures, Chemotherapy delivery and Diagnostics. An income envelope will be agreed between NHS commissioners and providers to an agreed baseline level of activity, this will then be adjusted for actual performance using the National Tariff. Any underperformance against baseline will be repaid at 100% of the national tariff and any over performance will be received at 100% of the national tariff.

The UEC blended element covers non-elective inpatients and A&E activity (incl Minor Injury Units). An income envelope will be agreed between NHS commissioners and providers to an agreed baseline level of activity, this will then be adjusted for actual performance using the National tariff. The contracting expectations for 2026/27 state that any under or over performance will be paid at a marginal % of the national tariff, negotiations are underway with the ICB to agree what marginal %'s will apply.

The tariff for each patient is calculated based on their clinical coding assessment. Coding is operated on a flex/freeze model where final coding must be completed by the freeze date to qualify for payment. The freeze date is typically 7 weeks after the end of the month in which the activity occurred, the full timetable is included for information. Any activity that remains uncoded after the applicable freeze date represents a loss of income for the Trust.

As at April 2026, the Trust has 2,297 uncoded elective spells & 2,574 uncoded non-elective spells. There is typically a 2 month lag at the end of each period where coding is completed to meet the applicable freeze dates. Based on coding trends captured over a rolling 12 month period, no significant coding issues have been incurred.



Month	Flex	Freeze
Apr-26	20/05/2026	17/06/2026
May-26	17/06/2026	17/07/2026
Jun-26	17/07/2026	19/08/2026
Jul-26	19/08/2026	17/09/2026
Aug-26	17/09/2026	19/10/2026
Sep-26	19/10/2026	18/11/2026
Oct-26	18/11/2026	16/12/2026
Nov-26	16/12/2026	20/01/2026
Dec-26	20/01/2027	17/02/2027
Jan-27	17/02/2027	17/03/2027
Feb-27	17/03/2027	19/04/2027
Mar-27	19/04/2027	20/05/2027

Key Risk Status
Red - Significant risk of non-delivery. Additional actions need to be identified urgently.
Amber - Medium risk of non-delivery which requires additional management effort to ensure success
Green -. Low risk of non-delivery – current actions should deliver.

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10/06/2026 16:10:45

Financial Position Update April 2026 - Month 1
Income & Expenditure

Dorset County Hospital
NHS Foundation Trust

Income and Expenditure

The overall revenue position of the Trust in Month 1 is a deficit of £1.306 million, which is £0.216 million adverse to a plan of £1.089 million.
The adverse position is largely driven by costs incurred supporting Industrial Action during month 1.

There are other offsetting movements in month 1, with temporary staffing experiencing significant adverse variances with Agency expenditure being £0.240 million overspent (£0.499m actual vs £0.259m plan) and Bank expenditure £0.663 million overspent (£1.351m actual vs £0.683m plan). This can be linked to the additional staffing required to support Yeovil maternity closure and increased operational pressures especially seen in ED which have continued into the new financial year.

The bank overspend continues to represent the most significant pressure, with utilisation across nursing, medical and support services remaining high to maintain safe staffing levels. Agency usage also remains above plan, largely within Nursing and Medical staffing groups.

The Trust continues to experience operational pressures with demand across urgent and emergency pathways contributing to workforce cost pressures. Temporary staffing is being utilised to support vacancies, sickness and service delivery requirements, with particular pressure across frontline clinical services.

The Trust's financial plan for 2026/27 remains challenging, including delivery of a significant cost improvement programme and mandated reductions in agency and bank usage. The Month 1 position highlights early year risk against these targets, with continued reliance on temporary staffing. Focus remains on strengthening workforce controls, reducing agency utilisation, optimising bank usage, and delivering planned efficiency schemes to mitigate cost pressures over the remainder of the year.

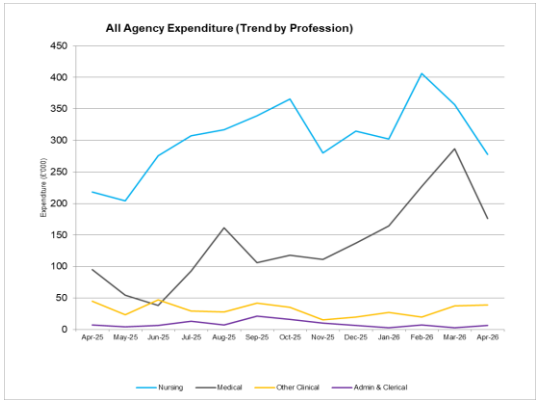
Statement of comprehensive income	In Month			YTD		
	Current Plan £'000	Actual £'000	Variance £'000	Current Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	27,131	27,760	629	27,131	27,760	629
Other operating income	2,570	2,190	(380)	2,570	2,190	(380)
Employee expenses:						
- Substantive	(18,459)	(17,667)	792	(18,459)	(17,667)	792
- Bank	(688)	(1,351)	(663)	(688)	(1,351)	(663)
- Agency	(259)	(499)	(240)	(259)	(499)	(240)
Operating expenses excluding employee expenses	(10,945)	(11,373)	(428)	(10,945)	(11,373)	(428)
OPERATING SURPLUS/(DEFICIT)	**(650)**	**(940)**	**(290)**	**(650)**	**(940)**	**(290)**
FINANCE COSTS						
Finance income	91	127	36	91	127	36
Finance expense	(61)	(66)	(5)	(61)	(66)	(5)
PDC dividend expense	(460)	(460)	0	(460)	(460)	0
NET FINANCE COSTS	**(431)**	**(399)**	**32**	**(431)**	**(399)**	**32**
Other gains/(losses) including disposal of assets	0	0	0	0	0	0
Share of profit/(loss) of associates/joint ventures	0	0	0	0	0	0
Gains/(losses) from transfers by absorption	0	0	0	0	0	0
Movements in fair value of investments, investment property, financial liabilit	0	0	0	0	0	0
Corporation tax expense	(2)	0	2	(2)	0	2
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(1,083)**	**(1,339)**	**(256)**	**(1,083)**	**(1,339)**	**(256)**

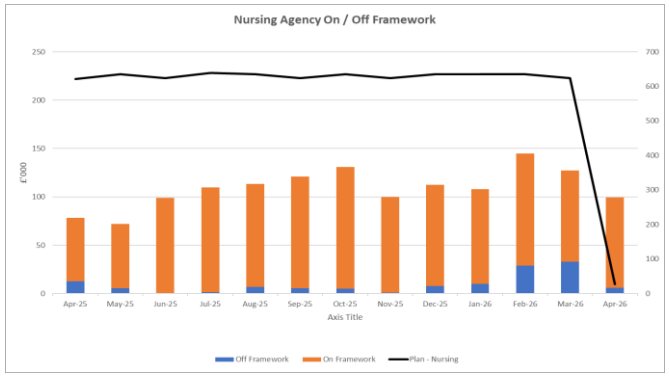
Adjusted financial performance	In Month			YTD		
	Current Plan £'000	Actual £'000	Variance £'000	Current Plan £'000	Actual £'000	Variance £'000
Surplus/(deficit) for the period/year	(1,083)	(1,339)	(256)	(1,083)	(1,339)	(256)
Add back all I&E impairments/(reversals)	0	0	0	0	0	0
Adjust (gains)/losses on transfers by absorption	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	**(1,083)**	**(1,339)**	**(256)**	**(1,083)**	**(1,339)**	**(256)**
Retain impact of DEL I&E (impairments)/reversals	0	0	0	0	0	0
Remove capital donations/grants/peppercorn lease I&E impact	(6)	34	40	(6)	34	40
Adjusted financial performance surplus/(deficit) including PSF as per a	**(1,089)**	**(1,305)**	**(216)**	**(1,089)**	**(1,305)**	**(216)**
Adjusted financial performance surplus/(deficit)	**(1,089)**	**(1,305)**	**(216)**	**(1,089)**	**(1,305)**	**(216)**

Ellis,Kara
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Financial Position Update April 2026 - Month 1
Trust Wide Performance: Agency

Pay Analysis - Agency
Agency costs in month 1 were £0.499 million against a plan of £0.259 million. This is a deterioration against spend in April last year (£134k) and an improvement against prior months spend of £185k. Plans included a nationally set 30% reduction in agency spend from 2025/26 outturn, requiring a reduction of c.£1.7 million across the year. Medical agency usage is due to rota gaps and costs supporting Industrial Action. Nursing agency spend improved in month compared to 25/26 by £79k, use of nursing agency continues to be linked to 1-2-1 staffing requirements for mental health patients, increased activity linked to ED attendances, sickness and significant operational pressures.





Agency Spend by Profession (£'000)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Nursing	218	204	276	307	317	339	366	280	315	302	406	357	278
Medical	95	54	38	93	161	106	118	111	137	164	227	287	176
Other Clinical	45	24	47	29	28	42	35	15	20	27	20	37	39
Admin & Clerical	7	4	6	13	7	21	16	10	6	3	7	3	6
Total	**365**	**286**	**367**	**442**	**513**	**508**	**535**	**416**	**478**	**496**	**660**	**684**	**499**
Plan - Total Agency	*464*	*487*	*456*	*548*	*464*	*548*	*500*	*492*	*387*	*426*	*404*	*354*	*259*
Variance to Plan	**99**	**201**	**89**	**106**	**(49)**	**40**	**(35)**	**76**	**(90)**	**(70)**	**(256)**	**(330)**	**(240)**

Nursing Agency Category	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Off Framework	36	15	1	4	19	15	14	3	22	28	81	92	16
On Framework	183	187	276	303	298	324	352	277	293	274	325	265	262
Total	**218**	**204**	**276**	**307**	**317**	**339**	**366**	**280**	**315**	**302**	**406**	**357**	**278**
Plan - Nursing	*222*	*227*	*223*	*228*	*227*	*223*	*227*	*223*	*227*	*227*	*227*	*223*	*10*
Variance to Plan - Nursing	**4**	**23**	**(53)**	**(79)**	**(90)**	**(116)**	**(139)**	**(57)**	**(88)**	**(75)**	**(179)**	**(134)**	**(268)**

YTD Actual	YTD Plan	Variance
278	10	(268)
176	228	52
39	21	(18)
6	0	(6)
499	**259**	**(240)**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	2.6%	2.6%
Off framework expenditure as % of total agency	3.3%	3.3%

Areas Using Nursing Agency Including Off Framework YTD (£'000)				
Area	**On Framework**	**Off Framework**	**Total Nursing Agency**	**%**
Emergency Dept Main Dept	57	7	64	**23%**
Purbeck Wd	49	1	50	**18%**
Day Surgery Unit	25	(2)	24	**8%**
Moreton Ward - Respiratory	18	1	19	**7%**
Ilchester Integrated Assessment	12	4	16	**6%**
Lulworth Ward	15	(0)	15	**5%**
Maternity Unit	12	2	15	**5%**
Abbotsbury Ward	12	1	13	**5%**
The Mary Anning Unit	8	2	10	**4%**
Scbu	10	(1)	9	**3%**
Crcu	9	(1)	8	**3%**
Stroke Unit	8	-	8	**3%**
Kingfisher Ward	6	1	7	**2%**
Fortuneswell Ward	5	0	5	**2%**
Surge Area	5	0	5	**2%**
Frailty Sdec	4	1	5	**2%**
Ridgeway Wd	3	-	3	**1%**
Sdec	2	-	2	**1%**
Prince Of Wales	1	-	1	**0%**
Cardiology Care Ward	0	-	0	**0%**
Discharge Team	0	-	0	**0%**
Grand Total	**262**	**16**	**278**	

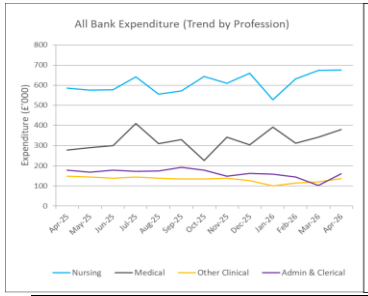
Healthier lives Empowered citizens Thriving communities

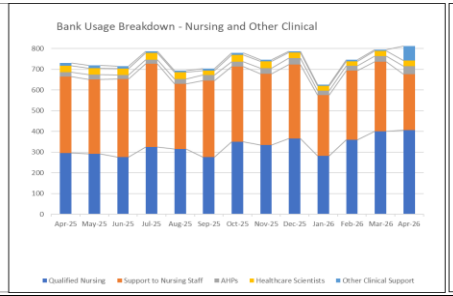
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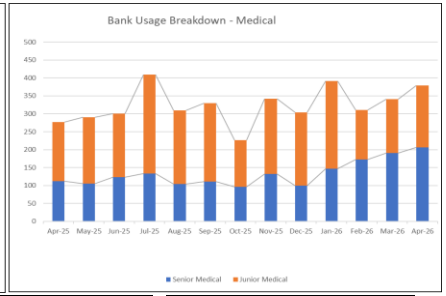
Financial Position Update April 2026 - Month 1
Trust Wide Performance: Bank

NHS
Dorset County Hospital
NHS Foundation Trust

Pay Analysis - Bank
Bank costs in month 1 were £1.351 million against a plan of £0.688 million, higher than the levels seen in 25/26 - in Month 1 in part due to costs incurred supporting Industrial Action and Easter. Reduction in bank expenditure is a key focus area nationally, with a minimum of 7.5% bank reduction expected, equating to a cost reduction of c.£1.0m. Workforce engagement is in place in this area to deliver enhanced booking controls across the Trust, and is being supported by NHSE to provide independent review and appropriate support. This area requires key focus and will remain a strong area of scrutiny, with the same levels of rigour applied to the agency cost reduction programme developed.







Bank Spend by Profession (£'000)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Nursing	585	575	577	642	556	571	644	609	660	527	631	674	676
Medical	277	290	300	410	309	329	226	342	304	391	311	341	379
Other Clinical	147	143	137	143	137	133	134	137	126	99	114	120	136
Admin & Clerical	178	168	177	171	174	191	177	148	161	158	143	102	160
Total	**1,187**	**1,176**	**1,191**	**1,366**	**1,176**	**1,224**	**1,181**	**1,236**	**1,251**	**1,175**	**1,199**	**1,237**	**1,351**

YTD Actual	YTD Current Plan	Variance
676	358	(318)
379	186	(193)
136	107	(29)
160	37	(123)
1,351	**688**	**(663)**

Bank Category	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Qualified Nursing	296	292	277	324	315	276	350	334	366	282	360	401	406
Support to Nursing Staff	369	358	375	402	315	368	362	343	357	293	333	336	270
AHPs	21	24	21	19	23	28	24	29	30	22	23	26	39
Healthcare Scientists	31	31	31	33	32	22	34	32	28	23	22	26	27
Other Clinical Support	14	13	10	8	8	9	8	8	5	6	7	5	70
Management / Admin	178	168	176	171	174	191	177	148	161	158	143	102	160
Senior Medical	112	105	123	133	104	111	96	132	100	147	172	191	206
Junior Medical	165	185	177	276	205	219	130	210	204	244	139	150	173
Total	**1,186**	**1,176**	**1,190**	**1,366**	**1,176**	**1,224**	**1,181**	**1,236**	**1,251**	**1,175**	**1,199**	**1,237**	**1,351**
Plan	*830*	*851*	*801*	*917*	*867*	*855*	*715*	*676*	*702*	*739*	*657*	*857*	*688*
Variance to Plan	(356)	(325)	(389)	(449)	(309)	(369)	(466)	(560)	(549)	(436)	(542)	(380)	(380)

Pay Metrics	In Month Actual	YTD Actual
Bank expenditure as % of total pay	6.9%	6.9%

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Financial Position Update April 2026 - Month 1
Sustainability & Efficiency

Dorset County Hospital
NHS Foundation Trust

Efficiency & Sustainability Programme Update

The annual efficiency target for the Trust is £23.3 million, made up of the following elements:
- Core annual requirement £15.6 million
- Central stretch £7.7 million

In month delivery of £0.6 million has been achieved, delivery schemes only slightly short of plan by £0.027m. Savings were mainly the result of efficiencies in pay slippage, COVID scheme and Bank Interest with further traction needed to commence planned efficiency schemes.

The total efficiency plan for the year is £23.3 million and 29% of this remains unidentified and a further 20% at high risk of not delivering. Continued identification and development of schemes is needed to ensure the full year financial plan can be achieved. NHSE have stated Trusts must identify full efficiency schemes with only 20% rated high risk by 30th June.

EQIA monitoring has been established led by the CNO and is required for all relevant schemes with careful assessment in place alongside the overall efficiency programme. EQIA process development will continue to be an area of focus as we head in to 2026/27.

Category	Pay £'000	Non Pay £'000	Income £'000	Totals £'000	%
Unidentified	884	4,382	1,500	**6,766**	29%
High Risk	1,647	2,552	505	**4,704**	20%
Medium Risk	134	4,128	489	**4,751**	20%
Low Risk	1,952	4,014	1,159	**7,126**	31%
Totals	**4,618**	**15,076**	**3,653**	**23,347**	**100%**

					Of identified:					YTD delivered				
					Risk level			R/NR						
Division	Target Allocations £'000	Identified £'000	(Unidentified) / over £'000	% identified	Low £'000	Medium £'000	High £'000	Recurrent	Non Recurrent	Plan £'000	Actual £'000	(Under)/ Over delivered £'000	Recurrent	Non Recurrent
Core - 5%														
Urgent & Integrated Care	6,349	4,701	(1,648)	74.0%	2,097	1,573	1,031	87.7%	12.3%	320	113	(207)	100%	0%
Family & Surgical Services	5,938	5,091	(847)	85.7%	1,500	1,299	2,292	97.5%	2.5%	114	165	51	69%	31%
Corporate & Commercial	229	141	(88)	61.6%	69	72	-	26.2%	73.8%	1	3	2	100%	0%
Director of Nursing	126	84	(42)	66.7%	84	-	-	100.0%	0.0%	-	2	2	100%	0%
Finance	372	340	(32)	91.5%	290	50	-	19.1%	80.9%	57	81	24	0%	100%
Estates & Facilities	1,196	806	(390)	67.4%	144	662	-	99.5%	0.5%	66	4	(62)	100%	0%
Digital	776	685	(91)	88.3%	685	-	-	19.4%	80.6%	11	-	(11)	0%	0%
Operational Support	256	256	-	100.0%	256	-	-	0.0%	100.0%	7	24	17	0%	100%
HR & Workforce	383	210	(173)	54.8%	150	60	-	100.0%	0.0%	12	4	(8)	100%	0%
Subtotal	**15,625**	**12,315**	**(3,310)**	**78.8%**	**5,276**	**3,716**	**3,323**	**66.9%**	**33.1%**	**588**	**397**	**- 191**	**61%**	**39%**
Central Stretch	7,722	4,266	(3,456)	55.2%	1,850	1,035	1,381	49.1%	50.9%	10	175	165	0%	100%
Total	**23,347**	**16,581**	**(6,766)**	**71.0%**	**7,126**	**4,751**	**4,704**	**75.4%**	**24.6%**	**598**	**571**	**- 27**	**42%**	**58%**
					43%	29%	28%							

Ellis Kelly
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Financial Position Update April 2026 - Month 1

Cash

Dorset County Hospital NHS Foundation Trust

Cumulative cash balance	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
2026/27 Submitted Plan	18,849	24,402	25,196	26,281	24,394	23,039	23,593	25,102	23,831	24,952	27,224	16,623
2025/26 Actual	23,738											

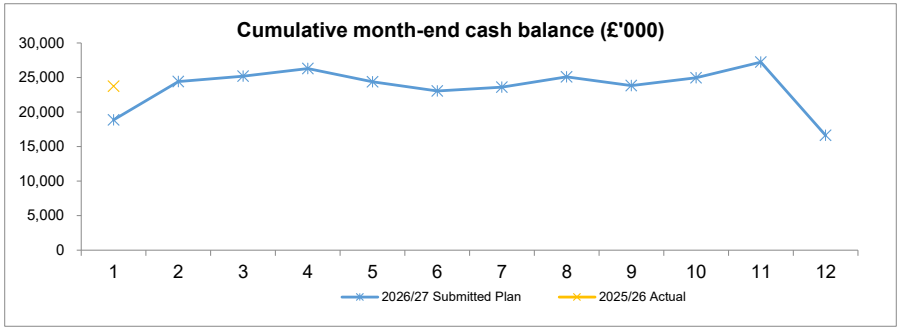
Cash Balance incl Forecast

The graph shows the trajectory of the actual year to date cash balance during the year, with identified direct intervention taking place to mitigate shortfalls in cash.

The cash position at the end of April is £23.7 million, which is £4.9 million ahead of submitted plan. This favourable variance is driven by the receipt of Q1 HEE income, of which £2.1 million relates to May and June, a higher than normal VAT recovery £0.7 million received in month and the timing of capital creditor payments, which provides a short-term cash-flow benefit £2.1 million. These factors collectively enhance the Trust's short-term cash resilience; however the a portion of the benefit is timing-related and will unwind in future periods.

Whilst the Trust currently has a healthy cash level, there is still a risk to cash flows as we head into 2026/27 as a result of planned deficits at the beginning of the year and a challenging CIP programme of £23.3 million noting any shortfall delivering monthly planned targets will further negatively impact cash. This is reflected in internal BAF and risk register reporting.

The Trust is continuing to carefully monitor cash inflows and outflows through regularly updating and reviewing the cashflow forecast. System colleagues and NHSE are being kept up to date and aware of the potential risks.



Working Capital Ratios	Target	2025/26 Actual	YTD Actual
Current Ratio (Net Current Assets / Current Liabilities)	Above 1	1.07	1.00
Quick Ratio (As above excluding Inventories from current assets)	Above 1	0.94	0.90
Creditor Days (Average days to pay creditors)	30-60	159	141
Debtor Days (Average days to receive payment for debtor invoices)	Below 30	23	25
Inventory Holding Days (Average days inventory is held)	Below 30	40	32

Both the current and quick ratios have decreased since last month, reflecting the payment of 2025/26 invoices offset by slower settlement of debtor invoices raised in March 2026. Creditor days have reduced from 159 to 141 reflecting decreases in trade payables Conversely, debtor days have increased from 23 to 25 due to delays in receiving payment for invoices issued. Inventory holding days reduced from 40 days to 32 days as stock was utilised in April.

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10/06/2026 16:10:45

Financial Position Update April 2026 - Month 1

Capital

NHS
Dorset County Hospital
NHS Foundation Trust

Capital Programme Narrative

Capital expenditure year to date to the end of April was £3.4 million and ahead of plan by £0.1 million.

Internally Funded
Internally Funded schemes are behind plan at the end of April by £0.7 million.

Digital and Medical Equipment Schemes combined are behind plan due to EHR and the timing of the purchase of replacement medical equipment items. This is offset by timing of expenditure on digital schemes.

Estates schemes are behind of plan due to timing of expenditure on the generator and other schemes.

Donated expenditure is behind plan.

Externally Funded
Externally Funded capital expenditure was £0.8 million ahead of plan due to timing of expenditure on New Hospital Programme (NHP).

CAPITAL	CURRENT MONTH			YEAR TO DATE			FULL YEAR 2026/27			
	Plan	Actual	Variance	Plan	Actual	Variance	Committed Spend	Forecast	Annual Plan	Variance
Estates	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Generator	200	64	136	200	64	136	2,400	2,400	2,400	-
Estates Schemes	248	73	175	248	73	175	738	2,830	2,830	-
Digital Services										
EHR Matched Funding	285	40	245	285	40	245	2,069	3,423	3,423	-
IT Schemes	111	338	- 227	111	338	- 227	1,184	2,259	2,259	-
Equipment										
CT Scanner (2nd Machine)	-	-	-	-	-	-	-	1,800	1,800	-
Other Equipment	396	87	309	396	87	309	591	2,650	2,650	-
Sub-Total Internally Funded Expenditure	**1,240**	**602**	**638**	**1,240**	**602**	**638**	**6,982**	**15,362**	**15,362**	**-**
Donated										
Other Donations	40	-	40	40	-	40	-	480	480	-
Sub-Total Planned Donated Expenditure	**40**	**-**	**40**	**40**	**-**	**40**	**-**	**480**	**480**	**-**
IFRS 16 Lease Additions										
MSCP Lease remeasurement	-	-	-	-	-	-	-	500	500	-
CEF Lease remeasurement	-	-	-	-	-	-	-	400	400	-
Accommodation & Vehicle Lease Remeasurements	-	-	-	-	-	-	-	50	50	-
Sub-Total Planned IFRS 16 Expenditure	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**950**	**950**	**-**
Total Internal & Leased Capital Expenditure	**1,280**	**602**	**678**	**1,280**	**602**	**678**	**6,982**	**16,792**	**16,792**	**-**
Additional funded schemes										
NHP Works	2,000	2,826	- 826	2,000	2,826	- 826	42,118	42,118	42,118	-
CIR Funding - Generator	50	-	50	50	-	50	1,000	1,000	1,000	-
CIR Funding - Fire	10	-	10	10	-	10	-	360	360	-
Acute Assessment Unit Development	-	-	-	-	-	-	-	300	300	-
ED Diagnostic Equipment	-	-	-	-	-	-	-	750	750	-
ENT Stacks	-	-	-	-	-	-	-	200	200	-
MH suite fit out (Dorchester)	-	-	-	-	-	-	-	256	256	-
Total Externally Funded Capital Expenditure	**2,060**	**2,826**	**- 766**	**2,060**	**2,826**	**- 766**	**43,118**	**44,984**	**44,984**	**-**
Total Capital Expenditure	**3,340**	**3,428**	**- 88**	**3,340**	**3,428**	**- 88**	**50,100**	**61,776**	**61,776**	**-**
Expenditure as a % of Plan			103%			103%				0%

Ellis,Kara
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Report to	Board in Common (DHC) Part 1	
Date of Meeting	Wednesday 17th June 2026	
Report Title	DHC Health and Safety Annual Report for 2025/26	
Prepared By	Steve Harper, Associate Director of Health and Safety / Fire / Emergency Planning	
Approved by Accountable Executive	Rachel Small, Chief Operating Officer	
Previously Considered By	Finance and Performance Committee in Common, 27/05/26	
Action Required	**Approval**	
	Assurance	**Y**
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	"SR1: Safety and Quality"	
Financial	Business, Legal and Moral	
Statutory & Regulatory	Health and Safety at Work etc. Act 1974 Health and Safety Strategy CEO Health and Safety Statement of Intent	
Equality, Diversity & Inclusion	Nil	
Co-production & Partnership	Nil	

Executive Summary

This annual report is submitted to the Board as a summary of the Trust's health and safety quality management processes in compliance with Regulation 5 of The Management of Health and Safety at Work Regulations 1999 (The Health and Safety Management Model). The health and safety strategy continues to support and promote the maintenance and development of a 'Positive H&S Culture' through the Occupational Health and Safety Standards provided by the NHS Staff Council.

This report contains annual reporting data that meets the Trusts legal requirements under Regulation 5 of Management of H&S Regs. Key aspects include; Effective Arrangements, Monitoring & Review, including accident statistics (RIDDOR), results of safety inspections and audits, updates to health and safety policies, and training updates. The health and safety team have continued its approach to self-harm and suicide prevention through its ligature management support to clinical teams and services.

The impact of staff reported incident gradings remain low at 98% (''no harm' 70% 'minor' 28%), with external reporting categories to the HSE being lower than the average of the past 2 years. Incidents reported as 'prevented' (near miss) and 'moderate' are at 2%. The Trust continues to have a high reporting culture.

Ongoing works with Learning and Development (L+D) continue to identify those managers (through the appraisal route) who are required to attend managers face to face health and safety training. Training is being expanded to include ligature cutters across Community Mental Health Team (CMHT) sites.

Following amendments to the HTM: 05-01 Managing Healthcare Fire Safety the Trust will formalise the Trusts Fire Safety Group with governance reporting to the Health and Safety Committee.

Ellis Kirby
10/06/2026 16:10:03

Recommendation

Members are requested to receive the report for assurance

Health and Safety Annual Report for 2025/26

1.0 INTRODUCTION

1.1 This is the fourteenth annual health and safety report for Dorset HealthCare and has been prepared to provide a summary of the health and safety activities and trends in the relevant period.

1.2 The Trust remains committed to protecting and promoting the health, safety and wellbeing of all staff, service users, carers, visitors and others who may be affected by its activities and aims to foster a positive and proactive occupational health and safety culture, whereby safety is everyone's responsibility.

1.3 An overarching focus for DHC as embedded within the approved health and safety strategy and workplan, is continually aimed at maintaining a positive health and safety culture. This report is aligned with the strategy framework and those legislative and national guidance strategies e.g. HSE, CQC and other regulatory bodies.

1.4 In the period covered by this report, no visits were made by the Health and Safety Executive (HSE) and no enforcement action has been taken.

2.0 HEALTH AND SAFETY ARRANGEMENTS

2.1 Structure

2.1.1 Health and Safety, Fire Safety and Emergency Planning reside within the Chief Operating Officer's operational management structure, working closely with all directorates, clinical services, localities, estates and facilities, safety representatives and other services (including external agencies) to promote and partner collaborative occupational health and safety.

2.1.2 The Chief Operating Officer is the nominated responsible executive director for health and safety in the Trust providing the direct link to the Trust Board for health and safety matters.

2.2 Duties

2.2.1 The health and safety team are responsible for:

- Providing assurances to the Board that the Trust is compliant in matters relating to health and safety, and fire safety;
- Leading and assisting in the development and review of the health and safety policies and other supporting legislative guidance and procedures.
- Reviewing new legislation and regulations and advising the Trust regarding the implementation of any required changes;
- Reporting as necessary under The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013;
- Consultation with and provision of competent advice to management and staff on health and safety matters including the development and maintenance of records such as risk assessments and safe systems of work;
- Leading the Trusts ligature management in collaboration with clinical teams and services and providing governance and support on ligature managed environments.
- Overseeing and collating the annual self-audit programme and undertaking a structured plan of workplace audits and visits to collect information in relation to training, risk assessments, information provision and record keeping;

Ellis,Kara
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- Liaising with the HSE, DWFRS, CQC and other external regulatory bodies;
- Assisting all DHC owned and leased sites with fire evacuation procedures, fire risk assessments and supporting emergency planning;
- Developing, providing and supporting health and safety training for all staff within the Trust (including associated e-learning packages);
- Assisting with the provision of fire Personal Emergency Evacuation Plans (PEEPs) for all staff and patients with disabilities;

3.0 KEY ACTIVITIES AND ACHIEVEMENTS

3.1 Compliance

3.1.1 Throughout this period, the health and safety team have endeavoured to ensure that the Trust remains compliant with health and safety legislation by supporting services with workplace risk assessments following new ways of working and changes in service structures, as well as providing expert advice for all New Hospital Programmes (NHP) capital build schemes for both patient and non-patient environments.

3.1.2 Representation at key working groups ensures that regulatory requirements for maintenance within regulatory governed standards are monitored with Estates and Facilities providing regular assurance reports to the health and safety committee. These include Fire Compartmentation, Asbestos, Water, Electrical and Planned Preventative Maintenance (PPM).

3.2 Ligature Management

3.2.1 Making safety and improving our patient environments through risk assessments and ligature improvements remained a driving focus. This is fully covered in **Section 4**.

3.3 Safer Sharps – Task & Finish Group

3.3.1 The Trust maintains a Task and Finish group led by the Head of Occupational Health and includes key stakeholders from H&S, IP&C, L&D, Clinical Managers and Medical Devices. Meetings are held quarterly and discusses / reviews the following areas:

- The unnecessary use of sharps or use of safer devices; Regulation 5.
- Provision of appropriate information, training (refresher), Regulation 6
- Recording and investigation of sharps incidents, Regulation 7
  (Health and Safety (Sharp Instruments in Healthcare) Regulations 2013)

3.3.2 The group analyses reported sharps incidents together with the necessary steps to take post incident, including recommendations for additional awareness training via e-learning. A dedicated intranet page on safer sharps is available for staff to access.

3.3.3 Occupational Health presents quarterly reports to the Health and Safety Committee.

4.0 PROFILING HEALTH AND SAFETY

Ellis Kara 16/06/2026 15:10:45

4.1 Ligature Management

4.1.1 The Trust maintains a diverse range of properties that facilitate the provision of mental health services, some of which are modern and some estate that holds English Heritage status for inpatients such as Nightingale House and at St Ann's Hospital.

4.1.2 Some of our existing buildings are not environmentally updated in line with the appropriate patient/client acuity group that occupy them, combined with the ever-evolving complexities around mental health illness. This obligates the Trust to apply an ongoing risk-based capital expenditure process to address significant hazards by removing or managing the means of hanging (ligature anchor points and the ligatures) as the most important step towards prevention.

4.1.3 The complexity and differing levels of acuity provides many challenges with managing patients and ensuring that our inpatient environments remain fit for purpose (safe) balanced against the running costs and maintenance has been a major contributory factor. All mental health inpatient wards/units maintain full Ligature Management Plans (LMPs) that are reviewed on an annual basis (as a minimum).

4.1.4 As capital new builds schemes and refurbishment works are completed, LMPs are reviewed and where necessary updated by health and safety to ensure that all clinical managers have the most up-to-date ligature risk profile for their ward and service. Issued LMPs document common high risks with clear environmental recommendations that can either mitigate or reduce the likelihood of patients self-harming either directly or indirectly (e.g. bridging or wedging).

4.1.5 The Trusts new build schemes accommodating 4 wards, Chaddesley House at St Ann's and Seastone House at Alumhurst Road are nearing completion and handover respectively. LMPs are currently in draft format awaiting the delivery of furnishings to finalise their respective ligature portfolios.

4.1.6 Accommodating patients with physical disabilities into our mental health environments has necessitated the need for enhanced clinical assessments into the provision of safe facilities, to not only support their care needs but also to focus on ligaturing and self-harm risks.

4.1.7 The introduction of hi/low profiling beds and associated medical equipment to support disabled patients into high acuity settings brings additional challenges and one which the Health and Safety team are working closely with manufacturers for future design proofing.

4.2 Ligature Monitoring and Reporting

4.2.1 The Trust maintains an approved and published ligature risk reduction policy and has an established Inpatient Environmental Safety Group (IESG) that convenes on a quarterly basis to review incident data and themes concerning all ligature incidents and to consider if further actions must be taken to reduce the potential of reoccurrence.

4.2.2 The purpose and function of the IESG has recently been reviewed to ensure that its terms of reference remains relevant and that a forum for governance and decision making is upheld. Meetings to ensure that the agenda is topical and relevant has taken place.

4.2.3 A ligature management report is submitted quarterly to the Quality Governance Group.

4.3 CQC Guidance

4.3.1 The Trust continues to use an improved and adapted ligature management plan based upon the CQC guidance that includes functionality to enhance the whole risk profile.

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4.4 Ligature Improvements / Capital Works

4.4.1 All high-risk priority ligature works identified in individual LMPs are documented onto the Trust risk register with each individual action identifying priorities for works. This is replicated into

a capital works programme for removing high priority ligature anchor points. Residual works to mitigate further anchor points continue.

4.4.2 In addition to the NHP build schemes, the following works have been achieved in this reporting period:

- Refurbishment of the toilets, showers and bathrooms on Twynham Ward.
- Replacement of windows at Twynham Ward for anti-ligature.
- The removal of climbing risk / handrails in Haven courtyard.
- Re-adjustment of decking and removal of climbing risk at Pebble Lodge.
- Installation of improved collapsable window blinds on Herm Ward.
- Replacement door latches to Pebble Lodge doors. (Kingsway replacement)

4.4.3 To support the installation of new electronic doors, each ward maintains a written Standard Operating Procedure (SOP) outlining the strict controls for the manual disconnecting of individual door alarms, a master key protocol, as well as training and routine testing.

4.4.4 The Health and Safety Team continually explores safer solutions and seeks to discover several products or solutions that can lead towards safety recommendations for change. These are predominately long-term methodologies for materials, fixtures and hardware that have been specifically designed for use within mental healthcare facilities to reduce the risk of harm to inpatients.

4.4.5 The Trust maintains its partnership with the Design in Mental Health (DIMH) Network with a continual joint pledge to encourage more manufacturers and suppliers to provide independently tested and assessed performance as part of their product selection process, especially where the term ‘anti-ligature’ is used. DHC are connected and respected by DIMH contributors to improve patient safety environments.

4.5 Ligature Incidents 2025/26

4.5.1 There were 26 incidents of inpatients ligaturing with anchor points throughout 2025/26, in comparison to 6 incidents of 2024/25. Of those 26 incidents, 16 were associated to using the top of the bedroom doors as an anchor point, combined with ‘same patient’ repeatable incidents.

4.5.2 All self-harm incidents involving alarmed doors are reported and included **as actual events.**

4.5.3 The wards with the highest total of incidents were 7 at Haven Female (all from the same patient, using alarmed doors) and Chine Ward, with 7 being relative to three patients. Two patients ligaturing twice and one on three occasions (total 7).

4.5.4 The rolling comparison of ligature incidents with anchor points (over the last 6 years) is captured in the below graph. **See Fig 1.**

Ellis,Kara
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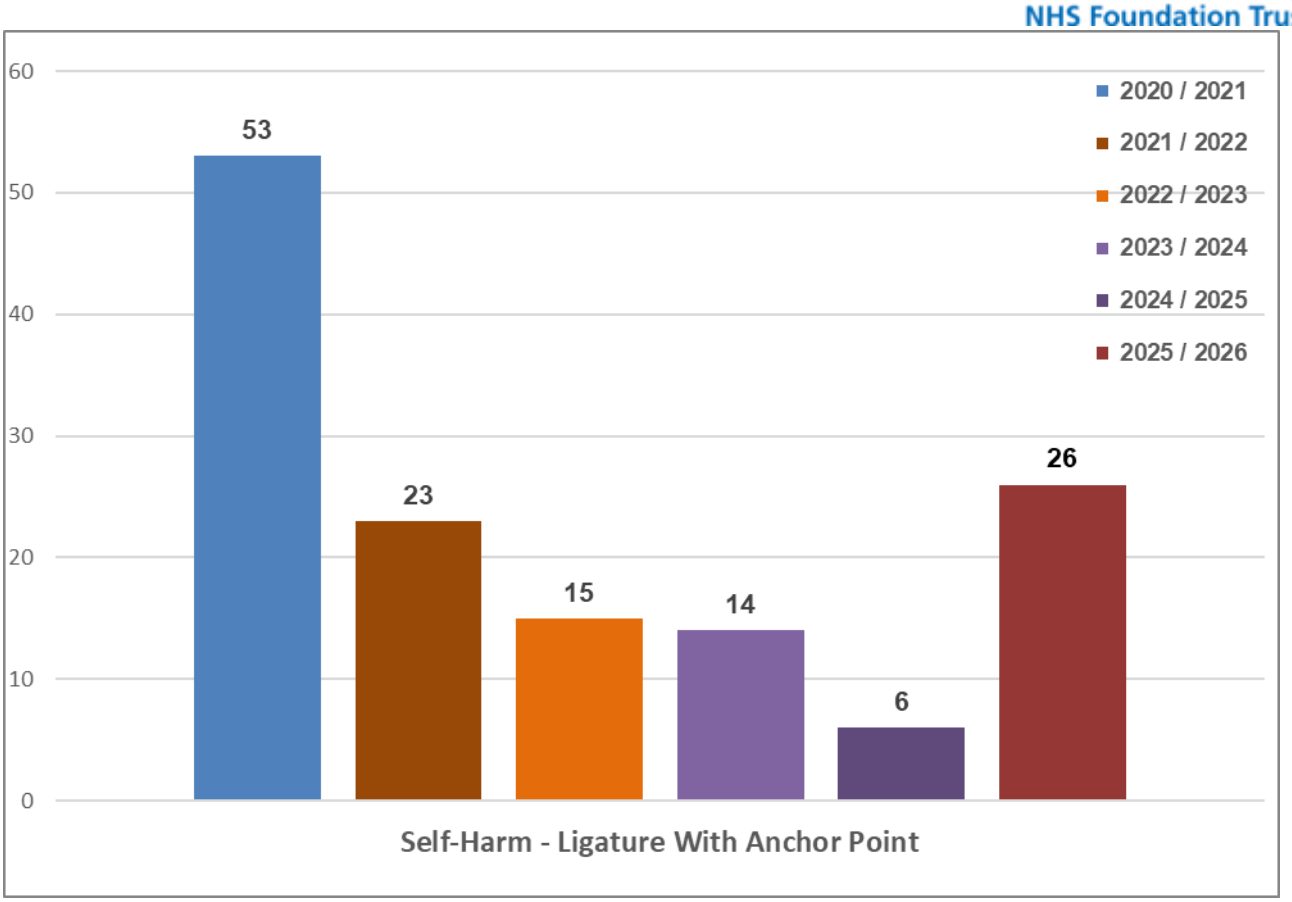


Fig 1. Ligature incidents with anchor point - rolling yearly comparison

4.5.5 The rolling comparison of incidents by each quarter of 2025/26 is provided in the table below. **See Fig 2.**

4.5.6 There were 7 incidents of ligaturing with anchor point in Q4. Five were on Chine Ward.

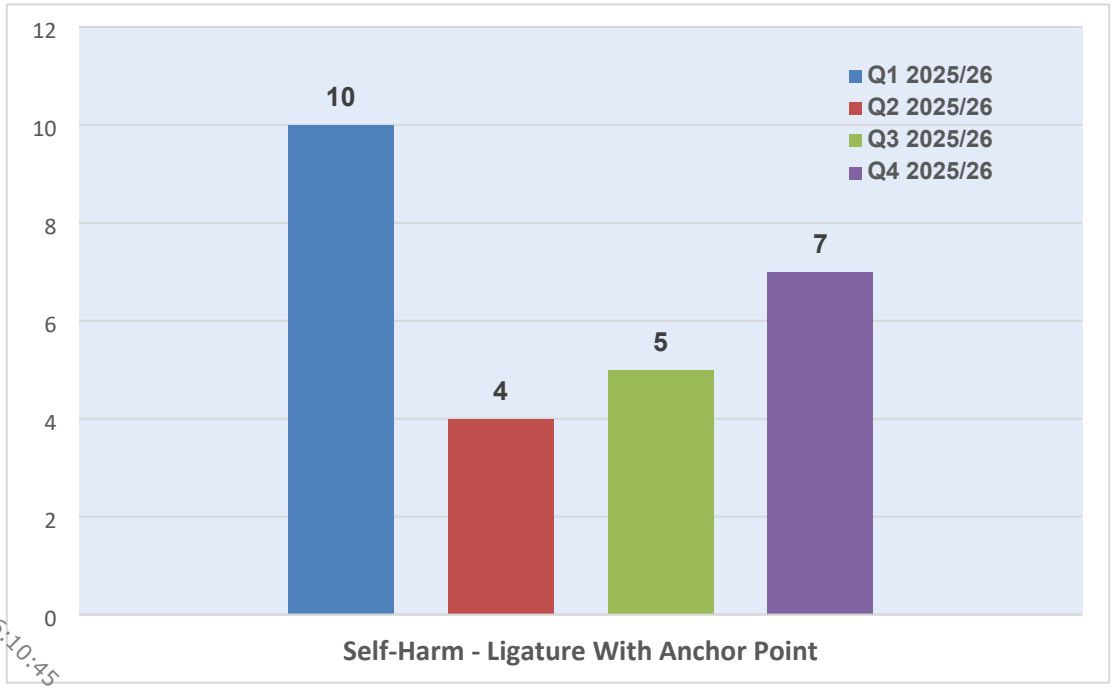


Fig 2. Ligature incidents with anchor point - rolling comparison for the past quarters:

4.6 Collaborative Working with Others

4.6.1 Health and Safety continue to maintain a high precedent towards ligature management and does so through supporting Dorset acute Trusts (DCH & UHD) with their new hospital build schemes for the provision of mental health facilities.

4.6.2 Ligature advisory support was provided to NHS Wales (Swansea Bay University Health Board) and to the Institute of Occupational Safety & Health (IOSH) NHS South West forum.

5.0 ORGANISING AND MANAGING HEALTH, SAFETY AND FIRE

5.1 Health and Safety Committee

5.1.1 The health and safety committee is constituted in accordance with The Safety Representatives and Safety Committees Regulations 1977 (as amended) to ensure employee representation by recognised trade unions in matters relating to health and safety; and The Health and Safety (Consultation with Employees) Regulations 1996 (as amended) for those employees that are not in a trade union.

5.1.2 The committee meets on a quarterly basis and includes representation from the health and safety team, learning and development, occupational health, security, fire, estates, trade unions along with directorate clinical and specialist service areas.

5.1.3 The committee operates in partnership with the trade unions and is chaired by the Chief Operating Officer, who is deputised by the Associate Director of Health and Safety.

5.1.4 Membership and key functions of the committee are clearly outlined in the terms of reference. For governance, the health and safety committee compiles reports and unique matters for escalation and oversight to the Quality Governance Group and Finance & Performance Committee in Common.

5.2 Policies/Guidance

5.2.1 The monitoring of legislative changes for new and existing health and safety related Acts, Regulations and Guidance continue. The following policy related documents were reviewed and approved at the health and safety committee.

- The Prevention and Management of Falls from Height policy.
- The Lone Working Risk Assessment guidance.
- The Health and Safety policy (Annually)
- Health and Safety Statement of Intent (SOI) signed by CEO.
- The Prevention and Management of Stress (an OH policy).
- Hot Works policy.
- Guidance for Fire Resistance of Fabrics and Upholstery.

5.2.2 A bespoke team policy database informs when policies are due for review in advance of their review dates and thereby ensuring that legal requirements are duly met and remain current. There are no health and safety related policies that are overdue their reviews.

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5.3 Health and Wellbeing

5.3.1 The team continues to support staff returning to work following sickness absence in partnership with Occupational Health. This includes workplace assessments to accommodate temporary or permanent adjustments.

5.3.2 Additional awareness campaigns endeavour to amplify the core requirements of managing workplace stress along with the provision of monthly Managers health and safety training where the learning content includes a session on the HSE stress management standards.

5.4 Security Assurance Group (SAG)

5.4.1 The Trust has an established Security Assurance Group that meets quarterly and aims to reduce the number of incidents of violence and assault and security related incidents across the Trust through incident analysis and investigation. **(See section 8.22)**

5.4.2 In tandem with the health and safety quarterly incident report, security incidents are verbally presented by the Security Management Specialist as a standing agenda at the Health and Safety Committee for noting and comment. (**See also RIDDOR in section 8.3**)

6.0 IMPLEMENTING HEALTH AND SAFETY

6.1 Managing Health and Safety/Refresher and Update courses

6.1.1 The one-day bespoke face to face “Managing Health & Safety” course continues to be delivered monthly with 2 courses per month.

6.1.2 The course is benchmarked against the ‘IOSH Managing Safely’ course provided by the Institute of Occupational Safety & Health with an adapted syllabus to provide relevance to the Trust requirements. It is available for all staff and grades to attend and is mandatory for managers.

6.1.3 Attendance rates for the Face-to-Face managers health and safety training remains low. This is being associated to the inability to define a master list of those managers / attendees that are required to attend. Learning and Development are currently working to establish an identifiable list of managers through linked appraisals on eHub.

6.1.4 Face to face manager training was first identified by HSE Inspectors during an advisory visit in 2011. Since then, the Health and Safety Team have facilitated these training courses and have recently increased the capacity and frequency. Staff remain legally compliant while undertaking online H&S e-hub training, but this falls outside of the HSE training recommendation for managers and its enhanced content to support management functions.

6.1.5 There were 24 courses arranged during this period with 26 staff attending out of a maximum of 288 vacancies with 9 DNAs for varied reasons. The Health and Safety team will continue to facilitate bookable training sessions (2 per month).

6.2 Health and Safety E-Hub Training

6.2.1 As of 31st March, 2,298 staff completed the online 3 yearly health and safety essentials module achieving a compliance total of 96.1%.

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6.3 Fire Safety Training

6.3.1 The provision of face-to-face training for Fire Warden and Fire Marshal responsibilities has continued for all clinical nursing staff working in inpatient areas and where there was a need to undertake and maintain coverage for progressive and horizontal evacuation of patients.

6.3.2 During this reporting period 1,500 appointed staff received their annual fire warden and fire marshal training over 216 sessions and 2,884 staff completed the 3 yearly fire safety e-hub module. This achieved a rolling Trust compliance of 98% (Set target of >90%)

6.3.3 A total of 160 staff working in clinical environments also received training with emergency ski-pads over 28 sessions.

6.4 Ligature Awareness Training

6.4.1 Awareness training continues to be delivered during PMVA induction for all mental health inpatient staff through a 20-minute dedicated session focussing on raising awareness of potential ligature anchor points and associated patient behaviours that can lead towards self-harm.

6.4.2 The Health and Safety team delivered ligature awareness training to 159 staff during PMVA, reaching a compliance target of 100%. The team will be introducing ligature cutter training to all CMHT staff in 2026/27 as part of a new initiative to support their LMPs.

6.5 Toolbox Talks

6.5.1 Organised Toolbox Talks continue to be regularly facilitated with Trust staff, focussing on key subjects such as topical safety issues and trends to further promote and maintain the existing safety culture.

6.5.2 Each Toolbox Talk has emphasised safety topics, such as workplace hazards and safe working practices. They continue to be effective in refreshing staff knowledge whilst exchanging clear information and feedback. Ligature awareness training continues to be delivered to Estates maintenance staff as a refresher.

6.6 Learning and Development report on Manual Handling

6.6.1 For all levels, 5,815 staff received their moving and handling training. As the training is repeated on a 3 yearly basis, our current compliance is illustrated in the table below:

Course	Update	Target Group	Actual
Moving & Handling Patient Handlers	3 yearly	All staff who handle patients. **Target: 1,271** **Outstanding: 243** **Completed 1,028**	**80.9%**
Moving & Handling Non-Patient / Manual Handlers	3 yearly	All staff who do not handle patients but undertake other handling. **Target: 4,919** **Outstanding: 175** **Completed: 4,744**	**96.4%**

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6.6.2 Emails are sent every month to all individuals listed as outstanding for either level. If no moving and handling champions are available on site, they can attend the face-to-face sessions provided for inductees.

6.7 Prevention and Management of Violence & Aggression (PMVA) Training

6.7.1 New starters working in mental health inpatient service areas are required to successfully complete the Trust's PMVA training programme immediately after commencing their employment. Staff are required to complete a 2-day annual update thereafter.

6.7.2 As at the end of Q4, 100% of the target group had completed the required training (initial and refresher).

7.0 MEASURING HEALTH AND SAFETY PERFORMANCE

7.1 Health and Safety Work Plan

7.1.1 The annual health and safety work plan is regularly reviewed and developed to consider the fiscal year and is prepared and measured using the NHS Staff Council document "Workplace Occupational Health and Safety Standards" to identify potential gaps in all areas managed by the health and safety team.

7.1.2 These standards are HSE recognised and conform to the Health and Safety Guidance model Plan, Do, Check, Act approach. **(HSG 65 – Managing Health and Safety)**

7.1.3 The health and safety workplan review for 2026/27 is scheduled for 14 May 2026.

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7.1.4 Ligature management plans (LMPs) for all inpatient mental health and dementia units continue to be reviewed. Local site reviews are undertaken routinely with ward managers on an annual basis or whenever there are environmental changes or increased reports of incidents. CMHTS are now included in LMP assessments and reviews.

7.1.5 Enhanced fire risk assessments for inpatient areas have remained a key with reviews being annually in line with best practice. Fire safety being integral to all future new capital build schemes.

7.1.6 Policy reviews have continued in line with the dated review plan and when circumstances and/or legislative changes are issued. The bespoke health and safety 'policy database' allows for all policies requiring review to be identified and flagged two months in advance of their intended review date; this ensures a simplified transition for approval and maintaining regulatory compliance.

7.1.7 Health and safety site visits were undertaken at a variety of Trust premises during 2025/26 supporting managers and staff in new directorate structures and roles. This period, visits fell into 6 specific categories:

- WASH (Workplace Assessment of Safety and Health).
- Incident investigations and assurance checks. (Audits)
- Ligature management surveys.
- Premises fire risk assessments.
- Contractor pre-construction works and inductions.
- Space utilisation/overcrowding.

7.1.8 The team also regularly attended various committees and groups:

- Health and Safety Committee.
- Quality Governance Group.
- Emergency Planning Group.
- Inpatient Environmental Safety Group. (hosted by H&S Team)
- Infection Prevention and Control Group.
- Medical Devices Group.
- Estates Water Safety Group.
- Estates Ventilation Group.
- Estates Electrical Safety Group
- Joint Estates/IT/Health & Safety (non-formal).
- Joint Unison/Trade Union monthly meeting (non-formal).
- Sharps Task and Finish Group (non-formal)

7.2 Fire Safety Group

7.2.1 Following the amendments to this year's **HTM: 05-01 Managing Healthcare Fire Safety** the Trust will be transferring the existing fire safety compartmentation and maintenance meetings held with Estates over to a newly formed **Fire Safety Group** commencing on 13 May. This group which includes representatives from Health & Safety, Fire and Estates and will operate under a new term of reference with governance reporting to the Health & Safety Committee.

7.3 Workplace Assessment of Safety and Health (WASH)

7.3.1 A intranet based online WASH declaration form is continually enhanced and monitored by the health and safety team to assist managers and staff in monitoring their level of health and safety compliance for their workplaces. The declaration acts as a prompt for staff to identify areas of potential weakness that may require addressing further.

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7.3.2 The online WASH declaration incorporates a mandatory 'reporting' list to better identify sites and services that require completing as a minimum. This informs the planned premises audit schedule by highlighting areas of high or higher risk.

7.3.3 Areas of non-compliance are then identified for joint workplace inspections with the health and safety trade union representatives. Quarterly reports are provided at the Health and Safety Committee.

8.0 INVESTIGATING INCIDENTS

8.1 Health and Safety Incident Report

8.1.1 A quarterly health and safety specific incident report is produced, tabled and discussed at the health and safety committee. This includes data for incidents that directly affect or involve staff, split by directorates and services. **(See Appendix 1)**

8.1.2 This reporting forms part of the Trust's active monitoring of health and safety performance at the health and safety committee. Data contained in the health and safety incident report includes:

- Fire (actual and false alarm activations) – (**See Appendix 2**)
- Control of Substances Hazardous to Health (exposure to hazardous substances).
- Moving and Handling.
- Infection Control.
- Sharps (including needle stick injuries).
- Slips, Trips and Falls (non-patient).
- Staff Shortages.
- RIDDORs.
- Burns

8.2 Incident Category Analysis

8.2.1 The Trust upholds a high incident reporting culture using Ulysses as the online reporting system. A total of 2,278 staff incidents were reported, of which 1,570 were categorised as 'no harm' (70%) and 590 as 'minor' (28%). Incidents categorised as 'prevented' (near miss) and 'moderate' totalled less than 2% of the total.

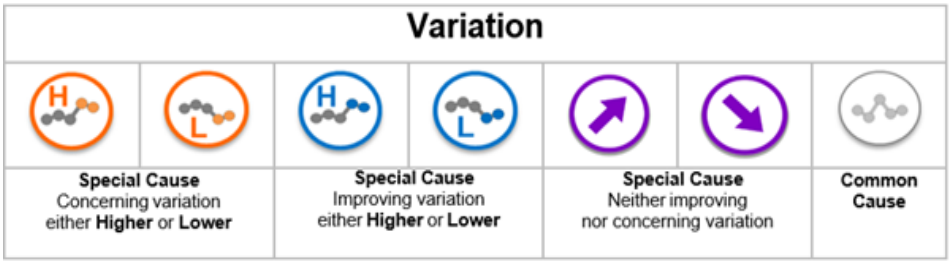
8.2.2 The highest reporting category of incidents in the Trust are 'Patient on Staff Violence' primarily associated to mental health. To date a total of 1,465 incidents were reported against the total of 2,278 staff related incidents. (813 remaining in all other categories)

8.2.3 The top 3 reported incident categories are:

- Patient Violence on Staff (1,465)
- Staffing Levels (373),
- Fire in Q1 & Q2 (42), Sharps in Q3 (22), IP&C in Q4 (33), - Total (97)

8.2.4 Statistical Process Control (SPC) analysis is used to determine whether processes are stable and predictable by looking at variation. 'Natural variation' is regular or ordinary predictable variation. 'Special cause variation' is unexpected or abnormal variation which warrants further investigation. Special cause variation is shown by coloured dots and orange dots show areas of potential concern.

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8.2.5 Following a spike in March, the number of incidents reported was just under the process control limit. This is due an increase in patient on staff violence. **See Appendix 1.**

8.3 Reporting of Injuries, Diseases & Dangerous Occurrence Regulations 2013 (RIDDOR)

8.3.1 Injuries that lead to a member of staff being incapacitated for more than seven consecutive days as the result of a work-related accident or injury (not counting the day of the accident but including weekends and rest days) must be reported to the HSE within 15 days of the accident. All major injuries and dangerous occurrences must be reported to the HSE within 10 days.

8.3.2 This report reflects the 8 incidents reported to the HSE during 2025/26 under RIDDOR as listed in the following Directorate structures. Full details of the patient death (following a fall) were reporting to the HSE and there has been no follow up action required of the Trust as a result to date. The incident was also reviewed under the Patient Safety Incident Framework.

Directorate	RIDDOR Category	Qty	Incident Category
Mental Health & Learning Disabilities	Over 7 Day Injury	1	Violence & Assault
	Over 7 Day Injury	1	Violence & Assault
Integrated Community Services	Over 7 Day Injury	1	Moving & Handling
	Over 7 Day Injury	1	Moving & Handling
	Specified Injury	1	Fracture
	Death	1	Patient Death
Estates & Facilities	Over 7 Day Injury	1	Slip, Trip & Fall
	Over 7 Day Injury	1	Moving & Handling
	Total	**8**	

8.4 RIDDOR Incidents –comparison

8.4.1 The total number of reported incidents (8) is below average for the past three years. (11)

9.0 REVIEWING HEALTH, SAFETY AND FIRE SAFETY PERFORMANCE

9.1 Fire Safety

9.1.1 The Trust is committed to ensuring that the culture around incident reporting is just, balanced, reflective and promotes understanding and recovery. Where harm has occurred or might have occurred an opportunity thereby arises to sufficiently identify if there is any learning that can improve and prevent reoccurrence.

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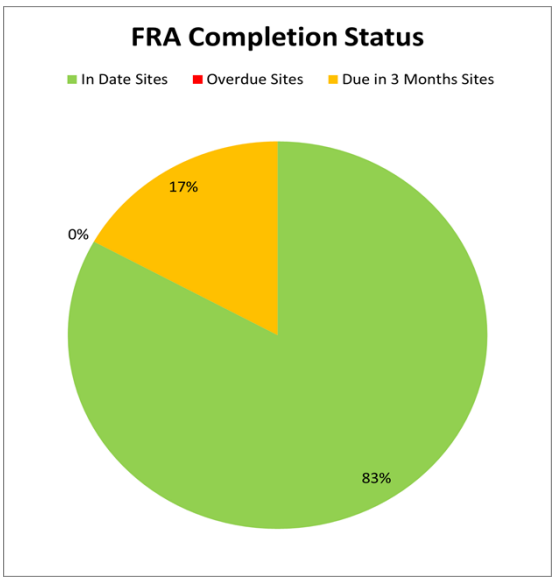
9.2 Fire Safety Arrangements

9.2.1 The Trust maintains a proactive approach to fire prevention which is facilitated by three full time Fire Safety Advisors and a part-time Fire Safety Advisor/Trainer within the health and safety team structure.

9.2.2 Fire risk assessments for all Trust premises are regularly updated and reviewed for all inpatient sleeping areas (annually). Ensuring full compliance is facilitated through the management of a comprehensive fire safety database.

9.2.3 Fire Safety Advisors are continuing to review these assessments timely, whenever significant changes to buildings occur or when risks are identified, including post incident.

9.2.4 Within the completion status shown in the below graph, all the Trusts main properties have an 'in date' premises fire risk assessment with 17% (amber) showing as being scheduled for their review in the next 3 months (in Q1 of 2026/27).



9.2.5 In addition to completing fire risk assessments for Trust owned premises, Fire Safety Advisors support the Trust Property and Assets Team with the review of compliance documentation of unmaintained leasehold and sessional use of properties (where Trust staff are temporarily based or work occasionally).

9.2.6 Fire Marshall and specialist fire training continues and is bookable for staff via learning and development using the online booking system. Staff mandatory attendance is incorporated into the Learning and Development management reporting.

9.2.7 An extensive programme of fire compartmentation works continue across the Trust. This work is being organised through the Estates Capital Team with advice and support from the Fire Advisors in assessing and decreeing lines and levels of compartmentation and remains an agenda for the Fire Safety Group.

9.2.8 The health and safety team continue to work collaboratively with DWFRS in accommodating and promoting routine inspections and audits of Trust premises. During this report, there were 6 (72D) familiarisation visits, 5 at St Ann's Hospital and 1 at Alumhurst Road to support all crews / watches. Further familiarisation visits are being arranged for the NHP new build schemes prior to patient occupancy.

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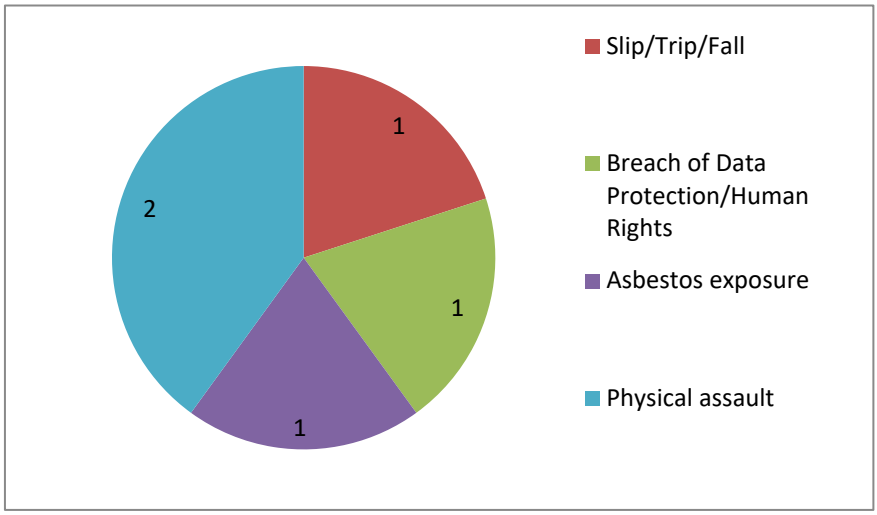
9.3 Non-Clinical Litigation

9.3.1 Non-Clinical Litigation claims management resides within the Health and Safety Team portfolio. Cases are overseen and managed in collaboration with the NHS Resolution (NHSR) and, if required, panel solicitors as appointed by NHSR.

9.3.2 It is the aim of the administrating protocols, which govern the management of cases, to limit the risk of claims reaching court and incurring high additional costs. With this basic principle in mind, the non-clinical litigation leads works with NHSR to find ways to potentially defend claims, mitigate costs and challenge case merit.

9.3.3 The NHSR Liabilities to Third Parties Scheme (LTPS) typically covers employers' and public liability claims from NHS staff, patients and members of the public. Under the scheme the Trust is liable for the Excess payment per claim £10,000 (Employee Liability) and £3,000 (Public Liability & Data Protection Act).

9.3.4 There are 5 active non-clinical litigation cases open with NHS Resolution as of 31 Mar, compared to 6 cases this time last year. These 5 cases can be broken down into the following claims type:



9.3.5 As at Q4, there was 1 non-clinical claim closed.

- Under the category of Slip/Trip/Fall which was settled out of court.

9.3.6 There were no identifiable trends in respect of the claims received.

9.4 Management of Contractors

9.4.1 Contractors working on behalf of the Trust undergo rigorous processes that include the scrutinising of legislative assurances and pre-requisites in accordance with the Trust's Control of Contractors policy. Assurances through company method statements and task specific risk assessments are checked prior to and during their employed works.

9.4.2 All contractors operate under the requirements of the Health and Safety at Work etc. Act 1974 and other associated safety regulations including The Construction (Design and Management) Regulations 2015. To facilitate this, a full health and safety induction tailored to the type of workplace environment is carried out for all contractors that are officially employed on Trust sites with particular emphasis when working in mental health sites.

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9.5 New Build Schemes

9.5.1 Health and Safety continues to be a valid contributor for our new hospital build schemes at St Ann's and Alumhurst Road sites and major refurbishments completed in other areas e.g. No 2 Nuffield Road HQ build.

9.5.2 Meetings with designers and architects in partnership with Capital Planning team have ensured that the building regulations and fire safety have been appropriately considered throughout the projects. These requirements and values include the additional safe standards for mental health and environmental considerations for patients who are at risk of self-harm.

9.5.3 Contractors working on large-scale building works continue to be subjected to routine safety inspections by the Trusts health and safety and fire safety advisors to ensure that they are demonstrating compliance with regulations and maintaining safe working practices, especially where they interact with other functional services.

9.5.4 The health and safety team will continue to monitor and address unsafe practices as and when they occur. Repeat offenders can and will be banned from future Trust works and or reported to the HSE and local authorities.

10.0 HEALTH AND SAFETY SUMMARY

10.1.1 Throughout this period, the continued strategy to maintain a positive health and safety culture remains constant, despite the varying service changes to meet operational delivery. Workplace risk assessments amongst sites and services remains important and is linked to the assurance evaluation work completed for any potential HSE inspections.

10.1.2 The health and safety team have continued its successful approach to self-harm and suicide prevention through its ligature management using a collaborative approach.

10.1.3 The impact of reported incident gradings remains low at 98% (''no harm' 70% 'minor' 28%), with external reporting categories to the HSE being lower than average. Incidents reported as 'prevented' (near miss) and 'moderate' are at 2%.

10.1.4 Future works includes collaboration with L&D to identifying managers who are required to attend face to face health and safety training. Extend ligature cutter training across CMHT sites and formal establishment of the Trusts Fire Safety Group.

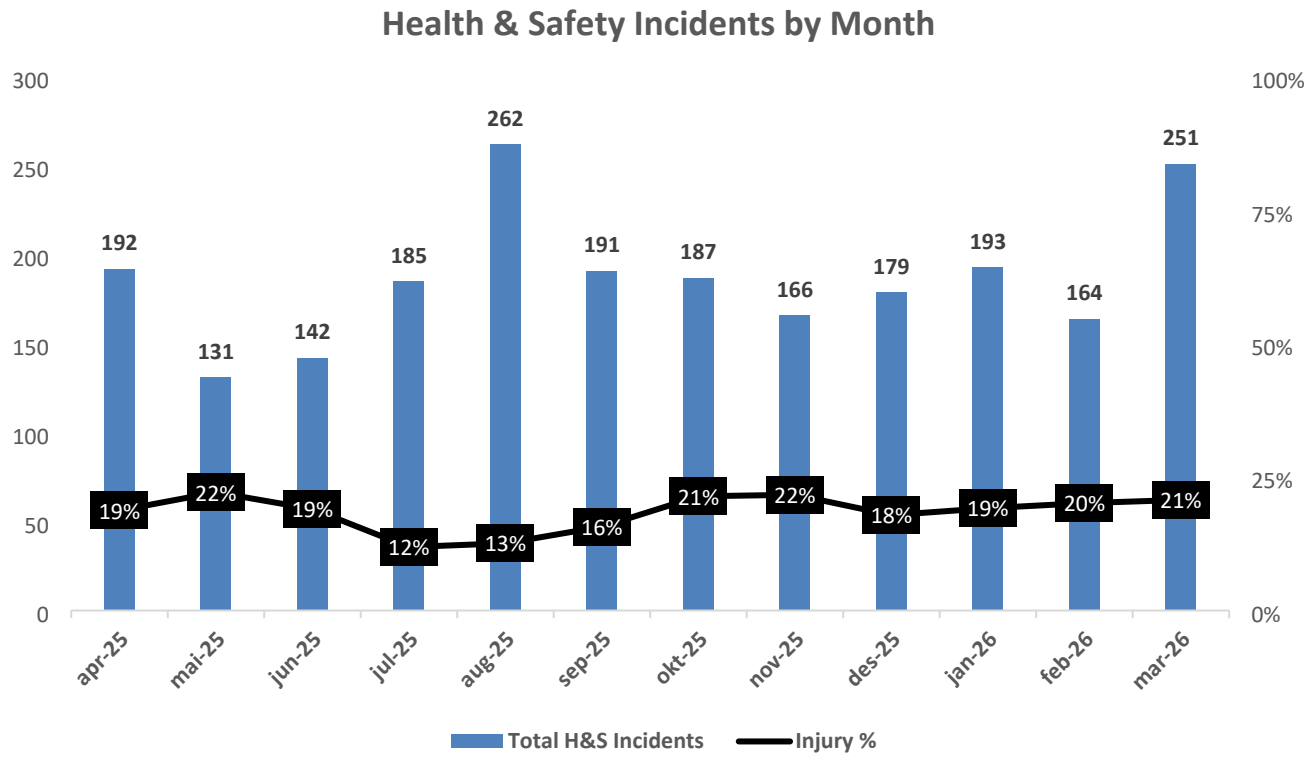
10.2 Recommendations

10.2.1 The Board is recommended to: **Receive the report for assurance**.

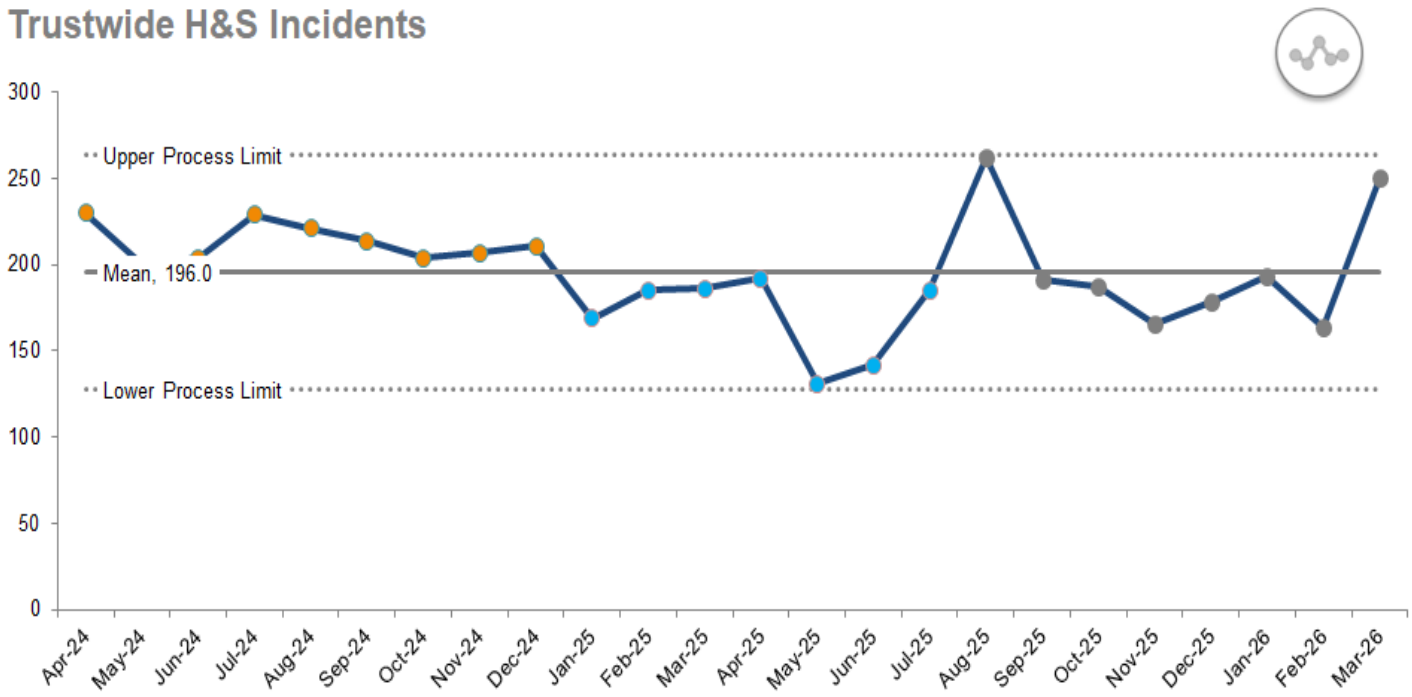
Steve Harper
Associate Director
Health & Safety / Fire / Emergency Planning

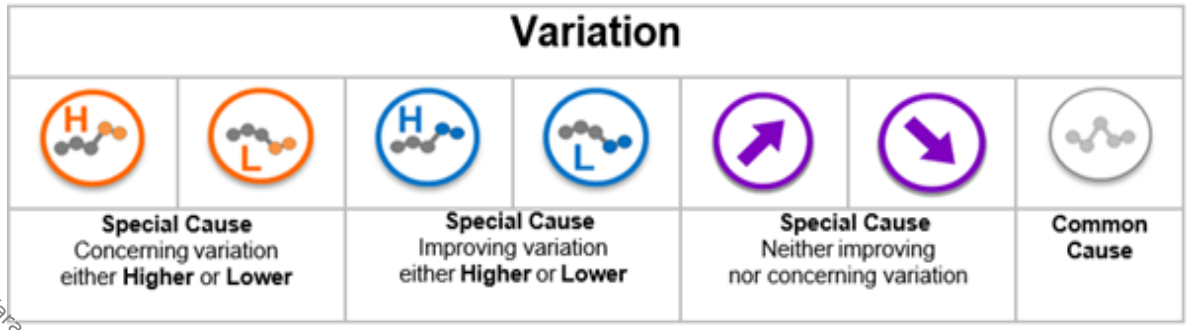
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Dorset HealthCare University NHS Foundation Trust



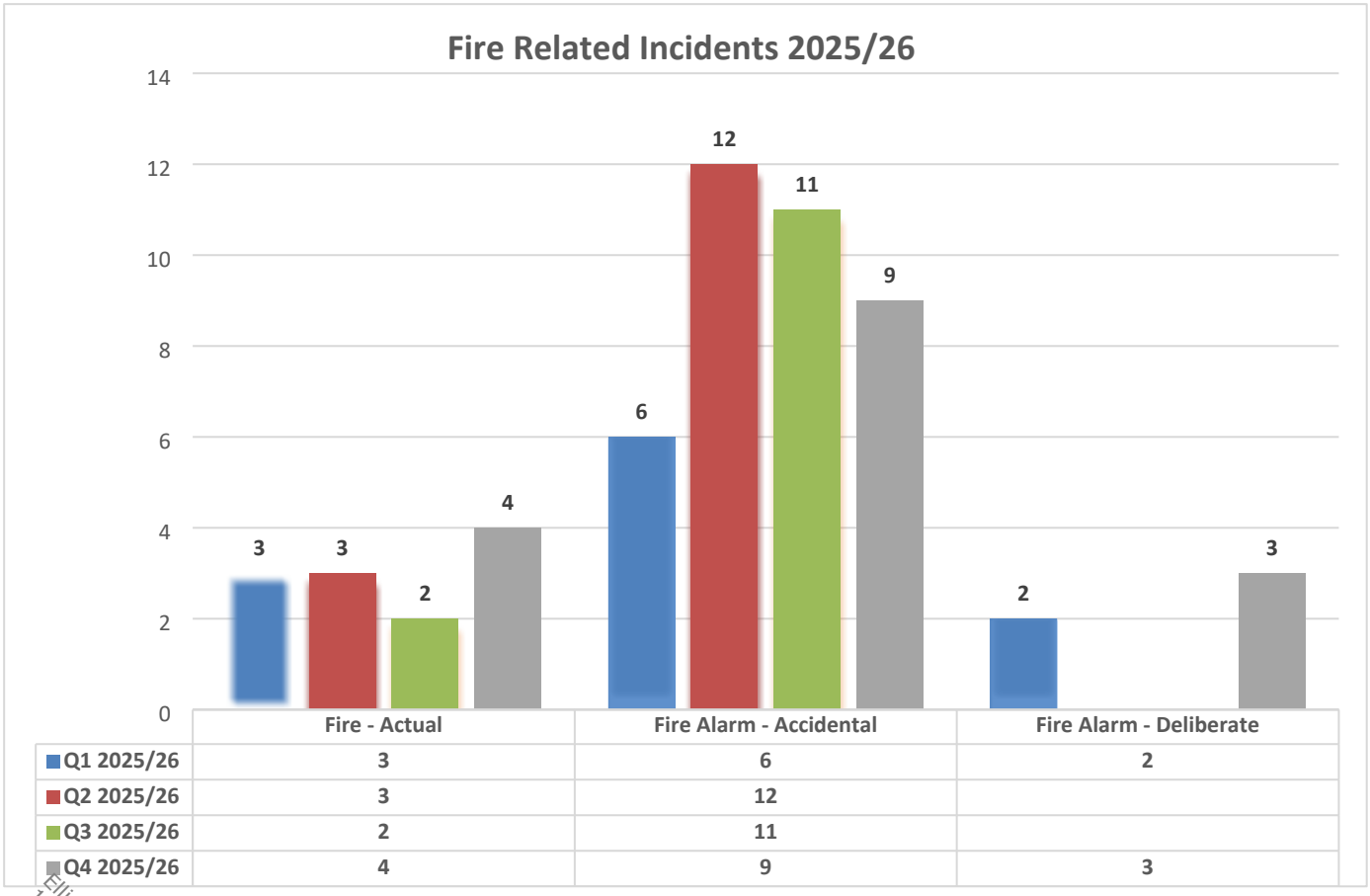
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APPENDIX 2 – FIRE SAFETY ACTIVITY



Ellis Kara
10/06/2026 16:10:45

Report to	Board of Directors in Common (DCH)	
Date of Meeting	17 June 2026	
Report Title	Health and Safety Bi Annual Report 2026	
Prepared By	Gary Jones (H&S Manager)	
Approved by Accountable Executive	Chris Hearn	
Previously Considered By	Health, Safety, Fire & Security Group Meeting Finance and Performance Committee in Common – May 2026	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR5 Estates	
Financial	No implications	
Statutory & Regulatory	Health and Safety at Work Act 1974	
Equality, Diversity & Inclusion	n/a	
Co-production & Partnership	n/a	

Executive Summary

- The Health and Safety report provides information about health and safety processes being delivered across the Trust. These will be implemented at all sites as far as possible, to support the health, safety and welfare of staff and others.
- Health and Safety incidents for the period have been reviewed for the report period and investigations, and learning has been cascaded to relevant parties involved.
- RIDDOR incidents for the current reporting period are 5 with one of these being a specified injury (amputated finger) that HSE has requested further information on.
- Occupational health services are now provided by Dorset Healthcare and there has been an improvement in data; this is now being tracked monthly.
- Fire and Estates compliance work remains ongoing, with Estates compliance presently at approximately 80%. This position reflects the seasonal nature of inspections and servicing activity, and further improvement is expected as works conclude.
- A short postponement of the Health & Safety Committee meeting was agreed to allow the newly appointed advisor sufficient time to familiarise themselves with Trust-wide arrangements, systems, and risks.

Recommendation

The Board is recommended to:

- Receive the report for assurance

Ellis Kara
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Health, Safety and Welfare Report
for the period 01.01.2026 – 15.05.2026

1. Executive Summary

1.1. The Health and Safety at Work Act 1974 is the primary piece of legislation covering occupational health and safety in Great Britain. Under these Regulations, employers must put arrangements in place to control health and safety risks. This means balancing the level of risk against the measures needed to control it in terms of money, time, actions, training or policies and processes.

1.2. Under the Management of Health at Safety at Work Regulations 1999, every employer must have arrangements for 'effective planning, organisation, control, monitoring and review' of measures to protect people. Whilst the Trust has a legal obligation to ensure the safety of employees and the workplace, employees also have a duty to ensure that they take care of their own health and safety and that of others who may be affected by their actions at work.

1.3. Health and safety regulations are the guidelines, procedures and programmes that protect individuals in the workplace. The regulations pertain to staff, contractors, visitors, clients, customers or anyone else who enters the Trust premises. The objective of health and safety is to prevent health risks and injury.

1.4. Health and safety guidelines determine the procedures to follow, the use of special equipment to ensure safety, the provision of items like fire extinguishers and the prohibition of certain substances. From the employer's perspective, these regulations constitute responsibility and protection.

1.5. An organisation with a reputation for caring about the health and safety of its staff and others is more likely to enjoy a good reputation. A positive reputation can attract talented individuals to the organisation easier as prospective employees are more likely to favour an organisation that cares about staff health and safety.

1.6. A good contribution to a healthy and safe workplace is a culture that emphasises teamwork, transparency and accountability. It's important for staff to care about each other's well-being, including both physical and mental health. Health and safety affect everyone in the workplace, not just individuals.

1.7. Effective health and safety performance comes from the top; members of the board have both collective and individual responsibility for health and safety.

1.8. Protecting the health and safety of employees or members of the public who may be affected by our activities is an essential part of risk management and must be led by the board.

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1.9. Failure to include health and safety as a key business risk in board decisions can have catastrophic results. Many high-profile safety cases over the years have been rooted in failures of leadership.

1.10. Health and safety law places duties on organisations and employers, and directors can be personally liable when these duties are breached: members of the board have both collective and individual responsibility for health and safety.

2. Introduction

2.1 Health and safety management is an ongoing process, not a one-off task. It is not enough to just control the risks across the Trust; we must ensure that they stay controlled.

2.2 Implementing good health and safety measures lowers the overall risk of accidents, injuries and illnesses in the workplace. For example, if employees work in an environment with unavoidable risks, employers provide them with personal protective equipment (PPE). Following principles of 'Hierarchy of risk' and using appropriate risk assessments.

2.3 Health and safety measures also include the provision of adequate facilities for washing, toilets and ventilation, as good hygiene in the workplace can help to prevent illness and contagion. In addition, employers usually inform staff of the procedures in place using staff handbooks and posters in the workplace, ensuring that everyone is aware of how to stay safe. All these measures can lower the overall risk of workplace incidents.

2.4 Monitoring for health and safety is broadly categorised by two types:

- Proactive monitoring and reactive monitoring.
  Proactive monitoring is intended to be preventative – identifying and resolving hazards before they lead to incidents.

- Reactive monitoring
  Reactive monitoring is conducted after an incident has occurred, and often seeks to identify root causes, or other process or system causes, of incidents and to prevent recurrence by implementing corrective actions. This could include:

2.5 The Trust has again received no prosecutions or Improvement Notices from any of the enforcing agencies of the HSE, CQC or Dorset & Wiltshire Fire & Rescue Service during 2025/26 relating to health and safety matters.

2.6 To ensure that the health and safety agenda is not only embedded, but embraced throughout the Trust using a variety of monitoring methods, including:

- Health, Safety, Fire and Security Group (quarterly)
- Divisional Governance (monthly) meetings
- Risk based monitoring groups, such as water, electrical and mechanical safety.

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2.7 Review of annual health and safety audit as part of management oversight and assurance.

The Trust Health and Safety Audit programme is a paper-based system for ensuring general Health and Safety standards are maintained for patients, visitors, and staff. The audit looks at many of the Trust's Day to day activities and includes risk assessments and inspection regimes.

It is a legal requirement that health and safety processes are audited, and the Trust does this through the annual health and safety audit. Assurance of this review is provided by a quality check which is carried out every three years and was last done in 2025.

3. Overview of Legal Compliance

3.1 The table below outlines the main health & safety legislation and identifies the reactive and proactive work that the Trust has carried out in order to ensure compliance.

Legislation	Description of Actions / Compliance	RAG
Health and Safety at Work Act 1974	• Health and Safety Policy reviewed and published. • Competent people in place to provide compliance advice. • Health, Safety, Fire and Security Group (HSFS) held 4 times a year	
Management of Health & Safety at Work Regulations 1999	• Annual Health and Safety Audit Plan • Annual Health and Safety work plan • Training in Health and safety related topics provided	
Display Screen Equipment Regulations 1992	• DSE Self-assessment tool has been reviewed and includes instructions for managers and staff members. • Where Occupational Health has made recommendations, Health and Safety Manager undertakes the DSE assessment and makes recommendations. • DSE assessments are also to be completed by home workers.	
Health & Safety Information for Employees Regulations (Amendment) 2009 Health & Safety Consultation with Employees Regulations 1996 Safety Representatives and Safety Committees Regulations 1977	• Employers have a duty to consult with their employees, or their representatives, on health and safety matters. • HSFS Group acts as consultative committee for H&S policies. • HSFS Group is attended by Managers, Trust Competent Persons, and TU safety reps. • Terms of reference have been reviewed for the HSFS Group • H&S Policy has been updated. • H&S Trade union H&S Reps in place • Reports on Audits, Action Plan progress, etc. • Receives escalation / assurance reports from sub-groups.	

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Legislation	Description of Actions / Compliance	RAG
Control of Substances Hazardous to Health 2002 Electricity at Work Regulations 1989 Workplace (Health Safety & Welfare) Regulations 1992 Provision and Use of Work Equipment Regulations 1998 Lifting Operations and Lifting Equipment Regulations 1998 The Control of Noise at Work Regulations 2005 Control of Asbestos Regulations 2012 Personal Protective Equipment at Work Regulations 1992 Construction (Design and Management) Regulations 2015 (CDM)	• Regulations are monitored by the HSFS Group and managed through meetings of the specialist groups. • Authorising Engineers are in place to advise on subject matters. • Premises Assurance Model reviews compliance on an annual basis. • Health and Safety Manager attend the subject matter groups to monitor compliance.	

4. Health and Safety Objectives

Objective	What was achieved	RAG
To review and implement the Health and Safety policy	• Reviewed and in date until next review July 2026.	
To ensure as far as reasonably practicable DCHFT is compliant with all relevant Health and Safety Legislation	• Policy and training programme in place – need to review local inductions.	
To audit Health and Safety Systems throughout the Trust to ensure compliance with Health and Safety Guidance Note 65 (HSG 65)*, Health and Safety Management Systems. And to compare with performance measures BS 45002-0:2023 Occupational health and safety management systems – general guidelines for the application of ISO 45001:2018.	• H&S Manager is new in post and cannot guarantee the validity of previous works that have been undertaken. Need to work with Div A & B to ensure that auditing has been completed. Spot checks will be carried out in the future.	
Continually improve processes for identifying and managing health and safety related risks.	• H&S Manager is new in post and cannot guarantee the validity of previous work that has been undertaken. • H&S Manager is currently undertaking stakeholder engagement and mapping where weakness is evident and working with groups to ensure compliance.	
To ensure compliance with DHSCFFP3 fit testing resilience principles and that all staff who require face fit testing have been fitted to two FFP3 masks every 2 years.	• This is now an established programme of work, which is managed by the Education team and supported by Health and Safety Manager and Infection Control.	
To implement the Control of Substances Hazardous to Health (COSHH) Risk	• H&S Manager is working with the Education team to produce a COSHH	

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Objective	What was achieved	RAG
assessment and training programme.	Assessors course. • Working with DHC H&S Team to align training for staff.	
Continue to support members of staff, visitors and patients who may have sustained injury or been involved in incidents on Trust premises	• All H&S incidents are investigated, and improvements implemented were reasonably practicable and proportionate.	
Continue to work closely with the DCHFT project managers to ensure all contractors work safely on Trust sites.	• H&S Manager sits on the project groups and task and finish Groups to ensure compliance. • Ad hoc walk around to 'spot-check' are also undertaken and any non-compliance is reported to Project Leads.	
Ligature light environments	• H&S Manager needs to review policy.	
Seek further collaboration for H&S with other health care Trusts.	• Initial H&S meeting has taken place with H&S team from DHC. Will be working more closely together in the future	

* HSG 65 aimed to set out the 'big picture' describing the scope and nature of good health and safety management and how this could be integrated into management practice. The core idea was to provide a framework illustrating how health and safety could be managed as a process rather than just a series of good practices.

5. Reporting mechanisms

5.1 Estates and Facilities have a governance structure that covers some of the aspects of Health and Safety, such as Fire Safety, Water Safety, Electrical Safety, Ventilation Safety, and general estates compliance with national and legislative standards. These Groups report by exception to the HSFS Group.

5.2 The Premises Assurance Model (PAM) and the Estates Return Information Collection (ERIC) are annual assessments undertaken by the Estates team that has a Health and Safety section. This is also a standard agenda item at the Estates and Facilities Risk and Compliance Group. Again, escalations are reported to the HSFS Group.

6. Incident Reporting

6.1 The Trust Incident Reporting system is a significant part of the open and transparent reporting culture and continues to remain strong in the clinical sphere. Further work is needed to encourage reporting in the EFM division as things are not being reported and safety culture needs to be improved.

- Issues have included water ingress at South Walks House and Nitrous Oxide Workplace Exposure Level exceeded in Maternity.
- Emerging Issues have included the lack of a Magnetic Resonance Safety Expert, but support is being sought from another trust.

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- Risks involving safety for pedestrians and corridor congestion have been added to the Register. H&S Manager has been tasked with leading auditing what we have in the streets and reporting back to SLT.

- Some issues remain outstanding and some of these regard electrical issues. There are still issues with the fixed wiring specification that need to go out for tender.

7. Control of Substances Hazardous to Health

7.1 The Control of Substances Hazardous to Health 2002 (COSHH) requires organisations to risk assessing the substances they use that could cause harm to workers and others and put in suitable controls to manage the risks.

- COSHH risk assessment course is currently being developed by the new H&S manager, but this may take some time due to current workload.

8. Risk Assessments

- H&S Manager will be providing ad hoc support to colleagues regarding all types of risk assessments.

- There are several generic risk assessments on the H&S pages that need to be checked to ensure that they are fit for purpose.

9. The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

9.1 Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013, some incidents must be reported to the Health and Safety Executive (HSE). All RIDDOR notifications for the Trust are made by the Health and Safety Manager.

- There have currently been 4 Riddor reportable injuries year to date and 1 specified injury which led to an amputation of the end of a finger.

10. Face Fit Testing

10.1 H&S manager is new to post and cannot complete a narrative on this section at this time as they are unsure of the process and want to ensure that the correct governance is in place with the education team and IP&M.

11. Training

11.1 The H&S Manager is new to post and is currently reviewing all training.

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11.2 H&S Manager has developed a training package for preceptorship training with international employees.

11.3 H&S Manager is currently working with education team in relation to COSHH

assessors' training course.

12. Inspection of annual health and safety audit report

- Further strengthening of the Trust's Health and Safety governance arrangements has been achieved with the appointment of a dedicated Health & Safety Advisor. This provides increased professional oversight and capacity to address ongoing compliance and assurance requirements.
- No major health and safety incidents were reported during the period, offering short-term assurance on operational safety performance. However, compliance performance remains mixed. Division A has currently achieved 55% compliance with the required annual Health & Safety audit programme, highlighting the need for continued focus and improvement.
- Assurance reviews have identified variability in the quality and management of local safety documentation. Departmental electrical equipment registers are inconsistent and difficult to maintain; adoption of the Estates-managed PAT register as a single source of truth is recommended. Similarly, while examples of high-quality risk assessments exist, these are not applied consistently across the Trust, limiting overall assurance. Inconsistent management sign-off safety documentation further weakens governance controls.
- COSHH compliance continues to represent a significant area of risk. Current processes are resource-intensive, inconsistent, and prone to misunderstanding at departmental level. Implementation of a centralised digital COSHH system (SYPOL) is recommended to improve consistency, efficiency, and assurance. A costed proposal has been received and is presented for executive consideration.

13. Conclusion:

13.1 The report summarizes progress against strategic and annual objectives for health and safety, informing the Group of the compliance with legal obligations under the Health and Safety at Work Act 1974

- The Health and Safety report provides information about health and safety processes being delivered across the Trust. These will be implemented at all sites as far as possible, to support the health, safety and welfare of staff and others.
- Health and Safety incidents for the period have been reviewed for the report period and investigations, and learning has been cascaded to relevant parties involved.
- RIDDOR incidents for the current reporting period are 5 with one of these being a specified injury (amputated finger) that HSE has requested further information on.
- Occupational health services are now provided by Dorset Healthcare and there has been an improvement in data; this is now being tracked monthly.
- Fire and Estates compliance work remains ongoing, with Estates compliance presently at approximately 80%. This position reflects the seasonal nature of inspections and servicing activity, and further improvement is expected as works conclude.
- A short postponement of the Health & Safety Committee meeting was agreed to allow the newly appointed advisor sufficient time to familiarise themselves with Trust-wide arrangements, systems, and risks.

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Dorset County Hospital
Dorset HealthCare

People and Culture Committee in Common Assurance Report for the meetings held on Monday 27 April 2026 (informal) Wednesday 28 May 2026 (formal)

Chair	Eiri Jones, NED
Executive Lead	Nicola Plumb, Joint Chief People Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Board Assurance Framework & Corporate Risk Register as described below. • A number of reports will be presented to Board in line with the workplan including the Equity, Diversity and Inclusion Annual Report, the Guardian of Safe Working Reports, and Freedom to Speak Up Reports • General reflections on the risks relating to changes in people services arising from the target operating model and potential gaps in capacity.
Key issues / matters discussed at the meeting	**The informal meeting of the committee held 27th April 2026 was a staff engagement session:** The meeting centred around a freeform discussion with representatives from staff networks and other staff forums, to help committee members fully understand the diversity of experience in our Trusts, as well as identify what more the Board can do particularly, to support improvements in our day to day lives in the workplace. Themes highlighted by colleagues included: • The challenge for staff network chairs of dealing with and supporting colleagues through crises especially from staff who are carers. • The opportunity to combine networks across the two trusts • The need to support staff networks and network chairs, including relating to time commitment for the chairing role. A need for a 'cocoon of support' was described throughout the meeting. This is something the committee would like to see explored further through the wellbeing offers • Variability across the trusts in staff being able/allowed to attend network meetings • The need to break down barriers between 'us and them' i.e. staff and managers (middle and senior) • The role of the sponsor in supporting networks; their role, time commitment and access to them • How to promote the work of the networks across the county

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- Examples of experiences of discrimination and abuse from staff and patients, and fears about the impact of raising grievances
- The need to find a balance between meeting individuals needs and ensuring safe services. This was a challenge, but there was evidence of innovative solutions to flexible working.
- That HR policies are guidelines and that personal circumstances should be taken in to account when applying policies
- The positive impact of valuing and recognising staff contributions
- The broad development offer available from the EDI team to network chairs
- Recognition that culture was not a short-term fix, but took time to embed

Committee members commended the work of the networks and the level of candour with which those present shared their experiences and thoughts.

The meeting held 27th May 2026 received, discussed and noted the following reports:

Chief People Officer Update highlighting:

- Emerging national workforce direction, including the anticipated 10-year plan, with a continued focus on productivity and workforce reshaping, and a likely reduction in reliance on international recruitment
- Ongoing development of national leadership standards and oversight metrics, with further detail awaited, although key measures are expected to include sickness, agency use, and morale
- Progress in refocusing the Joint Culture and Belonging Group, with an emphasis on balancing meaningful staff engagement and psychological safety with clear, purposeful outputs
- The initiation of a review of DBS checking processes, with future proposals to be presented in line with best practice and proportionate risk-based approaches

Board Assurance Framework (Joint) noting no changes to risk scores, no overdue actions, and alignment across both trusts. The Committee discussed the proposed revisions to the strategic risk narratives noting that some further changes were required and noting improved clarity and alignment to risk appetite, including increased tolerance for disruption in the context of transformation. Discussion highlighted the importance of clear articulation of culture and empowerment, alongside the need to maintain effective approaches to workforce engagement recruitment and retention and to ensure consistency across staff groups. The Committee also noted the interdependency between workforce, culture, and transformation programmes, and requested continued visibility of this integration within future reporting.

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Corporate Risk Register (DHC/DCH)

DHC:

- New risk relating to Seastone CAMHS high intensity with recruitment ongoing and plans evolving for medical staffing
- Risk relating to Bournemouth West CMHT staffing has now reduced to 12 and likely to close following successful recruitment – significant improvement and positive work to reach this position
- Risks scores broadly reducing or remaining stable
- Discussion around the importance of ensuring proactive workforce and digital integration in new service developments, with assurance provided that dedicated leadership capacity has been established to support infrastructure programmes such as new hospital developments.

DCH:

- A stable position with risks either reduced or maintained and no issues requiring escalation.
- Ongoing recruitment challenges, alongside progress in workforce development and risk reduction.
- Variation in how risk scores are reduced across divisions and agreed that there is an opportunity to improve consistency and transparency, supported by the development of a shared risk management system.

Workforce KPI Dashboard (Joint) noting the below KPIs:

Trust	Sickness	Vacancy Rate	Turnover Rate	Appraisals	Mandatory Training
DCH	4.4%	8.2%	8.8%	77%	89%
DHC	4.7%	8.26%	9.3%	66.3%	92.5%

- A broadly stable position with improvements in sickness absence and reduced agency use.
- Ongoing challenges were noted in appraisal compliance, vacancy rates, and workforce capacity, with continued reliance on temporary staffing.
- The Committee discussed the complexity of sickness absence and the need for clearer data and alignment between analysis and actions.
- The committee emphasised its continued focus on appraisal and supervision

The Committee received a presentation of the **NHSE Transforming People Services** (Joint) and recommended that this be scheduled for review at an upcoming Board Development Session. The plan aligned with the national 10-year plan and the two trusts approach to digital. It was noted that the south west region have been chosen as an early implementer alongside the London region.

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People Enabling Plan 2026/27 Objectives and Delivery Plan (Joint) noting the priorities reflect:

- targeted support to key programmes aligned to organisational priorities and available capacity
- delivery of operational plan commitments
- continued integration of people services
- a sustained focus on culture, engagement, and inclusion

A number of priorities represent ongoing work rather than discrete time-limited initiatives, reflecting the need for continuity within a complex and evolving environment. The plan aligns with emerging national workforce priorities and wider organisational transformation programmes.

Health and Wellbeing Action Plan (Joint) noting good overall progress with most actions on track and wellbeing increasingly embedded into business as usual. The future approach is being aligned across both Trusts. Discussion questioned the long-term sustainability and reliance on staff goodwill for health and wellbeing services, with emphasis on the importance of leadership, working conditions, and workforce capacity in supporting wellbeing.

Equity, Diversity and Inclusion Annual Report (Joint) noting strong progress and a comprehensive overview of EDI activity across both organisations. The focus on joining EDI work with health inequalities work was highlighted.

Digital Workforce Update (Joint) noting progress in strengthening digital leadership, workforce capability, and a Dorset-wide operating model with an approach of 'must have' rather than 'nice to have'. Discussions around digital as a key enabler of workforce productivity and staff experience, and the opportunities and benefits it affords. The importance of supporting staff engagement and confidence was also noted.

Staff Voice Report (Joint) providing an update on work to develop a report to capture and combine workforce feedback, data, and quality indicators to provide a more integrated understanding of staff experience. Discussion emphasised the importance of ensuring a balanced representation of staff voices, including those less likely to engage.

Quarterly Guardian of Safe Working Report (DHC/DCH)

<u>DHC:</u>

- 11 exception reports, all of which were now closed. No safety concerns
- Discussions ongoing with resident doctors about how to use the fines

<u>DCH:</u>

- stable trends across the full year with no significant areas of concern or vulnerable shifts identified
- reporting continues to improve, which is viewed positively as an indication of staff engagement and willingness to raise concerns.

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- challenges in interpreting “immediate safety concerns” due to limitations in reporting processes and recognised the need to refine how concerns are captured and escalated. Triangulation with other data was importance to provide context.

Freedom to Speak Up Report and Annual Report (DHC/DCH) noting that the FTSU Guardians now report to the Director of Corporate Affairs in line with the recent review of speak up arrangements, and the learning being shared between the two Trusts. Nationally, the National Guardian Office will cease from 1st July with the Department of Health to take over national oversight. Team was congratulated for getting an article accepted for the national newsletter

DHC:

- 215 cases in 2025/26. Training compliance now at 92%. Work continues to fully understand and further address worries about detriment in raising concerns.

DCH:

- 475 contacts in year. 240 contacts in Q3 and 4, in line with previous reports. Only 1 anonymous contact suggesting good level of psychological safety. Listening and engagement events continue in order to hear staff feedback.

Positive examples working across the federation were noted.

Update on the Impact of 10 Point Plan to Improve Resident Doctors’ Working Lives (DHC/DCH). For both trusts good overall progress was noted with most actions complete or compliant and improved engagement with resident doctors, with stronger connection and increased participation in forums. Outstanding actions are being actively managed through established governance routes, including medical leadership forums and representative groups.

Joint Violence Prevention and Reduction Strategy (DHC/DCH) noting alignment with new national standards and a strong focus on staff safety. The approach brought together data, staff feedback, and wider intelligence to better understand trends and inform targeted improvement actions. An increase in reporting is anticipated as awareness and training improve. The importance of considering this alongside related areas, including restrictive practice and wider system factors such as workforce pressures was noted.

The below items were taken under consent, without discussion:

Assurance reports from below sub-groups of the People and Culture Committee in Common

DHC:

- Workforce Wellbeing Group
- Trade Union Partnership Forum

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	• Equality, Diversity, Inclusion and Belonging Steering Group • Local Negotiating Committee DCH: • Partnership Forum • Health and Wellbeing Steering Group • Local Negotiating Committee **Nursing and Midwifery Job Profiles** (DHC/DCH)
Decisions made at the meeting	• Approval of the Reducing Violence and Aggression Update (DHC/DCH) • Approval of the People Enabling Plan 2026/27 Objectives and Delivery Plan
Issues / actions referred to other committees / groups	• Nil

Quoracy and Attendance						
	27 May 2026	**28 Jul 2026**	**29 Sept 2026**	**24 Nov 2026**	**26 Jan 2027**	**23 Mar 2027**
Quorate?	Y					
Suresh Ariaratnam	Y					
Margaret Blankson	Y					
Dawn Dawson	A					
Eiri Jones	Y					
Lucy Knight	Y					
Nicola Plumb	Y					
Rachel Wharton	Y					

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Report to	Board in Common (DCH & DHC)	
Date of Meeting	17th June 2026	
Report Title	DHC - Freedom to Speak Up Guardian Q3 & Q4 and Annual Report DCH - Freedom to Speak Up Guardian Q3 & Q4 and Annual Report	
Prepared By	Anne Hiscock - Freedom to Speak Up Guardian; DHC. Lynn Paterson- Freedom to Speak Up Guardian; DCH.	
Approved by Accountable Executive	Jenny Horrabin - Joint Director of Corporate Affairs	
Previously Considered By	People and Culture Committee in Common 27th May 2025	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR2 Culture	
Financial	No implications arising from this report	
Statutory & Regulatory	The standard NHS contract requires that all trusts to employ a Freedom to Speak up Guardian and was a recommendation of the Freedom to Speak Up Review by Sir Robert Francis that was published in 2015. *'Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services'* (2022), p33-34.	
Equality, Diversity & Inclusion	The reporting methodology includes staff data relating to the protected characteristics where this is known.	
Co-production & Partnership	The report includes data provided by the learning and development team, the Organisational Development team and the HR team.	

Executive Summary

This is the quarter 3 & 4 and Annual report on Freedom to Speak Up (FTSU) in Dorset County Hospital (DCH) and Dorset HealthCare (DHC) for 2025/26. Themes and learning are captured within this report; the FTSU Guardian's share learning with staff and colleagues in a variety of ways in order to promote a positive culture of raising concerns.

Dorset Healthcare (DHC)

- The Guardian at DHC has now been in post for over 5 years and has been working part-time in the role since January 2020 (was previously an Associate Guardian for 5 years).
- Currently at DHC we have 4 Associate Guardians who have undertaken the National Guardians Office (NGO) training who support the Guardians when capacity allows.
- Work commenced in January 2026 to recruit local Champions in order to increase reach across the organisation, which will be a continual drive throughout this year and beyond. So far we have recruited over 70 Champions.
- Quarterly data returns are sent to the National Guardians Office (NGO) and published on the NGO website, alongside all other NHS Trust returns. Quarter3 & 4 returns have been submitted.
- In Q 3 & 4, **90** contacts were made to the FTSU service as per Trust policy, bringing the year end position to **215** cases in total - an annual increase of 2**0%** on the year before. Out of these, **34** cases

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remain open, largely due to them being more recent cases or in the instance of longer established cases, HR process and long-term sickness being a factor. Staff who raised concerns throughout the year, mainly work in Community Services **[92]** and Mental Health Directorates **[83]** as these have the largest workforce

Quarter 2025	Number of contacts: DHC
Q1	57
Q2	68
Q3	37
Q4	53

- Training compliance is **92.21%** compliant compared to the year end 2024/25 position of **83.29%** which equates to an overall increase of around **10.7%.**

Dorset County Hospital (DCH)

- The Guardian at DCH has now been in post for over 3 years and has been working full-time in the role since July 2024.
- DCH now have 1 Associate Guardian and over 70 Champions in post all trained as per NGO recommendations.
- Quarterly data returns are sent to the National Guardians Office (NGO) and published on the NGO website, alongside all other NHS Trust returns. Quarter 3 & 4 returns have been submitted.
- In Q3 & 4 of 2025/26, **240** contacts were made to the FTSU service, a very similar picture to the previous reporting period of 235. This brings the year end position to 475 cases in total, of which only 1 remains open. There has been an increase in contacts seeking advice/guidance which are quicker to resolve and close, hence only 1 case remains open. There was a similar number of concerns raised from both Division A and Division B. A new database has now been established which will be able to demonstrate further breakdown of services as currently only the 2 Divisions, People and Corporate Services are recognized

Quarter 2025	Number of contacts: DCH
Q1	119
Q2	116
Q3	120
Q4	120

- There has been a significant increase in training compliance from last year's 68% to 88% of staff compliance, which is a very encouraging.

Joint working and National Developments

- From the 1st July **NHSE will take over the function of the NGO** at which point the NGO will cease to exist. The emphasis is on NHS organisations to take on the local responsibility for embedding effective FTSU arrangements: https://www.england.nhs.uk/long-read/the-future-of-freedom-to-speak- up/
- The Guardians attend national and regional events to ensure best practice is brought back and embedded within both DHC and DCH. The Guardians receive supervision from a peer Guardian and at DHC receive robust support from the previous DHC Guardian.
- The Guardians receive support and supervision additionally from Executive/Non-Executive team members as required.

Recommendation

Members are requested to: Receive assurance on the ongoing programme of work that the Guardian continues to support via targeted work to improve visibility and psychological safety across the organisation, and support ongoing learning from speak up cases.

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Dorset HealthCare Freedom to Speak Up Report

Quarter 3 & 4 and Annual Report

1.0 Introduction

1.1 Sir Robert Francis in his Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013) described the experiences of nurses and doctors who raised concerns about the poor care of some patients at Stafford Hospital. As a result, he was asked to conduct a further review into raising concerns in the NHS.

1.2 'Freedom to Speak Up – an independent review into creating an open and honest reporting culture in the NHS' was published in 2015. The report identified a need for culture change, improved handling of cases, measures to support good practice, particular measures for vulnerable groups, and extending the legal protection. In particular, he recommended that all Trusts should have a Freedom to Speak Up Guardian to 'act in a genuinely independent capacity' and support staff to raise concerns.

1.3 In 2016-17 it became a contractual requirement for all NHS provider Trusts to have a Freedom to Speak Up Guardian. All Trusts in England have made appointments and all Guardians are now in post.

1.4 From the 1st July **NHSE will take over the function of the NGO** at which point the NGO will cease to exist. The emphasis is on NHS organisations to take on the local responsibility for embedding effective FTSU arrangements:

https://www.england.nhs.uk/long-read/the-future-of-freedom-to-speak-up/

1.5 For us in DHC there will be little material impact as the requirements outlined in the new guidance document are mostly already being met:

- Sole responsibility for Guardian **contact details** to be accurate, easy to access & shown publicly on Trust website (the national NGO register will cease)
- **Submission of quarterly data** – from April 2026; the data will be submitted via the existing NHS national data collection process. The Guadian will feed into this process. This will then be added to the model health system.
- Ensuring that the Guardian is compliant with **training/CPD**. As part of trust-level Well-led assessments, the CQC will consider how effectively trust leadership ensures that Guardians are appropriately trained.
- Ensuring the Guardian has access to **psychological support** – this will be covered by our existing Trust EAP arrangement.

1.6 The core functions of the NGO will be taken over by NHSE such as:

- Support regional networks & general enquiries
- Training provision for Guardians (E Learning for Health platform)
- Data collection (model health)
- Oversight of national policy & guidelines

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1.7 It will be the CQC's responsibility to ensure that adequate speak up arrangements are in place as part of the well led domain.

2.0 Main narrative

Assessment of Cases

2.1 Through Q 3 & 4, **90** contacts were made to the FTSU service as per Trust policy, bringing the year end position to **215** cases in total - an annual increase of 2**0%** on the year before. Out of these, **34** cases remain open, largely due to them being more recent cases or in the instance of longer established cases, HR process and long-term sickness being a factor.

Table 1

Period	Patient Safety	Staff Safety	B&H	Other Inappropriate Behaviours	Anon
Q3 2025/26	4	24	0	32	1
Q4 2025/26	1	42	4	53	5
YEAR 2024/25	19	127	23	137	0
YEAR 2025/26	28	170	7	215	11

2.2 Compared to the previous year, bullying and harassment concerns have dropped by 70%, whilst we received **11 anonymous** concerns through 2025/26. This may be an indication of lack of psychological safety and correlates to staff concerns around detriment and fear of reprisals that are reported by staff when raising concerns.

3.0 Other inappropriate behaviours Concern Themes

3.1 Below is a table outlining themes that historically did not fit into the original NGO defined reporting categories which now sit under the 'other inappropriate behaviours' category [215]. The same concern can come under different categories for example a B&H concern will usually have an impact on worker safety.

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Table 2

Inappropriate Behaviours	No. of cases
Lack of support from manager	39
N/A	38
Colleague behaviour	33
Manager behaviour	31
Being treated harshly or unfairly by manager	23
HR process (inc recruitment)	14
Line manager relationship	7
Colleague welfare	6
Other	6
Colleague relationship	4
Clinical Practice	4
Restructure	4
Work related stress	2
Discrimination	2
Workload	1
Team Culture	1
Grand Total	**215**

(N/A denotes where there were no other inappropriate behaviours reported)

3.2 **Relationships:** reflect staff and line manager interactions that could have been managed differently. Some staff reported that they have been treated harshly; feel that they have not been fully supported by their line manager resulting in a breakdown in relationship in some cases. Where this happens, the Guardian offers a facilitated conversation or signposts the member of staff to the Trust's Mediation service.

3.3 **Colleague behaviour:** some relate to bullying behaviours in the workplace – raised voices; behaving in an intimidating manner; accusatory style of communication and inappropriate handling of a work base situation.

3.4 **HR process:** Some staff [9] were going through formal HR process; others were around the perception of unfair recruitment processes, and the remainder were related to the 'sub co' plan that has since ceased.

4.0 Action taken by the Guardians.

4.1 Different approaches are adopted by the Guardians in order to facilitate a local informal resolution where possible and appropriate:

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Table 3

Action taken	No. of cases
Escalation	105
Seek more info	29
Coaching Conversation	26
Listening event	17
Sign post to partner colleague (team)	16
Sense checking	12
Await further info	7
Facilitated Conversation	3
Grand Total	**215**

4.2 Most cases require escalation which often results in the Guardian working in partnership with the manager to seek resolution.

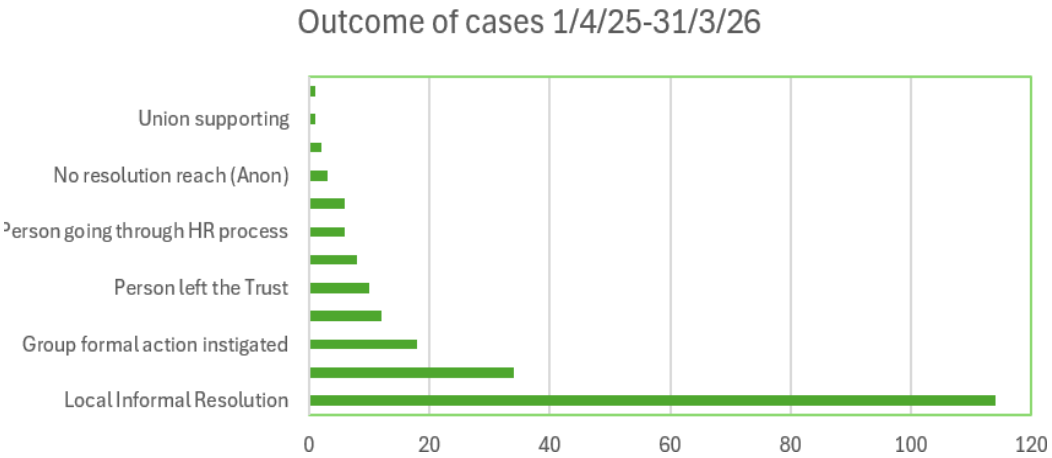
4.3 We have a good deal of success with our coaching conversations as this usually equips/empowers the member of staff to address their concerns for themselves.

4.4 The three facilitated conversations resulted in resolution.

5 Outcomes

5.1 As previously mentioned the Guardian service is largely around supporting and facilitating local / informal resolution where possible and where appropriate, and being **solution focused**. The table below illustrates outcomes of staff speaking up:

Table 4



5.2 Out of the **215** speak up cases **114** were resolved locally/informally which equates to **53%** of all cases. Although there is no hard evidence to demonstrate a direct link to

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'formal process avoidance' within this data there will be a good proportion that have been successful in this way.

5.3 When considering the national average cost of formal processes to employers i.e. just under £30bn a year according to ACAS (2021) - for the NHS there has never been a more crucial time in our history to avoid situations like this where possible.

5.4 The ACAS report emphasises the need for early intervention; conflict competence and changing practice [managerial & HR] based on the learning and insights we gain as a result of conflict, with a just & learning culture being at the heart of how staff are treated/managed:

https://www.acas.org.uk/research-and-commentary/estimating-the-costs-of-workplace-conflict/report

5.5 As important to consider, is the human cost - the most significant impact being on staff mental health, staff morale and reduced staff effectiveness. (ACAS 2021).

5.6 Ensuring we have robust management capability and capacity in relation to people management is crucial.

5.7 The 'Expectations Framework' published by NHSE in February 2025 outlines what these expectations are.

https://www.england.nhs.uk/long-read/the-expectations-of-line-managers-in-relation-to-people-management/#:~:text=The%20impact%20of%20health%20and,their%20leave%20regularly%20and%20proportionately.

6 Failure Demand Rates (avoidable contacts)

6.1 Coupled with the data above, we also measure the failure demand rate (FDR) for each case.

6.2 As part of our initial conversation with the member of staff we ask - who else have they raised their concerns with. Often they haven't attempted to speak with anyone, partly due to fear of detriment or due to feeling raising a concern will be futile. The table below outlines the number of contacts we have received, despite the person trying to address their concerns locally or with different teams; a further development is to identify where the FDR lies i.e. managers / HR etc this data will be collected in 2026/27 data :

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Table 5

No of other avenues tried	No of cases	Total avenues tried
0	55	0
1	63	63
2	46	92
3	22	66
4	29	116
Grand Total	**215**	**337**

6.3 As highlighted in this data, around **25%** staff contact the guardian as their first port of call and around **33%** make at least one attempt to raise concerns locally before reaching out for help. Then there is the group who have attempted to resolve their concern locally several times (**13.5%)** by approaching four different people/teams for support before they finally approach the guardian, often as a last attempt to resolve. This is significant amount of lost opportunity for staff concerns to be addressed swiftly effectively and locally.

6.4 The year end position for staff safety is illustrated in the table below:

Table 6

Worker Safety	No. of cases
Psychological/wellbeing	164
N/A	45
Physical	4
Sexual safety	2
Grand Total	**215**

6.5 To note these cases are from the perspective of the staff raising the concern; some may well be the case; others have an element of the case and others are the perspective of the member of staff.

6.6 With regards to psychological safety 76% of staff reported feeling unsafe.

6.7 In relation to the physical safety, two were due to a members of staff with a physical disability working in challenging environments; two related to the person having physical symptoms resulting from high levels of anxiety.

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6.8 Regarding the two sexual safety concerns one was formally investigated, and a lack of evidence resulted in no further action. The second case resulted in formal action.

6.9 **Detriment** is a growing national concern as well being a concern locally, this forms part of our quarterly data submission to the Office. Out of the 215 contacts we received through the year, we had **six** concerns raised around detriment compared to **eight** in 2024/25 equating to **3.5%** from the group of 164 staff who were fearful.

6.10 The detriment themes reported are as follows:

- Colleague behaviour towards for being a witness in an investigation.
- Line manager keeps staff member at arm's length.
- Career opportunity withdrawn.
- Line manager ignoring.
- Lack of support from line manager.
- The sixth case was anonymous but describe line manager behaviour.

6.11 Out of the six cases only one person wished to escalate, which resulted in a facilitated conversation with the service director and senior service lead, the person had already decided to leave the organisation.

6.12 The others were too fearful to escalate out of fear of further reprisals.

6.13 The **Board Reflective tool** concluded in January 2026 with a compliance rate of **99%**. There is one standard that remains partially addressed:

Explore how to understand what detriment for speaking up looks and feels like.

6.14 Whilst work has been undertaken to understand what detriment looks and feels like for example:

- The Guardian collects and report on the data around staff reporting detriment as well as the anonymous concerns.
- Additional questions were included in the local pulse survey as well as the national staff survey [by NHSE]; further analysis of this data is required.
- A further question has been added to the TED tool where six-monthly reports are provided, which allows the Guardians to be more targeted with awareness sessions.
- A newsletter has been developed, the '*article of the quarter*' in Q1 was around detriment, to raise people's awareness of this (May 2025)
- Is also included in the FTSU Champion training.
- Is integral within the escalation plan within the policy.

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6.15 The Guardians and the Board recognise the need to strengthen the process for when detriment is reported. Additional work is required, to develop further our organisational/team culture to prevent detriment as far as we can, which will need to

be a collective effort with partner teams such as L&D/OD/Leaders at all levels etc . This will form part of our work plan for 2026/27.

6.16 Earlier this year the Guardian submitted an article to the NGO which has been accepted to go into their final annual report later this year. The article is called:

Strengthening the Speak Up culture at Dorset HealthCare University NHS Foundation Trust

Which describes how the effective use of the Board reflective tool was implemented to effect positive change within the FTSU space.

7.0 Analysis of trends

Service

7.1 Staff who raised concerns throughout the year, mainly work in Community Services **[92]** and Mental Health Directorates **[83]** as these have the largest workforce. Please see table below for a high-level breakdown:

Table 7

Directorate	No. of cases
Community Services	92
Mental Health (Inc Children & Families & LD)	83
Finance & Strategic Development	16
People & Culture	8
Nursing and Quality	7
Corporate Services (Fire & Safety, CEO, COO, E	4
Undisclosed	4
Medical	1
Grand Total	**215**

7.2 Finance & Strategic development relates mainly to facilities [15] with one case from Estates. The Guardians meet monthly with the Director of Estates who is aware of the challenges with the Facilities teams and has plans to develop this service further.

7.3 Of note is the higher number in the P&C Directorate which has jumped from **2** in 2024/25 to **8** cases for 2025/26.

7.4 To add a little more context the following tables illustrate pay grades of staff who have raised concerns over the year 2024/25:

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Table 8

Pay Grade	No of Cases	Cases as % of total cases
Bands 1 to 4	67	31%
Bands 5 to 7	122	57%
Bands 8A and above	8	4%
Non AFC	6	3%
Not known	12	6%
Grand Total	**215**	100%

Pay Grade	DHC Headcount	No of Cases	Cases as % of staff in pay grade
Bands 1 to 4	2992	67	2%
Bands 5 to 7	3345	122	4%
Bands 8A and above	463	8	2%
Non AFC	195	6	3%
Not known	0	12	n/a
Grand Total	**6995**	**215**	

Professional Background

7.5 Roles of staff expressing concerns are listed below:

Table 9

Role	No. of cases
Nursing - Registered	85
Admin & Clerical	48
Add Clinical Services	32
Allied Health Professionals	16
Estates and Ancillary	11
Unknown	10
Medical & Dental	6
Add Prof Scientific and Technical	4
Students	3
Grand Total	**215**

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7.6 Registered Nurses [85] are usually the larger staff group to report concerns, which is in alignment with the national picture as this is one of the largest workforce groups, with Admin & Clerical coming second and additional clinical services (support workers) being third, demonstrating clinical staff are more inclined to raise concerns than non-clinical illustrating a 66% / 34% split.

Red Flag Services

7.7 In April 2025 the Patient Experience Library published '*Respond to Challenge'* report

This report highlights patterns of behaviour that crop up time and again in healthcare related public enquiries. It shows what poor cultures look like. Examples are:

- Poor team culture
- High level of patient safety incidents
- High level of FTSU contacts with similar themes.
- Cliques within teams
- High level of complaints

7.8 Poor team/closed culture is the most common red flag observed from a FTSU point of view where staff are unkind to each other. This could be manager on staff / staff on manager and staff on staff. Over the past year we have had 5 teams who red flagged all of which have been discussed at the Senior FTSU Oversight group and have been addressed or still in the process of being addressed:

- One in-patient unit that had been known to the Guardian service for some time, had a very closed culture, ongoing work is in place to support the team.

- Another in-patient unit that works closely with a neighbouring unit were flagging in terms of number of concerns The Guardian team carried out a listening event, A follow up meeting is scheduled to review what changes have been made as a result.
- A community team continues to be supported where there is a poor culture of staff behaviours towards colleagues.
- One in-patient team took out a group grievance As a result the 'Organisational Change' policy will be reviewed.
- Another community team raised a group concern around the way they perceived their manager was treating them This is yet to conclude due to a complex HR process being in place.

Protected characteristics

7.9 The top 2 categories recorded were **12%** of people were from different ethnic backgrounds and **12%** had a disability whilst **73%** were not known. The themes from the known groups were:

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- Pay
- Impact of neurodivergence / how staff are supported
- Feeling of being intimidated by manager

- Breach of confidentiality
- Unhappy about performance management
- Colleague behaviour
- Poor working relationships

7.10 The NGO does not currently require us to collect this data however the Guardian feels this is vital data to collect that may potentially inform other internal DHC workstreams, in order to support our corporate and moral stance on discriminatory behaviours in the workplace; furthermore, it is a recommendation from the 'Insightful Provider Board' guide (November 2024):

https://www.england.nhs.uk/long-read/the-insightful-provider-board/

Contacts That Led to Formal Action

7.11 Out of all the concerns raised, twelve led to formal action, the themes were:

- Grievances due to colleague behaviour
- Grievances due to unfair recruitment
- Sexual misconduct

8.0 Learning and improvements

8.1 In relation to the patient safety concerns, as through all quarters, these were resolved at the time of the concern being raised, bar two that are still under review.

8.2 In the summer of 2025 an external **FTSU Review** was commissioned by the CEO in response to concerns raised by the FTSU NED [at the time] relating to whistleblowing cases and DHC's arrangements for FTSU.

8.3 The review concluded in November 2025, which illustrated that all FTSU arrangements *are* aligned to the NGO policies, standards and guidelines.

8.4 The Reviewer made 11 recommendations to further strengthen these arrangements:

- Seek staff views on the FTSU policy [not yet due]
- Develop an escalation process [complete and in operation]
- Board to strengthen 'check & challenge arrangements [complete]
- CPO to develop a comprehensive 'staff voice report to include FTSU [not yet due]
- Remove the terms whistleblowing/PIDA from policy [complete]
- Whistleblowing/pida terminology to be discussed at Board workshop [complete]
- The guardian to more closely oversee information to medics to ensure consistency [not yet due]
- The Guardian to undertake a 'prescribed persons' review of escalated concerns [not yet due]
- Ensure NED role is clear [complete]

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- Change reporting line for Guardian [complete]
- Carry out short survey to ascertain staff views of Board transparency [not yet due]

8.5 A new question for the 2026/27 Q2 pulse survey will be "I know where to find the Freedom to Speak Up policy and find it easy to follow" with a free text box for staff to add suggestions for improvement. This will cover the action from the FTSU review.

8.6 Improvements to the database have been made with the addition of new datasets such as:

- Escalation risk & compliance tool
- Failure Demand Rate (FDR)
- Primary FDR
- Annotation of Bank staff
- Addition of sexual safety concerns
- Time to close cases
- Outcome data

8.7 The Guardian worked in collaboration with HR colleagues to introduce a decision-making tool to support decisions around instigating formal processes based on the just & learning principles.

8.8 An outcome from the 'Joint Belonging and Cultural Group' the Guardian supported OD to develop a simple form for staff to raise concerns regarding unwanted cultural/racial behaviours.

8.9 The Guardian is currently developing a Staff Neurodiversity policy in collaboration with OD to be published later this summer. This is as a result of themes received, relating to how neurodivergent staff are managed and supported in the workplace.

8.10 The Guardian has also worked in collaboration with HR & OD on our sexual safety campaign and is supporting a team alongside HR around this topic.

8.11 In addition to the above the Guardian & HR work together on specific cases such as the sexual safety case annotated in this report and provided joint support to the staff affected.

8.12 A joint newsletter was developed, which shares our FTSU high level themes and learning, as well as having an educational component relating to a speak up topic. This has been well received.

8.13 Each quarter we peer review/audit our cases [anonymously] across the federation as an internal check.

8.14 Our joint policy document was reviewed in April this year to reflect the recommendations form the FTSU review.

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9.0 Actions Taken to Improve FTSU Culture and Awareness and Guardian visibility.

9.1 The Guardians continue to visit teams in person and deliver face to face sessions to raise FTSU awareness/listening events as capacity allows. Teams visited through 2025/26: Herm [x2]; West Mental Health CRT; Twynham [x2]; Melstock; IUCS [x3]; Bournemouth & Christchurch CAMHS; Seaview & HBPOS [x3]; Audiology; Chine Ward; SALT team leads; Safeguarding team; finance leads; OT network; West DN teams; Pharmacy; Participation team. We collectively covered **219** staff over the year.

9.2 The Guardian has a presence on social media and Doris. High level findings from the FTSU annual report will be shared via Trust Communication and social media when available and will be added to Doris.

9.3 Training is available via e hub on the intranet, and since it became mandated on the 1st April 2024, we have seen over **68% increase** in compliance which is a positive trajectory.

9.4 The Guardians deliver awareness sessions on the Trust Preceptorship programme, the manager induction programme and the Trust induction programme.

9.5 The Guardians attend various staff network meetings on a regular basis where it is anticipated that more champions will be recruited from this year.

9.6 The Guardian monitors how staff knew about FTSU; it is of interest to note [top 3] that **48%** were sign posted by colleagues/word of mouth; followed by **16%** who had used the service previously and **13.5%** looked up policy/Doris.

9.7 In light of the new resource allocated to Freedom to Speak Up, the Champion model was rolled out in January which will increase the reach across the organisation and significantly contribute to raising FTSU awareness.

9.8 The newly developed joint newsletter has been running for the past year (quarterly) and is instrumental in raising awareness further – illustrating FTSU activity. This is published on the FTSU page on Doris as well as being published via the regular round up communication notices and on the staff Facebook group.

9.9 As with previous years we look forward to boosting awareness through Freedom to Speak Up week in October.

10.0 Assessment of The Effectiveness of The Speaking-Up Process

10.1 Current research suggests that employee engagement has a positive correlation, with lower patient mortality, lower sickness levels and lower patient complaints.

10.2 The National Staff Survey (NPS) and the National Quarterly Pulse Survey (NQPS) provide insights into how well we are meeting the standards outlined in the People Promise (2025/26) and in particular the section 'we each have a voice that counts' of which Freedom to Speak Up forms part. Please see results below:

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National Staff Survey [2025/26]: Quarter 3 Staff Feedback

10.3 *I would feel secure raising concerns about unsafe clinical practice*

(better than national average)

I am confident that my organisation would address my concern

(better than national average)

I feel safe to speak up about anything that concerns me

(better than national average)

If I spoke up about anything that concerns me I am confident my organisation would address my concerns

(Better than national average)

10.4 On the whole the results are not drastically different from previous years and have broadly remained within a 10% variance with the national best results, with some being much less of a difference.

10.5 All results are better than the national average, however they are lower across the board compared to our 2020 results, although this was most likely impacted by the Covid pandemic, as everyone was working from home during this period and into 2021: which most probably gave a slightly artificial result at that time.

National Quarterly Pulse Survey (NQPS): Quarter 4

10.6 Quarter 4 pulse survey feedback on:

"I feel safe to speak up about anything that concerns me in my organisation"

64% reported positively; 19% neither agreed/disagreed; 17% disagreed.

"If I speak up about anything that concerns me I feel confident that action would be taken"

45% reported positively; 30% neither agreed/disagreed; 17% disagreed.

10.7 Again these results are broadly similar to the previous quarter's results reflecting futility and fear of detriment as being the two main barriers to staff raising concerns. Clearly there is much more to do in these areas.

Worker feedback

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10.8 As part of the process for closing down cases, the Guardian sends staff a feedback questionnaire - **70%** of staff who responded said they would speak up again with **13%** saying they would not. The remaining **17%** were not sure. This is predicated on a response rate of **35%.**

10.9 Of the people who responded *"no"* some were going through performance

improvement plans or formal processes and others had false expectations & misunderstood the remit of the role.

Peer review and Audit

10.10 As mentioned in paragraph 8.13, peer review and audit has recently been developed by the team which will enable the service to measure successes and make improvements where needed. This alongside the 'post speak up' questionnaire will support our continuous improvement cycle. This information will be presented in future reports.

Learning from case reviews

10.11 In March 2026 the NGO published *Temporary Workers, Permanent Voices: A Speak Up Review:*

https://nationalguardian.org.uk/wp-content/uploads/2026/03/Temporary-workers-review_march2026.pdf

10.12 The review was commissioned by the Executive Health Services Safety Investigations Body (HSSIB) who commissioned the NGO to explore the experiences of temporary workers and the obstacles that prevent them from speaking up.

10.13 When national case reviews take place, there is an expectation that the Guardian will self-assess /benchmark their own organisation against the findings of the review.

10.14 Most of the organisational expectations are already in place for DHC – the Guardians have arranged to meet with the Trust Bank Managers to verify that we meet all of the standards outlined in this review which will be reflected in the (2026) Q1&2 FTSU report. Bank workers represent **4%** of the speak up cases for 2025/26, which may indicate we have further work to do with this group.

11.0 Actions taken to improve the skills, knowledge and capability of workers to speak Up.

Training

11.1 The NGO developed in association with Health Education England online FTSU training, which is freely available for anyone who works in healthcare.

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Table 9

FTSU % Compliance for the Directorate as at 31.03.26 Q4 2025 / 26				
Directorate	**Target**	**Outstanding**	**Completed**	**% Compliance**
Chief Executive	23	0	23	100.00%
Chief Operating Officer	5142	339	4803	93.41%
Director Of Finance + Strategi	625	107	518	82.88%
Director Of Nursing & Quality	183	18	165	90.16%
Medical Director	18	1	17	94.44%
People And Culture	167	15	152	91.02%
Grand Total	6158	480	5678	92.21%

11.2 Compliance compared to the year end 2024/25 position of **83.29%** which equates to an overall increase of around **10.7%.**

12.0 Recommendations

12.1 **The Board to** receive assurance on the ongoing programme of work that the Guardian continues to support via targeted work to improve visibility and psychological safety across the organisation, and support ongoing learning from speaking up cases.

13.0 Message from the Guardian

13.1 Unsurprisingly it has been another very busy year with the number of contacts increasing by 20% [increased by 18% in 2024/25].

13.2 Securing the additional resource has been so welcome, which has enabled all of the initiatives/improvements outlined in this report.

13.3 Going through the external review with Russ Parkinson was a very positive experience that provided Board assurance that our FTSU arrangements in DHC are aligned to the national guidance and where they should be. Russ made recommendations on how we can make things even better, which was warmly welcomed and is currently being worked though as previously mentioned.

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13.4 Where possible the additional resource is being shared across the two organisations in that, where we are developing an area for DHC we will also develop it for DCH together with the DCH Guardian e.g. newsletter / audit / recruitment of Champions / FTSU month - where we can gain economies of scale.

13.5 We have made some inroads into introducing a Just & Learning culture however we have much more work to do on this and I would like to explore this further with the Board.

13.6 I continue to feel passionate about organisational/team culture and wish to influence how we do things in DHC – striving to be the best organisation to work for and deliver the best care possible. I appreciate the support I receive from the Board and Senior Leadership team and look forward to another year of hard work and collaboration to achieve this ambition.



Anne Hiscock
Freedom to Speak Up Guardian
May 2026

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Freedom to Speak Up Report

Quarter 3 & 4 and Annual Report

1.0 Introduction

1.1 Sir Robert Francis in his Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (2013) described the experiences of nurses and doctors who raised concerns about the poor care of some patients at Stafford Hospital. As a result, he was asked to conduct a further review into raising concerns in the NHS.

1.2 'Freedom to Speak Up – an independent review into creating an open and honest reporting culture in the NHS' was published in 2015. The report identified a need for culture change, improved handling of cases, measures to support good practice, particular measures for vulnerable groups, and extending the legal protection. In particular, he recommended that all Trusts should have a Freedom to Speak Up Guardian to 'act in a genuinely independent capacity' and support staff to raise concerns.

1.3 In 2016-17 it became a contractual requirement for all NHS provider Trusts to have a Freedom to Speak Up Guardian. All Trusts in England have made appointments and all Guardians are now in post.

1.4 From 1st July, NHSE will take over the function of the NGO and the NGO will cease to exist. NHSE are hosting engagement sessions with both Guardians and senior healthcare leaders who have FTSU responsibilities. The emphasis is on NHS organisations to take on the local responsibility for embedding effective FTSU arrangements:

https://www.england.nhs.uk/long-read/the-future-of-freedom-to-speak-up/

1.5 There will be little material impact as the requirements outlined in the new guidance document are largely already being met:

- Sole responsibility for Guardian contact details to be accurate, easy to access and shown publicly on Trust website (the national NGO register will cease).
- Submission of quarterly data – from April 2026; the data will be submitted via the existing NHS national data collection process. The Guadian will feed into this process. This will then be added to the model health system.
- Ensuring that the Guardian is compliant with training/CPD. As part of trust-level Well-led assessments, the CQC will consider how effectively trust leadership ensures that Guardians are appropriately trained.
- Ensuring the Guardian has access to psychological support – this will be covered by our existing Trust EAP arrangement.

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1.6 The core functions of the NGO will be taken over by NHSE including:

- Support regional networks & general enquiries

- Training provision for Guardians (E-learning for Health platform)
- Data collection (model health)
- Oversight of national policy & guidelines

1.7 The CQC will assume responsibility to ensure that adequate speak up arrangements are in place as part of the Well-led domain.

2.0 Main Narrative

Assessment of Cases

2.1 In Q3 & 4 of 2025/26, **240** contacts were made to the FTSU service, a very similar picture to the previous reporting period of 235. This brings the year end position to **475** cases in total, of which only 1 remains open. There has been an increase in contacts seeking advice/guidance which are quicker to resolve and close, hence only 1 case remains open.

Table 1

Reporting period	Contacts	Patient Safety & Quality	Staff Safety & Wellbeing	Bullying & Harassment	Other Inappropriate Behaviours	Anon
Q1 & Q2	235	35	175	22	158	4
Q3 & Q4	240	40	180	18	163	1
Total	475	75	355	40	321	5

2.2 There continues to be a distinct correlation between wellbeing and other inappropriate behaviours (OIB). The predominant recurring themes within OIB are colleague behaviour, poor communication followed by manager behaviour and lack of support from manager. Similar themes are reported locally via the Dorset and Somerset Network Guardians. With so much organisational change occurring, it can be difficult for managers to navigate when to communication to teams. Where possible, managers need to provide clarity for their staff and close the communication gap to create an environment of stability and security in the continuing changing environment.

2.3 In many cases, concerns are attributed to more than one element of perceived risk, for example, a colleague worried about staffing levels might assign both patient safety and worker safety/wellbeing to the concern. To note, all cases are assigned from the perspective of the colleague raising the concern.

2.4 Different approaches are adopted by the Guardian and are discussed with the individual to facilitate a local informal resolution where possible and appropriate. 143 of cases during Q3 & Q4 were for advice/guidance, 52 needed escalation, 29 were listen and log only, 7 required a feedback session, 3 for signposting to partner services, 2 involved restorative conversations, 1 for sense checking, 1 improvement idea and 1 for investigation. This gives reassurance that the FTSU service is being utilised appropriately.

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2.5 Over 50% of contacts were met with face to face, a further 22% corresponded via email. Around 13% contacted by telephone, 10% were met with via Teams, 1% by WhatsApp, with letter being the least utilised contact to the Guardian.

2.6 Any colleague raising a patient safety concern is strongly advised to complete a Datix and guided to anonymous Datix reporting where appropriate. 40 contacts reported concerns relating to patient safety/quality during Q3 & Q4 taking the annual total to 75. The Guardian presents monthly to the Patient Safety Incident Response Framework huddle (PSiRF) to feedback the previous month's themes and data particularly in relation to patient safety.

2.7 Anonymous concerns accounted for just 0.5% of contacts made, mirroring the previous 2 quarters. This could suggest of a good level of psychological safety. Colleagues are encouraged to raise a concern by any means they feel most comfortable.

2.8 The Guardian submits data online via the NGO portal quarterly. This data includes number of contacts, professional group, number of anonymous concerns, number of colleagues who suffered detriment and categories eg. patient safety, worker safety/wellbeing.

2.9 Benchmarking against a similar size Trust has not been possible at this time as the NGO's data collection is incomplete.

3.0 Analysis of Trends

Service

3.1 There was a similar number of concerns raised from both Division A and Division B. A new database has now been established which will be able to demonstrate further breakdown of services as currently only the 2 Divisions, People and Corporate Services are recognised.

3.2 The following table illustrate pay grades of staff who have raised concerns in 2025/26:

Table 2

Pay Grade	Headcount	No of Contacts	% of Headcount	% of Total Contacts
Bands 1 – 4	1402	181	13%	38%
Bands 5 – 7	1685	222	13%	47%
Bands 8A and above	208	25	12%	5%
Non AFC	517	32	6%	7%
Not known		15	N/A	3%
Total	3812	475	N/A	100%

3.3 Targeted listening events are held if the Guardian has several concerns raised within that service, or at the request of the local manager sometimes due to lack of engagement from staff or when an area is reporting concerns anonymously, which could indicate staff are feeling psychologically unsafe in their work environment. The risk management team assist the Guardian to flag areas reporting anonymously via Datix.

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3.4 During 2025-2026 listening events have taken place for Ward Clerks, Acute Hospital at Home, Phlebotomy, Pathology, Pre-Assessment Unit, Catering, Theatres and the People Team. Staff concerns from these events are collated into themes and anonymised. Action plans are drawn up with the managers and shared with teams to address the themes raised.

3.5 Robust triangulation of data continues to help identify areas that may need additional support. Fortnightly Patient Safety huddles are attended by the Guardian and relevant stakeholders, in addition to regular meetings with the Safeguarding Lead. The Guardian meets separately every month with the Chief Nursing Officer, Chief People Officer, NED for FTSU, Temporary Staffing Lead, EDIB Lead and the Heads of Nursing to discuss and escalate matters as necessary. Monthly local intelligence meetings between HR, Workforce Business Partners, Education, Recruitment and the OD Team continue and prove incredibly useful in flagging areas requiring support. Additionally, the Guardian meets quarterly with the Chief Executive Officer.

Flagging Services

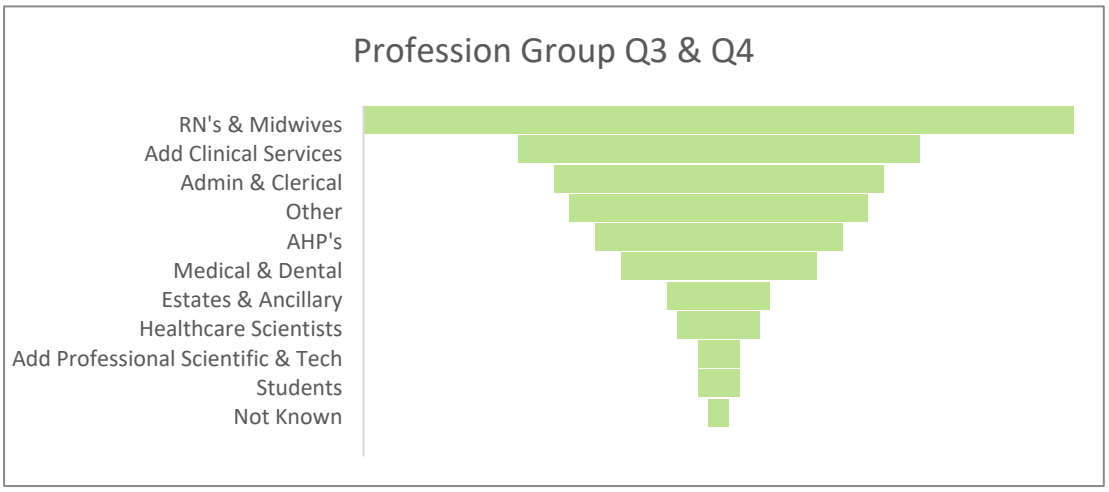
3.6 A number of concerns came from a team due to poor communication, lack of transparency and lack of updates and feedback from management. This has been escalated and awaiting a timeline for updates to be shared.

3.7 Several concerns were raised within a department around culture and poor behaviour. This has been escalated to the Service Manager who is being supported by HR and OD to address poor behaviour and commence work on a Team Charter.

Professional Background

3.8 Roles of staff speaking to the FTSUG are listed in Table 3.

Table 3



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3.9 Registered Nurses (RNs) & Midwives remains the group with the highest number of concerns reported, accounting for 29% of cases. Additional Clinical Service roles accounted for 16% of the cases, followed by Admin & Clerical at 13% so a very similar

picture to Q1 & Q2. This mirrors the national picture as RNs are the largest workforce group. Concerns have been raised from every professional group and raising awareness of speaking up can be targeted to those groups with the lower number of contacts.

For the year end position RNs & Midwives made up 141 of the contacts received, followed by 79 Additional Clinical Services.

3.10 Detriment is nationally a growing concern for the NGO who require Guardians to report 'where detriment is indicated'. Out of the 475 contacts made to the Guardian, to the Guardians knowledge, none have reported detriment. The NGO has published further guidance on the subject, it is highlighted in the policy and it was the topic of focus in our first newsletter.

Detriment-guidance.pdf

3.11 The **Board Reflective tool** has been updated and will be reviewed at Director level before being submitted for consideration by the Board.

3.12 From the 240 contacts, 54 members of staff were from a protected characteristic group that the guardian was aware of (22%). This takes the annual number to 89 (19%). The NGO does not require us to collect this data and we do not ask directly, however it is a recommendation from the 'Insightful Provider Board' guide (Nov 2024) and could inform other workstreams.

https://www.england.nhs.uk/long-read/the-insightful-provider-board/

Contacts That Led to Formal Action

3.13 From the concerns raised in Q3 & Q4, all bar 1, have been resolved informally through supportive discussions, giving advice and guidance, facilitated meetings, restorative conversations, referring onto coaching/mediation or speaking to the relevant manager to seek a resolution. 1 concern required formal management.

4.0 Learning and Improvements

4.1 In collaboration with the DHC Guardian a joint single policy document for FTSU was developed and ratified then published in May 2025. The policy has been recently updated to reflect recommendations from DHC's FTSU review.

4.2 Several improvement initiatives have been undertaken by the Guardian in collaboration with the DHC Guardian:

- A newsletter has been developed and published quarterly. This provides a platform to share learning and themes from FTSU activity with our colleagues.
- A FTSU audit tool was created to enable the service to anonymously measure standards of speak up practice against KPI's as part of a peer review arrangement across DCH/DHC. Results can be found in paragraph 6.5.
- Data collation has been reviewed to capture the KPI information for audit

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including time to respond to contacts; time to close cases; failure demand rates; was the contact thanked etc. The database itself has recently been amended to support with capturing this information.

- The FTSU feedback questionnaire has been updated and unified between DCH/DHC.

- Joint core Guardian meetings are well underway to support collaborative working and sharing of resources where possible.

- Joint Champion Network meetings have been established, offering training opportunities, Q&A's, ideas for improvements and a chance for the Champions to meet virtually throughout the year.

5.0 Actions Taken to Improve FTSU Culture & Awareness and Guardian Visibility.

5.1 The Guardian continues to visit teams in person and deliver face to face sessions to raise awareness and hold listening events as capacity allows. The Guardian attends Peer Support Ward Leaders meetings monthly and meets with night duty colleagues often.

5.2 The Guardian attends various staff network meetings and staff forums including Student Nurse forums throughout the year which helps to capture the some of the professional groups that might be unrepresented. The Guardian attends the Joint Culture and Belonging Group, Health and Wellbeing Steering Group and Staff Experience Southwest Network. Additionally, the Guardian has been part of several Task and Finish Groups with a view to effecting change and sharing best practice.

5.3 Regular Wednesday walkarounds continue, often with either Network Chairs, Temporary Staffing manager or Practice Educator for HCSW's.

5.4 'Third Thursdays' continue, in collaboration with the Chaplaincy service offering regular engagement opportunities for colleagues in the Chapel.

5.5 The Guardian delivers awareness sessions on the Trust Preceptorship programme; Student Nurse Induction, Non foundation Drs Induction and has taken ownership of the regular Trust Induction slot previously facilitated by OD.

5.6 The Guardian routinely supports OD to deliver Dignity & Respect in the Workplace workshop and following discussion with the Education Centre, now leads its introduction into the Preceptorship programme and the new FY1 Drs induction programme. This supports the FTSU agenda as it incorporates incivility and the impact of colleague behaviour.

5.7 FTSU training is available via ESR on the intranet and was mandated on the 1st September 2024. Since then, there has been a significant increase in uptake from just a few hundred to well over 3000, a further 20% increase from last years 68% to 88% of staff compliance, which is a very encouraging. The goal is >90%, so consideration will be given on how to achieve this.

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5.8 The Guardian monitors how staff knew about FTSU; it is of interest to note that the majority were through word of mouth from colleagues, followed by posters.

5.9 Champion recruitment continues with now over 70 in post. Further recruitment will take place with a view to establishing a Champion in areas currently not represented. 1 colleague has successfully been appointed into the new Associate Guardian role to align with DHC's model. Promoting this new role will be the next step.

5.10 The recently developed newsletter will be instrumental in raising awareness further. This is published quarterly on the FTSU page as well as utilising the usual communication channels including Supporting our People bulletin. To date, we have published 3 newsletters and utilise this opportunity to improve culture by highlighting recurring themes and signpost to support, training and advice.

5.11 As with previous years we boosted awareness through FTSU month in October, which consisted of various drop-in sessions, walkabouts with some of the Executive team and Network chair colleagues.

6.0 Assessment of The Effectiveness of The Speaking-Up Process

6.1 Current research suggests that employee engagement has a positive correlation with lower patient mortality, lower sickness levels and lower patient complaints.

6.2 The National Staff Survey (NSS) and the National Quarterly Pulse Survey (NQPS) provide insights into how well we are meeting the standards outlined in the People Promise (2020/21). The section 'we each have a voice that counts' is pertinent to the speaking up culture.

6.3 In relation to the 'Raising Concerns' NSS questions, every score was higher than the national average, however not quite back to pre-pandemic levels.

Worker Feedback

6.4 As part of the process for closing cases, the Guardian sends contacts a feedback questionnaire - 96% of colleagues who responded said they would recommend speaking to the FTSUG and consider speaking up again.

Peer Review and Audit

6.5 As mentioned in paragraph 4.2, peer review and audit have been developed by the team which enables the service to measure successes and make improvements where needed. This, alongside the colleague feedback questionnaire, supports our continuous improvement cycle. From the results of the audit and feedback questionnaires, the improvement that could be made is more timely updates.

Learning from Case Reviews

6.6 The NGO have carried out a couple of case reviews including a review into the experiences of 'trained overseas workers' and most recently a review into the experiences of 'temporary workers.'

https://nationalguardian.org.uk/wp-content/uploads/2026/03/Temporary-workers-review_march2026.pdf

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6.7 When national case reviews take place there is an expectation that the Guardian will self-assess/benchmark their own organisation against the findings of the review. A joint approach will be taken to see where improvements can be made.

6.8 DHC had an external review of their FTSU arrangements and following receipt of recommendations made, it has been agreed that these will be jointly worked on and implemented in both Trusts.

7.0 Actions Taken to Improve the Skills, Knowledge and Capability of Workers to Speak Up

Training

7.1 The NGO developed in association with Health Education England, online FTSU training, which is available to anyone who works in healthcare. The training is divided into three modules:

- Speak Up – core training aimed at all NHS staff.
- Listen Up – aimed at all Line Managers/Supervisors.
- Follow Up – aimed at Senior Leaders (8a and above including executive & non-executive Directors).

7.2 Our current compliance is reported in paragraph 5.7 and is a sizable improvement on the previous year.

8.0 Recommendations

8.1 **Board to receive assurance** on the programme of work that the Guardian supports via targeted work to improve visibility and psychological safety across the organisation and ongoing learning from speaking up cases.

8.2 **Board to endorse** the proposed joint working areas with DHC, including a joint strategy, recruitment/training of Champions and gap analysis reviews.

8.3 **Board to note** that further work is to be undertaken to support our temporary staff in line with the national mandate.

9.0 Message from the Guardian

9.1 There has been lots of activity this year with the number of contacts remaining high so it is encouraging that many of our colleagues are speaking up.

9.2 Collaboration with DHC has enabled many of the improvements outlined in this report and has contributed to efficiencies within the service.

9.3 I feel very privileged to work for the NHS and be a source of support for colleagues to raise concerns. The Guardian role is complex and requires resilience but most of all, incredibly interesting and often very rewarding. I am passionate about influencing cultural change, reducing incivility within the workplace and continue to facilitate workshops to support this agenda. The endorsement from the Board is highly valued and I look forward to the year ahead, continuing to listen with intent, collaborating and empowering colleagues to courteously challenge where needed to create a civil working environment for all.



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Lynn Paterson
Freedom to Speak Up Guardian
April 2026

Report to	Board in Common (DHC)	
Date of Meeting	17/06/2026	
Report Title	Guardian of Safe Working Report of Safe Working Hours of Doctors in Training Q4 (Nov 2025- Jan 2026)	
Prepared By	Dr Claire Vick (Guardian of Safe Working Hours)	
Approved by Accountable Executive	Dr Lucy Knight Chief Medical Officer	
Previously Considered By	People & Culture Committee in Common 27/05/26	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety & Quality.	
Financial	Fines are incurred for breaches of safe working	
Statutory & Regulatory	NA	
Equality, Diversity & Inclusion	Adherence to the GOSW provisions helps us treat resident doctors fairly and consistently.	
Co-production & Partnership	NA	

Executive Summary

The introduction of the 2016 contract for resident doctors established the role of the Guardian of Safe Working Hours, who is required to provide assurances to the Trust Board in relation to the compliance with these hours on a quarterly basis.

- This report covers the time period 01/11/2025 – 03/02/2026, in-line with the rotation of resident doctors
- There were 11 exception reports raised during this period. All these were reviewed by the Assistant DME who was covering the absent GOSW.
- Seven of the exception reports raised were in relation to breaches of working times during on-call shifts.
- Four of the reports related to additional hours worked during the working week.
- There were no reports relating to missed educational opportunities.
- Seven reports resulted in fines to the Trust
- No reports raised an immediate safety concern.
- No reports required an escalation.

The Guardian of Safe Working is assured that Resident Doctors working hours are safe.

Recommendation

Members are requested to:
Receive the report for **assurance**

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1. Background

1.1 Following the introduction of the 2016 resident doctor contract, the role of guardian of safe working hours (GOSWH) was created to provide assurances to both the board and resident doctors that their working hours would be safe (in line with the new contract.) These reports are intended to provide an overview and assurance of the Trust's compliance with safe working hours for resident doctors and to detail any areas of concern.

1.2 All resident doctors are issued with a work schedule (which details hours to be worked and educational opportunities expected in each job) and a proposed Rota (detailing frequency as well as Rota dates) prior to the start of each rotation. The Trust currently operates a normal intensity Rota which is compliant in terms of weekend frequency and number of consecutive days worked.

1.3 Deviations from the work schedule that result in additional hours worked or inability to take appropriate rest periods during a scheduled workday should result in the resident raising an exception report. Residents should also raise an exception report if they do not achieve the required 5 hours continuous rest between 10pm and 7am and or 8 hours total rest during a 24 hour on-call period. These exception reports are overseen by the Guardian of Safe Working Hours.

1.4 The amendments to the contract also require residents to raise an exception report when they have been unable to attend training related activities due to clinical commitments. These are discussed with their educational or clinical supervisor in the first instance as above and are passed to the Director of Medical Education for information. Exception reports raised in relation to education are beyond the remit of the Guardian of Safe Working Hours but the number of reports raised will however be added to this report for completeness.

1.5 All resident doctors in this Trust are on the new contract.

1.6 Exception reports raised by Foundation Doctors are dealt with by the GOSW in the acute trusts and are therefore beyond the remit of this report.

2 Information for consideration

2.1 Exception reports relating to working hours from 06/08/2025- 31/10/2025

Training programme	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
CT/ GPVTS	10	10	0
ST	1	1	0
Total	11	11	0

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2.2 Outcomes of exception reports

2.2.1 The 11 exception reports were all reviewed and closed by the Director of Medical Education who was covering the absent Guardian of Safe Working.

2.2.2 Seven of the exception reports raised were in relation to breaches of working times during on-call shifts - all of these involved residents having less than five hours of continuous rest between 10pm and 7am.

2.2.3 One of the exception reports that reflected a breach in rest requirements also noted an excess of hours worked over a weekend.

2.2.4 Four of the reports related to additional hours worked during the normal working week.

2.2.5 All reports were from resident doctors placed in psychiatry posts. There were no issues raised by residents in community hospital or sexual health posts, which do not entail on-call work with the Trust.

2.2.6 There have been no instances of exception report outcomes not being agreed by a trainee and therefore needing a level 2 or 3 resolution.

2.3 **A: Exception report raising immediate safety concern**

2.3.1 There were no exception reports raising an immediate safety concern.

2.4 **B: Exception reports related to missed education/ training**

2.4.1 There were no other reports related to missed education or training.

2.5 **C: Work schedule reviews**

2.5.1 There have been no new work schedule reviews required over the last period

2.6 **D: Vacancies and locum bookings**

2.6.1 There were no further changes in vacancies and the residents that had been moved remained in place to complete the rotation.

2.7 **E: Fines**

2.7.1 The amendments to the contract which have been rolled out since September 2019 have introduced stricter adherence to aspects of the contract, which has increased the number of fines.

2.7.2 Fines are payable in two parts with one part going directly to the doctor and the remainder going to the Guardian of Safe Working Hours to be spent on training and education in agreement with the Resident Doctors Forum.

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2.7.3 Seven of the exception reports registered in Q4 resulted in fines to the Trust for breaches of working times.

2.7.4 Monies raised through the fines process are to be used to improve the education, training and working environment for trainees. Disbursement of these funds are discussed at each quarterly Resident Doctors Forum.

2.7.5 Fines by Rota:

Rota	(No fines) Value against department Q1	(No fines) Value against department Q2	(No fines) Value against department Q3	(No fines) Value against department Q4
CT/GPVTS	(7) £1013.64	(8) £1451.11	(4) £958.12	(6) £987.97
ST	(3) £302.29	(0)	(2) £598.84	(1) £755.70
Total cost to department	(10) £1315.93	(8) £1451.11	(6) £1562.72	(7) £1743.67

2.7.6 Cumulative Balance in Guardian Cost Centre

Balance Q1	Balance Q2	Balance Q3	Balance Q4
£1180.54	£2087.47	£3064.16	£4153.93

2.8 **F: Additional Information**

2.8.1 The Resident Doctors Forum continues to meet quarterly and is well attended.

3 Guardian of Safe Working Hours Safety Statement

3.1 The Guardian of Safe Working Hours is assured that working hours for resident doctors in the Trust were safe during this period.

Contact for further information:
Dr Claire Vick, Consultant Psychiatrist and Guardian of Safe Working Hours for the Trust

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NHS
Dorset County Hospital
NHS Foundation Trust

Report to	Board in Common, Part 1 (DCH Board)	
Date of Meeting	17th June, 2026	
Report Title	Annual Guardian Report of Safe Working report: Resident Doctors 2025_26	
Prepared By	Dr Andy Macklin, Guardian of Safe Working (GoSW)	
Accountable Executive	Dr Rachel Wharton, Chief Medical Officer, DCH	
Previously Considered By	Joint People and Culture Committee In Common. 26.05.2026	
Action Required	**Approval**	-
	Assurance	Y
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	Relates to Board Assurance Framework: SR1: Safety and Quality SR2: Culture SR3: Workforce Capacity The guardian of safe working ensures that issues of compliance with safe working hours are addressed by the doctor and the employer or host organisation as appropriate. It provides assurance to the board of the employing organisation that doctors' working hours are safe.	
Financial		
Statutory & Regulatory	Adhering to requirements of the Junior Doctor Contract 2016	
Equality, Diversity & Inclusion	People Plan Principle – we will improve safety and care by creating a culture of openness, innovation, and learning, where staff feel safe themselves	
Co-production & Partnership	The report is also shared with the Local Negotiating Committee for Medical and Dental staff once seen by PCCiC.	

Executive Summary

1. This is the Annual Report submitted to the Trust Board by the Guardian of Safe working (GoSW). Dates from 31st March 2025 – 1st April 2026.
2. Report generated using data extracted from the Healthrota IT system for Exception Reporting, supplemented by data on Locum spend. This is the first full year of data from Healthrota. Exception reporting is easier for Residents using this new system.
3. During this period of time there were 904 Exception reports from 112 Resident Doctors, representing a rate of approx. 2% of shifts. 41 reports were identified as Immediate Safety Concerns (ISCs). The Guardian of Safe Working analyses all ISCs to identify risk and to support Residents within 48 hours of submission (with deputising from CMO and deputy CMO).
4. The 5 areas with the highest number of ERs were Trauma & Orthopaedics(117), Respiratory Medicine(89), General Surgery(77), Geriatric Medicine(64), Cardiology(61)

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5. F1s generated 544 Exception reports, with 283 arising from F2 to IM2 grades, & 77 from IM3 to ST7 grades.
6. Some Exception reports breached the 2016 Terms & Conditions & would be eligible for GoSW fines. Fines have not yet been raised but would have totalled £1600 for 25/26.

Recommendation

The Board is requested to:

- Receive the report for **assurance**

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Annual Guardian Report of Safe Working report: Doctors in Training 2025_26

Executive Summary

1. This is the Annual Report submitted to the Trust Board by the Guardian of Safe working (Dr Andy Macklin). Dates from 31st March 2025 – 1st April 2026.
2. Report generated using data extracted from the Healthrota IT system for Exception Reporting, supplemented by data on Locum spend .
3. During this period of time there were 904 Exception reports from 112 Resident Doctors, representing a rate of approx. 2% of shifts, regardless of weekday. 41 reports were identified as Immediate Safety Concerns (ISCs).
4. The 5 areas with the highest number of ERs were Trauma & Orthopaedics(117), Respiratory Medicine(89), General Surgery(77), Geriatric Medicine(64), Cardiology(61)
5. F1s generated 544 Exception reports, with 283 arising from F2 to IM2 grades, & 77 from IM3 to ST7 grades.
6. 60 Exception reports breached the 2016 Terms & Conditions & would be eligible for GoSW fines. Fines have not yet been raised.

High level data for Dorset County Hospital NHS trust

Number of training posts (total)	**210**
Number of doctors in training post (total)	**191.8**
Number of LED's (Training Grade Equivalent) posts	**56**
Actual Number of LED's in Post	**53.4**
Annual average vacancy rate among this staff group based Deanery numbers for Q3	**20.8**

Amount of time available in job plan for Guardian of Safe Working 1 PA

Amount of job planned time for educational supervisor 0.25 PA per trainee

Exception report numbers (where n > 5)

Specialty	*Number of Exception reports*
Emergency Medicine	*16*
Acute Internal Medicine	*35*
General Internal Medicine	*28*
LED (All Medical Areas)	*21*
Cardiology	*47*
Gastroenterology	*44*
Geriatric Medicine	*50*
Respiratory Medicine	*39*
Stroke	*24*
ENT	*32*
General Surgery	*39*
Trauma & Orthopaedics	*84*
Urology	*43*

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Grade	*Number of Exception reports (n>5)*
F1	377
F2	103
GPST ST1	27
IM 1 & 2	18
LED (all grades)	67
ST3+ grades	34

Vacancies
Appendix 2 Details all vacancies among the deanery appointed medical training grades during the year, split by specialty and grade.

Fines
There were no fines levied during this period, although there were 60 Exception reports which have breached the threshold for levying fines.
There were 60 rule breaks identified in the year, with 54 of these breaching maximum shift length (13 hours) & 56 reported as breaching the minimum rest period (11 hours). The latter may be partly a calculation issue within HealthRota.
The estimated number of fineable hours was 46.25 amounting to approximately £1600 in fines if these had been raised.

Immediate Safety Concerns
41 ISCs were submitted for the year. These all attract a review by the GoSW. 9 occurred on a Tuesday & Wednesday, with approximately half that rate on the other days of the week. 20 ISCs were submitted by F1 grade doctors, with only 2 from ST3+ grade doctors. 28 of the ISCs were from the medical division, 13 from the surgical division. 6 ISCs were from T&O, 4 or fewer arising from any of the other specialties.

Qualitative information
Part of overseeing the Exception Reporting mechanism involves constant awareness of under reporting and a constant effort to promote appropriate engagement with the mechanism via the Medical Director, DME, GMC regional officer and the local BMA representatives.

Data for the 2025 Report has been extracted from the Healthrota IT system, which has been the sole source of ER reports for Q1 2025 onwards. The data presented here has been post-processed after downloading that data in bulk. The information I have obtained is to the best of my knowledge.

Any numbers of reporting less than 5 are not disclosed, to prevent any risk of identifiability.

Data collection from Healthrota includes the list of shifts that are staffed on any given day. Analysis of this has allowed the rate of Exception reports to be calculated at 2% of the shifts available on any given weekday. ISCs represent 4% of all exception reports for weekdays, apart from Friday where the proportion is 8%. Weekend rates are too low for comment.

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In addition to the Exception reports I have been able to access data on locum spend, which has also been useful in highlighting areas in which substantive staffing is not aligned with requirements. The Emergency department, General/Acute medicine & Trauma & Orthopaedics were the highest users of Locum's Nest.

The 5 areas with the highest number of ERs were Trauma & Orthopaedics(117), Respiratory Medicine(89), General Surgery(77), Geriatric Medicine(64), Cardiology(61)

The free text descriptions for the exception reports have some core common themes with computational text analysis centered strongly on "patient" & "ward" with clinical administrative tasks correlating highly on the accompanying details.

The main patterns are that exception reports are most common at the end of the normal working day shifts, with additional peaks at the end of the evening shifts. There are notably fewer exception reports at weekends, but there are also many fewer doctors working meaning that the reporting rate is essentially the same.
Exception reports for excess time worked are strongly clustered in the 30-90 minute range, averaging 69 minutes for weekdays & 75 minutes for weekend days, reflecting some tolerance of minor delays in leaving work. Only 38 Exception reports (by 25 resident doctors) were for more than 2 hours of additional work.

Exception report data suggests that some resident doctors submit more exception reports than others, with 5 resident doctors having submitted >= 20 exception reports in this year, amounting to a total of 120 ERs. Of these 90 cited workload (58 as the sole cause) with 29 referring only to admin tasks. 1 gave no explanation.

There are trends in the ISC narratives: the themes are sickness/unpredictable reduced support & excessive/ inappropriate workload for the staffing/experience of the doctor. Not all of the ISCs meet the definition – something that will be addressed in the coming year, while maintaining the GoSW oversight of ERs with safety concerns, even if not "immediate" in nature.

It is important to appreciate there has been a significant increase in ERs this year; related partly to the new Healthrota System, partly to changes in reporting practices encouraged by changes in the T&Cs & by the BMA, & partly an improvement in the supporting processes lowering the barrier to submitting an ER. This trend seems likely to continue & offers an opportunity to detect & remedy structural issues in the work schedules, as well as opportunities to support changes in doctors' expectations in managing workload. HR now approve the majority of ERs; exceptions being any over 2 hours; Immediate Safety Concerns (For GOSW) or Educational Concerns (For DME).

The Guardian acknowledges the Trust's compliance with the safeguarding aspects of the 2016 contract; recognizes good practice within the Trust and a concerted effort to support Resident Doctor's as much as possible. They are aware that the data arising from the GoSW reports has been used to support a business case for improved staffing in T&O & also to provide insights at divisional level into the support & resourcing of resident doctors.

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Recommendations

The Guardian asks the committee to note this annual report, considering it to provide an assurance of compliance with the safeguarding aspects of the 2016 Junior Doctors Contract and approve its submission to the Trust Board.

APPENDICES

Appendix 1 Background detail and context

Appendix 2 Details all vacancies among the medical training grades during 2025_26, split by specialty and grade and quarter.

Appendix 3 – Exception Report submission from 2023/24 to 2025/26

Appendix 4 – Histogram of the Additional time worked when an exception report is submitted

Appendix 5 – Frequency of Exception reports, by planned end time

Appendix 6 – Specialty of doctor submitting exception reports during this year

Appendix 7 – Themes present in the text analysis of (all) ERs this year

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APPENDICES

ANNUAL GUARDIAN REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

2025_26

Appendix 1 – Background Context

All eligible doctors in training between the above dates were working under the terms of the 2016 Junior Doctors Contract with 2019 Updates ("the 2016 Contract") and as such have had access to formally report occasions when their actual working pattern diverged from their contracted work schedules, as "Exception Reports", for review by the Trust's Guardian of Safe Working (GoSW). The trust extends Exception reporting access & safe working hours limitations to the locally employed resident doctors. Exception reporting analysis uses all submitted reports.

All work schedules provided to doctors in training within 2025 complied with contractual commitments under the 2016 Contract.

The provision of three quarterly reports and one annual report from the Guardian of Safe Working is a contractual requirement outline in the T&CS of the 2016 Contract.

Work schedule reviews

Upon the submission of an Exception Report that suggests a mismatch between a junior doctor's work schedule and the actual clinical demands required in that post, it is the responsibility of the guardian of Safe Working to request that the reporting doctor's educational supervisor trigger a *Level 1 (Work Schedule) Review*. Example outcomes of such a review include no requirement for change, a prospective requirement to adjust existing work schedules, or even institutional change. The Exception Report is closed at Level 1 if the junior doctor and educational supervisor agree an outcome or escalated to *Level 2 Review* (with involvement of Guardian/DME and service management) if the junior doctor is not in agreement with the outcome. *Level 3 Review* constitutes a formal grievance hearing with HR representation.

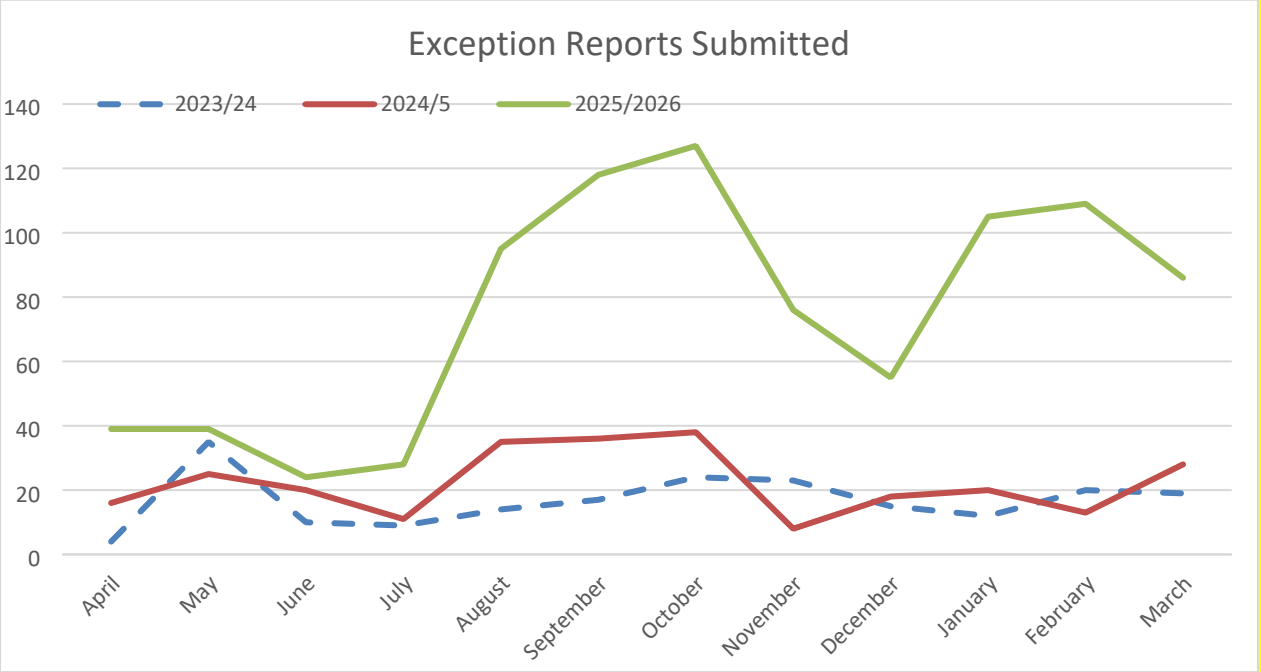
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Appendix 2 – Trainee Vacancies within the Trust based Dorset County Hospital NHS Foundation Trust **on Deanery numbers 2025_26**

Department	Grade	Q1				Q2				Q3				Q4				Annual Average
	April 25 - March 26	Apr	May	June	Avr Q1	July	August	Sept	Avr Q2	Oct	Nov	Dec	Avr Q3	Jan	Feb	Mar	Avr Q4	
Paediatrics	ST3	1	1	1	1.0	1	1	0	0.7	0	0	0	0.0	0	0	0.2	0.1	1.7
Paediatrics	ST4+	0.8	1.4	1.4	1.2	1.4	1.4	0	0.9	0	0	0	0.0	0	0	0.4	0.1	2.3
O&G	ST1	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
O&G	ST3+	0	0.4	0.4	0.3	0.4	0.4	0.4	0.4	0	0	0	0.0	0	0	0	0.0	0.7
ED	ST3+	1	1	1	1.0	1	1	0.2	0.7	0.2	0.2	0.2	0.2	0.2	0.4	0.4	0.3	2.3
Surgery	CT1	0	0	0	0.0	0	1	1	0.7	1	1	1	1.0	1	1	1	1.0	2.7
Surgery	CT2	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Surgery	ST3+	0	0	0	0.0	0	0	0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.4
Orthopaedics	ST3+	0	0	0	0.0	0	1	0.2	0.4	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.8
Anaesthetics	CT1/2	1.4	1.4	1.4	1.4	1.4	0.2	0.2	0.6	0.2	0.2	1.2	0.5	1.2	0.4	0.4	0.7	3.2
Anaesthetics	ST3+	1.2	1.2	1.2	1.2	1.2	1.5	1.5	1.4	1.5	0.7	0.7	1.0	0.7	2.2	2.2	1.7	5.3
Clinical Radiology	ST1/2	1	1	1	1.0	1	0	0	0.3	0	0	0	0.0	0	0	0	0.0	1.3
Medicine	CT1/2	4.1	4.1	4.1	4.1	4.1	4.6	4.6	4.4	0.6	0.6	0.4	0.5	0.4	0.4	0.4	0.4	9.5
Medicine COE	ST3+	0.2	0.4	0.4	0.3	0.4	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0
Medicine Diab/Endo	ST3+	1	1	1	1.0	1	1	1	1.0	0	0	0	0.0	0	0	0	0.0	2.0
Medicine Gastro	ST3+	0	0	0	0.0	0	1	0	0.3	0	0	0	0.0	0	0	0	0.0	0.3
Medicine Resp	ST3+	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Medicine Cardio	ST3+	0.2	0.2	0.2	0.2	0.2	0	0	0.1	0	0	0	0.0	0	0	0	0.0	0.3
Medicine Acute Internal	ST3+	1	1	1	1.0	1	1	1	1.0	1	1	1	1.0	1	1	1	1.0	4.0
Medicine Renal	ST3+	1	1	1	1.0	1	0	0	0.3	0	0	0	0.0	0	0	0	0.0	1.3
Haematology	ST3+	1	1	1	1.0	1	1	0.4	0.8	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	2.6
Med/Surg	FY1	2	2	2	2.0	2	1	1	1.3	1	1	1	1.0	1	1	1	1.0	5.3

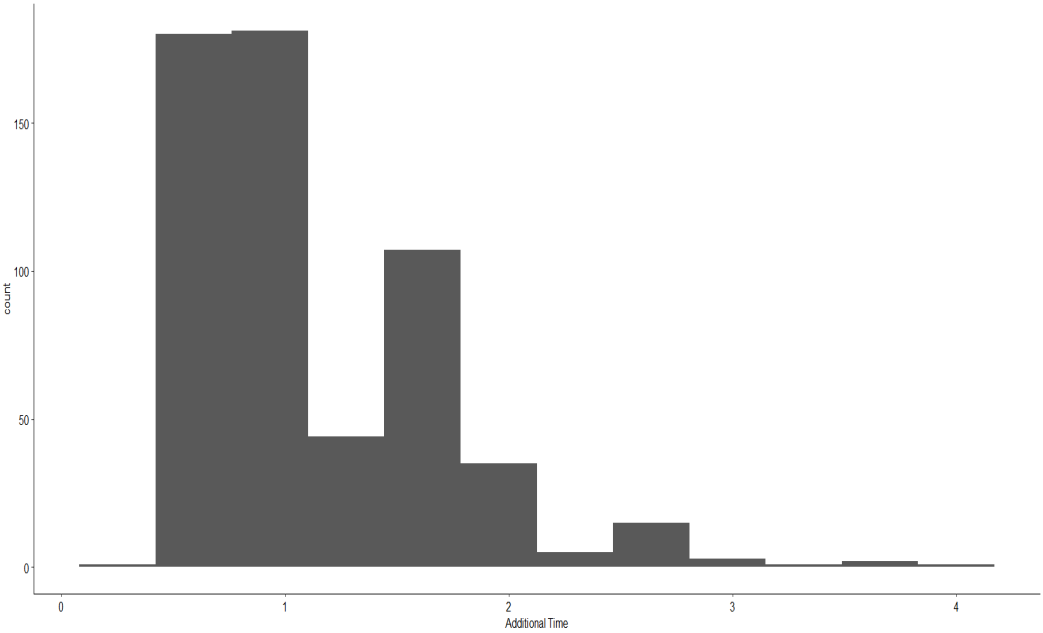
Med/Surg	FY2	1.5	1.5	1.5	1.5	1.5	2.8	2.8	2.4	2.8	2.8	2.8	2.8	2.8	2.8	2.8	2.8	9.5
GPVTS	ST1	0.2	0.2	0.2	0.2	0.2	1.2	1.2	0.9	1.2	1.2	1.2	1.2	1.2	2	2	1.7	4.0
GPVTS	ST2	0	0	0	0.0	0	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.2	0	0	0.1	0.4
GPVTS	ST3	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Orthodontics	ST3	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Ophthalmology	ST3	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0	0.0
Total		18.6	19.8	19.8	19.4	19.8	21.5	15.9	19.1	10.7	9.9	10.7	10.4	10.7	12.2	12.8	11.9	60.8

Ellis,Kara
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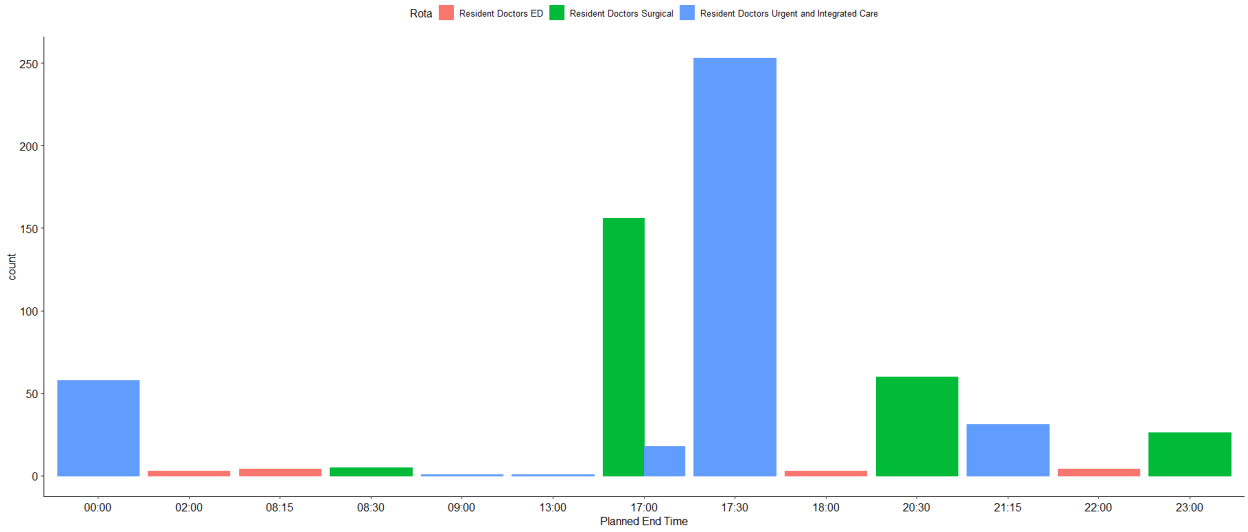
Increase is related to changes in submission processes (software) & T&Cs

Appendix 4 – Histogram of the Additional time worked when an exception report is submitted

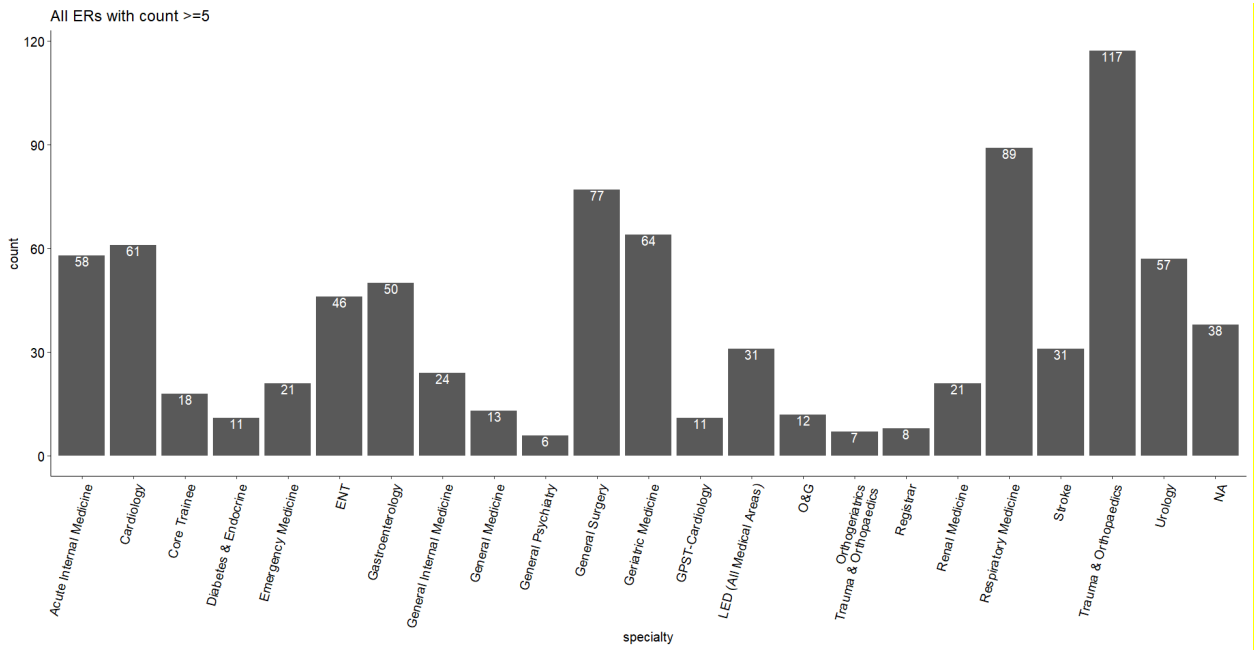


Ellis,Kara
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Appendix 5 – Frequency of Exception reports, by planned end time (HealthRota "shortcuts" explain times >24:00)

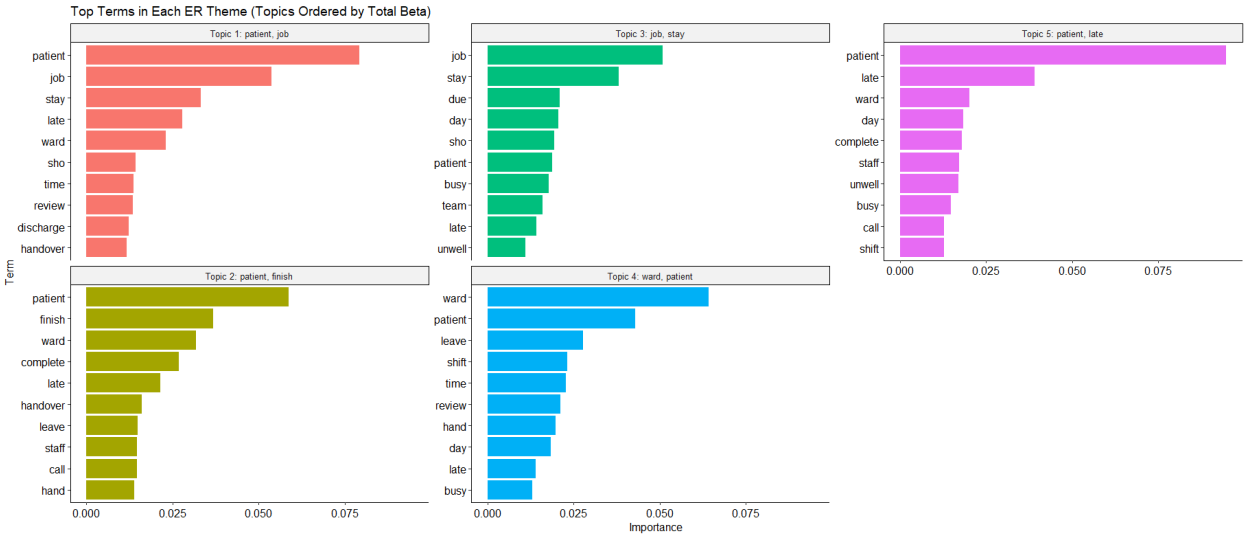


Appendix 6 – Specialty of doctor submitting exception reports during this quarter



Ellis,Kara
10/06/2026 16:10:43

Appendix 7 – Themes present in the text analysis of (all) ERs this quarter



Ellis,Kara
10/06/2026 16:10:

Report to	Board in Common (DCH & DHC)	
Date of Meeting	17 June 2026	
Report Title	Equality, Diversity and Inclusion (EDI) Annual Report 25/26	
Prepared By	Harry Coburn, EDI Advisor (DHC) Clare Riley, OD Facilitator (DCH) Manpreet Aujla-Gudgeon, EDI Lead (DHC) Jan Wagner, EDIB Lead (DCH)	
Accountable Executive	Emma Hallett, Deputy Director of Workforce Development Nicola Plumb, Joint Chief People Officer	
Previously Considered By	N/A	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR2: Culture – EDI Annual Report is one of the reports as a control within the Board Assurance Framework (BAF).	
Financial	No implication	
Statutory & Regulatory	Publishing the EDI Annual Report helps both Trusts meet the Public Sector Equality Duty (PSED) under the Equality Act 2010 by demonstrating transparency, accountability, and compliance with the legal obligation to eliminate discrimination, advance equality, and foster good relations.	
Equality, Diversity & Inclusion	This report is one of the annual reports aligned to the Equality Act 2010 and our joint Inclusion & Belonging Strategy.	
Co-production & Partnership	This paper has been developed through joint working across Dorset HealthCare (DHC) and Dorset County Hospital (DCH), with contributions from colleagues across both organisations. It also reflects wider EDI activity delivered in partnership with system colleagues, including NHS Dorset, University Hospitals Dorset (UHD) and local authorities.	

Executive Summary

This joint Equality, Diversity and Inclusion (EDI) Annual Report covers the period from April 2025 to March 2026 and brings together progress across Dorset HealthCare and Dorset County Hospital. It provides a month-by-month account of key activity, alongside a wider summary of the work undertaken across both Trusts to strengthen inclusion, belonging, equity and accountability. The report is aligned to our joint Inclusion and Belonging Strategy and the associated Inclusion and Belonging Action Plans.

Both Trusts recognise that equality, diversity, inclusion and belonging are not separate from the delivery of safe, effective and high-quality care, but are integral to it. Workforce experience, organisational culture, patient experience and health inequalities are closely connected, and the Trusts' approach to inclusion is therefore considered through both a workforce and patient equity lens.

Across both organisations, this work is grounded in our statutory responsibilities under the Equality Act 2010 and the Public Sector Equality Duty, alongside wider NHS priorities relating to workforce equality,

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population health and reducing inequalities in access, experience and outcomes. This includes our responsibilities through frameworks such as the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Equality Delivery System (EDS 2022) and, where relevant, the Patient and Carer Race Equality Framework (PCREF).

Over the past year, both Trusts have strengthened their approach through visible leadership, closer joint working and a stronger focus on staff voice and lived experience. Key developments include the joint adoption of the UNISON Anti-Racism Charter, development of the Joint Anti-Racism and Inclusion Framework, expansion of Conscious Inclusion and Inclusive Leadership training, and continued work to support Staff Networks as a source of colleague voice, challenge and organisational learning.

The report also highlights practical work to improve workplace culture and access to opportunity. This includes guidance on unacceptable behaviours and respectful workplace conversations, work on reasonable adjustments and health passports, activity on gender inclusion and safe spaces, widening participation through Supported Internships and Skills Bootcamps, and a range of awareness, engagement and community-facing events across the year.

Workforce data and statutory reporting show areas of progress alongside continuing inequality. Improvements are visible in some areas of representation, disclosure, leadership development and inclusive practice, but challenges remain in relation to workforce experience, progression, senior representation, disability inclusion, access to opportunities and consistency of lived experience across teams and services.

Overall, the report provides assurance that both Trusts have continued to develop their inclusion and belonging work in a more structured and evidence-informed way. It also recognises that activity alone is not enough. The next stage of work will need to maintain momentum, strengthen accountability, use data and lived experience more consistently, and focus on measurable improvements in outcomes for staff, patients and the communities we serve.

Recommendation

Members are requested to:

- Receive the report for Assurance.

Ellis,Kara
10/06/2026 16:10:45

Equality, Diversity and Inclusion (EDI) Annual Report 2025-2026

1. Introduction

The joint Equality, Diversity and Inclusion (EDI) Annual Report covers the period from April 2025 to March 2026 and reflects activity and progress across Dorset HealthCare and Dorset County Hospital. It provides a month-by-month overview of key developments during the year, while also drawing together the wider themes, learning and evidence that have shaped our inclusion and belonging work.

Our Inclusion and Belonging Strategy 2024–2026 commits us *to "working together as one community to provide outstanding quality of care, in an environment where diverse voices are not only heard but valued, where differences are celebrated as sources of strength, and where discrimination has no place."*

The report shows how activity during the year has supported our wider strategic priorities, including anti-racism, inclusive leadership, Staff Network development, workplace culture, widening participation, equality reporting and the use of data and staff voice to inform action.

Both Trusts recognise that equality, diversity, inclusion and belonging are not separate from the delivery of safe, effective and high-quality care, but are integral to it. Workforce experience, organisational culture, patient experience and health inequalities are closely connected, and the Trusts' approach to inclusion is therefore considered through both a workforce and patient equity lens.

Across both organisations, this work is grounded in our statutory responsibilities under the Equality Act 2010 and the Public Sector Equality Duty, alongside wider NHS priorities relating to workforce equality, population health and reducing inequalities in access, experience and outcomes. This includes our responsibilities through frameworks such as the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Equality Delivery System (EDS 2022) and, where relevant, the Patient and Carer Race Equality Framework (PCREF).

Our joint Inclusion and Belonging Strategy provides the framework for this work, but inclusion and equity are also intended to be reflected more broadly through leadership, quality improvement, workforce development, service design, staff voice, patient engagement and organisational decision-making. This recognises that creating inclusive environments for colleagues directly supports safer, more compassionate and more equitable care for the communities we serve.

The Trusts also recognise that, while progress has been made in a number of areas, workforce and patient inequalities continue to exist. Data, staff feedback, patient insight and lived experience continue to highlight variation in experience and outcomes for some groups. The purpose of this report is therefore not only to describe activity undertaken during the year, but also to provide assurance regarding governance, transparency, areas of progress and the further work required to support measurable and sustained improvement.

Ellis Kirk
10/06/2026 10:10:45

The report recognises progress made across both Trusts, while also identifying areas where further work is needed to translate policy, governance and individual initiatives into consistently improved experience and outcomes for staff, patients and communities.

2. Main narrative

April 2025

Joint Trust activity – Diversity in Health and Care Partner Programme

Both Dorset HealthCare and Dorset County Hospital participated in the Diversity in Health and Care Partner Programme during 2024 and 2025. This national programme supports organisations to strengthen their approach to EDI through shared learning and collaboration. EDI colleagues took part in four in-person modules across the year (October 2024 in Leeds, February 2025 in London, April 2025 in Liverpool, and July 2025 in Leeds), covering systemic change, accountability, leading change and sharing good practice. Learning from the programme has informed strategic priorities across both Trusts, strengthening leadership capability and supporting a more consistent, values-driven approach to embedding inclusion and belonging across our organisations.





Dorset HealthCare – Launch of Inclusive Recruitment and Selection training

Dorset HealthCare launched Inclusive Recruitment and Selection training to support recruiting managers to carry out recruitment through the lens of inclusion. The programme focuses on aligning recruitment with Trust values, increasing awareness of bias and assumptions, and strengthening fair and equitable selection processes. To date, 84 managers have been trained, supporting more consistent and inclusive recruitment practices across the organisation.

Dorset County Hospital – Strengthened Equality Impact Assessment Framework

The Trust approved a revised Equality Impact Assessment framework, strengthening how equality considerations are built into organisational decision-making. The updated approach supports staff to consider potential impacts on people with protected characteristics and other underrepresented groups earlier in the development of policies, projects, service changes and operational decisions, rather than treating equality analysis as a final compliance step.

Ellis Parr
10/06/2026 16:10:45

The framework strengthens accountability by requiring clearer evidence, consultation, mitigation and follow-up where potential impacts are identified. Where risks cannot be fully mitigated, the process provides a route for senior review and sign-off before implementation. This supports more transparent, inclusive and legally robust decision-making, in line with the Public Sector Equality Duty and wider NHS expectations on equality governance.

May 2025

Joint Trust activity – Gender Inclusion and Safe Spaces Task and Finish Group

Following the UK Supreme Court judgment in *For Women Scotland Ltd v The Scottish Ministers* and the continuing development of the national legal and policy position on sex, gender reassignment and single-sex spaces, Dorset HealthCare and Dorset County Hospital established a joint Gender Inclusion and Safe Spaces Task and Finish Group. The judgment provided important legal clarification, while also creating a period of legal, operational and practical uncertainty for NHS organisations about how these duties should be applied in workplace and patient-facing environments.

The group provides a structured forum to consider the legal, practical and human implications for staff, patients and services across both Trusts. It brings together EDI, HR, Estates, staff voice, Staff Networks, staff-side representation and clinical perspectives, while also drawing on emerging national discussions through relevant NHS and workforce equality forums.

The group is considering how both Trusts can maintain dignity, privacy, safety and inclusion in a lawful and proportionate way. This includes listening to transgender and non-binary colleagues and wider staff voices, while also considering workforce, patient, operational and facilities implications. The work also provides a route for staff concerns, questions and support needs to be identified and considered, so that colleagues are not left to navigate this complex area in isolation. The group's work is ongoing and is supporting a scoping exercise to prepare both Trusts for future national guidance and any required local implementation.

Dorset County Hospital – Strengthening Sexual Safety and Anonymous Speaking Up

The Trust introduced WorkInConfidence as an additional confidential reporting route to support staff to raise concerns about sexual safety and other sensitive workplace issues. The platform allows colleagues to report concerns anonymously while still enabling a two-way conversation, helping staff receive a response without having to disclose their identity. This was introduced as part of the Trust's work to strengthen sexual safety and support the commitments of the NHS Sexual Safety Charter.

Dorset County Hospital – Formal Recognition and Support for Staff Networks

Ellis.Kaye 10/06/2026 16:10:45

The Trust introduced its first Staff Network Policy, creating a formal framework for the recognition, support and governance of staff networks across the Trust. The policy establishes staff networks as a core part of the Trust's approach to inclusion and belonging, recognising their role in providing peer support, amplifying lived experience, informing policy development and offering constructive challenge to organisational decision-making.

The policy sets out clearer expectations around network membership, chair and sponsor roles, protected time, governance routes and access to resources. This provides a stronger foundation for networks to operate sustainably and to contribute meaningfully to culture change, staff engagement and inclusive practice across the organisation.

Dorset HealthCare – Staff Networks Day

Staff Network Day was celebrated, recognising the vital contribution of our Staff Networks across the Trust. Led by passionate Chairs and Co-Chairs, and supported by engaged members and senior leaders, the networks provide 1:1 support, regular opportunities to connect, events, and communications that amplify diverse voices. They also play an important role in influencing policy and improving the experience of colleagues, making a meaningful difference across our organisation.



June 2025

Dorset HealthCare – Dorset Mela

DHC engaged with local communities at the Dorset Mela, sharing information about Dorset HealthCare services and career opportunities while celebrating the diversity of the communities we serve. It was a valuable opportunity to connect, build relationships, and showcase our work, alongside colleagues from across the Trust and a visit from the Mayor.





"It was a pleasure to take part in the Dorset Mela this year. We had great interactions with diverse communities, who were all eager to learn about Dorset HealthCare. We were also very honoured to have Mayor Mark Howell visit our stall, who showed genuine interest in our Trust." – Ruth Konda, therapies lead and physio for older person's mental health services

Ellis Kara
10/06/2026 16:10:45

Dorset County Hospital – Pride Month Activity



Our Pride Staff Network attended several events during Pride Month, including Pop-Up Pride Dorchester, Chesil Youth Pride and Poole Pride. The Network also coordinated free and accessible activities within the hospital, creating opportunities for staff, families, patients and community members to come together, share learning and celebrate LGBTQIA+ inclusion. The local record store, Vinyl Van, kindly provided LGBTQIA+ inspired music in the hospital restaurant over lunchtime, helping to create a welcoming and visible celebration within the Trust. A courtyard space at the centre of the hospital was transformed into a colourful and thought-provoking Pride Garden, which received very positive feedback from colleagues and visitors.

Participation in Chesil Youth Pride also provided an opportunity to engage with young people and future workforce, showing the Trust's commitment to creating an inclusive environment where LGBTQIA+ staff, patients and communities feel seen, valued and supported.

July 2025

Joint Trust activity – Bourne Free Pride Parade



Our LGBT+ Staff Networks at both Trusts worked collaboratively with partner organisations, to participate in the Bourne Free Pride Parade in Bournemouth, as part of a wider NHS presence. Colleagues joined a large NHS contingent, walking from the Lansdowne area into the town centre, supported by strong community engagement along the route, before arriving at Meyrick Park where the event continued. The day provided a visible demonstration of our collective commitment to inclusion, with staff, families, and community members coming together to celebrate LGBT+ inclusion.

Ellis Kaye
10/06/2026 16:10:45

Joint Trust activity – Leading for Inclusion Conference

Colleagues from both Dorset HealthCare and Dorset County Hospital participated in the system-wide Leading for Inclusion programme, which culminated in a conference event on 15 July. The event provided an opportunity to reflect on learning, celebrate progress, and shape next steps across the system.

Through the programme, leaders from both Trusts strengthened their confidence and capability to lead inclusively, built cross-system relationships, and applied their learning within their teams and services. This has supported the development of more inclusive practices across services, strategy, and organisational culture. The conference included a joint presentation showcasing how participants have translated learning into practice within their teams, providing examples of early impact and reinforcing a shared commitment to inclusive leadership across the system.

Dorset HealthCare – Reciprocal Mentoring Programme Celebration

The third Reciprocal Mentoring Programme concluded with a celebration event at Alderney Hospital. The programme created meaningful opportunities for colleagues and senior leaders to connect, share lived experiences and learn from one another. All involved had open, honest conversations that challenge perspectives, built understanding, and strengthened inclusive leadership. It was an opportunity for reflection, learning, and driving positive cultural change, and we continue to build on the powerful conversations that took place.

"I have learnt that people are interested in my story, which is very validating. I have also learnt that by working together change can begin to happen, especially when the right people know what the difficulties are. I also found the Celebration session interesting as it brought together everyone's experiences and reflections."

"…the Trust is really willing and wanting to do better, that there is passion in this Trust and that we have the people who have the solutions."

"Very worthwhile programme, a time to learn, reflect and grow."

August 2025

Dorset HealthCare – Staff Network Involvement with Relocation to new Headquarters

Ellis,Kara
10/06/2026 16:20:36

Helping Disabilities, the staff network for colleagues with disabilities, undertook an accessibility review of the new Trust headquarters at Nuffield Road, ensuring lived experience informed the assessment. Feedback from the network directly influenced improvements to

accessibility and highlighted further areas requiring attention. This work reinforces the importance of staff voice in shaping decisions on inclusion and ensuring that environments are responsive to the needs of our workforce.

Dorset County Hospital – Oliver McGowan Mandatory training team

The Oliver McGowan Mandatory Training on Learning Disability and Autism is the government's preferred and recommended training for health and social care staff. The Trust's approved trainers completed their final rehearsal day, preparing them to begin delivering the mandatory full-day training sessions to patient-facing staff from September.



This training supports improved knowledge, confidence and capability in meeting the needs of people with a learning disability and autistic people. It contributes to improved patient experience and safety, supports compliance with national requirements, and reinforces the Trust's commitment to equitable, person-centred care.

September 2025

Joint Trust activity – Joint Staff Networks Conference

The first Joint Staff Networks Conference was held in Swanage, bringing together Network Chairs, members and senior leaders from both Trusts for a dedicated day of connection, reflection and shared learning. The conference created space to celebrate the contribution of Staff Networks, but also to listen carefully to what networks need to be sustainable, influential and better supported.

Discussions identified clear themes for future development, including the need for stronger visibility and influence, clearer routes for network issues and successes to reach senior leaders, better support and protected time for Chairs, stronger cross-network collaboration, improved succession planning, and greater clarity on the role and impact of executive sponsors. These themes have helped shape a more practical understanding of how Staff Networks can continue to amplify colleague voice, influence organisational decision-making and contribute to meaningful culture change across both Trusts.

Ellis,Kara
10/06/2026 16:10:45



Dorset County Hospital – Embedding EDIB into Recruitment Decisions

The Trust introduced mandatory EDIB interview questions for all interview panels, ensuring that equality, diversity, inclusion and belonging are visibly embedded into recruitment decision-making. The approach requires panels to include both a candidate-led EDIB question and a band-specific question, supported by scoring guidance to promote fairer and more consistent assessment.

By embedding EDIB into every interview process, the Trust has taken a practical step towards more values-led recruitment, improved consistency across panels, and stronger accountability for inclusive hiring decisions.

Dorset County Hospital – Supported Internships

The Supported Internships programme continues to be delivered through our partnership with Coastland College and the Southwest Regional Assessment Centre, supporting more equitable access to employment within the Trust. The offer has been expanded to include Employ My Ability, strengthening inclusive pathways for young people who are often underrepresented in the workforce.

The 26-week internships are designed for young people with Special Educational Needs and Disabilities (SEND), focusing on removing barriers to employment, promoting independence, and supporting individuals to thrive in a healthcare environment. Placements have included Damer's Restaurant, Evershot Ward and Volunteer Services, offering a range of accessible roles across clinical and non-clinical settings.

Ellis,Kara
10/06/2026 16:15:45

The programme has demonstrated positive outcomes, with interns at Dorset County Hospital progressing to apply for substantive roles. This year, eight internship placements have been

hosted, contributing to the Trust's ambition to build a diverse workforce that reflects the communities we serve.



Dorset HealthCare – New Group for Parents & Carers Returning from Parental Leave

The Parent Staff Network established a dedicated group to support colleagues returning from maternity and paternity leave, creating a space for connection, shared experience and peer support. This was a need raised by network members, and helps ease the transition back to work, encourages open conversations, and ensures parents and carers feel supported, valued and included as they navigate this important stage.

October 2025

Joint Trust activity - Workforce Race and Disability Equality Standards 2024-25

The mandatory annual WRES and WDES reports were reported to People and Culture Committee in Common and to the Board, with relevant actions added to the existing Joint strategy action plans.

Overall, the 2024/25 WRES and WDES results showed a mixed but improving position. Progress has been made in representation, recruitment and staff experience; however, inequalities remain in formal processes, workplace culture and senior leadership representation. This demonstrated that continued focus is required to embed inclusive practices and support equitable outcomes for all staff.

Dorset County Hospital – Diwali

Ellis Parker
10/06/2026 16:14:45

Colleagues from both Trusts came together for Diwali celebrations hosted by the Overseas Staff Network in Damer's Restaurant. The event created an opportunity to learn about the significance of the festival, celebrate cultural heritage, and bring staff together through music, food, conversation and cultural activities.



Senior leaders, including the Chief Operating Officer, Director of Nursing and Deputy Chief Nurse, joined the celebrations and took part in staff engagement activities, including henna art. Their visible participation helped demonstrate support for the Network and reinforced the importance of recognising and valuing the cultural diversity of our workforce.

The event supported cultural awareness, strengthened staff engagement, and contributed to a welcoming and inclusive environment for staff, patients and visitors. It also highlighted the important role Staff Networks play in creating spaces where colleagues can share identity, build connection and feel a stronger sense of belonging at work.

Dorset HealthCare – Black History Month Event



Black History Month was celebrated under the theme *'Standing Firm in Power and Pride'*, creating space to celebrate Black excellence and promote inclusion across the Trust. Through powerful storytelling and open panel discussions on racism, allyship and belonging, the event encouraged honest reflection, learning, and meaningful dialogue among colleagues. The event supported increased staff engagement and awareness, strengthened conversations around race and allyship, and reinforced the importance of inclusive behaviours in everyday practice. It also provided a platform for staff voice, contributing to a more open culture and informing ongoing work to improve the experiences of Black colleagues.

Ellis Kate
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November 2025

Joint Trust activity – Joint Anti-Racism Board Development Session

A joint Board development session on anti-racism provided a foundation for strengthening leadership understanding, commitment and accountability across both Trusts. This informed the development of a joint Anti-Racism and Inclusion Framework, bringing together workforce, leadership and patient-focused activity to address inequalities in experience and outcomes. Key actions have included the rollout of Unacceptable Behaviours Guidance, delivery of Inclusive Leadership and Conscious Inclusion training, and strengthened co-production with patients, carers and communities including through PCREF where relevant. Together, these actions are intended to support greater staff confidence in reporting concerns, greater consistency in organisational response, and a more inclusive culture that supports safer, more equitable care.

Dorset County Hospital – Clear, Respectful and Inclusive Communication

A new Trust-wide guideline was developed to support clear, respectful and inclusive communication with colleagues, patients, families, carers, visitors and external partners. The work began in response to concerns about language use in the workplace but developed into a broader framework recognising that communication is central to dignity, belonging, psychological safety and patient safety.

The guideline sets out practical expectations for everyday communication, including plain English, respectful tone, names and pronouns, accessible communication, multilingual working, clinical clarity, professional documentation and proportionate responses when language causes harm. It also makes clear that the aim is not to police language, but to support confidence, fairness and learning in how people speak, write and respond to one another.

December 2025

Dorset HealthCare – Launch of Unacceptable Behaviours Guidance and Listening Events

Guidance was launched to support colleagues in responding to unacceptable behaviours from patients and service users, alongside guidance on conducting respectful workplace conversations. This was developed in response to colleague feedback and a recognised increase in challenging interactions linked to wider societal tensions. The guidance provides practical tools to support consistent responses, aligned to our Violence Prevention and Reduction approach, Freedom to Speak Up principles, and wider EDI commitments. It reinforces expectations around respect, dignity and safety, while promoting active bystander behaviours and supporting colleagues to confidently challenge inappropriate conduct. This work contributes to creating a safer, more inclusive working environment and supports improved staff experience outcomes, including colleagues feeling safe to speak up and confident that concerns will be addressed.

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Dorset County Hospital – Skills Bootcamp Event

Our Education and Recruitment teams delivered the inaugural Skills Bootcamp in Health and Social Care for adults across Dorset and Somerset, supporting access into healthcare careers. This government-funded programme provides flexible training for people aged 19 and over and includes a guaranteed interview for support worker roles on completion.



Fourteen learners enrolled in the four-week programme, which combined Care Certificate-based learning, practical training, employability support and ward-based experience. Twelve participants completed the course, with nine progressing to job offers or inclusion in the talent pool. Of these, six are now in post at Dorset County Hospital, with a further two due to start shortly. Ongoing employability support is being provided to remaining participants.

The programme demonstrates a strong and practical pathway into employment, supporting widening participation and helping people who may not otherwise have considered a healthcare career to access roles within the Trust. It contributes to building a more diverse workforce and strengthens local recruitment pipelines aligned to the communities we serve.

January 2026

Joint Trust activity – Equality Delivery System 2022 (EDS 2022)

Both Dorset HealthCare and Dorset County Hospital completed their 2025–2026 Equality Delivery System (EDS 2022) assessments, demonstrating a mixed but developing position across services, workforce and leadership.

Strengths include targeted work to address health inequalities, improved governance and accountability, and continued engagement with staff, patients and communities. However, further work is required to strengthen the consistent use of data, improve staff experience for all groups, and embed inclusive leadership and representation at senior levels.

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Action plans are in place for both Trusts, aligned to the Joint Inclusion and Belonging Strategy, to drive continued improvement and deliver more equitable outcomes.

The overall organisational rating for DCH was 18.5 out of 33, assessed as Developing and the overall rating for Dorset HealthCare was 22 out of 33, assessed as Achieving. Both results showed incremental progress from the previous year while also highlighting where further work is needed to translate governance, policy and individual initiatives into consistently improved lived experience.

Dorset County Hospital – Supporting Neurodivergent Colleagues

Following a successful launch in October 2025, the Organisational Development department made the Supporting Neurodivergent Colleagues workshop part of their regular training offer. The training was developed by and in collaboration with a neurodivergent colleague. Uptake by managers and colleagues was very quick, highlighting the need for such an offer.

When asked what their most important take away from the session was, participants said, *"to treat everyone as an individual, rather than there being a specific approach for neurodiverse colleagues as a group" and "the information shared around the social model, language and reframing to adjustments as strength-based [rather than a tool to fix a disability]"*

Dorset County Hospital – Launch of the adapted version of Unacceptable Behaviours Guidance

The Trust adapted and implemented guidance to support managers in responding to staff who experience violence, aggression, harassment or discrimination from patients or visitors. Building on the work developed by Dorset HealthCare, the guidance was tailored to the DCH context and aligned with local reporting, security, HR and wellbeing routes.

The guidance reinforces a zero-acceptance approach and provides clearer expectations for managers, including immediate support for affected colleagues, timely incident reporting, follow-up conversations, wellbeing signposting and escalation where behaviour continues or presents a risk. It also recognises that staff from minority backgrounds can be disproportionately affected by violence, aggression and discrimination, and that these experiences must not be minimised or treated as "part of the job".

Dorset HealthCare – Freedom to Speak Up Champions Network

The EDI Team joined the Freedom to Speak Up Champions network meeting to facilitate discussion on inclusion and wellbeing, recognising the critical role Champions play in fostering a culture where colleagues feel safe to speak up. The session explored cultural competence, identifying bias, and the link between wellbeing and inclusive workplaces. This strengthened Champions' confidence to support colleagues, respond to concerns, and promote inclusive behaviours across teams. This work supports improvement in NHS Staff Survey outcomes, particularly in relation to staff feeling safe to speak up, confidence that concerns will be

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addressed, and experiences of inclusion, helping to build a more open, safe and respectful organisational culture.

February 2026

Joint Trust activity – Board Approval for Adoption of UNISON Anti-racism Charter

The Joint Board formally approved the joint adoption of the UNISON Anti-Racism Charter, marking a significant milestone in the Trusts shared commitment to anti-racism. As a voluntary commitment that goes beyond statutory requirements, the Charter provides a clear and visible expression of leadership accountability and intent. It complements existing frameworks, including WRES, EDS 2022 and PCREF where relevant, which continue to provide the mechanisms for delivery, measurement and assurance, and reinforces expectations for inclusive culture and practice across both organisations.

To support delivery of these commitments, both Trusts have strengthened their focus on inclusive leadership. In February 2026, Dorset County Hospital approved Conscious Inclusion and Inclusive Leadership training as mandatory for all staff with line management responsibility. This was taken up quickly, with more than 350 bookings already made for the current year. Dorset HealthCare made this training mandatory in July 2025 and has trained over 600 colleagues to date, strengthening leadership capability and accountability for embedding anti-racist and inclusive practice. This training has also been embedded within Dorset HealthCare's Leading Self and Leading Others programmes, supporting a sustained and consistent approach to inclusive leadership development.

This training has been positively received:

"The session opened my mind to consider areas of inclusion I wouldn't have typically thought of, but it has given me the confidence to be able to have open conversations with others and to be able to celebrate everyone's individuality and how they can uniquely contribute to the organisation."

"I attended the Inclusion Leadership course and found it extremely powerful and thought-provoking. Courses such as inclusion training are a crucial step beyond simply stating that racism is unacceptable or enforcing a zero-tolerance policy-they equip staff with the practical skills and confidence needed to recognise, address, and challenge discriminatory behaviour effectively."

Dorset HealthCare – Celebrating our Diversity

Dorset HealthCare marked National Race Equality Week with a celebration event at Alderney Hospital, where staff came together to share and showcase different aspects of their cultures and heritage. The event featured objects, photographs, textiles and traditional dress from across the world, and food that brought people together and sparked conversation and connection. It reminded us of our workforce's diversity, with colleagues sharing stories from

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countries including Russia, the Philippines, Lesotho and India, and of those who have come to work in the UK and Dorset.

The celebration highlighted that, while we come from many different backgrounds, we are united in our shared commitment to care for patients and support each other as colleagues.





Dorset HealthCare – Launch of Reasonable Adjustments Guidance and Health Passport through Listening Events

New guidance on Access to Work and our Health Passport was launched, providing practical support for colleagues and managers to better understand and meet individual needs in the workplace. Shaped by listening to colleagues' experiences, including dedicated listening events and input from Staff Networks, this work has enabled us to learn directly from staff voice and inform next steps to improve disability inclusion at the Trust. These resources aim to simplify processes, increase confidence, and normalise conversations about how colleagues can thrive at Dorset HealthCare.

Dorset HealthCare – Culture of Care Event

Dorset HealthCare hosted a Culture of Care event, bringing together a diverse cross-section of colleagues, including those with lived experience Facilitated by Black Thrive Global as part of the Culture of Care programme, the event focused on applying anti-racism approaches in practice. Through reflective and interactive sessions, colleagues explored how organisational systems and behaviours can support more equitable care. The event aligns with the principles of the Joint Anti-Racism and Inclusion Framework and the Patient and Carer Race Equality Framework (PCREF).

Dorset County Hospital – Supporting Respectful Workplace Conversations

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The Trust implemented local guidance to support managers in responding to workplace conversations or behaviours that may undermine dignity, respect, inclusion or psychological safety. Building on shared work developed by Dorset HealthCare, the guidance was adapted

for the DCH context and shaped through consultation with all DCH Staff Networks and the EDIB Delivery Group.

The guidance provides practical support for managers in distinguishing between respectful discussion and unacceptable workplace behaviour, including discriminatory, threatening or exclusionary language. It sets out clear steps for responding in the moment, following up privately, recording concerns where appropriate, and signposting colleagues to HR, Freedom to Speak Up, Staff Networks or wellbeing support.

This work supports a more confident and consistent approach to maintaining respectful workplace culture, particularly at a time when divisive rhetoric in wider society can affect staff experience at work. It reinforces that managers are not expected to police personal views, but do have a responsibility to protect dignity, respect and safety in the workplace.

Dorset County Hospital – Establishing a Young Staff and Volunteers Network

The Trust progressed the establishment of a new Young Staff and Volunteers Network, creating a dedicated space for younger colleagues, early-career staff and volunteers to connect, share experiences and contribute to the Trust's wider inclusion and belonging work.

The network strengthens staff voice by recognising that age, career stage and employment status can shape how confident people feel to speak up, access opportunities and influence workplace culture. It also provides an important bridge between staff network activity, widening participation, volunteering and future workforce development.

This work supports a more inclusive approach to engagement by ensuring that younger and less-established voices are heard alongside existing network perspectives. It also creates opportunities for peer support, leadership development and stronger connection between colleagues who may otherwise feel less visible within the organisation.

March 2026

Joint Trust activity – Quality Conference

A joint session was delivered at the joint Quality Conference focused on moving from 'not racist' to actively anti-racist practice. The session introduced our Joint Anti-Racism and Inclusion Framework and considered how it could be applied in practice across services. It explored key concepts, the case for action in addressing workforce inequalities and health disparities, and created space for reflection and discussion, including contributions grounded in lived experience. This supported increased awareness, encouraged personal and collective accountability, and prompted colleagues to identify actions to embed anti-racist practice within their roles.

The session contributed to strengthening understanding of anti-racism and supported ongoing efforts to drive meaningful, measurable change across our organisations.

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Dorset County Hospital – Supporting Neurodivergent Colleagues and Patients

The Learning Disability Team held a session in the Education Centre which focused on supporting patients with a learning disability and/or autism to make decisions. The session was invaluable to ensure service users receive care in a way that is meaningful to them. The Learning Disability team has also worked hard at growing the number of advocates across the Trust.

Dorset County Hospital – Overseas NHS Workers Day

With around one in five NHS staff in England reporting a non-British nationality, Overseas NHS Workers Day provides an important opportunity to recognise the contribution of international colleagues across the workforce. To mark the occasion, our Overseas Staff Network hosted a Cultural Diversity Celebration, inviting colleagues from across both Trusts to celebrate the richness of cultures represented in our workforce. The event featured music, dance and performances, creating a vibrant and inclusive space for connection and shared learning.

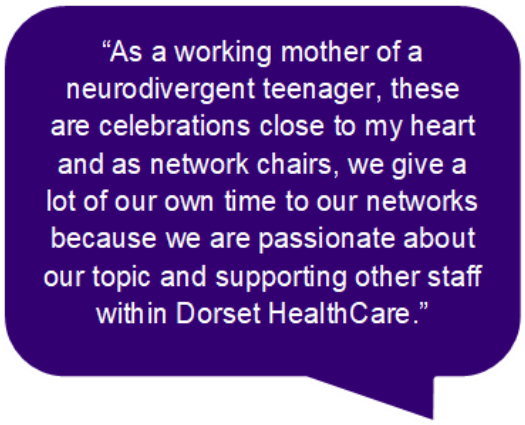
The event also incorporated the Network's AGM, providing an opportunity for colleagues to share experiences, strengthen staff voice, and build community. Strong attendance, including senior leadership presence, reflected the value of this work in promoting inclusion, engagement, and a sense of belonging. Our Joint Chief Executive, Matthew Bryant, actively supported the event, demonstrating visible leadership and commitment to inclusion by engaging with colleagues and contributing to the celebrations.



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Dorset HealthCare – International Women's Day and Neurodiversity Celebration Event

The Women's, Parent and Neurodiversity Staff Networks delivered a joint event to mark International Women's Day and Neurodiversity Celebration Week, bringing colleagues together to recognise, reflect and act. The session explored the need to move beyond awareness to meaningful change, while celebrating the experiences of women and neurodivergent colleagues. It created a supportive space for discussion, strengthening staff voice, awareness and understanding, and encouraging ongoing dialogue and action across our organisations.



Joint Trust Activity – Gender, Ethnicity and Disability Pay Gap Reporting

We remain committed to equality of opportunity and continue to take action to reduce our pay gaps. Pay Gap reports were submitted to the People and Culture Committee in Common and Board in March 2026. For the first time these included Gender, Ethnicity and Disability Pay Gap reports, strengthening transparency and accountability.

Across all three areas, the pay gap analysis provides an important governance baseline. The findings reinforced the need to focus on structural drivers of inequality: inclusive recruitment, equitable access to development, senior representation, data quality, and fair progression pathways. These priorities will inform the Trust's ongoing Inclusion and Belonging Action Plan and future annual pay gap monitoring.

3. Conclusion

Dorset HealthCare and Dorset County Hospital have made clear progress over the past year in strengthening inclusion and belonging through joint working, visible leadership, staff voice and practical delivery across workforce, services and governance.

The year has seen important developments, including adoption of the UNISON Anti-Racism Charter, expansion of Conscious Inclusion and Inclusive Leadership training, stronger Staff Network collaboration, work on unacceptable behaviours and respectful workplace culture, widening participation, and improved use of WRES, WDES, EDS 2022 and pay gap reporting to inform action.

At the same time, the data and engagement reflected in this report show that inequalities remain, particularly in relation to representation, staff experience, access to progression, and consistency of lived experience across teams and services. The next stage of work therefore needs to focus not only on maintaining activity, but on strengthening accountability, measuring impact, and ensuring that commitments translate into everyday practice.

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Both Trusts will continue to use data, lived experience, Staff Network insight and governance through their Inclusion and Belonging Action Plans to target action, monitor progress, and support more equitable outcomes for staff, patients and the communities we serve.

4. Recommendations

4.1. The Board is recommended to:

a. Receive the report for **Assurance.**

Name of Authors: Harry Coburn, EDI Advisor (DHC), Clare Riley, OD Facilitator (DCH), Manpreet Aujla-Gudgeon, EDI Lead (DHC) and Jan Wagner, EDIB Lead (DCH)
Date: April 2026

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Dorset County Hospital
Dorset HealthCare

Report to	Board in Common (DCH & DHC)	
Date of Meeting	17 June 2026	
Report Title	Joint Violence Prevention and Reduction Strategy	
Prepared By	Catherine Granville, Deputy Chief People Officer for Dorset County Hospital and Dorset Healthcare Ian Kilroy, Head of Emergency Planning and Security Management Specialist, Dorset County Hospital Roger Ringham, Assistant Director and Head of Service for Security and Fraud Experts, Dorset County Hospital	
Approved by Accountable Executive	Anita Thomas, Chief Operating Officer Dorset County Hospital Chris Hearn, Joint Chief Finance Officer, Dorset County Hospital and Dorset Healthcare	
Previously Considered By	27.05.26 People and Culture Committee in Common 12.05.26 Violence Prevention and Reduction Working Group	
Action Required	**Approval**	Y
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR2: Culture, SR3: Workforce Capacity	
Financial	No significant additional financial implications. Activity delivered within existing resources.	
Statutory & Regulatory	Supports compliance with Health and Safety legislation and NHS Violence Prevention and Reduction Standard.	
Equality, Diversity & Inclusion	Addresses known disproportionate impact of violence and aggression on staff with protected characteristics.	
Co-production & Partnership	Developed jointly across Trusts with operational, security, and workforce partners.	

Executive Summary

This paper presents the Joint Violence Prevention and Reduction Strategy for approval. The strategy sets out how Dorset County Hospital NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust will prevent, reduce, and respond to violence and aggression directed towards staff by patients, families, carers, visitors, and members of the public.

Key Issues

- Violence and aggression have a significant impact on staff safety, wellbeing, retention, and service delivery.
- National and local evidence shows under-reporting and disproportionate impact on some staff groups.
- Clear Board-level ownership and assurance are required under the NHS Violence Prevention and Reduction Standard.

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Risks and Mitigations

- **Risk:** Harm to staff and reduced workforce morale.

Mitigation: Clear strategy, training, leadership accountability, and support pathways.

- **Risk:** Regulatory non-compliance.

Mitigation: Alignment with statutory duties and NHS standards.

Options Considered

- Maintain existing arrangements without a joint strategy (not recommended).
- Approve a unified, joint strategy aligned to national requirements (recommended).

Recommendation

The Board is asked to approve the Joint Violence Prevention and Reduction Strategy and note the governance and assurance arrangements.

Recommendation

Members are requested to:

- Receive the report for **assurance**
- **Approve** next steps

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Joint Violence Prevention and Reduction Strategy for
Dorset County Hospital NHS Foundation Trust
Dorset Healthcare University NHS Foundation Trust

1. Executive Summary

This paper presents the Joint Violence Prevention and Reduction Strategy for approval. The strategy sets out how Dorset County Hospital NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust will prevent, reduce, and respond to violence and aggression directed towards staff by patients, families, carers, visitors, and members of the public.

Key Issues

- Violence and aggression have a significant impact on staff safety, wellbeing, retention, and service delivery.
- National and local evidence shows under-reporting and disproportionate impact on some staff groups.
- Clear Board-level ownership and assurance are required under the NHS Violence Prevention and Reduction Standard.

1. Introduction

Violence and aggression are not an acceptable part of NHS work. This strategy sets out a clear, joint approach to preventing and reducing violence and aggression directed towards staff, while ensuring appropriate support and proportionate escalation where required.

2. Scope

This strategy applies to all Trust employees, volunteers, contractors, and agency staff across all services and premises, including inpatient, community, and lone-working settings.

Staff-on-staff bullying, harassment, or misconduct are managed through separate HR and Dignity at Work policies and are out of scope.

3. Legal and Regulatory Context

The Trusts meet their duties under relevant legislation including the Health and Safety at Work etc. Act 1974, RIDDOR, the Equality Act 2010, and the Assaults on Emergency Workers (Offences) Act 2018. All incidents must be reported and reviewed. Where thresholds for criminal investigation are met, staff will be supported to engage with police processes.

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4. Strategic Aims and Objectives

The Trusts will:

- Reduce preventable incidents of violence and aggression
- Improve reporting, learning, and accountability
- Support staff affected by incidents compassionately and consistently
- Apply proportionate, risk-based escalation
- Provide clear Board-level oversight and assurance

5. Governance and Accountability

Delivery of the strategy is overseen by a joint, executive-led Violence Prevention and Reduction Group (VPRG), supported by Local Security Management Specialists and the Deputy Chief People Officer for both Trusts. Assurance is provided to the People and Culture Committee in Common, with twice-yearly reporting to the Boards.

6. Workforce Capability and Training

Staff receive role-appropriate training including induction awareness, conflict resolution, personal safety, and Prevention and Management of Violence and Aggression (PMVA) where required.

7. Staff Support

Staff affected by incidents are supported through managerial debriefs, Occupational Health, Employee Assistance Programme, TRiM, psychological support, and staff-side representation. Clear pathways are signposted following incidents.

8. Lone Working

Enhanced risk assessment, escalation arrangements, and monitoring are in place for lone-working staff, with LSMS involvement where security risks are identified.

9. VPRG Approach

- Utilisation of data to inform prevention actions – reviewed quarterly
- Use of 3 year trend reviews
- Use of incident data (Datix/Ulysses) to inform actions such as care plan reviews, training and formal enforcement
- Use of intelligence from data and Staff Networks, Staff Side Representatives and trade unions to identify, support and ultimately reduce incidents of violence and aggression against identified vulnerable groups and those who are identified as having protected characteristics.

In this way the group and Joint Strategy will reflect the National Standards requirement that organisations use data to proactively understand patterns, risks and impact and not simply report volume.

The VPRG will utilise quality improvement tools and methodologies to ensure prevention activities remain dynamic, developmental and iterative.

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9. Conclusion
This strategy confirms the Trusts' commitment to working without fear, protecting staff from harm, and meeting statutory and regulatory expectations.

Name and Title of Author:
Catherine Granville, Deputy Chief People Officer for Dorset County Hospital and Dorset Healthcare

Ian Kilroy, Head of Emergency Planning and Security Management Specialist, Dorset County Hospital

Roger Ringham, Assistant Director and Head of Service for Security and Fraud Experts, Dorset County Hospital

18.05.26

10. Appendices
Specific policies/guidance;

A. DCH Links:

- 1744-Violence-and-aggression
- Guidance Staff Safety and Managing Violence and Aggression in Healthcare Jun 2025.docx
- Reporting Incidents at Work - Violence and Aggression
- Guidance for supporting staff who have experienced violence, aggression or discrimination by a patient or visitor
- Sexual Misconduct Policy
- Disciplinary Policy
- Emergency Preparedness, Resilience and Response (EPRR) - EPRR Training and Exercise Programme - Unacceptable Behaviour - EDI Lead Support - All Documents
- Security Risk Management

B. DHC Links:

- Discipline :: Dorset Healthcare University NHS Foundation Trust
- Managers_Guidance_for_supporting_staff_who_have_experienced_unacceptable_behaviours_Final_Version.docx
- Supporting staff who have experienced unacceptable behaviours :: Dorset Healthcare University NHS Foundation Trust
- Sexual safety at work :: Dorset Healthcare University NHS Foundation Trust
- Lockdown_Policy_IN-557_.pdf
- Managing_Clinical_Risk_in_Mental_Health_Policy_IN-680_.pdf
- Security_in_Dorset_Healthcare_University_NHS_FT_IN-066.pdf
- Violence_Prevention_and_Reduction_Strategy_and_Policy_IN-939_.pdf
- Contents Disciplinary policy and procedure
- Incident_Management_and_Review_Policy_IN-175.pdf

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- SUPPORT OF STAFF, SERVICE USERS CARERS, RELATIVES AND/OR VISITORS FOLLOWING A SERIOUS ADVERSE INCIDENT (INCLUDING CLAIMS)
- Sexual misconduct policy
- EMERGENCY_PLANNING_RESPONSE__RESILIENCE_EPRR__BUSINESS_CONTINUITY_POLICY_IN-223_.pdf

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Dorset County Hospital
Dorset HealthCare

Strategy Transformation and Partnerships Committee Assurance Report for the meeting held on Thursday 28th May 2026

Chair	Dave Underwood, Chair
Executive Lead	Dawn Dawson Nicola Plumb Chris Hearn (Beverley Bryant)
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• A presentation outlining the DCH Ocean Midwives Service which focusses on supporting highly vulnerable women through pregnancy was highly commended (see appendix 1 to this report). • Board Assurance Framework – The committee noted the annual review of assigned risks including the proposed revised wording and endorsed the proposal that Strategic Risk 7 Collaboration and Strategic Risk 8 Transformation & Improvement should be merged into a single strategic risk going forward. • Corporate Risk Register – DCH the Chair noted that of the 7 risks on the register scoring 15+ the mitigations for 6, as presented, were either out of date or restatements of the problem rather than mitigations. • Clinical Digital Risks – Committee members agreed that a regular update for both Trusts from their digital governance groups on prioritisation of digital projects/resources and categorisation/themes of risks should routinely brought to committee for assurance. • Improving Together Plan 26/27 – detailed discussion amongst committee members on the importance of making the plan 'real' for all staff in the organisation from frontline to Board. • One Transformation Approach – a report including refreshed metrics will be presented to committee from July onwards with a focus on embedding measures that demonstrate impact. • Social Value – A joint Social Value plan for our Federation is in development and will be presented to committee members in July 2026. • One Dorset Provider Collaborative – agreement amongst committee members that a visual representation/infographic of the work streams and their interdependencies would be helpful at a future meeting.
Key issues / matters discussed at the meeting	An informal committee meeting took place 27th April 2026 covering the following topics for discussion: • Strategy/Transformation Impact Measures and Milestones to strengthen the information received by the STPCiC to provide greater assurance that the transformation programmes are driving the intended

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strategic outcomes and are maximising their value in delivering their full impact.
- CQC Well-Led Review preparation.

Board Assurance Framework Assigned Risks
Committee members received the report for assurance. There are no changes in the scores to the 4 assigned risks to the committee for DCH and DHC (strategic risks 7,8,9 and 10). A full explanation and assurances were provided on overdue actions. The Committee noted the annual review of strategic risks, including proposed revised wording developed with executive leads, and endorsed the proposal to merge strategic risks 7 and 8 ('Collaboration' and "Transformation and Improvement).

Corporate Risk Register Assigned Risks
DHC – The Committee received the risk report for assurance noting the escalation of a risk relating to the CAMHS High Intensity Unit, which has increased from 12 to 20. This reflects concerns regarding subcontractor performance and the potential impact on delivery timelines. Assurance was provided that the risk is being closely managed and is expected to reduce in the next reporting cycle. A reduction in risk score from 15 to 12 relating to the Estates Management Plan was noted, which reflects strengthened joint working with Dorset County Hospital. The overlap and importance triangulation of corporate risks across board sub-committees was highlighted.

DCH – 7 risks are assigned to the committee that score 15 or above. Overall, assurance was provided on the improvement in the risk profile and active management of remaining risks.

Clinical Digital Risks
A detailed summary of progress across the digital portfolio and the associated risks across the strategic pillars was received by the committee for assurance. Good progress is being made with EHR implementation including strong recruitment and alignment of system workstreams. Primary care integration is underway, and overall delivery remains on track. Progress continues on the target operating model and leadership structure, with recruitment underway. Assurance was provided on strengthening system-wide capability. Progress on infrastructure improvements was noted, including plans to enhance access and user experience. Assurance was provided on addressing legacy issues. Committee members agreed a regular update at future meetings from the DHC and DCH digital governance groups particularly on prioritisation would be helpful, as well as further categorisation/theming of risks to routinely be brought to committee meetings.

Strategy in action (including alignment to the 10-year plan): Safe maternity care for vulnerable families

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A presentation outlining the DCH Ocean Midwives Service which focusses on supporting highly vulnerable women through pregnancy was well received and commended by committee members as a powerful example of strategy realisation of empowering citizens, creating thriving communities, addressing health inequalities, improving outcomes and delivering the '3 shifts' in the NHS 10-year plan.

Strategy Delivery Review, Forward View and Dashboard
The report was summarised for assurance recognising that despite significant change in the wider NHS, the DHC/DCH joint strategy remains well-aligned with the NHS 10-year plan and national priorities. Progress was noted across key areas including neighbourhood health, partnership working and integrated delivery, with collaboration now embedded through joint governance and shared programmes. Evidence of impact included strong patient experience, improved performance metrics and increased access to community services. Priorities for the next phase include maintaining alignment with the external NHS environment, strengthening strategic oversight, embedding outcome-focused metrics and maintaining long-term strategic focus alongside operational pressures.

Improving Together Plan 2026/27
A summary of the Improving Together plan was provided which has been approved by the Joint Transformation and Improvement Board. Quality improvement activity is well established across both organisations, and the plan seeks to further strengthen and embed this into a more consistent and systematic approach with the three priority areas of Leadership, Strategy and Capability and Learning. assurance was provided on the direction of travel, with the plan supporting a more coordinated and mature improvement approach across the Federation. Detailed discussion amongst committee members on the importance of making the plan 'real' for all staff in the organisation ranging from frontline through to Board. Leadership happens at all levels. Committee members approved the plan.

One Transformation Approach Highlight Report
Assurance was provided on progress against the delivery of the 4 major change programmes in the transformation and improvement portfolio. A report with refreshed metrics will be presented from July 2026 with continued focus on embedding measures to demonstrate impact.

DCH Social Value Annual Report 2025/26 including verbal update on DHC Social Value activity
The committee received the DCH report for assurance recognising the significant amount of progress. Ongoing work to support local employment and training through partner organisations was noted, alongside progress on green and sustainability initiatives aligned to the wider strategy. A joint social value plan with DHC is in development and will be presented to

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committee members in July 2026. The work undertaken and progress made was universally congratulated by committee members.

Our Dorset Provider Collaborative Report including update on VistaHealth Workstreams

An overview and progress of the seven programmes of work overseen by the Our Dorset Provider Collaborative report was provided for assurance. The Committee was advised that the programme is transitioning to a revised structure, with four priority workstreams: proactive and preventative care, urgent care coordination, planned care (including single point of access), and women, children's and specialist service and all future reporting will align to these workstreams. Agreement amongst committee members that a visual representation of the workstreams and the interdependencies would be helpful at a future meeting, and acknowledgement of greater involvement is planned from non-executive directors.

Dorset Innovation Hub, Wessex Health Innovation Network & Wessex Health Partners – Bi-annual Update

A Federation Innovation Plan for 2026/27 was presented to the committee for assurance and received endorsement, noting the intention to strengthen and align innovation activity across both organisations, building on existing good practice and addressing variation in capability. stakeholder engagement and benchmarking have been undertaken with peer organisations and system partners to inform the proposed approach which centres around five core elements. Assurance was provided that the framework will support a more consistent, coordinated and strategically aligned approach to innovation across the Federation.

GP Alliance Memorandum of Understanding (MOU)

A proposed MOU was presented to the committee for approval, setting out a strengthened partnership approach with the Dorset GP Alliance. The MOU formalises the ambition to work more collaboratively with primary care, supporting greater integration at neighbourhood level and reducing fragmentation of care. It was highlighted that this supports delivery of strategic priorities, including shifting care closer to home and improving population health outcomes. The proposal includes reciprocal governance arrangements and establishment of a joint strategic oversight group to align priorities, delivery and performance. The MOU was commended and supported by committee members.

Joint Infrastructure Strategy

A summary of the strategy was received by the committee for approval noting it has been developed through extensive engagement with stakeholders and system partners, supported by asset data, population needs analysis and alignment with national and ICB priorities. Key priorities include rationalisation of the estate, investment in new capacity,

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	and development of integrated neighbourhood facilities in areas of highest need. The Committee welcomed the strategy, noting the importance of staff engagement and clear communication to support shared ownership and delivery. It was also recognised that further development of quantified plans will be required as the strategy matures. **Senior Information Risk Owner Annual Report (DCH & DHC)** The reports for DHC and DCH were received by the committee for assurance noting one reportable incident during the year at DHC relating to unauthorised data gathering, which had been referred to the ICO and remains under investigation. Assurance was provided that appropriate processes have been followed, with further actions to be taken pending the outcome. Data Security and Protection Toolkit submissions for both organisations are in progress, with internal audit review underway ahead of the deadline. Mandatory Information Governance and cybersecurity training compliance within DHC is slightly below target. Further work is underway to improve compliance. **NHP Realisation Update** A brief positive verbal update on new builds was received for assurance. **The following escalation reports from subgroups were received for assurance by the committee members:** Joint • Joint Transformation and Improvement Board Meeting Assurance Report • DHC & DCH New Hospitals Programme Board Assurance Report • DHC & DCH Information Governance Group Meeting Assurance reports
Decisions made at the meeting	Approvals by DCH and DHC committees: • Endorsed the proposal to merge strategic risks 7 and 8 ('Collaboration' and "Transformation and Improvement). • 2026/27 joint Improving Together Plan • GP Alliance Memo of Understanding • Joint Infrastructure Strategy
Issues / actions referred to other committees / groups	• None

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Quoracy and Attendance						
	28/05/2026					
Quorate?	**Y**					
David Clayton-Smith	N					
Eiri Jones	Y					
Dave Underwood	Y					
Andreas HAIMBOCK-TICHY	Y					
Claire Lehman	Y					
Chris Hearn	Y					
Dawn Dawson	Y					
Nicola Plumb	N					

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Report to	Board in Common – DCH and DHC	
Date of Meeting	17 June 2026	
Report Title	Strategy Delivery Review, Forward View and Dashboard	
Prepared By	Nicola Plumb, Joint Chief People Officer, Paul Lewis, Joint Director of Strategy	
Approved by Accountable Executive	Nicola Plumb, Joint Chief People Officer	
Previously Considered By	Joint Transformation & Improvement Board & Strategy, Transformation & Partnerships Committee in Common May 2026	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR7 Collaboration. SR8 Transformation & Improvement	
Financial	No implications arising from review	
Statutory & Regulatory	No implications arising from review	
Equality, Diversity & Inclusion	No implications arising from review	
Co-production & Partnership	No implications arising from review	

Executive Summary

Purpose

This paper provides an 18-month reflection on delivery of the Joint Strategy approved by both Trust Boards in 2024. It reviews how effectively the Strategy has guided decision-making and organisational development during a period of significant national and local change, assesses progress against the strategic objectives, and sets out priorities for the next phase of implementation.

Strategic Context

The external NHS environment has changed considerably since approval of the Joint Strategy. National policy direction, financial expectations, NHS organisational arrangements and system operating models have all evolved at pace.

Despite this, the Federation's strategic direction remains strongly aligned to the emerging NHS model, particularly the three shifts described within the NHS 10-Year Health Plan:

- From hospital to community
- From analogue to digital
- From sickness to prevention

The Federation has been well positioned to respond to these shifts through its focus on neighbourhood health, partnership working, population health, prevention, digital transformation and integrated delivery.

Strategic Review

The Strategy has continued to provide a clear and coherent framework for decision-making across both organisations. The Federation has matured significantly as a delivery system. Collaboration is increasingly the default way of working across organisational boundaries with greater strategic coherence, shared governance and federated delivery capability. Key developments include:

Ellis Fisher Trust 2026-27 1.6.1 v0.3

- Creation of joint Board Committees in common
- Increased integration of corporate leadership arrangements and expansion of joint executive and non-executive roles
- Development of aligned enabling plans across core functions
- Delivery of major transformation programmes through the One Transformation Approach
- Establishment of a shared improvement methodology and infrastructure through Improving Together

Strategic Impact
There is evidence of meaningful progress across all four strategic objectives despite continued operational and financial pressure.

Care
- Performance against the 62-day cancer standard has improved
- Patient experience measures remain strong across acute, community and mental health services
- Restrictive practice in mental health settings has reduced
- Emergency and flow pressures remain significant, particularly around urgent and emergency care performance and discharge pathways

Communities
- Significant growth in Access Wellbeing activity and community engagement
- Increased numbers of people accessing community mental health services
- Strong progress in neighbourhood and prevention approaches
- Ongoing challenges in diagnostic waiting times and health inequalities reporting

Colleagues
- Continued delivery of the Joint People Plan
- Progress in wellbeing, inclusion, leadership development and workforce modernisation
- Stronger alignment and integration of people services across the Federation
- Continued focus required on workforce pressures and organisational capacity

Sustainability
- Medium-term financial planning and digital strategy approved
- Significant delivery of cost improvement programmes despite operational pressure
- Progress in digital integration and shared infrastructure
- Mixed progress in recurrent efficiency delivery and environmental metrics

Key Risks
The principal risks remain:
- Short-term operational and financial pressures diverting focus from long-term strategic priorities
- Maintaining organisational capacity to deliver large-scale transformation alongside operational delivery
- Ensuring the Strategy is meaningful and visible to colleagues across the Federation
- Continued financial pressure and increasing demand impacting pace of transformation

Priorities for 2026/27
The next phase of implementation will focus on:
- Continued alignment of strategy, delivery plans and organisational priorities
- Further development of neighbourhood health and prevention approaches
- Strengthening strategic delivery oversight
- Development of longer-term strategic metrics beyond the initial breakthrough measures
- Embedding the Federation's shared improvement methodology and capability
- Using the NHS 10-Year Plan shifts as a framework for prioritisation and transformation

Ellis Kerley
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Recommendation
Board are requested to receive the report for assurance

Joint Strategy Implementation Update

1. Introduction and Strategic Context

1.1 Background

The Joint Strategy was approved by both Trust Boards during 2024 and established a shared strategic framework for Dorset County Hospital and Dorset HealthCare. The Strategy was intentionally designed to provide a long-term framework for collaboration, transformation and organisational alignment across the Federation.

Alongside a shared Vision and Mission, it established four strategic objectives:

- Care
- Communities
- Colleagues
- Sustainability

Delivery has been supported through:

- Enabling plans
- The One Transformation Approach (OTA)
- Improving Together
- Joint governance and leadership arrangements
- Partnership working across Dorset and beyond

This report provides an 18-month reflection and impact assessment of progress and implementation.

1.2 A Changing NHS Environment

The period since approval of the Strategy has been characterised by significant change across the NHS nationally, regionally and locally.

This has included:

- Increased operational and financial pressure across the NHS
- Greater national focus on productivity and financial sustainability
- Reconfiguration of NHS England and Integrated Care Board arrangements
- Development of neighbourhood health models
- Increased emphasis on prevention and population health
- Acceleration of digital transformation expectations

The publication of the NHS 10-Year Health Plan reinforced many of the areas already prioritised within the Federation's Strategy, particularly around:

- Community-based care
- Prevention
- Integration
- Digital transformation
- Partnership working

The Federation has therefore remained strongly aligned to national direction while continuing to focus on Dorset's local needs and priorities.

Ellis Kaye
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2. Has the Strategy Remained Fit for Purpose?

The Strategy has remained both relevant and effective during a period of substantial external change. Rather than requiring significant redesign, the Strategy has provided a stable framework that has enabled the Federation to respond coherently to emerging national expectations and local operational pressures.

The Vision continues to reflect both the needs of Dorset's population and the wider direction of the NHS: *Healthier lives, empowered citizens, thriving communities*. Similarly, the Mission continues to guide organisational decision-making: *To work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best.*

Importantly, the Strategy has also supported organisational maturity across the Federation. During the last 18 months there has been clear progress from strategic intent to a reality of increasingly integrated delivery. This has included:

- Greater alignment between the two organisations
- More mature shared governance arrangements
- Increased collaboration across corporate and clinical services
- Shared transformation infrastructure
- More consistent approaches to improvement and programme delivery

The Federation is now operating with materially greater strategic coherence and delivery capability than existed at the outset of the Strategy.

3. Maturing Strategic Delivery Across the Federation

3.1 Governance and Organisational Integration

Over the past 18 months, governance and leadership arrangements have continued to mature across the Federation. Key developments include:

- Establishment of joint Board Committees in common across People, Strategy and Quality, Finance and Performance and Mental Health Legislation
- Meeting of Board of Directors in Common
- Increased alignment of executive leadership arrangements
- Appointment of joint non-executive roles as vacancies arise
- Greater integration of corporate services and leadership teams

Joint leadership arrangements are now in place across several corporate functions including:

- Strategy and Improvement
- People
- Estates
- Communications
- Nursing and Quality
- Corporate Affairs

Ellis Kara
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This has strengthened organisational alignment, improved strategic coherence and supported more consistent delivery across both Trusts.

3.2 Enabling Plans

The Federation's enabling plans have provided the operational bridge between strategic ambition and delivery. The plans now cover:

- Clinical and Quality
- Digital
- Finance
- People
- Infrastructure and Estates

Collectively, they provide a coordinated framework for delivery and ensure alignment between strategic priorities and operational planning. The approval of the Digital Strategy and Medium-Term Financial Plan during 2025/26 represented important milestones in completing the Federation's enabling architecture. The enabling plans are overseen through relevant governance structures, with strategic oversight maintained through the Joint Transformation and Improvement Board.

3.3 One Transformation Approach

The One Transformation Approach (OTA) continues to provide the Federation's overarching framework for prioritising and delivering large-scale transformation. The OTA has enabled programmes to be developed and delivered across organisational and professional boundaries, recognising that many of the Federation's most significant challenges require integrated solutions. Major programmes include:

- Neighbourhood Health
- Mental Health Flow
- Inpatient Flow
- Improving Together
- Digital transformation and Electronic Health Record development
- New Hospital Programme schemes

The Neighbourhood Health programme particularly demonstrates the Federation's increasing role in shaping system transformation across Dorset. The programme aligns closely with the NHS 10-Year Plan and brings together primary care, community services, mental health, acute care, local authorities and the voluntary sector around a shared delivery model.

3.4 Improving Together

Improving Together has continued to mature as the Federation's shared approach to improvement. During the past year, work has focused on:

- Establishing a shared improvement methodology
- Assessing organisational maturity against NHS IMPACT
- Building improvement capability across the workforce
- Strengthening governance and delivery arrangements
- Developing a shared improvement culture across the Federation

Ellis Kara
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The programme is now moving into its delivery phase, with increasing emphasis on embedding improvement into day-to-day operational practice.

4. Strategic Impact and Progress

4.1 Care

Despite continued operational pressure across urgent and emergency care pathways, there is evidence of meaningful progress in patient experience, elective recovery and mental health practice.

Key areas of progress include:

- Improvement in performance against the 62-day cancer standard
- Strong inpatient experience scores across acute, community and mental health settings
- Reduction in restrictive practice within mental health services
- Increased access to children and young people's mental health services
- Improved overall experience within community mental health services

The Federation has also continued to strengthen integrated approaches to flow and discharge through programmes focused on inpatient flow, mental health flow and neighbourhood health.

However, significant operational challenges remain. Demand across urgent and emergency care pathways continues to increase and performance against key emergency care standards remains under pressure. Delayed discharge and criteria-to-reside challenges also continue to impact flow and bed capacity across the system.

Overall, the position demonstrates both the scale of operational pressure facing the NHS and the importance of continued transformation and community-based models of care.

Selected Indicators:

Indicator	Position
62-day cancer standard	Improved to 75.4%
Inpatient experience (inpatient DCH & DHC MH)	Strong across all identified services
Reducing restrictive practice	Improved position
CYP access to mental health	Increased engagement and access
ED performance	Remains challenged in rising demand
Criteria to reside	Challenged in acute and community

4.2 Communities

The Communities objective has seen strong progress in prevention, engagement and community-based support.

Access Wellbeing has expanded significantly and demonstrates the potential impact of partnership-based approaches involving the voluntary and community sector. Engagement across hubs, digital platforms and community-based services has increased substantially. There has also been significant growth in the number of people accessing community mental health services, alongside continued development of neighbourhood health approaches across Dorset.

Ellis, Fiona
10/06/2026 16:20:45

The Federation's strategic direction remains strongly aligned to prevention, early intervention and population health improvement.

Areas requiring further development include:

- More mature system-wide health inequalities reporting
- Improved diagnostic waiting times
- Stronger integration of population health intelligence and measurement

The next phase of implementation will place greater emphasis on prevention and the NHS 10-Year Plan shift from sickness to prevention.

Selected indicators:

Indicator	Position
Access wellbeing engagement	Significant increase
Community mental health access	Increased
Embedding prevention	Expanded
Neighbourhood working	Significantly strengthened
Diagnostic waiting times	Increased
Health inequalities reporting	Developing

4.3 Colleagues

The Joint People Plan has continued to provide the delivery framework for the Federation's colleagues objective. Over the last 18 months, work has focused on:

- Leadership and management development
- Workforce modernisation
- Wellbeing and inclusion
- Workforce planning
- Digital enablement and automation
- Shared people services

Progress has been made in strengthening collaboration across people services and in developing more aligned workforce approaches across both organisations. The Federation has also continued to invest in inclusion, wellbeing and organisational culture, including:

- Joint wellbeing initiatives
- Inclusive recruitment approaches
- Sexual safety work
- Violence and aggression reduction programmes
- Increasing numbers of Health and wellbeing champions
- A newly launched staff recognition scheme

At the same time, workforce pressures across the NHS remain significant and continue to impact organisational capacity and pace of delivery. The next phase of work will increasingly focus on workforce sustainability, leadership capability and supporting large-scale service transformation. This will be underpinned by delivering continued improvements in sickness absence and workforce availability, as detailed in the approved Medium Term plan.

Ellis, Kara
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Selected indicators:

Indicator	Position
Shared People Services	Phases 1 and 2 of integration completed
Leadership development	Ongoing expansion in both Trusts
Wellbeing initiatives	Expanded
Inclusion activities	Significantly strengthened
Organisational capacity pressures	Ongoing challenge

4.4 Sustainability

The Sustainability objective has continued to focus on financial sustainability, digital transformation, productivity and social value. Key achievements during the period include:

- Approval of the Medium-Term Financial Plan
- Approval of the Digital Strategy, shared across all Dorset organisations for the first time
- Significant progress toward a shared Electronic Health Record for Dorset and Somerset
- Delivery of significant cost improvement programmes
- Development of the Joint Social Value and Green Plan

The Federation has continued to strengthen digital infrastructure and shared approaches to technology and transformation.

At the same time, financial pressures remain substantial across the NHS. Although significant efficiencies have been delivered, a higher proportion than planned has been non-recurrent, increasing future financial challenge and delivery requirements. Environmental performance has also been mixed, with reductions in electricity usage but increased gas consumption.

Selected indicators:

Indicator	Position
Medium-term financial plan	Approved
Digital strategy	Approved
Electronic Health Record programme	Significant progress moving to deployment
Cost Improvement Delivery	Significant progress year on year
Recurrent efficiency delivery	Remains challenging
Environmental metrics	Mixed progress

5. Risks and Strategic Tensions

The Federation continues to operate within a highly pressured environment. The principal strategic risks are below.

- Balancing Short-Term Pressure with Long-Term Transformation:

Operational and financial pressures create a risk that immediate priorities displace longer-term transformation activity. Maintaining strategic discipline and continued focus on long-term objectives will remain critical, particularly given the scale of transformation ambition.

Ellis,Kara
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Ensuring sufficient leadership, programme and operational capacity to sustain delivery alongside day-to-day operational pressures remains a key challenge.

- Financial Sustainability:

The financial environment across the NHS continues to tighten. While progress has been made in delivering efficiencies, continued focus will be required on recurrent delivery, productivity and transformation with increasing national scrutiny.

- Embedding the Strategy Across the Workforce:

Although strategic alignment at leadership level has strengthened significantly, continued work is required to ensure the Strategy is visible, meaningful and connected to the experience of colleagues across the Federation.

6. Priorities for 2026/27

We are firmly into strategy delivery having put into place the foundation blocks and initiated implementation across operational and corporate activities. The next phase of implementation will focus on consolidating progress while strengthening delivery capability across the Federation. Priority areas include:

- Continued Strategic Alignment: maintaining alignment between strategy, operational planning, enabling plans and transformation programmes as we ensure we delivery our Medium Term Financial and Operational Plan
- Neighbourhood Health and Prevention: continuing to develop neighbourhood health approaches and strengthening prevention activity aligned to the NHS 10-Year Plan
- Strategic Metrics and Impact Measurement: ensuring we have the arrangements in place to provide the clearest assessment of strategic impact
- Sharpening focused delivery oversight: further maturing governance, accountability and programme oversight arrangements across the Federation and in the wider health and care system, particularly reflecting on requirements if Dorset HealthCare is successful in its application to become an Advanced Foundation Trust
- Embedding improvement capability: continuing to build a sustainable improvement culture through Improving Together and the shared improvement methodology
- Digital Transformation: progressing delivery of shared digital infrastructure and the Electronic Health Record programme.
- Strengthening the Federation.

7. Conclusion

The Federation has made substantial progress during the first 18 months of the Joint Strategy. Despite operating within a highly challenging NHS environment, the strategy has remained relevant, coherent and aligned to national direction, which has itself evolved during the first 18 months of our Federated strategy.

Importantly, the Federation has matured significantly as a delivery system. Collaboration is increasingly embedded as the normal way of working, and there is greater organisational alignment, shared leadership and transformation capability across both Trusts.

Ellis, Kelly
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While significant operational, workforce and financial challenges remain, these are well known and mitigated through the appropriate arrangements. The Federation is now better positioned to deliver

large-scale transformation and to respond to the changing needs of the population it serves

The next phase of implementation will focus on consolidating this progress, strengthening delivery capability further and continuing to deliver healthier lives, empowered citizens and thriving communities.

Appendices
Appendix 1 – Strategy on a page
Appendix 2 - Strategy metric dashboard

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Appendix 1: Strategy on a page



Our vision – what we want to see if we are successful in delivering our strategy

Our vision is for healthier lives, empowered citizens, thriving communities

Our mission – what we are here to do, our unique contribution to achieving our vision and that of our health and care system

Our mission is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best

Our values – the things we believe are important and guide us in the way we work

Dorset County Hospital
- Respect
- Teamwork
- Integrity
- Excellence

Dorset HealthCare
- Working together for patients
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts
- Commitment to learning

Our strategic objectives – where we will focus our efforts to translate our vision into a practical roadmap for success

Care: we provide safe, compassionate care	Communities: we help build strong communities where people live well and are healthier	Sustainability: our services are sustainable environmentally and financially and we make best use of resources	Colleagues: we are empowered, skilled, caring colleagues who can thrive at work



Our enabling plans – translating our objectives into meaningful action

Clinical and Quality | Digital | People | Finance | Infrastructure

Our mechanisms for change – the approaches and activities that help us reimagine the way we do business

One transformation approach | Improving together | Culture, comms and engagement plan

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Appendix 2: Strategy Metric Dashboard

Introduction
The breakthrough metrics were developed as transitional measures for the first phase of Joint Strategy implementation. The framework includes outcome, transformation and organisational maturity measures to reflect the breadth of delivery required across the Federation. The dashboard below brings together all agreed strategic measures across the four strategic objectives: Care, Communities, Colleagues, Sustainability. The framework intentionally includes: outcome indicators, transformation delivery indicators and organisational maturity indicators.

STRATEGIC OBJECTIVE: CARE

Strategic assessment: Despite sustained operational pressure across urgent and emergency care pathways, there is evidence of progress in patient experience, elective recovery and mental health practice. Demand, discharge and flow pressures remain significant constraints across the system.

OUTCOME metrics

Indicator	Baseline (year)	Current Position (Year)	Movement	DHC/DCH/ System	Comments
18-week treatment standard	60.2% (Feb 25)	61% (Feb 26)	0.80%	DCH	Improvement achieved but below planned trajectory of 5% improvement
62-day cancer standard	72.5% (Feb 25)	75.4% (Feb 26)	2.90%	DCH	Performance now above national expectation of 75%
ED 4-hour performance	78.1% (Feb 25)	57.2% (Feb 26)	21.10%	DCH	Continued operational pressure across urgent care pathways.
ED 12-hour performance	12.4%% (Feb 25)	18.0% (Feb 26)	6.40%	DCH	The position reflects increasing demand and flow pressures
Criteria to reside in community hospitals	24.3% (Feb 25)	32.5% (Feb 26)	5% off target	System	Ops plan target is 27.5%. Delays in discharges remain challenging despite significant improvement work
Inpatient survey satisfaction rate - recommendation rate – DCH	DCH: 97.5% (Mar 25)	DCH: 99.0% (Mar 26)	DCH: 1.5%	DCH	Improved inpatient experience whilst under sustained demand pressures
Inpatient experience – DHC MH Inpatient	DHC (MH): 87%	DHC (MH): 89%	DHC (MH): 2%	DHC	Improved mental health inpatient experience whilst increased demand
Patient experience – DHC Community	DHC: 91% (Jan 25)	DHC: 91% (Jan 26)	DHC (Community): 0%	DHC	Sustained positive experience
Community Mental Health survey. Overall Experience Mean Score	6.8 (2023 - 24)	7.1 (2024 - 25)	0.3	DHC	Overall experience of services is improved

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Maternity survey performance in the 'looking after you' sub score		Care while pregnant: 8.75 vs 8.18 national score Care after birth: 8.15 vs 7.73 national score	Care while pregnant: 0.57 Care after birth: 0.42	DCH	Sustained strong performance nationally, achieving the highest scores for care during pregnancy, labour and birth, and placing in the top three providers for 'care with feeding your baby'.
Safe and healthy staff survey score	6.55	6.49	-0.06	DHC	Slight movement, not significant
Safe and healthy staff survey score	6.08	6.09	0.01	DCH	Slight movement, not significant
Inpatient falls	6.1	6.0	0.01	System	Small reduction
Reducing restrictive practice (inpatient)	320	230	-40 (April Jan 24/25 vs April Jan 26/26)	DHC	Significant reduction in restrictive interventions: 40 fewer interventions carried out in the same period year on year.

TRANSFORMATION assessment			
Indicator	**Position**	**Direction**	**Comments**
Mental health flow programme	Well into delivery		Programme now progressing through delivery phase with a substantial reduction in out of area placements
Inpatient flow programme (DCH)	Established		Focused improvement work underway across acute pathways
Neighbourhood Health programme	Established and expanding		Supporting integrated community-based approaches through stronger working with primary care and VSCE partners
Improving Together programme	Developing and expanding		Shared improvement methodology and capability progressing
Therapeutic inpatient redesign	Progressing		Increased focus on flow, outcomes and local provision whilst demand continues to grow

MATURITY assessment			
Indicator	**Position**	**Direction**	**Comments**

Ellis Kelly
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Integrated flow approach across the system	Significantly strengthened		Greater collaboration across the three providers; agreed approach through ODPC to programme structure and delivery
Shared Improvement methodology	Established		Federation-wide approach being implemented
Cross-organisational delivery	Increased		Major clinical and corporate programmes increasingly delivered jointly
Strategic operational integration	Strengthening		Greater alignment across delivery and transformation functions through the single Transformation team and executive Joint Transformation and Improvement Board

STRATEGIC OBJECTIVE: COMMUNITIES

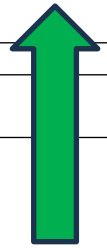
Strategic assessment: There is clear evidence of growth in community-based support, prevention activity and partnership working across Dorset. The Federation is increasingly shifting towards neighbourhood-based and preventative models of care, although diagnostic access and health inequalities measurement remain areas for further development.

OUTCOME metrics

Indicator	Baseline (year)	Current Position (Year)	Movement	DHC/DCH/ System	Comments
Access Wellbeing: Hub visits Groups in hubs Facebook reach Website visits	 6633 2200 attendances 36,100 9500	 16,743 50,000+ FB reach 12,270	 10,110 visits to hubs/drop-ins 13,900 + FB reach 2770 + website visits	DHC	Significant increase in community engagement and access to services, support and advice
Diagnostic waits DCH	68.5%	76.6%	8.1%	DCH	Performance improved by 8.1%. A reduction of 1,153 patients since December 2025. The total waiting list has reduced by 509 patients since December.
Percentage of patient-facing staff to receive a flu vaccination DCH	1814 (2024)	2383 (2025)	569	DCH	A 31% increase in uptake
Percentage of patient-facing staff to receive a flu vaccination DHC	2387 (2024)	2256 (2025)	131	DHC	A decline in activity

Ellis Kara 16/06/2026 14:10:45

Community Mental Health access (SMI)	7868 (Apr 23-Mar 24)	9456 (Apr 24-Mar 25)	1588	DHC	20% growth in service access
Smoking cessation advice provision				DHC / System	Data collection under development on access to inpatient smoking cessation offers in MH services
Annual growth in Children and Young People Mental Health access	7183 (24/25)	7211 (25/26)	28	DHC	Delivered 7211 against a target of 6835, an increase of 376 above target

TRANSFORMATION assessment			
Indicator	**Position**	**Direction**	**Comments**
Neighbourhood Health programme	Established and expanding		Significant Dorset-wide transformation programme underway
Prevention focus	Strengthening		Increasing alignment to NHS 10-Year Plan shifts
VCSE partnership model	Embedded		Strong partnership delivery through Access Wellbeing and significant progress being made in Neighbourhoods
Co-design approaches embedded into strategic programmes	Increasingly embedded		Greater involvement of patients and communities evidenced in co-production approaches explicitly adopted in major transformation schemes, particularly Neighbourhoods and Mental Health services' transformation. Joint Participation oversight group established to embed approaches in both Trusts.
Core20Plus5 implementation	Developing		System-wide approach and Trust reporting arrangements developing; a mapping exercise is underway of current reporting and activities
Population health approach	Expanding		Greater strategic focus on prevention and inequalities evidenced in Medium-Term Plan

MATURITY assessment			
Indicator	**Position**	**Direction**	**Comments**
Cross-system collaboration	Significantly strengthened		Greater integration across health, care and VCSE sectors
Shared prevention strategy	Developing		Prevention increasingly embedded across all major transformation programmes and in ODPC
Health inequalities governance	Developing		Reporting and oversight arrangements continuing to evolve

Ellie Clara
13/06/2025 16:14:45

Population health intelligence capability	Developing		Data and reporting infrastructure still maturing
System leadership role	Increasing		Federation increasingly shaping Dorset-wide transformation; DHC invitation to apply for AFT status

STRATEGIC OBJECTIVE: COLLEAGUES

Strategic assessment: The Federation has continued to strengthen workforce collaboration, leadership development and inclusion activity across both organisations. Shared people services and workforce approaches continue to mature, although workforce pressure and organisational capacity remain significant challenges.

OUTCOME metrics

Indicator	Baseline (year)	Current Position (Year)	Movement	DHC/DCH/ System	Comments
Recommend as a place to work DHC	70.29% (2024)	68.88% (2025)	1.41%	DHC	The best, average and worst benchmarked scores have all similarly reduced and DHC is ahead of the average score by 4.8%
Recommend as a place to work DCH	67.58% (2024)	62.84% (2025)	4.74%	DCH	The national trend has seen the average score drop 3.12% points to 57.77% with DCH 5% above average

TRANSFORMATION assessment

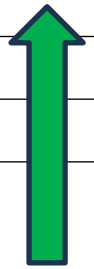
Indicator	Position	Direction	Comments
Deliver the new appraisal system DHC*	Completed		Launched in September 2025. An expected decline in completion rates was experienced and the recovery rate slower than a Recovery Plan has been developed and internal audit completed. April 2026 compliance is at 69.12% and the recovery plan will see us reach target of >85% by end of June 2026.
Deliver targeted people & management skills / leadership development	Strengthened		Both Trusts have seen their management and leadership programmes expanded, with opportunities made available across the Federation in some instances.
Drive automation of transactions & processes	Underway or complete		DCH: Manager and employee self-service already implemented, alongside TRAC onboarding and Health Rota implementation. DHC: Manager self-service implementation underway; work underway for ESR optimisation. Trac optimisation programme underway. Substantial systems transformation paused in anticipation of national Target Operating Model

Julia Clara
16/06/2026 16:10:45

Deliver in full the Joint Wellbeing strategy	Close to completion - Improved		Both Trusts have seen an increase in numbers of health and wellbeing champions and the ongoing availability of wellbeing-related training and interventions. A business case for improved psychological support to colleagues is in draft and remains the only outstanding item.
Deliver in full the actions from the Sexual Safety Charter	Close to completion – Improved awareness		DCH: All actions are in to delivery. 80% colleagues have completed mandatory training (Dec 2025) DHC: 42/27 actions completed, 5 in progress. 82% substantive staff have completed mandatory sexual safety training (Jan 2026)
Develop and deliver the Reducing Violence, Aggression and Discrimination Plan	Underway		Both Trusts signed up to anti-racist charter (Jan 2026). Managers guidance launched in DHC active bystander training due to be implemented for both Trusts.
Implement revised staff recognition scheme	Completed - improved		Scheme launched in Q3 2025/26 and a review completed to streamline the administrative processes
Deliver in full actions from the joint Inclusion and Belonging Strategy	Underway and near to completion - strengthened		DCH: 8/10 actions completed, including ethnicity and disability pay gap reports published for the first time, launch of the culture and inclusion group, roll out of sexual safety training and bias and interview training launched. DHC: 7/9 actions completed, including ethnicity and disability pay gap reports, a refreshed day 1 orientation and induction, joint culture and inclusion group launch and launch of inclusive recruitment and selection training. Both Trusts have adopted the Unison anti-racism charter and the associated work programme is in to delivery. Review of mandatory EDI training and launch of active bystander training are outstanding in both Trusts but already in draft or underway.
Deliver tailored people services & support to major transformation programmes	Strengthening		Placement capacity increased in both Trusts & annual Education reviews very positive with NHS England. Joint Organisational Change policy in place & progress on a joint Staff Partnership Forum. Major transformation programmes have dedicated WF input with skills-mix toolkits and resources increasingly available. Workforce planning aligned to major transformation schemes.

MATURITY assessment			
Indicator	**Position**	**Direction**	**Comments**
Joint workforce governance	Matured		Increased alignment across workforce oversight through the FRB, People Services integration and the Joint People Committee in Common

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Shared organisational culture	Strengthening		Greater consistency across both organisations
Federation-wide leadership alignment	Increased		Integrated leadership arrangements in place for People Services
Strategic workforce capability, planning and controls	Improving		Workforce planning increasingly aligned to transformation priorities, evidenced in the Medium Term Plan; controls strengthened
Strengthen collaborative working across people services	Developing – a shared People Operating has been designed is in to implementation		Tier 1 and Tier 2 consultation phases completed A customer satisfaction survey will be introduced.

STRATEGIC OBJECTIVE: SUSTAINABILITY

Strategic assessment: The Federation has continued to strengthen its strategic infrastructure through digital transformation, financial planning and collaborative delivery models. Significant progress has been made in digital and organisational integration, although recurrent efficiency delivery and long-term financial sustainability remain challenging.

OUTCOME metrics

Indicator	Baseline (year)	Current Position (Year)	Movement	DHC/DCH/ System	Comments
DCH recurrent efficiencies increased	£3.66m	£4.93m	Improved position	DCH	Continued efficiency delivery achieved
DHC recurrent efficiencies increased	£6.79m	£6.98m	Improved position	DHC	
Medium-Term Operational, Financial and Workforce Plan approved		Approved		DCH / DHC	Federation financial planning framework mobilised and plans signed off
Reduced Electricity usage DCH	2,526,962 (24/25)	2,267,333 (25/26)	Gas usage broadly similar	DCH	Gas consumption increased year on year, costs reduced due to price decreases per unit
Reduced Gas usage DCH	22.3 (24/25)	24.6m (25/26)	An increase in use	DCH	Reduction in electricity consumption achieved

TRANSFORMATION metrics

Indicator	Position	Direction	Comments

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Approved Digital strategy	Approved		The first pan-Dorset Digital Strategy has been approved
Electronic Health Record	Progressing		EPIC selected and into development phase
Joint Social Value and Green Plan in place	Established		Shared sustainability framework in place
Shared digital infrastructure	Strengthening		Evidence of increased collaboration across providers
Technology-enabled care	Developing		
New Hospital Programme	Progressing		Major schemes progressing according to plans
MATURITY metrics			
Indicator	**Position**	**Direction**	**Comments**
Shared strategic infrastructure	Significantly strengthened		Greater alignment across enabling plans and delivery
Federation delivery capacity	Matured		More coherent programme and governance arrangements
Long-term transformation readiness	Improved		Federation better positioned for future NHS reform and to support partners' future transformation schemes
Integrated enabling plans oversight	Strengthened		Governance and assurance arrangements continuing to mature

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Dorset County Hospital
Dorset HealthCare

Report to	Board in Common (DCH & DHC)	
Date of Meeting	17 June 2026	
Report Title	Joint Green Plan 2026-2029	
Prepared By	Bev Lagden, Patrick McDermott	
Approved by Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	Finance and Performance Committee in Common 27th May 2026	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care		No
Colleagues		No
Communities		No
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR5 Estates, SR7 Collaboration & SR8 Transformation and Improvment	
Financial	Climate change impact on operations	
Statutory & Regulatory	Climate Change Act 2008/Health & Care Act 2022/Environment Act 2021.	
Equality, Diversity & Inclusion	EIA completed	
Co-production & Partnership	DCH and DHC and external delivery partners e.g. Dorset Council, Centre for Sustainable HealthCare, working with UHD	

Executive Summary

- The paper presents the Joint Green Plan refresh with SMART actions with action lists appendices previously agreed.
- The Joint Green Plan, across DCH and DHC, sets out governance process, Board oversight and Executive Leadership.
- It embeds sustainability into clinical decision making and procurement.
- The Joint Green Plan develops the staff engagement work already being undertaken.
- It facilitates the development of circular economy opportunities.
- The previous DCH Green Plan achieved 70% of its objectives, with others materalising.
- Future appendices will be a Green Travel Plan and a summary of the Climate Change Adaptation Report.
- The NHS Trusts in Dorset Adaptation Project, funded across the 3 Dorset NHS trusts, with Sustainability West Midlands, has begun with invitations to relevant colleagues sent out, to engage in a workshop and survey, and wider contacts in Dorset Police, Dorset & Wiltshire Fire and Rescue and Dorset Council, Bournemouth, Poole and Christchurch Council, Sustainability, Climate adaptation, flood risk and Geographic Information Systems, the study is due to complete November 2026 and as a first step will identify high level findings, areas to investigate, with recommendations.
- A task and finish group is underway for a Green Travel Plan due to complete December 2026.
- The Joint Green Plan meets the requirements of the guidance issued by NHSE in February 2025

Recommendation

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

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Joint Green Plan 2026-2029

1. Executive Summary

1.1 The trusts have committed to meet their duties regarding Net Zero Carbon. This is restated in 'Working together, improving lives' where the trusts commit to minimising their negative impact on public health and the environment while maximising positive social value for local communities. In line with national ambition, the NHS became the world's first health system to commit to reaching net zero in 2020.

1.2 The Trust's first Joint Green Plan sets out actions over a three-year period and is now refreshed through the first joint Green Plan of Dorset HealthCare and Dorset County Hospital. This refresh establishes a clear trajectory towards an 80% reduction in directly controlled emissions by 2030 and indirect emissions by 2036.

1.3 The Joint Green Plan refresh presented meets the requirements in the guidance.

1.4 The Joint Green plan will this year have appendices of

1.4.1 NHS Trusts in Dorset Adaptation Project, funded across the 3 Dorset NHS Healthcare trusts, with Sustainability West Midlands

1.4.2 Green Travel Plan will be appended to the Green Plan by December 2026 with an initial task and finish group meeting and meeting with Dorset Council travel team taken place and this is a requirement for trusts to append travel plans

2. Introduction

2.1 In 2021, NHS England guidance on how to produce a green plan asked systems and trusts to develop green plans spanning 3 years (2022/23 to 2024/25). Significant progress towards achieving net zero was achieved and Dorset County Hospital has achieved around 70% of its actions, with some organically arising further initiatives, such as a woodcast trial in hand therapy. The updated guidance in May 2025 gave guidance to trusts and systems to refresh their green plans for the next 3 year cycle.

2.2 NHS England Guidance came out later than expected, and initially the 3 Dorset trusts began work on a joint green plan, this was postponed. Meanwhile DHC and DCH began work on action lists. The request to support funding a Green Travel Plan, was determined to do within existing resources and Climate Change Risk Assessment (CCRA) and Adaptation Plan was supported across the 3 trusts.

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2.3 The Dorset trusts' requested an extension in the context of significant organisational change and requested to NHS England the option to prepare a joint plan going forward. NHS Dorset report the requirement to refresh the green plans of DCHFT and DHC was extended to October 2025 and both trust's action lists were submitted to NHS Dorset at that time.

2.4 The action lists were derived from the Sustainability Steering Committee, DHC, and DCH Sustainability and Travel Working Group within the focus areas determined by NHSE England 2025 Guidance, reflecting existing and newly formed subgroups, including Greener theatres, and Green Spaces, with a potential Greener Critical Care (CCr) and focus area leads such as Digital transformation, Food & nutrition, Supply chain and procurement.

2.5 leadership in sustainability is a cornerstone of the NHS England Green Plan refresh Guidance and the Annual Reporting Manual 2025/6 Sustainability pages based on Task Force for Climate related Disclosures is likely to feature in the 2025/6 ARM, which also brings in actions to identify and reduce climate impact risks

2.6 Requirements summary of Green Plan refresh

- Board approval
- Publicly accessible on a website
- A focus on SMART actions
- The Focus areas determined by NHS England
- Key Performance Indicators
- Stakeholder engagement
- Alignment with national net zero targets and guidance
- Covers 3-5 years, with annual reviews and governance to measure progress and legal duties such as reducing inequalities

2.7 The Federated trusts and UHD work closely on initiatives such as Dorset NHS Lift share and EcoEarn staff pledge platform and are jointly working on the Climate Change Risk Assessment and Adaption Plan to achieve value for money and non-fiscal benefits of delivering healthcare services in many joint instances and in same or linked environments

3 Main narrative

3.1 The Health and Care Act 2022, passed in July 2022, embedded carbon reduction targets for the NHS into UK law. This legislation requires that NHS Foundation Trusts must have regard to the Environment Act 21 target areas including air quality; water; biodiversity, resource efficiency and waste reduction.

3.2 There remains a considerable challenge of 'Carbon Footprint' Scope 1& 2 emissions, we directly control (diagram 1)

- Fossil fuels
- NHS Facilities
- Anaesthetics
- NHS Fleet and leased vehicles

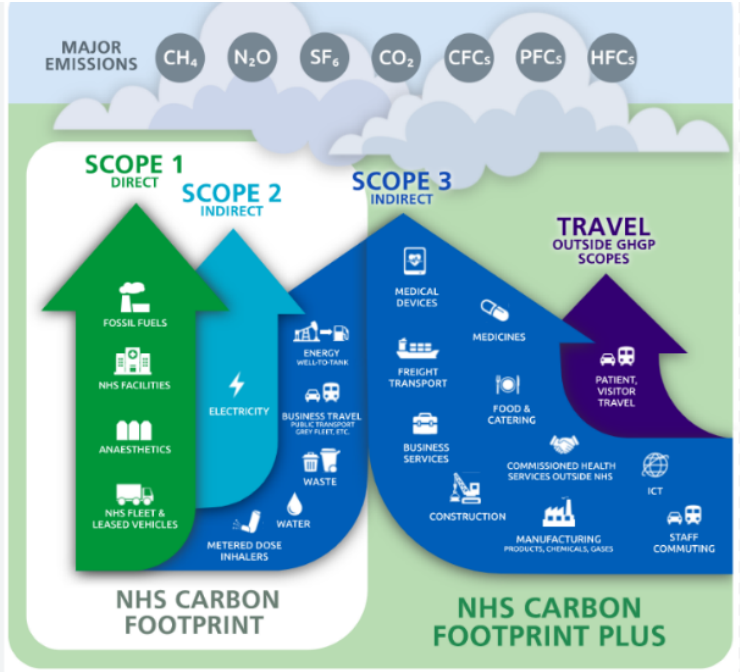
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3.3 The Green Plan refresh focus areas address those we indirectly influence, but are not scope 1 and 2 but material to our operations and ability influence (diagram 1)

- Waste
- Water consumption
- Business travel
- Metered dose inhalers
- Medical devices
- Food and catering
- Staff commute
- Business services
- Construction
- Freight

Patient and visitor travel are outside of scope but can affect clean air and will be considered in the green travel plan.

Diagram 1 NHS Carbon Footprint scope 1 & 2 emissions and Carbon Footprint Plus scope 3 emissions



3.4 The Green Travel Plan Tasks and Finish group will consider scope 3 emissions 'Carbon Footprint Plus' and outside GHGP scopes of patient and visitor travel outside of scope but impact on clean air and site patient and visitor travel and benchmarking survey with other Dorset Public Sector on Clean Air and the Clean Air Framework.

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3.5 The trusts progress to net zero is exemplified under each focus are with SMART actions. These are

- Workforce and system leadership

- Net Zero Clinical transformation
- Digital transformation
- Medicines
- Travel and transport
- Estate and facilities
- Supply Chain and procurement
- Food and nutrition
- Adaptation and resilience
- Greenspaces and biodiversity
- Sustainable buildings

4. Context

4.1 Sustainability is 1 of our 4 key objectives in '*Working together, improving lives'* Joint Strategy, so that - our services are sustainable environmentally and financially and we make best use of resources. Committing to reducing carbon, take opportunities to positively contribute to our local environment, minimise our negative impact on public health and the environment and uphold our social value pledges as we are significant employers, use travel and infrastructure and buying goods and services, so how we carry our functions can contribute to healthier environment, communities and populations we serve as a significant factor in people's health and wellbeing.

4.2 Within sustainability objectives we are working to minimise our negative impact on public health and the environment. We have made progress in measuring our impact on the environment and reducing this with sustainable models of care and digital innovation increasing and sustaining 25% of our outpatient activity delivered virtually and sustainable models of care, including Infection Prevention Control leading on gloves off initiatives and with procurement changing to re-useable tourniquets. Estates & Facilities in both trusts have seen large scale transition to LED lighting; ward staff, housekeeping, waste and portering teams across the hospital are improving segregation of waste to reduce costs and carbon.

4.3 This Joint Green Plan of the 2 trusts focuses on the areas we can make most impact in emissions we directly control, and map a route to net zero, even if all solutions and funding are not always clear ahead. We have many joint actions, while some are trust or site-specific, listed with a general aim in common. These SMART actions set out ways to reduce carbon and our impact on the environment with metrics alongside actions, to play our part alongside all NHS trusts towards net zero target's and reduce the likelihood of the most devastating impact of climate change.

4.4 The decarbonisation of heath and energy, efficiencies in energy consumption, efficiency, through fabric improvements with older buildings and suitable energy generation to achieve net zero emissions within current resources. Some efficiencies from the with maintenance backlog would aid efficiencies. We have decommissioned the nitrous manifold and alternative methods of anaesthesia without desflurane.

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4.5 We can see the impact of extreme weather events taking place and taking steps to mature our adaptation plans working across Dorset with a Climate Change Risk Assessment for health care, as we face increasing climate extremes, concurrent droughts, intense rainfall, storm events, with buildings not adapted to heat extremes, cold and flood events.

4.6 The heat and energy decarbonisation projects in the previous report are in progress, apart from DCH Solar and EVCP that could not be delivered. A new funding opportunity with a short time scale is being explored with a revised EVCP project for DCH but with potential Capital Projects project management support.

4.7 The theme of everyone a Sustainability Champion, including a line around sustainability in job descriptions, the enthusiasm of groups, and individuals and the materialisation of idea, projects across a range of operations, multidisplinary expertise working for sustainability require a team approach and a communications plan is drafted to take this forward

5. Conclusion

a. This is the first joint Green Plan capturing the progress towards net zero emissions and sustainability of both trusts and was a developmental process with stronger focus area engagement and clearer SMART outputs, objectives and working towards outcomes.
b. leadership in sustainability is a cornerstone of the Green Plan delivery, and the Chief Medical Officer and Chief Financial Officer were asked to provide an introduction quote.
c. A communications plan to convey the urgency, and how all can contribute and why it is relevant is attached.

6. Recommendations

a. The Board / Committee is recommended to:
- **i.** Receive the report for **assurance**
- **ii.** Review and **Approve** the Green Plan refresh report

Name and Title of Author:
Bev Lagden, Sustainability Manager, DCH, Patrick McDermott, Head of Sustainability DHC.

Date May 2025

7. Appendices

a. Joint Green Plan 2026-2029

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Dorset County Hospital
Dorset HealthCare

NHS

Joint Green Plan 2026-29

Ellis Kara
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Healthier lives Empowered citizens Thriving communities

Foreword







Lucy Knight,
Chief Medical Officer,
Dorset HealthCare University Foundation Trust

Rachel Wharton,
Chief Medical Officer,
Dorset County Hospital Foundation Trust

Chris Hearn,
Joint Chief Financial Officer
Dorset County Hospital Foundation Trust and Dorset HealthCare University Foundation Trust

As healthcare leaders, we are united in our responsibility to protect and improve the health of our population—today and for generations to come. Climate change, environmental degradation and the unsustainable use of resources are no longer abstract risks; they are already shaping health outcomes, widening health inequalities and placing additional pressure on health and care services. This Joint Green Plan for Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust sets out how we will respond collaboratively and responsibly to this challenge.

Sustainability is inseparable from high-quality healthcare. The conditions in which people live, work and receive care directly influence physical and mental health, recovery and long-term wellbeing. As major employers, care providers and anchor institutions across Dorset, our trusts have a unique opportunity—and responsibility—to work together, across our federation and with partners across the wider Dorset system, to reduce our environmental impact while strengthening financial resilience, social value and patient care. Working at scale enables us to share learning, align priorities and maximise the impact of our collective action.

We are proud of the progress already made. Together, we have:

- reduced emissions through significant investment in energy efficiency, solar power and digital transformation
- supported greener clinical practice, including changes in anaesthesia and waste reduction
- embedded sustainability and social value into procurement decisions
- and empowered colleagues, patients and partners to play their part.

Ellis Kara
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We also recognise that there is much more to do. Reaching net zero, building resilience to climate impacts and embedding sustainability into every aspect of decision-making will require continued collaboration across organisations, professions and care pathways. It will demand innovation,

evidence-based prioritisation and a strong focus on actions that support both environmental sustainability and better clinical outcomes.

Our shared vision is for services that are environmentally responsible, clinically effective, financially sustainable and socially inclusive—supporting healthier people and healthier places across Dorset. This Joint Green Plan provides a framework to support our teams, guide decision-making and measure progress, while remaining flexible enough to evolve as evidence, technology and partnerships develop.

We look forward to continuing this work together with our colleagues, patients, system partners and communities to turn shared ambition into meaningful and lasting change.

Classification: Official

NHS England

Delivering a 'Net Zero' National Health Service





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   - 1.1. Operational context of the trusts
   - 1.2. Working together, improving lives – sustainability pillar
   - 1.3. Our net zero commitment
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4. The focus areas
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   - 4.4. Medicines
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   - 4.6. Estates and facilities
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   - 4.10. Greenspaces and biodiversity
   - 4.11. Sustainable buildings
5. Governance and metrics
6. Communication and engagement
7. Summary areas for action
8. Appendices

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1 Introduction

1.1 Operational context of the trusts

The NHS is one of the largest employers in the country and contributes to almost 5% of UK carbon emissions. The emissions in health operations adversely impacts our environment and has a harmful effect on our health and wellbeing. Gov.uk blogs report that during four periods of heat in 2024, there were 1,311 heat-associated deaths in England. Our Green Plan sets out the actions we are taking to reduce emissions and to work towards a resilient, low carbon and sustainable health system. The BMJ reports that 90% of NHS buildings are vulnerable to overheating and the Dorset NHS trusts are working together to undertake a climate change risk assessment and identify mitigation measures

The Dorset HealthCare University NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust healthcare services span a small acute 350 bed Dorset County Hospital in Dorchester, a South Walks House outpatient facility, Weymouth Hospital in the west of Dorset, inpatient mental health, community hospitals and outreach services over 300 sites as well as working out of village hall, GP surgeries. These serve a large, mostly rural area, and the conurbation of Bournemouth and Poole while the larger Hospitals of Poole, Royal Bournemouth (acute services) and Christchurch form University Hospitals NHS Foundation Trust Dorset who undertake a range of services for the region While UHD are not part of this federation's Green Plan, for more information see UHD Green Plan the Dorset trusts work closely together in ways to support patients, provide cross-Dorset services, and innovate towards clinical excellence and sustainable healthcare.

Dorset County Hospital's 3,500 staff provide high quality acute and specialist services including district general services including urgent and emergency care, planned and specialist care, renal services across Dorset and South Somerset, maternity and paediatric services, care for long-term conditions, frailty and end of life care and links with 5 Community Hospitals.

Dorset Healthcare encompasses around 7,000 staff across a wide range of services and specialisms run Dorset's 12 community hospitals. All host a range of outpatient clinics, some have inpatient beds and a number also have minor injuries units (or, in Weymouth's case, an urgent treatment centre). Responsible of all of Dorset's NHS Mental health services Dorset HealthCare provide adult inpatient mental health services at a number of sites around Dorset. These are for people who are struggling with severe mental health issues. The aim is to provide person-centred care and treatment, focused on recovery, to allow people to return home as quickly as possible. With University Trust status DHC works with Bournemouth University for innovation in care and clinical excellence, and both trust work with the university on training and placements for clinical staff.

We are part of Our Dorset Integrated Care Partnership, with the county's NHS organisations, BCP and Dorset Councils, Police, Fire and partners in the community and voluntary sector. Supporting resident populations of 380,000 people in the Dorset Council area and 400,000 in Bournemouth, Poole and Christchurch council area.

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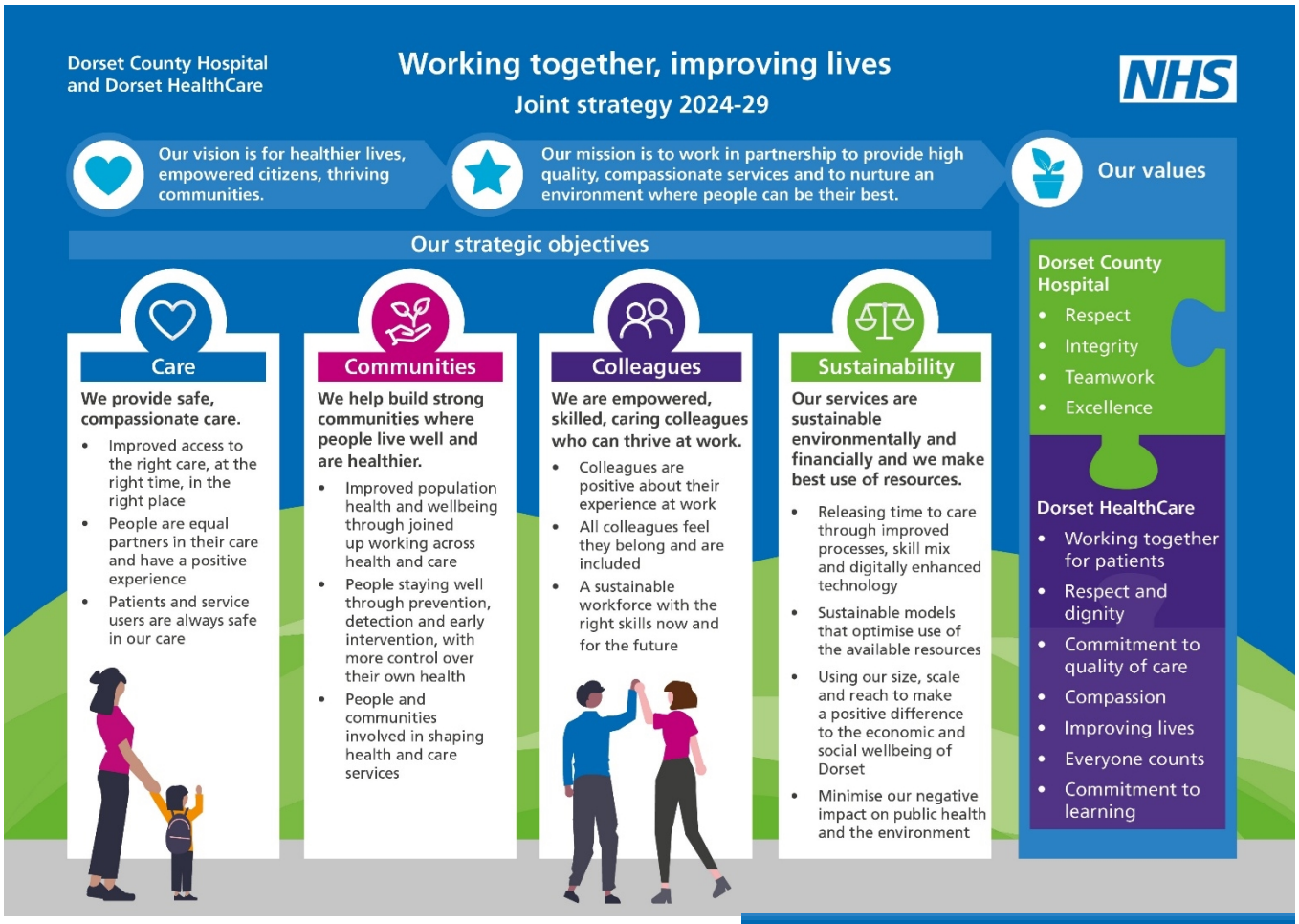
The Dorset resident population also has a smaller than average under 5's and higher than average over 65's, highest of any unitary authority in England. This can increase pressure in different way about both age ranges of care. The population is forecast is that the next 25 years will see an increase of 50% of current number of over 65's. Dorset Council reports early years lay a foundation for health and wellbeing with 64% achieving 'good levels of development.' Dorset residents generally have better health outcomes than the England average, health inequalities can sometimes be less seen in amongst more affluent areas, or the challenges of accessing dispersed populations within this inequalities show 10-year life expectancy difference between the most and least deprived areas, and higher issues in least deprived areas of mental health, substance misuse and childhood obesity that disproportionately affect disadvantaged communities. This all presents a key challenge to health and wellbeing with levels lifestyle related conditions higher amongst those living in deprivation. The trusts are regarded as 'Anchor Institutions,' they are significant employers in the area, procuring a wide range of goods and services, offering training opportunities, undertaking staff and business travel. Therefore, we have opportunities to make a meaningful impact on the economic, social and environmental wellbeing of the local population, and the ways we work have a key role to play in the movement towards net zero carbon. Our Social Value pledges recognise that people's health is influenced by the environment they live and work in. Dorset has an above average 16+ residents high life satisfaction, who also comment how natural, cultural and recreational activities play an important role in safer and stronger communities.

Within or close to 'Dorset Area of Outstanding Natural Beauty' internationally important natural and wildlife areas, geological icons including the famed Jurassic coastline, Durdle Door and Chesil Beach and a myriad of beaches, coves, cliffs, harbours and the South-West coast path with a large range of walking, riding and cycling trails, cliffs and bays. These attract an increase in summer months of seasonal populations and demand for workers in seasonal industries, for Dorset as whole the population increases by around 30 million visitors a year, with about 4.7 million in Bournemouth, Poole and Christchurch, doubling or tripling the resident population in peak months. This increases demand in urgent care, primary care pressure, public health risk, emergency transport, intense working periods and potential inequality of healthcare access. There is greater use of transport, water, levels of congestion and stress, potential for impact on sensitive habits, including risk of wildfires, air pollution, carbon emissions and litter, such as spikes in single use plastics, food waste. It highlights the need for clear communication on sustainability messages and robust strategies.

1.2 Working together, improving lives – sustainability pillar

Dorset HealthCare University NHS Foundation Trust and Dorset County Hospital Foundation Trust missions are working together, improving lives.

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Our Vision

Our services are environmentally, economically and socially sustainable



Sustainability is 1 of our 4 key objectives for - our services are sustainable environmentally and financially and we make best use of resources. Committing to reducing carbon, take opportunities to positively contribute to our local environment, minimise our negative impact on public health and the environment and uphold our social value pledges as we are significant employers, use travel and infrastructure and buying goods and services, so how we carry our functions can contribute to healthier environment, communities and populations we serve as a significant factor in people's health and wellbeing.

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Minimise **our negative impact on public health and the environment.** We have made progress in measuring our impact on the environment and reducing this with sustainable models of care and digital

innovation increasing and sustaining 25% of our outpatient activity delivered virtually and sustainable models of care, including Infection Prevention Control leading on gloves off initiatives and with procurement changing to re-useable tourniquets. Estates and Facilities in both trusts have seen large **scale transition to LED lighting; ward staff, housekeeping, waste and portering teams across the hospital are improving segregation of waste to reduce costs and carbon.**

Net Zero Clinical transformation included woodcast trials in hand therapy to reduce plastic and energy, anesthesia practitioners working with estates on a more focused provision of medical gases, removing a nitrous manifold and setting up a Greener Theatres Group. **The food and nutrition** provision of both trusts removed single use plastic cutlery and cups, in fact in Damers restaurant there is a 20p discount if you bring your own cup, and a take back scheme has reduced contamination of recycling loads with unrecyclable used or wax lined cups, we have a late plates scheme for staff and we are measuring food waste. We have made improvements to **greenspaces** at our sites and are hosting a Centre for Sustainable HealthCare Dorset Ranger, funded by National Lottery Communities Fund. Sustainability leads are working with NHS colleagues in NHS Dorset, SWAST and UHD and with **sustainability and social value** delivery partners and other public sector organisations such as Dorset Council, Bournemouth Poole and Christchurch, Dorset Police, the Dorset & Wiltshire Fire Service and Bournemouth University.

This Joint Green Plan of the 2 trusts focuses on the **areas we can make most impact on emissions we directly control, and map a route to net zero**, even if all solutions and funding are not always clear ahead. We have many joint actions, while some are trust or site-specific, listed with a general aim in common. These SMART actions set out ways to reduce carbon and our impact on the environment with metrics alongside actions, to play our part alongside all NHS trusts towards net zero targets and reduce the likelihood of the most devastating impact of climate change. We can see the impact of extreme weather events taking place and taking steps to mature our adaptation plans working across Dorset with a **Climate Change Risk Assessment** for health care, as we face increasing climate extremes, concurrent droughts, intense rainfall, storm events, with buildings not adapted to heat extremes, cold and flood events.

1.3 Our NHS Net Zero commitment:

- For the emissions we control directly (the NHS Core Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.

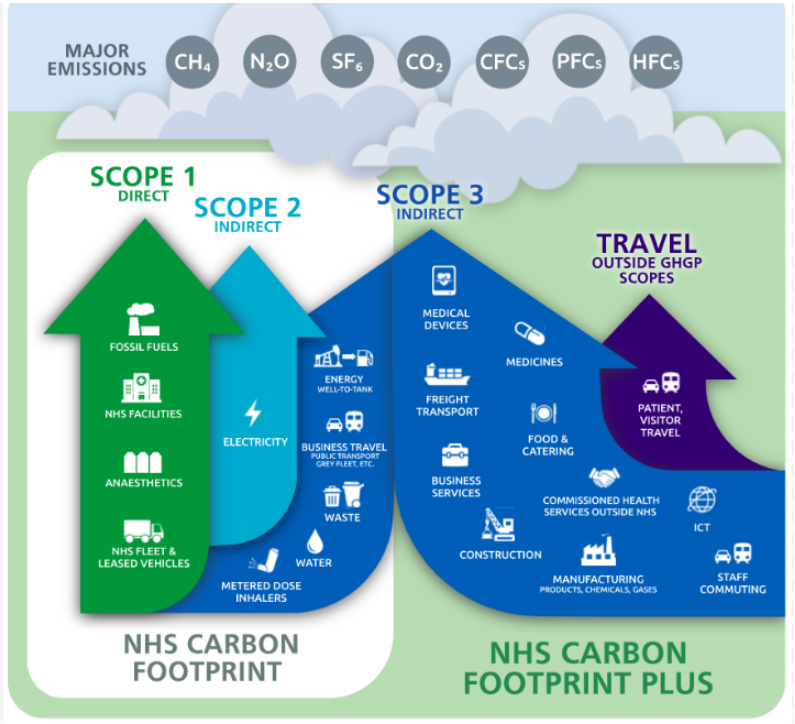
- For the emissions we can influence (the Net Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

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2. Aims, objectives, outputs and outcomes

The Health and Care Act 2022, passed in July 2022, embedded carbon reduction targets for the NHS into UK law. This legislation requires that NHS Foundation Trusts must have regard to the Environment Act 21 target areas including air quality; water; biodiversity, resource efficiency and waste reduction.

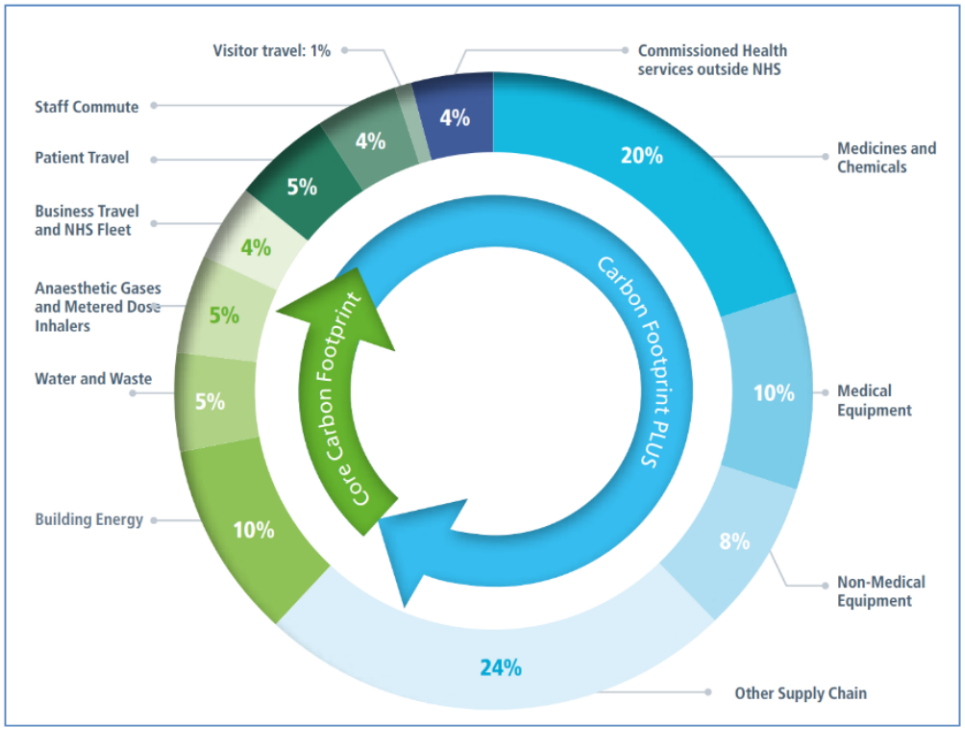
The diagram below shows the elements that make up the NHS carbon emissions – the carbon "footprint". **"NHS Core Carbon Footprint"** (shown by the green arrow) includes carbon emissions that are directly produced through using building energy, water, waste processes, anaesthetics and inhalers and business travel. The "**NHS Footprint PLUS"** (shown by the blue arrow) includes the other emissions associated with products and services that the NHS purchase.



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2.1 Aim

In 2020 the NHS became the world's first health system to commit to reaching net zero and take action to reduce the future impacts of climate change. The Trusts' Green Plan set out actions across both trusts spanning 3 years, now the refresh of the first Green Plans and first joint plan must set the path to the first target of 80% reduction of emissions it controls directly by 2030 and indirect emissions by 2036.



2.2 Objectives

1. committing to reducing carbon
2. take opportunities to positively contribute to our local environment
3. minimise our negative impact on public health and the environment
4. uphold our social value pledge and develop the joint social value programme

2.3 Outputs

1. leadership vision, through green plan focus leads, and focus area specialists, at the top of the organisation on sustainability green teams
2. a raft of steps and actions, supported by strategic decisions to map a route of the next 5 years to the first NZC target of reducing 80% of emissions we control directly by 2028-2032
3. everyone a sustainability/green champion, supported by empowering sustainability group members or green leads, green teams, staff and volunteers with toolkits, innovation support, administration, procurement and feedback

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4. methods to monitor and measure our progress, including our carbon footprint energy, waste, water, fleet and anaesthetics, and carbon footprint plus, staff commute, medicines and food and nutrition

5. aligned with Strategy: **Sustainability** is 1 of 4 pillars of the Federated trusts “Working Together, Improving Lives: The joint strategy for Dorset County Hospital and Dorset HealthCare” (2024) with Green Plan objectives 1-4 from the joint strategy. NHS England Net Zero targets, including Delivering a Net Zero NHS Strategy, NHS Clinical Waste Strategy, Five years of greener NHS: progress report



sustainability

What we want to achieve	How we will measure progress
Releasing time to care through improved processes, skill mix and digitally enhanced technology	• Productivity and effectiveness metrics • Digital plan metrics
Sustainable models of care that optimise use of the available resources	• Dorset per capita spend on health and care • Financial balance • Number of resilient services
Using our size, scale and reach to make a positive difference to the economic and social wellbeing of Dorset	• Progress against our social value pledge
We minimise our negative impact on public health and the environment	• Green plan metrics

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3 Our Green Plans progress since 2022

3.1 Our Key Achievements

- ✓ travel information and discount schemes on the staff intranet ‘staffnet’ and a Green Travel Plan for South Walks House, a range of travel plans for Dorset HealthCare
- ✓ Significant progress in replacing 90% lighting to Light-Emitting Diode (LED) across both trusts, 90% achieved in DCH, and DHC 95% through NHSE/GBE Grants of £62,000 and £1m respectively
- ✓ Dorset HealthCare was awarded £1m by NHSE/GBE Grant in spring 2025 to install Solar PV arrays a 6 of its sites. The Trust already has Solar PV at 5 sites and this will take the total to 11 sites.
- ✓ New builds striving towards Net Zero Carbon Hospital Standard, the 2 New Hospital Program Sites at DHC meeting the NHS national standard and BREEAM requirements, and DCH achieving BREEAM ‘Very Good’ for South Walks House outpatients facility refurbishment.
- ✓ Digital transformation across Dorset to reduce the need for paper, records, printing and postage and 20% of outpatient appointments delivered remotely
- ✓ Sustainability and social value in tenders’ weighted at 10% of decision to buy goods and services
- ✓ Removal of the Nitrous manifold and adjusting clinical practice to use less of the useful, but high greenhouse factor gas, desflurane
- ✓ Establishment of Sustainability Working groups, and sustainability sub-groups such as Greener theatres, Greenspaces, energy decarbonisation plan task and finish group
- ✓ Sustainability in job descriptions and staff with a sustainability focus as part of their specialist area, such as Infection Prevention Management
- ✓ Clinical Waste Targets achievements of 60/20/20 NHSE Target to reduce cost and carbon
- ✓ Catering paper cup take back scheme, recycling station and a food waste baseline
- ✓ Nature based wellbeing page on staffnet and presentations to wellbeing coaches and lunchtime walks

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3.2 A good neighbour

Both trusts work with Dorset Council on sustainability, cycling and e-bikes. With e-bikes outside South Walks House and Williams Avenue and around Weymouth. We are working on sustainability issues and opportunities with Public Sector Decarbonisation and Ecology Group, (PDSEG) Dorset national landscape and Public Health Dorset.

3.3 EcoEarn Platform

Dorset NHS Partners have commissioned a staff engagement platform to help promote net zero carbon reduction activities and other sustainability and wellbeing behaviours. EcoEarn has the facility to track the environmental difference made and can provide individual, team, Trust wide and Dorset wide impact data.

3.4 Dorset NHS Lift share

A matching journey application for all NHS staff across Dorset to help find people to share journeys, reduce costs and carbon and enable access for example with cars in for MOTs, with a guaranteed ride home via taxi or public transport in event of the unexpected issues with the other car sharer.

3.5 Staffnet low carbon travel options

A range of information is now available on staffnet for staff discounted travel, public transport and active travel and we are getting a better picture of staff commuting with an annual staff travel survey. We would like to extend this to all sites.

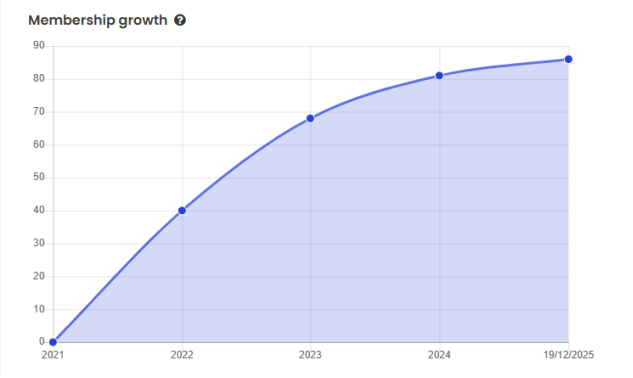
3.6 Delivery partners

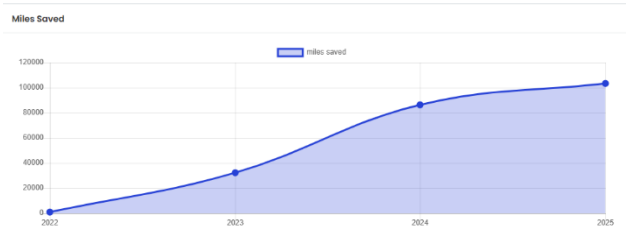
Dorset County Hospital was one of the trusts selected to run an ‘Active Hospital’s Project’ from October 2021 to April; 2023, with 15 projects and 50 members of staff trained on behaviour change and physical activity and identified trends of occupation and activity levels.

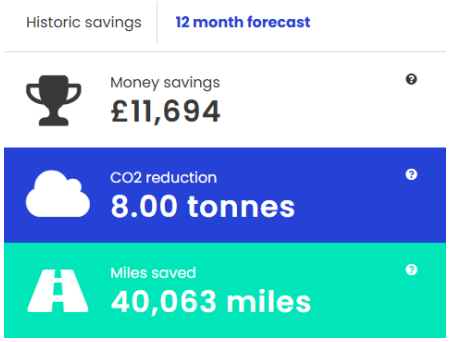
We are working with Centre for Sustainable HealthCare and NHS Forest to host a Dorset Recovery Ranger from 2025 to 2027. Their role is to engage staff, patients and visitors with NHS greenspaces in nature-based activities to improve wellbeing and increase the amenity and biodiversity of our greenspaces, siting within the Sustainability team and working closely with arts in hospital and the greenspaces group and external partners such as Dorchester Men’s Shed, Dorset Wildlife Trust, RSPB and Nature Buddies to deliver greenspace improvements. This role works with the Arts in Hospital team’s creative therapies.

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Dorset NHS Liftshare

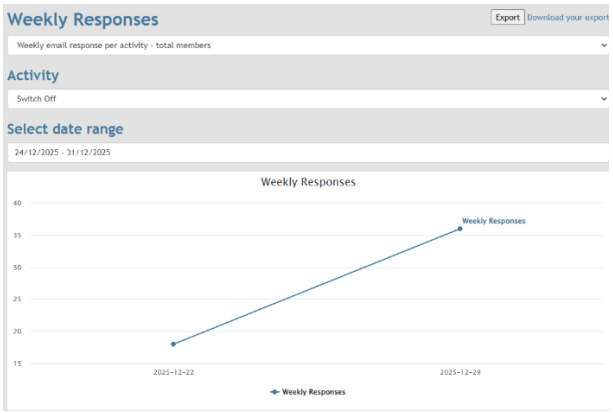






- 94 members added
- 80 added a journey available to share
- 21 members confirmed as sharing
- 27 staff induction coffee breaks
- and over 250 engagements with EcoEarn or Dorset NHS Liftshare

EcoEarn



tCO2e avoided last financial year:**14,461**
(Dorset County Hospital)

- 17 new members added 24/25 for DHC and DCH
- 20% hike in the membership growth in FY 24/25
- Main events: Mindful tech challenge, Festive food waste, junk and Sustainable Festive season combined with Staff Bulletin and Staffnet pages. Previous joint initiatives – Bike week, Big Garden Birdwatch
- The Dorset trusts have worked for a more NHS specific, repeatable version reducing costs to each trust, with an estimated 74.5tCO2e avoided in 24/25 by staff eco actions.

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4 Focus areas

These are the different areas of focus we used to define our Green Plans in 2022 and for the joint refresh in 2025 we look at these again with a renewed emphasis on suggested areas of focus for greatest impact for emissions we directly control, these are from NHS England green plan guidance for NHS England that refers to the “Delivering a Net Zero National Health Service” strategy published in October 2020.

This strategy outlines the NHS's commitment to reaching net zero emissions and includes the requirement for NHS trusts and integrated care boards to develop green plans. The guidance was updated in July 2026 to reflect the NHS's progress and the evolving needs of the healthcare system. The focus areas are broadly consistent since 2022 and reflect where the most significant impact will be made on reducing our overall impact on the environment and greater sustainability. The guidance in each areas shows we often already know what can be done, have the ability in some areas to make changes and the path is well defined. They focus on how we can make the areas of our activities, services, support services, clinical activity and operating our services greener, more sustainable and enable provision of good healthcare in a well stewarded environment.

Focus areas go beyond achieving Net Zero Carbon working to develop thriving communities, reduce health inequalities, protect land and water, address poverty in a twin approach of sustainability and social value programmes, in relation to working towards the UN Sustainable Development Goals and as anchor institutions influencing our community through significant levels of employment, training, using local facilities, procurement, housing and transport to reduce health inequalities and positively contribute to the local environment.

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4.1 Workforce and system leadership

Net Zero Carbon is a priority and, accordingly, it is led at Board level is by our Chief Financial Officer. We have a Sustainability Group whose members represent departments across the Trusts and support bringing together the Sustainability Work. The Work groups report to the Strategy, Transformation and Partnership Committee in Common, this group has responsibility for Net Zero Carbon and is chaired by David Clayton-Smith, Joint Chair. The Joint Director of Estates and Facilities manages the team to ensure this joint Green Plan is delivered, with Sustainability leads, a Sustainability Officer and Waste Officer. The Director of Nursing Chairs the cross departmental Greenspaces Group leading on actions to improve access, condition and biodiversity of the grounds and courtyards.

Progress: Green Plan focus area leads have been established since the last Green Plans and feed in the to the Sustainability Work Groups, including the Greener theatres group, Green travel and representation from clinical areas, food & nutrition, Estates & Facilities, Digital transformation, waste procurement and pharmacy.

Sustainability Champions have led on initiatives, engagement of EcoEarn staff pledge platform at Staff Induction coffee breaks has increased including linking to the e-learning Building a Net Zero NHS, a bi-monthly e-news goes out to all signed up as Sustainability Champions, and regular articles in the Staff Bulletin to all staff.

Key focus area training on Biodiversity Net Gain for the trusts Sustainability, Strategic Projects and Estates and Facilities staff. The Waste officer completed NHS Waste Manager training. The Sustainability Manager and Sustainability Officer completed NHS Energy Management training. The Director of nursing participates in a Clinical Masterclass in sustainability and establishing a clinical sustainability lead and how we can focus on the 5 suggested areas and capture actions in clinical delivery underway or in the pipeline, developing mutually supportive transformation.

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Workforce and system leadership actions

Specific	Measurable	Achievable	Relevant	Time Bound
Sustainability team, Champions and Sustainability Working Group Members who lead the plan focus areas of Estates, Facilities and Procurement to complete Carbon Literacy training.	Number who complete training. Sustainable Champions initiatives such as toolkit, e-news, teams drop ins	Dependent on manager support to take time to complete and making the case.	Informed decisions not led by external supplier statements.	NHS England has funded places for all NHS staff up to October 2026
Facilitate further the sub-groups on each of the GP focus areas, currently includes Greener theatres, Green Travel and Energy and develop clinical green leads and green teams'	Sub-groups in common in 8 focus areas plus measure, monitor and engage	Build on the trusts prior work and clarify focus	To the Green Plan focus areas	Sustainable Champions joint initiatives such as Champions toolkit, e-news and teams drop-ins
Sustainable Champions joint initiatives such as Champions toolkit, e-news and teams drop ins, with some becoming green teams	Champions toolkit; bimonthly news	With current resources and effective joint working	To deliver objectives	Sustainable Champions joint initiatives such as Champions toolkit, e-news and teams drop-ins
Board Level Oversight of NZC and Climate Related risks following CCRA.	Board Level oversight of NZC and Climate Related risks	With current resources and effective joint working	To deliver Net Zero objectives	In place October 2026 and on-going

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4.2 Net zero clinical transformation

Embedding net zero principles across all clinical services is critical. Green plan guidance outlines 5 areas of focus of critical and perioperative care; mental health; urgent and emergency care; diagnostic tests and procedures; medical pathways, with a focus on acute or long-term conditions such as renal disease, diabetes or cardiovascular disease. Dorset County Hospital provides services across Dorset and South Somerset for renal disease, with a range of services for cardiovascular disease and diabetes and Dorset HealthCare provides the mental health services for Dorset.

To ‘Embed sustainability into clinical pathway design’ engage with Quality Improvement and transformation frameworks and yearly sustainability campaign. This would allow QI to partner with the Joint Transformation and Improvement Team. There is an opportunity to be part of our Improving Together Programme ‘Capability Building’ workstream working group to ensure that sustainability and the triple bottom line are threaded through the guidance, support and training that will be integral part of the Improving Together Framework.

Progress: We set out to achieve 3 clinically equivalent lower carbon emission interventions by March 2025 and exceeded this with a wood cast trial in Hand Therapy at Dorset County Hospital, use of ‘Cool sticks’ or ice in Maternity instead of Ethyl Chloride spray, re-useable tourniquet's roll out, Infection Prevention and Management have led on gloves off initiatives, pee in a pot cardboard alternatives, Antimicrobial Mitigation plan, with IPC and IV to Oral switch encouraged to enable patients to go home sooner and removal of devices early, sterilising facilities in SCBU reduces waste and Pharmacy working on ways to reduce waste and plastic. We have developed a Greener Theatres Group working to the Intercollegiate Greener Theatres Checklist.

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Net zero clinical transformation actions

Specific	Measurable	Achievable	Relevant	Time-bound (deadline)
Support the Greener Theatres Group clinicians to develop further 3 clinically equivalent lower carbon interventions and report to Sustainability group.	Achieve the refreshed Greener Theatres Intercollegiate Checklist V2.0	QI; across a range of procurement, pathways or practice, supported by cross department working and the Sustainability team	Reduction of waste, energy or travel	1-2 projects each financial year
Develop Clinical 'Green Teams'	Sustainable projects, pilots and innovation.	Developing ideas for funding application process and Quality Improvement. Share opportunities and support apprenticeships, fellowships and innovation.	Reduction of waste, energy or travel, for same or better outcomes.	1-2 proposals supported each financial year
Trial further single use plastic reduction projects in clinical and related non-clinical (support services) environments	2 schemes across both trusts, likely to be medically suitable Durable plastic service wear in wards, Uniform recycling or tailored Theatre packs	Groundwork in place	Reduction of plastic pollution that can impact on the environment and public health	March 2028

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4.3 Digital transformation

Digital technology allows us to deliver some care remotely. We currently use video consultation software to conduct virtual consultations and will support our healthcare professionals to sustain and grow this approach. We already use digital systems to reduce the use of paper records, printing and postage. We will continue to harness existing digital technology and systems to streamline our service delivery, supporting functions and the work of the NHS Greener by Design Green Digital programme launch in 2026/7.

Progress: The previous Green Plans referred to the Home First service, which enables patients to recover at home or a more local setting (e.g. care home or community hospital), reducing hospital stays and the Acute Hospitals at Home service which enables patients who are medically stable and safely able to receive the required treatment and rehabilitation in the comfort of their own home. Dorset County Hospital are consistently delivering over 20% week on week of outpatient activity remotely. The South Walks House outpatient facility enables smart use of digital technologies including virtual conferencing patients, colleagues and other experts in their field. We reviewed paper use and replacement of leased printers across the trust to achieve greater efficiency, support the procurement of 100% recycled paper, apart from limited use of colour for accessibility and card for specific projects.

Dorset HealthCare are changing the way they communicate with patients by using Text and emails. They are maximising the opportunity for supplier takeback schemes. Improving the monitoring and return rates of trust-owned digital equipment.

DCHFT is implementing the DrDoctor patient engagement platform to automate digital appointment confirmations and reminders via SMS and email, as well as integrating with the NHS App, giving patients secure online access to appointment details and the ability to cancel or request rescheduling digitally. This supports improved patient experience, reduced Did Not Attend (DNA) rates, lower administrative burden, and progress toward a digital-first operating model. The first service went live in March 2026, and implementation of this functionality will complete in quarter 2 of 2026/27, with clinics onboarded by specialty. Further sustainability benefits are planned to start later in 2026 and early 2027, including the digital delivery of clinic outcome letters via DrDoctor, significantly reducing printing and postage.

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Objectives

Digital technology underpins many aspects of the sustainability of net zero clinical transformation, workforce, estates building energy and sustainable buildings.

1. Develop appropriate opportunities for remote patient care though technologies and relevant to specific clinical pathways or services

2. Monitor and where possible incorporate developments of the unfolding Greener by Design programme

3. Sustainability and Social Value within digital strategy, including delivery plans, procurement and the sustainable delivery of healthcare

4. Align with developments of Health hubs and ways to address health inequalities, including digital access.

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4.3.2 Digital transformation actions

Specific	Measurable	Achievable	Relevant	Time-bound (deadline)
Implement digital pre-assessment tools	Collect data on use	In-progress	Avoid need for travel	Currently in development
Communicate good IT housekeeping, including channels for version control and ditch the IT junk clean ups build on EcoEarn 'Mindful Tech Challenge'	Communications on top tips and reduce users near to storage limits	Management support needed, determine detail with digital services and communications	To the Green Plan focus areas	Develop by March 2026 and on-going
Achieve or maintain least 25% of Outpatient care will be delivered remotely	Metric is collected by patient access teams	Consistently at 20-23%	Reduce need to travel	Measurable weekly data
Use improved data and analysis to optimise sustainability and adaptation reporting. Data and analysis can include NHS tools such as Greener NHS, ERIC and CCRA; in house excel dashboards and BI data. Updating/developing local carbon footprint dashboards.	Trial climate change risk software; use of Power BI software in house and sustainability dashboards.	In progress by existing staff resources to seek continuous improvements, Green Plan metrics of actions, feedback and reporting	Progress and feedback towards the targets to staff, leadership and public.	On-going including presentation in Annual Report
An effective and robust Electronic Health Record to enhance patient care and reduce waste, cost, travel by patients or staff and reduce carbon that integrates with NHS app and allows secure mobility of records across practices and co-ordinated delivery of care.	Business case statements of benefits	Signed up to the EHR transformation programme	Greener by design, can reduce paper waste, patient travel, energy, operational cost	Deliver benefits in 2028/29
Develop innovative ways to deliver care closer to home with development of Neighbourhood Health Hubs in the most deprived areas with greatest health inequalities while continue to focus on Dorset wide service provision roles such as Mental Health with DHC, and renal care with DCH.	Percentage of outpatient activity delivered remotely or in neighbourhood hubs.	Developing joint opportunities is already in practice and led at Director and Board level	Identify barriers to accessing services and	March 2028

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Specific	Measurable	Achievable	Relevant	Time-bound (deadline)
The inclusion of accessible sustainability information via a Sustainability Dashboard will be developed. This will enable staff empowerment through both visibility and access to use simple carbon measurement at an organisational and service level as well as in use within individual change projects – which links with the Clinical Transformation and Sustainable Models of Care sections.	Usage analytics and service-level access monitoring.	Supported by communications and guidance.	Supports staff empowerment through visibility of information.	Early 2027
NHS Dorset, Dorset County Hospital, University Hospitals Dorset and Dorset HealthCare are working together to see how a common electronic health record (EHR) system might be introduced across the three provider trusts and primary care networks in Dorset. This is a major step towards realising our vision of joining up our healthcare records, providing a clear picture of each person's health. It will help us improve care and avoid the need for patients and service users to retell their story as they move around our health systems.	Enables system-wide agreement and investment decision on a common EHR system. Inputs completed by September 2026. A shared system-wide vision and high-level functional requirements for a common EHR are agreed and signed off. Reduces duplication and the need for patients and service users to retell their story.	Developed collaboratively through stakeholder and clinical engagement across organisations. Ensures the Aligned with national interoperability standards and existing digital strategies.	EHR supports joined-up care, interoperability and improved patient and staff experience. Vision and requirements agreed. The OBC clearly specifies that the EHR will support a single, joined-up patient record accessible across organisational boundaries.	DHC and DCH are looking to have an EHR system in place in 2026/27, and each organisation has begun to gather information to feed into a collective outline business case (OBC).
DCHFT is implementing the DrDoctor patient engagement platform to automate digital appointment confirmations and reminders via SMS and email, as well as integrating with the NHS App, giving patients secure online access to appointment details and the ability to cancel or request rescheduling digitally.			This supports improved patient experience, reduced Did Not Attend (DNA) rates, lower administrative burden, and progress toward a digital-first operating model. From 2026/7, the digital delivery of clinic outcome letters via DrDoctor, significantly reducing printing and postage.	The first service went live in March 2026, and implementation of this functionality will complete in Q2 2026/27, with clinics onboarded by specialty. Further sustainability benefits are planned to start later in 2026 and early 2027.

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4.4 Medicines

The prescribing and use of medicines makes up 25% of the NHS's overall carbon footprint. Anaesthetic gases and metered dose inhalers account for 21% of the emissions the NHS directly controls so we focused our actions of the first green plans here. As part of the Dorset Medicines Quality Safety Strategy (Section 9) to meet the various requirements to improve inhaler use and adherence Use of solid dosage forms – promote more sustainable prescribing practices by identifying opportunities to switch from liquid to solid dosage forms.

Progress: We have worked with the ICB to develop clinically appropriate prescribing of lower carbon inhalers. Through Consultant Anaesthesia expertise to reduce the use of a helpful gas desflurane, but that has a big impact on the atmosphere to less than 10% of previous use of this volatile anaesthetic gas. Clinicians and estates have worked to turn off the Nitrous manifold, these gases can stay in the atmosphere for 100 years, smaller cylinders are placed in areas of most need and used in the community by Midwives. Ethyl Chloride spray in Maternity was also reduced but less facilities for ice present a challenge. Anti-Microbial Plan, supported by Infection Prevention and ward staff initiative on 'making the switch' to oral medicine shortening the time to home and reducing infection risk. Pharmacy have reduced clear plastic bags for cold chain transfer of medicines.

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Specific	Measurable	Achievable	Relevant	Time-bound (deadline)
Develop an inhaler recycling project	• Engagement • Recycle points in place • Number of recycled inhalers,	Potential for engagement with Children's centre, primary care and respiratory services	Responsible disposal and supports effective use.	March 2028
Investigate ways to support Ethyl Chloride spray with reusable, low impact cold sticks for sensory testing in maternity units	Reduce in line with targets by 90% tracked through stock and use audit or procurement.	Cold sticks are readily available, cost effective and staff can be trained in their use within exiting clinical governance processes. The ward layout and access to ice or fridges explore fridge free alternatives (gel packs/insulated cold sticks in central fridge).	Supports NHS Net Zero goals by replacing ethyl chloride with reusable, low-impact alternatives in maternity care, improving environmental sustainability while maintaining safe, effective sensory testing for mothers.	2026/7
Good Nitrous cylinder use and management including testing	Use and test results	Discussions in place and testing	Management of a gas with higher equivalent to Carbon Dioxide and atmospheric persistence, to cut waste and emissions while ensuring patient care and safety	March 2026
Investigate a prescription-related project	Develop a team to consider - a pill project in one or both trusts - Your medicines matter	• Assist people and young people to consider tyring tablets over liquid medicines • Encourage patients to bring their own medications to hospital • Staff order minimum needed to go home.	Less volume, less carbon - same efficacy. Whilst still focussing on maximising compliance, reducing readmission and providing patient choice. Avoids duplication and medication waste	2026/7
Potential for green social prescribing explored with Dorset Recovery Ranger	Monitor, Evaluate and Learn and wellbeing feedback	Ranger in place for 18 months	Demonstrate benefit and potentially less prescriptions and increased staff wellbeing	June 2025-2027

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4.5 Travel and transport

“Air pollution alone contributes to 1 in 20 deaths in the UK. Reducing emissions would support the reduction of cases of Asthma, Cancer, and heart disease.”
Dr Nick Watts – Chief Sustainability Officer NHS, 31 October 2021.

We serve a predominantly rural area with lower public transport options than larger urban areas, and shift patterns discouraging in winter for active travel, so emissions from staff, patients and visitors travel are likely significant. We have already taken action on the emissions we directly control in our fleet by buying exclusively ULEV vehicles, removing supplies delivery predominantly off site from DCH, and changes to fleet, and the ambulance fleet. Promoting alternatives for staff and volunteers there are some areas of cycle parking, lockers and showers but these are due a refresh to encourage active transport, we only offer car parking discount permits to those who live more than two miles away. Within a Joint Green Travel Plan and work with Public Sector Decarbonisation and Ecology Group be can explore how to further reduce air pollution from vehicle emissions with reviewing the ICS Action for Clean Air framework.

Progress: We have published low carbon and active travel options on Staffnet Sustainability pages and worked with Dorset Council on highways and Beryl bike suggestions. We have a Bicycle Users Group channel on teams. Existing cycle parking will be renewed and expanded in time for the new Emergency Department & Critical Care Unit building to be operational. We have an annual Staff Travel Survey for DCH and will extend this to both trusts to gain a picture of staff commuting (scope 3 emissions).

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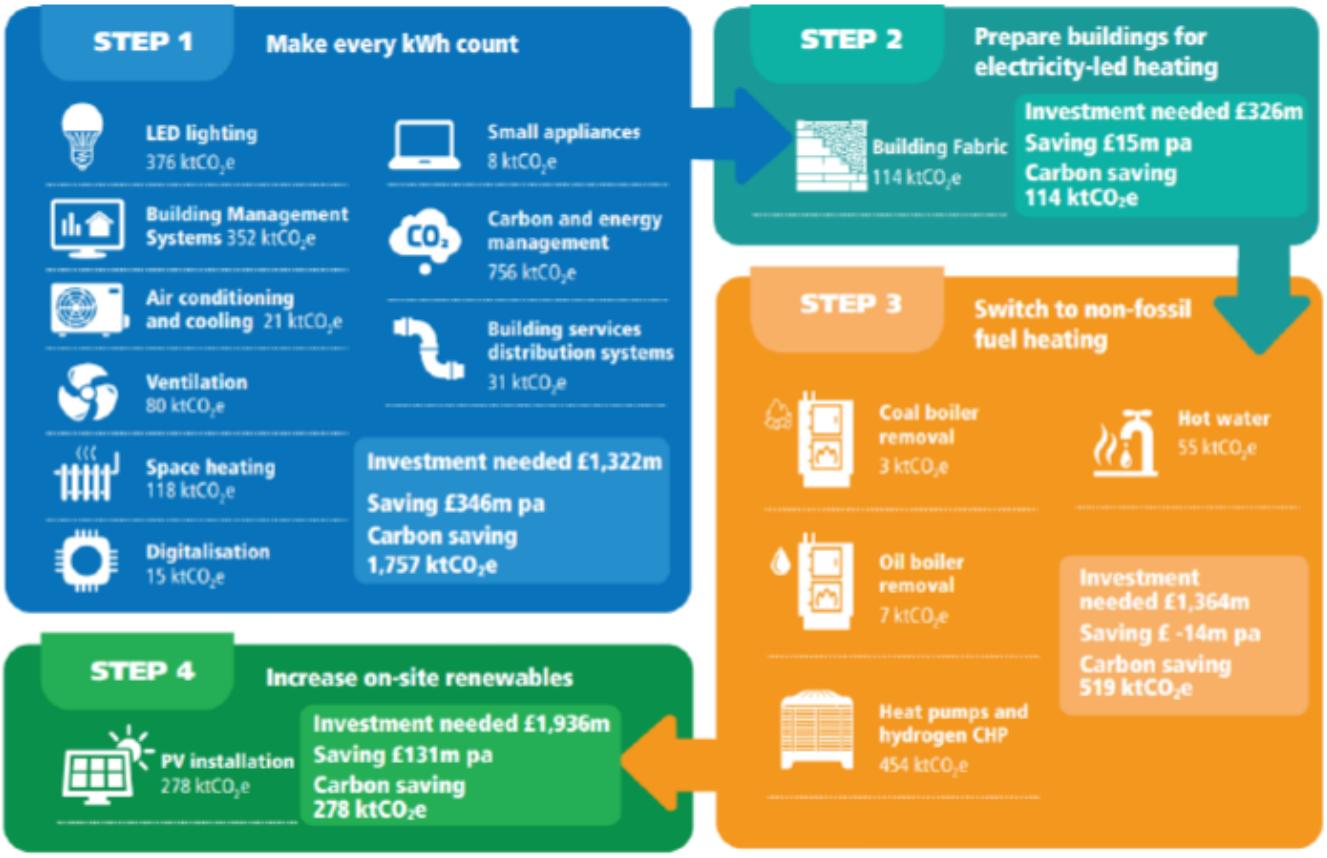
Specific	Measurable	Achievable	Relevant	Time-bound (deadline)
Develop a joint Green Travel plan to support active travel and public transport of staff, outpatients and visitors	Plan, annual survey and review of travel with SMART actions, reduce single occupancy journeys	In-progress	Avoid need for travel, increase single occupancy travel, less cars on site and local roads	December 2026
Renew and expand cycle parking	Defined in New Hospital Project plan	Within project programme	Increase active travel	April 2027
Engage with Dorset Council and Bournemouth and Poole Council on cycle, bus groups and walking routes serving and routes within sites	Meetings and potential projects	Begun, expand, joint working	Increase active travel	December 2026
Liftshare scheme supported and communicated	Inductions, website	On-going	Less cars on site and roads	On-going
Site specific active travel and low carbon travel available to job applicants and outpatients	Webpages and emails	Coordinate and engagement within existing resources	Reduce single occupancy at key decision point	December 2026
Review car parking usage and revenue options	Business case	Within existing resources	Revenue, less cars on site	April 2026

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4.6 Estates and facilities

NHS Estates Net Zero Carbon Delivery Plan Technical Annex

Figure 4: 4-step process for minimising NHS building energy and water use. Includes indicative numbers to illustrate the scale of the challenge of decarbonising the NHS estate by 2040. These are not actuals.



Emissions resulting from its buildings, water and waste account for a massive 63% of the emissions the NHS directly controls. Energy efficiency is a priority for our estates and facilities management.

Energy Efficiency hierarchy

Align with hierarchy

1. save

2. supply efficiently

3. reduce emissions

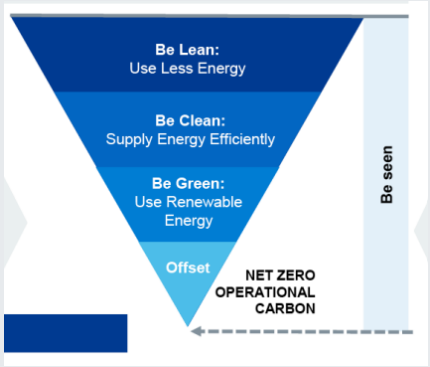
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Hierarchy	Actions
1. Save	Net zero principles to be embedded in all projects for both trusts. While this increases efficiency and reduces whole-life costs, it does require funding to cover the additional investment costs
	DCH has developed a Heat & energy Decarbonisation plan with details of potential interventions focused on improved air conditioning and cooling, building fabric, space heating, insulation, ventilation and hot water, funding is yet to be achieved with some previous public sector grant opportunities no longer available, while others arise via Greener NHS
2. Supply efficiently	DCHFT undertook LED replacements with Centrica CHP project, and subsequent success with 2 NEEF applications for around HS National Energy Efficiency Fund (NEEF) as part of work to install LED lights across the hospital. The Trust has received £62,000 from the fund over the last couple of years which has allowed us to install nearly 400 LED light fittings on our main site.
	Dorset HealthCare was successful with NEEF funding for an extensive £1m LED lighting replacement scheme.
3. Reduce emissions	The use of renewable energy is developing, with the Solar PV on the DCH Portesham discharge lounge modular building, and as part of the New Hospital Project investment of an array on the energy centre rooves.
	Dorset HealthCare was awarded £1m by NHSE/GBE Grant in spring 2025 to install Solar PV arrays a 6 of its sites. The Trust already has Solar PV at 5 sites and this will take the total to 11 sites.
Innovation & partnerships	Enquiries on local biogas and hydrogen was initially undertaken but these technologies and supplies are developing capacity in Dorset with older CHPs adaptability requires technical and supply investigation and certifying local biogas supply in the network is difficult to quantify
	A Heat Network Development Unit (HNDU) grant equipped DCHFT to investigate ground source and geothermal technical, environmental and financial feasibility and a subsequent joint application to HNDU by Dorset Council using this initial work, was unsuccessful, but there maybe future opportunities.

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Specific	Measurable	Achievable	Relevant	Time-bound (deadline)
Energy	**Measure and monitor**			
Decarbonisation Plan & Energy Strategy developed – keep this live with energy data and dive deeper into actions to meet decarbonisation plans Fig 1: NHS Building Standard; operational energy  	Reduce demand through behaviour	Catering behaviour change project	Reduce carbon intensity and carbon emissions from our estate (energy, water, waste): energy Increase energy security Reduce peak demand on local electricity infrastructure	March 2027 DCH
		Hot spots and lights on surveys		Autumn/Winter 2025/6 DCH
		Sustainability Champions toolkit		Winter 2025/6 (Joint trusts)
	Reports of Greener theatres team, consider as part of submetering plan	Theatre ventilation downtime IPC and Theatres, Estates teams working together.		On-going
	Develop a submetering plan	Building by building at DCH and site by Site DHC decarbonisation planning		March 2026
	Submetering scheme			October 2026
	Increase efficient lighting			December 2025 December 2026
	LED deliver grant fundings schemes Apply for remaining areas	Increased energy-efficient lighting		
	Renewable Generation - Solar PV			
	Grant preparation Increase renewable energy (kWh)	NHP team DCH solar scheme DHC solar scheme investigations		By completion of NHP Project By October 2026 for potential decarbonisation funding across ?? sites
	Solar PV on Energy Centre Expression of Interest details for:- Solar PV on one of Damers accommodation Children's centre DHC across estate	Supplier appointed and review of works ready to begin Outline information in decarbonisation plan, to action with Sustainability team Solar PV scheme on energy centre as part	Solar PV would increase energy security and generate electricity directly to buildings on site	

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		of New Hospital Project. Develop scope and planning permission if needed for a further 2 schemes and apply for funds or purchase options.		

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Specific	Measurable	Achievable	Relevant	Time-bound
Waste	**Measure and monitor**			
More staff follow the waste hierarchy and best 	Baseline measurement of food waste Reduce food waste from this baseline	Underway in DCH extend to wards and to DHC sites	Reduce carbon intensity and carbon emissions from our estate (energy, water, waste): Waste Protect land and water Sustainability Champions toolkit	March 2027 DCH
		Digital food ordering service		2026 DCH
		Late plates for staff		2026 DHC
	Clinical Waste targets (60:20:20) potential to reduce cost (and increase waste disposed in correct stream with lowest carbon emissions	Develop an education tool for waste streams and hierarchy		On-going
	Recycling increase vs general waste by volume	Sustainability Champions toolkit, recycling station information	Reduce carbon intensity and carbon emissions from our estate (energy, water, waste): Food and Nutrition Food and Nutrition, reduce waste and cost, improve patient experience Reduce waste while maintaining care Net Zero Clinical Transformation	March 2026
				March 2027
	Increase cup recycling and reduce recycling contamination – feedback from Cuproud	Cuproud take back scheme Re-useable cup discount		March 2026
	Manage/ Projects			March 2026
	Reduce single use plastic Procurement of reuseable tourniquets Business case for fabric, washable theatre caps Business case for theatre packs Recycle uniform	Ward hosts and durable service wear – business case		
		Widespread use of reuseable tourniquets – roll out IPC		October 2026
		Greener theatres explore Facilities explore		October 2026
	Circular economy			

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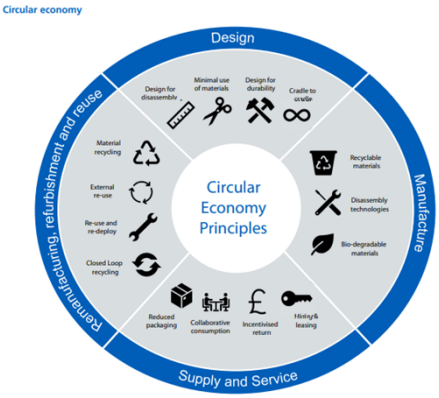
	Build on 75% equipment and furniture rehomed	Joint rehoming, a repair pilot	Opportunities for circular economy principles into the full life-cycle of the procurement ‘Applying net zero and social value in the procurement of NHS goods and services’ on the GreenerNHS website.	March 2017
	Life cycle considerations NHS Supply Chain webpage (https://www.supplychain.nhs.uk/sustainability/waste-and-the-circular-economy/ NHS staff via the NHS Central Commercial Function Hub on the Future NHS website	Life cycle considerations with procurement and projects		March 2027
		Uniform recycling explored		

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4.7 Supply chain and procurement

Dorset County Hospital NHS Foundation Trust and Dorset Healthcare University NHS Foundation Trust collectively spend over £277 million annually on goods and services. This scale of procurement provides a significant opportunity to reduce environmental impact and influence suppliers to adopt more sustainable practices. With 66% of the NHS carbon footprint arising from purchased medicines, equipment and services, action in this area is essential. The trusts are working with the NHS Net Zero Supplier Roadmap.

Linking this with the Digital Transformation to enable guidance and education for staff to be informed of the carbon footprint alongside costs of materials and equipment both within procurement as well as use (e.g. printers and photocopiers).
Also supporting the making of sustainable, circular-economy led choices in ordering, use, reuse and disposal of physical resources



Objectives

1. improving efficiencies through continuous improvement on wider decision making, duplication and use of resources.
2. Net Zero: Meet NHS Net Zero Supplier Roadmap requirements and achieve net zero across the supply chain.
3. Social Value: Ensure procurement strengthens local economies and supports wider determinants of health.
4. Modern Slavery: Eliminate modern slavery risks across the NHS supply chain, domestically and international
5. Optimising Sustainability: Ensure sustainability requirements are applied in a way that maximises benefits and remains strategically aligned

Progress: In 2024 we updated our Sustainable Procurement Policy., setting out what we mean by sustainable procurement and increased from 5% to a minimum 10% weighting towards sustainability and social value in the award criteria to maximise local investment and increase local employment and reduce associated carbon emissions, minimise our impact on public health and the environment. We have adopted the Government's 'Taking Account of Carbon Reduction Plans' (PPN 06/21).

Objectives

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Specific	Measurable	Achievable	Relevant	Time-bound (deadline)
Clarify examples of sustainability and social value in our tender process	Clear guidance	The policy is in place and this is an adjustment	Ensure local and other suppliers can understand what is the requirement and focus social value and environment to our core objectives and focus supporting service delivery and reducing health inequalities	Quarterly and annually
Rehoming scheme is first call for furniture items and developed across both trusts, circular economy is considered more widely	* Investigate and enact further return and reuse programs for suitable equipment.		Reduce costs, waste to landfill and carbon, maximise life of available resources, develop repair capacity. This relates to the object that we make best use of resources'	2027
Procurement managers consider Carbon Literacy training for staff which helps embed carbon impact information into procurement processes, alongside costs, and promote circular economy approaches	3 members of staff complete training Assess all new products for environmental impact and re-use potential	Leadership commitment	Awareness specific to role around Life Cycle Analysis, Carbon reduction and circular economy, trusts joint strategy objective 'our services are sustainable environmentally and financially'	Funded until October 2026
Develop more sustainable supply chain and decisions on procurement in relation to NZC and environment	Engage with Dorset HealthCare's suppliers to complete the Evergreen Assessment and increase their maturity level Embed Net Zero Supplier Roadmap including adopting new methods for reporting on supply chain carbon emissions and environmental progress.	In progress and requirement	NZ Supplier Roadmap https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2024/04/NHS-Net-Zero-Supplier-Roadmap-2024.pdf https://www.england.nhs.uk/nhs-commercial/sustainability/evergreen/	On-going

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4.8 Food and nutrition

It is estimated that food and catering services in the NHS accounts for approximately 6% the NHS' Carbon Footprint Plus. A healthy balanced diet, with reduced ultra processed foods high in sugar, salt and fats is also a low-carbon diet. Healthier, locally sourced food can improve wellbeing while cutting emissions related to agriculture, transport, storage and waste across the supply chain and on NHS estates. It can support local suppliers as part of the Social Value. Plant based options can provide nutrition with reduced carbon impact, and these options are regularly provided across both trusts. Many staff are in shared housing or hospital accommodation with reduced opportunity to grow vegetables.

Clinical practice, in particular with Dieticians and Occupational Therapists, work with ward staff/inpatients and community patients to empower them to make informed sustainable, healthy choices in meal planning, preparation and consumption.

Progress: A baseline of food waste is collected at Dorset County Hospital, and we have instigated a restaurant recycling stated. We are researching initiatives to reduce this include an electronic ordering scheme, ward housekeeper trial, access to 'late plates' for staff who would benefit and working with a local food fridge. We are reinvigorating Soil Association standards at DCH, with the aspiration to achieve at Dorset HealthCare.

Recently, as part of the collaborative federated working between Dorset County Hospital (DCH) and Dorset HealthCare (DHC), a joint Food and Hydration Strategy Group was established. This group brings together key stakeholders from across both organisations to develop a unified and forward-looking approach to catering services. The strategy has been shaped through collective input and is supported by dedicated workstreams, each aligned to specific, measurable objectives to ensure clear progress and accountability and there are 3 aims that are progressing to prioritising into time related actions.

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Joint Food and Hydration Strategy Aims

Aims	Specific	Measurable & Time related	Relevant
1. Personalised patient nutrition and hydration	focuses on ensuring that every patient's food and drink needs are met through a personalised, safe, and clinically appropriate approach, structured around SMART principles.	Objectives such as completing nutritional screening within 24 hours of admission, introducing standardised menus by set deadlines, and implementing fluid monitoring systems provide clear, measurable and time-specific targets.	The approach ensures that nu care is tailored to individual cli cultural, and dietary needs, inc texture-modified diets, while al promoting improved hydration, mealtimes, and consistent mou Collectively, these objectives a and directly aligned to improvi outcomes, ensuring progress c tracked and evaluated effectiv
2. Accessible healthy choices for staff and visitors	centres on making healthy food and drink options readily available and appealing to staff and visitors at all times.	promoting healthier options across all venues, measurable through availability and uptake, and achievable through practical interventions such as improved vending, 24-hour access, and clearer food labelling. Time-bound elements, such as ongoing improvements to shift worker access and menu variety, ensure continuous progress	highly relevant to staff wellbein encouraging hydration, regular and engagement with health in while making healthy choices c visible, and sustainable in the
3. Sustainable Food and Catering Practices	These objectives are achievable through improved data collection, benchmarking, and operational changes, while remaining directly relevant to environmental and financial sustainability goals.	By embedding SMART principles, the strategy ensures that progress in reducing waste and improving procurement practices can be clearly monitored, evaluated, and continuously improved.	highlights the importance of su in food procurement and cater services.

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Actions identified to date

Specific	Measurable	Achievable	Relevant	Time-bound (deadline)
Work through Soil Association 'Food for Life Served Here application	Undertake actions specified in the standard.	The application process is funded and about to be progressed from Spring 2026.	Ensure local and other suppliers can understand what is the requirement and focus social value and environment to our core objectives and reducing health inequalities and supporting the Social Value Action Plan	Quarterly and Annually
National Standards for Healthcare Food and Drink	Framework of standards for NHS trusts all 8 areas...	All achieved in DCH and DHC	https://www.gov.uk/government/publications/independent-review-of-nhs-hospital-food & https://www.england.nhs.uk/long-read/national-standards-for-healthcare-food-and-drink/#4-improving-sustainable-procurement-and-reducing-food-waste	2027
Electronic Food Ordering Scheme	A ward level trial	Enabling works are challenging but in progress.	The trusts joint strategy objective 'our services are sustainable environmentally and financially' and patient experience	October 2026
Durable servicewear	Business case for 7 service item types, an overall Life Cycle Analysis	Research into types, clinical needs, completed	Re-useable is generally lower carbon option and is likely to enhance s patient experience versus a paper cup and consideration to fine motor control and other needs. Waste and carbon reduction	Summer 2026
Ward hosts trial	A trial is evaluated	Research and options undertaken	Potential to reduce food waste and enhance patient experience	2026
Community partnership explored	1 community food scheme link developed into a funding application	Flash freezers at DCH and local community fridge an option	Addressing health inequalities and potential to significantly reducing food wastage with links to Electronic Food Ordering scheme to support labelling	2027

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Behaviour change and submetering project with 'measure it and manage it.'	Measure catering electricity use and investigate potential for 1. More efficient equipment 2. Efficient cooking design 3. Training and engagement Feedback any reduction	resources through NHS England Decarbonisation Funding scheme to submeter the main DCH site by June 2026	Data from the catering electricity use informs reduction in cost and carbon.	**June 2026 baseline begins**
Encourage 'grow your own' knowledge with planted examples and interpretation. Inside kitchen planters explored.	Herb planters and information on grow your own including window-sill plants.	Relative fundraised and hospital charity grant planting around Damers and interpretation board & signs funding in place with Recovery Ranger	Many staff are in hospital staff accommodation or shared housing with limited access to gardening. Food origin information can help people make healthier more sustainable choices and increase awareness of smallholders and local family farmers.	**Summer 2026**

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4.9 Adaptation and resilience

Here in Dorset, we are already experiencing the effects of climate change on our weather, such as more frequent heavy rainfall events and prolonged heat waves. There is also a risk of snowstorms. These severe weather events are likely to increase in number as global temperatures continue to rise. Our Business Continuity Plans prepare for and mitigate the disruption (increased patient numbers, difficulties in staff getting to work, disruption to supplies).

In addition to this, we recognise the value our immediate green spaces hold, both in terms of mitigating some of the impacts of severe weather (e.g. flash flooding and overheating), and the wellbeing benefits they can bring as potential 'cool spots.' We have a Garden Club comprising a team of volunteers who manage our grounds in ways to promote biodiversity and want to take a strategic look at our green spaces to identify where more action could be taken and identify partnerships to help us deliver this.

Progress

- DCH and DHC are part of the Dorset wide 'Public Sector Decarbonisation and Ecology Group' led by Dorset Council with members in Police, Fire, Bournemouth University, Dorset Trusts working to share good practice in sustainability and Climate Change Risk Assessment
- DCH Business Continuity Plans include ways to mitigate the effects of extreme weather events, including service plans with a Corporate Risk Register risk severe weather
- Both trusts have gardens groups, and DCH has a greenspaces group led by the Director of Nursing, and members from Arts in Hospital, Patient Experience & Volunteering, Capital Projects and Sustainability, this led to Greener Communities Funding for a Sensory Garden and winning 'Dobbies in the Community'
- Nature and Wellbeing pages and resources on staffnet, developing the 'HealthybyNature' and Arts in Hospital Nature inspired activities with Mary Anning patients
- DHC work with League of Friends to support a number of highly successful gardening groups including at Westminster Memorial Hospital, Shaftesbury. Other sites including Westhaven Hospital have a therapeutic garden and St Anns Hospital patients can undertake gardening activities.
- DCH Sustainability Team, Strategic projects and all DHC Capital Planning Staff have undertaken Biodiversity Net Gain training to better understand the requirements of the 2024 planning legislation to protect and enhance biodiversity across sites and future developments

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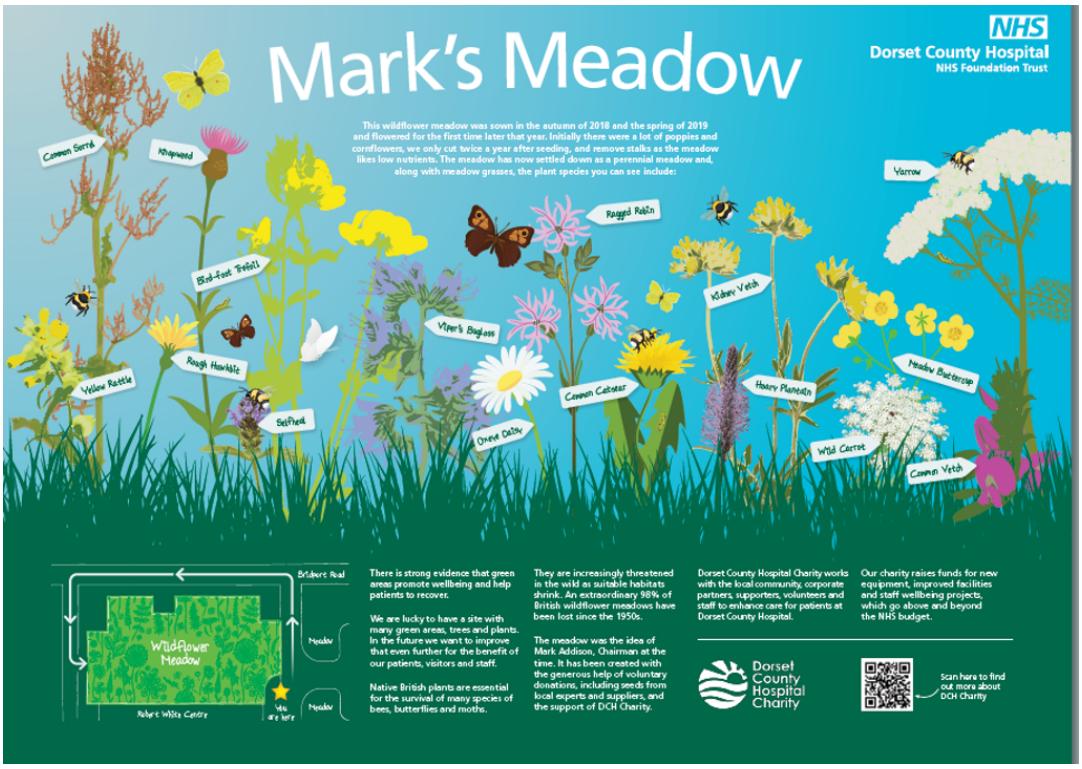
Specific	Measurable	Achievable	Relevant	Time-bound (deadline)
We will work across the Dorset Trusts to develop a Climate Change Risk Assessment, for impacts such as flooding, heatwaves and snowstorms on our infrastructure, patients, staff, visitors and volunteers, and service delivery	Climate Change Risk Assessment for all Dorset Trusts, and engagement with Heads of Risk, the Risk Register and Senior Leadership. Complete the NHS Climate Change Risk Assessment tool	Finance agreed and scope and consultant appointment in progress Resources for any actions are not yet identified	Climate change threatens the ability of NHS to deliver its essential services in the near and long term. Resilience and adaption needs to be build in to avoid related disruptions. A climate change adaption framework for NHS organisations in England May 2025	**December 2026**
Develop a site plan and actions recommended to improve our green spaces for the health and wellbeing of staff, patients and visitors and biodiversity	Plan and 3 projects i-naturalist data from 2025 baseline of the Dorset County Hospital site	Working with the Recovery Ranger, Sustainability Manager and volunteers	Minimise our impact on the environment is a core objective, and enhance wellbeing is part of healthier workforce and community. Ensure adequate cascading of weather health alerts and relevant messaging across the organisation, in line with the government's Adverse Weather and Health Plan	**December 2026**
Update DCH Adaption Plan/ develop a joint plan during 2026 to reflect the CCRA recommendations	Scope of the adaptation plan to build on CCRA and maturing relationships with those affecting the physical landscape and resilience partners	To develop from CCR including potential resource planning and recommendations.	all providers and commissioners of NHS-funded services must comply with the adaptation provisions within the NHS Core Standards for emergency preparedness, resilience and response (EPRR) and the NHS Standard Contract to support business continuity during adverse weather events set out actions to prepare for severe weather events and improve climate resilience of local sites and services, including digital services (see Annex B: selected resources for a supporting Climate Change Risk Assessment Tool)	**March 2027**
Investigate opportunities for innovation in Nature Based Solutions to mitigate and adapt to flooding, heatwaves, winds or snow events including cool spots in heat waves and our tree canopy	Flood events, hot days leading to innovation and cool spot places	Evolving knowledge and innovation; suppliers, community partners	trusts should: factor in the effects of climate change when making infrastructure decisions and designing new facilities, including enhancements like improved green spaces, drainage systems and passive cooling solutions	**March 2028**

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4.10 Greenspaces and biodiversity

We are committed to protecting our natural environment and reducing the risk of pollution to land, water or air. The trusts already work to comply with all regulatory and legislative environment requirements such as COSHH, responsible waste disposal, Asbestos, dust management.

This area links with Clinical Transformation with a more explicit focus on patient care and clinical/therapeutic interventions with OTs, Physios, mental health and exercise practitioners, etc. using green spaces as part of care provision as well as empowering patients with the benefits of green and blue spaces in physical and mental health promotion, rehabilitation and self-management.



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Progress:

- DCH is hosting a Centre for Sustainable Health Care ‘HealthybyNature’ Dorset Recovery Ranger starting wildlife count events and enlisting volunteers to record on I-naturalist to get a baseline of wildlife on the site, we are developing ideas for future joint events with DHC
- We are working to improve gardens at DHC hospitals and sites, DCH sensory garden opposite special care dentistry and Mark’s Meadow wildflower areas, with support of Greener Communities, Dobbies in the Community, Kingston Maurward college and Men's Shed Dorchester and adjoining stakeholders
- DCH met the biodiversity plan for the MSCP of bee bricks, bird boxes, wildflowers and native hedges and began a review of the living wall.
- We aim to signposting these greenspaces, ‘cool spots’ and potential innovation in nature-based solution to refurbishments and improvements to achieve biodiversity net gain for the future for both trusts
- We have undertaken NHS Forest planting with staff volunteers on the DCH site and will consider NHS Forest applications once a greenspaces plan is drafted
- We will incorporate green space within new builds and refurbishments and re-purpose courtyards previously unavailable to staff or the public, develop a manageable Environmental Impact Assessments for business cases and proposals.



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Specific	Measurable	Achievable	Relevant	Time-bound (deadline)
Develop an Environmental Impact Assessment on a page pro forma for future business cases	A concise EIA pro forma and explanatory notes in use across the trusts Estates & Facilities and other depts	Utilising in house expertise and supported by Board level leadership	Ensure business cases and projects are considered for Environmental, Ecological and Sustainability implications in the same way as QIA.	March 2026 and reviewed annually
Dorset Recovery Ranger supported in role and nature-based activities promoted, assessed and improved. Learning and resources shared across trusts.	Number of sessions, feedback and adaption, achieving project plan. Resources shared to Dorset trusts and satellite activities considered	Role in place and funded from June 25 – March 2027. working with Communications. Locally Manager of Sustainability Manager, co-design the-March am of evaluation, steered by Greenspaces Group and cascaded through Sustainability SG and relevant opportunities.	Related to health and wellbeing, staff wellbeing pathways, potential reduction in prescriptions and health inequalities https://sustainablehealthcare.org.uk/new-nature-recovery-rangers/	2025-2027
Greenspaces plan including consideration of tree canopy, Nature Based Solutions, Biodiversity and Access	A living document plan that is related to grounds maintenance and future projects	In house resources of Sustainability, EF and Projects	Awareness specific to role around Life Cycle Analysis, Carbon reduction and circular economy, trusts joint strategy objective 'our services are sustainable environmentally and financially'	October 2026
Improvements to greenspaces and greenspace access including rest benches, cool spots and wildlife and sustainable planting	Before and after photographs, funding applications and project delivery	Teamwork of Recovery Ranger, Sustainability Manager, Head of Facilities and Steering of Greenspaces Group	Health and wellbeing benefits to staff, patients and actions that may contribute to Biodiversity Net Gain, engagement with wildlife and sense of positive environment and potentially more pro-environmental behaviours	2026/2027 & ongoing

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5. Governance and metrics

Our progress against the Green Plan will be reviewed every two months by a joint Sustainability Working Group and assurance summary into the Joint Strategy Transformation and Partnerships Committee in Common who holds responsibility for Net Zero Carbon. It will be reported formally to the Board on an annual basis and a named board-level lead for Green Plan delivery. Progress will be tracked against the outlined measures, key milestones and proposed Key Performance Indicators and identify risks to future delivery. Many metrics will be tracked via the Greener NHS dashboard, Estates Return Information Collection (ERIC).

KPIs proposed (quarterly to steering group & annual summary to Board):
1. Compliant Green Plan Actions Achieved (metrics in this report)
2. Carbon Footprint decreasing in line with NHSE targets (this is not a requirement but a local picture aids actions)
3. National Target for clinical waste strategy targets 60:20:20 (offensive: alternative; high temp)
4. EcoEarn activity – increasing
5. Joint Green Travel Plan by December 2026
6. Sustainable Development Assessment Tool 2 - set a baseline/improve score

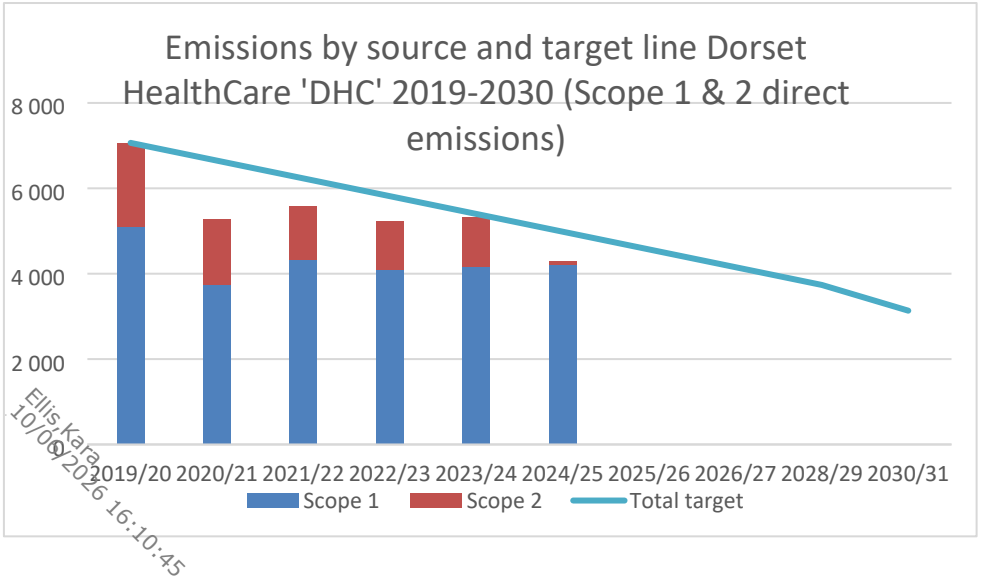
The Green Plan is a live document and with the previous plan, sometimes we achieved more, or had to divert into different ways of achieving in similar aims, so where there are opportunities to increase the ambition, or create opportunities, we will. Since 2023 Greener NHS will have developed a carbon footprint specific to our trusts, and a Greener NHS Dashboard. As part of Dorset County Hospital Decarbonisation Plan, we have a carbon footprint workbook we update and share via Business Intelligence. England coordinates the overall carbon footprints. The trusts monitor scope 1&2 emissions, although scope 3 is harder to capture locally and unavailable on the NHS England Greener NHS Dashboard at present.

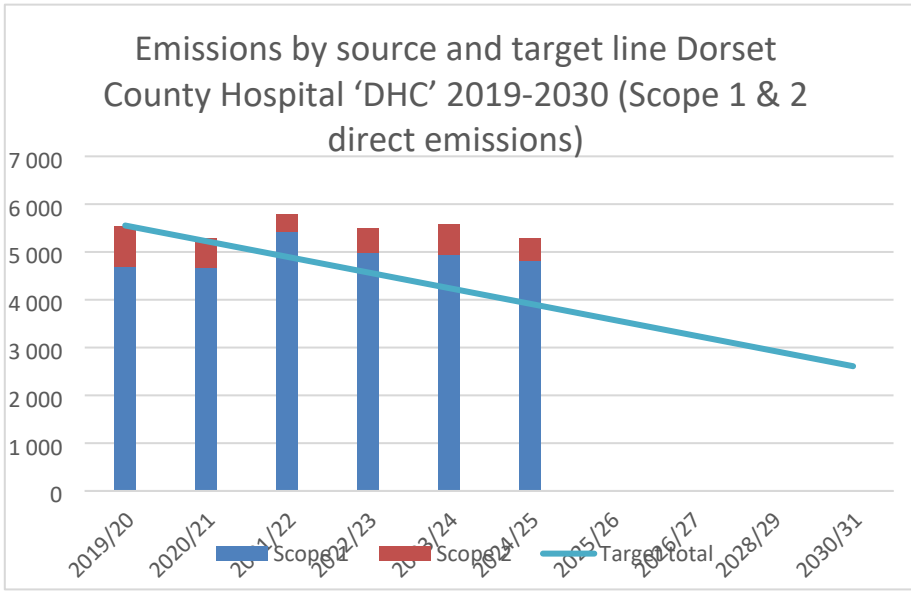


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Specific	Measurable	Achievable	Relevant	Time-bound (deadline)
Track out Green Plan metrics	As defined in this document and Actions, with detailed actions metrics available on request. Greener NHS Dashboard – quarterly reporting ERIC – annual reporting	The metrics are agreed and most are within our capacity to measure and monitor. There are some detailed metrics that would need prioritisation or focus lead support	The Department of Health and Social Care (DHSC) group accounting manual, the Foundation trust annual reporting manual and the NHS Standard Contract set out sustainability reporting requirements for NHS organisations. NHS England will also consider progress on delivery of green plans as part of its annual assessment of ICB performance.	Quarterly and annually

Key Metric: *Are Carbon Footprints decreasing in line with NHSE targets?*





Estate Decarbonisation & Renewable Energy (Scope 1 & 2) Dorset HealthCare Trust

KPI	Baseline (2024/25)	Target 2027	Target 2030
Renewable electricity generated	**267,000 kWh**	600,000 kWh	900,000 kWh
Grid electricity consumption	5.9 GWh	Reduce 10%	Reduce 25%
Scope 2 emissions	1,450 tCO_2e	Reduce 15%	Reduce 45%
Sites with on-site renewables	5	11	15

Carbon impact focus: Reduced reliance on grid electricity; direct Scope 2 reduction.

2. Fleet Electrification & EV Infrastructure (Scope 1)

KPI	Baseline (2024/25)	Target 2027	Target 2030
Total Trust fleet vehicles	257	250	240
Electric vehicles (% of fleet)	**10% (EVs)**	25% (62 EVs)	100%
EV charge points available across the Trust Estate	22	55	75

Carbon impact focus: Elimination of tailpipe emissions; compliance with NHS zero-emission fleet mandate.

3. Clinical Waste & HTM 07-01 Compliance (Scope 3)

KPI	Baseline (2024/25)	Target 2027	Target 2030
HTM 07-01 20/20/60 compliance	100%	Maintain 100%	Maintain 100%
Clinical waste generated	160 tonnes	Reduce by 15%	Reduce by 25%
Clinical waste sent for high temperature incineration	26 tonnes	Reduce by 10%	Reduce to 25%
Clinical waste-related emissions	39 tCO_2e	Reduce by 20%	Reduce by 35%

Carbon impact focus: Better segregation reduces high-carbon incineration.

- **High-temp incineration is only ~16% of total tonnage** but produces **~60% of total emissions**.
- **Offensive waste is ~60% of tonnage** but only **~5% of emissions**.
- Segregation accuracy is therefore one of **the highest-impact carbon levers** available in healthcare waste management.

4. Circular Economy & Waste Management Policy

KPI	Baseline (2024/25)	Target 2027	Target 2030
Reuse/recycling rate (non-clinical)	15%	25%	40%
Total waste generated	531 tonnes	Reduce by 10%	Reduce by 20%
Waste (non-clinical) carbon intensity	11 tCO_2e	Reduce by 10%	Reduce by 25%

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Carbon impact focus: Waste prevention and reuse drive the largest Scope 3 reductions.

5. Water Efficiency & Embedded Carbon

KPI	Baseline (2024/25)	Target 2027	Target 2030
Total water consumption	90 m³	Reduce by 10%	Reduce by 20%
Water saved – HQ waterless urinals	100k litres per urinal	**400,000 L/yr**	Sustained
Carbon from water use	32 tCO_2e	↓ 15%	↓ 30%

Carbon impact focus: Indirect carbon reduction via reduced treatment and pumping.

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Dorset County Hospital

Scope	Focus	Action	tCO2e	Volume saved	ghg factor 2025	Unit	Data sources	Presume
2	Food & nutrition/Waste	Food waste measure, late plates and recycling station	6.56	1400	4.68568	kgCO2e/t	ghg 2025; Baseline food waste tracking first year	Per year 6.5tCO2e
2/3	EFM/ Food & nutrition	Catering electric complete ballpark of 20% of the hospital electric use, 10GWh (2GgWh)	17.70	5-10%, 0.01 GWh	0.177	kgCO2e/kWh	estimate and behaviour change study (national) to be clarified by submetering during 2026	Per year 17.7tCO2e
2	EFM/ Food & nutrition	The gas supply is a separate fiscal meter using around 170,000kWh, total of 0.7% total site use	1.56	5-10%, 8500kWh	0.18323	kgCO2e/kWh	Fiscal meter direct to catering	Per year 1.557tCO2e
2/3	EFM/ Food & nutrition	Catering reduction in tCO2e/annum	25.82					
3	Digital transformation	Reduction in paper usage with new HER system	27.23					
3	EFM/ Waste/ Supply chain	Rehoming disposal avoided						
3	EFM/Waste	Clinical Waste targets						
1/2	DECARB SCHEMES EFM	Submetering Phase II Dorset County Hospital	61.59	320,909 kWh	0.177	kgCO2e/kWh	5-10% save in energy consumption through increased awareness of costs, behaviour change and areas of	Per year 61.59 tCO2e

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								highest consumption	
1/2	DECARB SCHEMES EFM	LED replacement Phase III Dorset County Hospital	8.20	46,744kWh	1.177	kgCO2e/kWh	BEIS emission factors, quotes from suppliers	Per year 8.2 tCO2e	
1/2	DECARB SCHEMES EFM	Full decarbonisation plan to achieve heat and power not yet funded while Capital Projects & Sustainability seeking funding and ROI cases							
		DCH Schemes	**122.836**	**TOTAL**					
		First year target (1&2)	327.00	TARGET					
		Total in the pipeline in first year	122.84	PLANNED					
		Target minus in progress schemes	204.16	SHORTFALL					
		Number of uncalculated actions that will reduce Carbon emissions							
3	Travel & Transport	Green Plan (Staff Commute, clean air hospital)		Calculate as part of EIA					
2	EFM Waste	Theatre hats trial (reduce waste)		Calculate as part of EIA					
3	EFM Waste	Theatre packs/ uniform recycling		Calculate as part of EIA					
1/2	Energy / Digital	Ditch the junk IT challenges		Calculate as part of EIA					
1	Medicines	Nitrous cylinder management		Calculate as part of EIA					
3	Medicines	Pharmaceutical waste projects		Calculate as part of EIA					

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3	EFM Waste	Rehoming	Calculate as part of EIA
3	EFM Waste	Maintain Clinical Waste targets and implement updated Waste Management policy, including circular economy	Calculate as part of EIA
1/2	EFM	Future decarbonisation applications - solar, EVCP, LED	Calculate as part of EIA
1/2	EFM	Fabric improvements (not yet funded)improve energy efficiency	Calculate as part of EIA
3	Food & Nutrition	Soil Association	Calculate as part of EIA
2	Food & Nutrition/ Waste	Durable servicewear (reuse reduce waste)	Calculate as part of EIA
3	Food & Nutrition/ Waste	Electronic food ordering (accurate ordering, production and reduce waste)	Calculate as part of EIA
1/2/3	Digital transformation	Remote outpatient activity	Calculate as part of EIA
3	EFM Waste	Repair scheme (Less waste, procurement)	Calculate as part of EIA
3	Travel & Transport	electrification of fleet (continue in DHC, begin in DCH) and Green Travel Plan	within GTP (2026/7)

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6. Communication and engagement

We need to inspire specialist and trust wide action from staff, patients, the community and partners to deliver the Green Plan objectives

- Green Plan focus area leaders drawing together expertise and commitment
- Managers to consider Carbon Literacy training, for themselves, and staff, funded to October 2026
- staff we meet and those at induction coffee breaks about EcoEarn and Dorset Liftshare
- Development of further waste stream e-learning
- Travel options at recruitment stage, and at appointment letter stage
- Sustainability Champions with packs with everyone using correct waste streams, switching off lights, monitors and closing doors
- calls to action and progress updates in staff bulletins, sustainability days, wildlife count days.

Our communication and engagement channels at the start of this plan

- Sustainability Working Group and focus areas, Sustainability Group, Health & Wellbeing
- E-newsletter to all Sustainability Champions
- Staff bulletins
- Staff travel survey (annual 2024, 2025)
- Bicycle User Group Teams channel
- Greener theatres
- Gardening Group members



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Specific	Measurable	Achievable	Relevant	Time-bound (deadline)
Joint Sustainability Working Group to share opportunities, information and best practice and deliver focus areas	Minutes of Joint Sustainability Group	The establishment of joint Sustainability Group support and encourage focus area leads	Skill requirements for delivering the Green Plan	Summer 2026
Carbon literacy training for Sustainability team, focus leads and procurement	Number of staff completed Carbon Literacy training	Funded spaces until October 2026 requires Line Manager sign off	Green Plan guidance states promote specialist training for staff groups who underpin the delivery of green plans, such as board members, procurement, finance, estates and facilities staff and clinicians.	October 2026
Staff pledge platform EcoEarn engagement	Activity statistics increasing	Within current resources	Green Plan guidance: organisations should support their staff and leaders to learn, innovate and embed sustainability into everyday actions.	On-going
Waste stream e-learning developed with Waste Officer and Training	E-learning resource with Waste streams and waste hierarchy	Development of ideas and content in place	NHS Clinical Waste Strategy ensures waste processed in cost-effective, safe, efficient and sustainable manner and the NHS is the largest producers of waste in the country.	Contributes to reaching NZC by 2024
appointment, recruitment contact and staff induction includes low carbon travel options	Information on website, staffnet and recruitment and outpatient admin supported to include this	Information for DCH is ready to go online and be linked to, it is in place on staffnet	Green Plan guidance: Develop a sustainable travel plan focusing on active travel, public transport and zero emission vehicles, and clear understanding of staff commuting – guidance available in 2025.	By December 2026

Ellis Kara
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7. Summary areas for action

Estates and Facilities – Scope 1 and 2 'NHS Carbon Footprint' greenhouse gas emissions we control directly

"Our aim is to embed sustainability and efficiency, using smart design and emerging technologies across our improvement works, consider preventing waste, rehoming and lifecycle considerations in refurbishments and new building works."

Emissions resulting from its buildings, water and waste account for 63% of the emissions the NHS directly controls. The aim for both trusts is to improve sustainability by transforming heat decarbonisation plans into building-by-building actions, to build on rehoming furniture and equipment schemes, achieve or maintain correct use of waste streams, improve recycling rates, and develop a Green Plan refresh that can map the NHS commitment on route to the direct emissions 'carbon footprint' target of 80% reduction by 2028/32

Energy Efficiency

Align with hierarchy – 1. save, 2. supply efficiently 3. reduce emissions

Energy efficiency is a priority for our estate and facilities management including:

- The use of renewable energy is developing with the Solar PV on the discharge lounge modular building and as part of the New Hospital Project investment of an array on the energy centre rooves.
- DCHFT undertook LED replacements with Centrica CHP project, and subsequent success with 2 NEEF applications for around HS National Energy Efficiency Fund (NEEF) as part of work to install LED lights across the hospital. The Trust has received £62,000 from the fund over the last couple of years which has allowed us to install nearly 400 LED light fittings on our main site
- Dorset HealthCare was successful with NEEF funding for an extensive LED lighting replacement scheme and also received funding for Solar PV at six sites. There are currently another 5 sites with Solar PV installed.
- A Heat Network Development Unit grant equipped DCHFT to investigate ground source and geothermal technical, environmental and financial feasibility and a subsequent application to HNDU by Dorset Council is using this initial work
- Enquiries on local biogas and hydrogen was initially undertaken but these technologies and supplies are developing capacity in Dorset with older CHPs adaptability requires technical and supply investigation
- Interventions focused on improved air conditioning and cooling, building fabric, space heating, insulation, ventilation and hot water are outlined in the DCHFT Heat Decarbonisation Plan
- Net zero principles to be embedded in all projects for both trusts. While this increases efficiency and reduces whole-life costs, it does require funding to cover the additional investment costs

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Estates and Facilities – Scope 3 greenhouse gas emissions that we control indirectly 'NHS Carbon Footprint Plus'

The NHS supply chain accounts for 62% of total carbon emissions and is a priority for our Green Plan. We are working towards a soil association award in catering, that considers local suppliers; delivering 10% weighting for sustainability and social value in tender decisions and carbon literacy training as currently subsidised by NHS England until October 2026

Our aim is to embed sustainability and efficiency, using data, lifecycle considerations, including sustainable procurement policy and culture that considers the process, materials, transport, social value and longevity, repairability of items or services are considered."

Site Management and Travel

- flexible working and working from home policies where practicable can reduce travel
- At least 25% of outpatient activity delivered remotely, currently consistently over 20%
- The Dorset trusts developed an NHS Dorset Lift share schemes, promoted at staff inductions, we would like to see this in recruitment stages
- DHC has worked to increase the number of electric vehicles in their fleet and is continually adding charging locations to support this ambition.
- DCH has a public / staff EV charging points in the MSCP and some fleet areas
- Promote public transport information on staffnet to recruitment and outpatients and develop a Green Travel Plan across the sites with annual staff travel surveys to follow the South Walks House GTP that contributed to BREEAM Very Good for the refurbishment
- Investigate ways to fund cycle storage, showers and facilities for staff who cycle to work, support the staff Bicycle Users Group, additional bike shelters as part of NHP scheme at DCH

As a good neighbour we work with Dorset Council highways to promote cycleway improvements and an e-bike scheme in Dorchester that now serves the main site, South Walks House and areas of Weymouth. Our Green Travel Plan will explore staff use of the scheme, further work is needed to link in with bus service groups

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Sustainable procurement

- DCH have, and DHC are developing, a sustainable procurement policy and developing culture, that consider processes, materials, transport and social value towards lower carbon and sustainable products, reusable items and services. We are also

working with other public sector decarbonisation leads, led by DC, on sustainable procurement.

- The trusts are developing the soil association award in catering and carbon literacy training across green leads and sustainability champions.
- IPM and a Greener theatres group are working to develop green initiatives that relate to estates and facilities such as theatre ventilation downtime, sterilising facilities in SCBU, re-useable tourniquets', pee in a pot container changes and gloves off campaigns

Biodiversity and greenspace

- We are committed to protecting our natural environment and reducing the risk of pollution to land, water or air. While estates & facilities operations do not have an Environmental Impact Assessment the trusts work to comply with all regulatory and legislative environment requirements such as COSHH, responsible waste disposal, Asbestos, dust management.
- We will incorporate green space within new builds and refurbishments and re-purpose courtyards previously unavailable to staff or the public, such as where we have working on gardens at DHC hospitals and sites and DCH sensory gardens opposite special care dentistry and Mark's Meadow wildlife areas.
- We have undertaken NHS Forest planting with staff volunteers
- DCH is hosting a CSH Dorset Recovery Ranger starting wildlife count events and enlisting volunteers to record on I-naturalist to get a baseline of wildlife on the site, some events are joint with DHC
- We have met the biodiversity plan for the MSCP of bee bricks, bird boxes, wildflowers and native hedges and began a review of the living wall.
- Signposting these spaces, 'cool spots' and potential innovation in nature-based solution to refurbishments and improvements to achieve biodiversity net gain for the future.

Sustainable models of care

- Carbon savings will arise from reducing presentations in A&E as the prevention and early intervention models of care mature. More digital appointments for outpatients and in primary care will help reduce staff and patient mileage.
- We will continue to work on models of care that help to further reduce the number of hospital visits and consider different travel options when planning changes to services.
- Infection Prevention Management are working with colleagues and teams on IV to Oral switch to enable patients to go home sooner including early removal of devices to prevent infection.

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8. Appendices

1. Detailed Green Plan Action List – Dorset County Hospital NHS Foundation Trust (Internal)
2. Detailed Green Plan Action List – Dorset HealthCare University Foundation Trust (Internal)
3. Joint Sustainable Travel Plan (to be inserted by December 2026)
4. Resilience and Adaptation statement (to be inserted by December 2026 following CCRA)
5. Greenspaces, trees and biodiversity outline first plan (aspirational)

Focus areas explanatory note between versions

Supporting Documents

Bournemouth, Christchurch & Poole Council tourism data - https://www.publichealthdorset.org.uk/documents/40757/0/BCP+JSNA+Annual+Narrative+-+Dec+2023.pdf/4680a616-9711-cc78-f4ec-33ceb6c66769
Census - Office for National Statistics
DCH Climate Change Adaptation Plan 2021-2026 (internal)
DCH Sustainability Policy (internal)
DCH Sustainable Procurement Policy (internal)
Dorset County Hospital Green Plan 2022/3-2024/5
Dorset County Hospital Social Value Pledge
Green Plan Guidance: https://www.england.nhs.uk/long-read/green-plan-guidance/
Sustainability Group Terms of reference (internal)
Visit Dorset tourism statistics
Working Together, Improving Lives: The joint strategy for Dorset County Hospital and Dorset HealthCare (2024)
Your Future Hospital: Dorset County Hospital Foundation Trust Strategy 2025
Social Value Programme, DCH (internal)
Health Inequalities Work Plan (internal)
Health Technical Memorandum 07-01: Safe and sustainable management of healthcare waste, NHS England, (2022)

Footnotes:

1Dorset Council: Dorset statistics and census information - Dorset Council https://www.dorsetcouncil.gov.uk/data-and-insight-for-dorset
2Delivering a 'Net Zero' National Health Service
3Home First – helping you recover at home
4Dorset County Hospital: Acute Hospital at Home

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Green plan refresh focus 2025	Green plan focus 2022	Comment
Workforce and System Leadership	Workforce and Leadership	This is an area of focus for the Annual report related to Task Force for Climate related Disclosures reporting standard, embedding sustainability into organisational culture & staff engagement
Net Zero Clinical Transformation	Sustainable Models of Care	Care pathways and clinical practice reducing waste, such as 'gloves off' and the greener theatres checklist as we work together across Dorset County Acute and a range of community hospitals
Digital transformation	Digital transformation	Delivering 25% of outpatient activity remotely, ordering technologies and printer rationalising
Medicines	Medicines	Clinical practice with lower emissions such as changes from anaesthetic gases, use of cool sticks instead of ethyl chloride, exploring inhaler recycling
Travel and transport	Travel and transport	Facilitating active travel, Dorset NHS Liftshare, EV Fleet (DHC) and EVCP at DCH for staff and public
Estates and Facilities	Estates and Facilities	Energy efficiency, waste reduction, heat decarbonisation, water, sustainable buildings
Supply Chain and procurement	Supply Chain and Procurement	Sustainable procurement policy with tenders 10% weighting for social value and sustainability, single plastics reduction, local suppliers, re-useable tourniquets.
Food & nutrition	Food & nutrition	Measuring food waste, recycling station, cup take back scheme, staff late plates, ward hosts trial
Adaptation & Resilience	Adaption (and greenspaces)	Adaptation Plan update, developing Climate Change Risk Assessment
Greenspaces & biodiversity		'HealthybyNature' Project hosting a Dorset Recovery Ranger, Active Hospitals, Sensory gardens, Mark's Meadow and staff gardens club, biodiversity recording
Sustainable buildings	Your Future Hospital Project	Net Zero Hospital Standard targets, South Walks House refurbishment BREAAM 'Very Good'
Governance & metrics	Tracking & reporting progress	KPIs proposed (quarterly to steering group & annual summary to Board): - 1. Compliant Green Plan Actions Achieved (metrics of use of resources and engagement) 2. Carbon Footprint decreasing in line with NHSE targets 3. National Target for clinical waste strategy targets 60:20:20 (offensive: alternative; high temp)

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		4. EcoEarn activity – increasing 5. Joint Green Travel Plan and staff travel surveys by December 2026 5. Sustainable Development Assessment Tool 2 - improve score
Engage & communicate	Call to action and co-deliver	Sustainability Champions, EcoEarn staff pledge platform, Sustainability in all our JDs, volunteers, community and working with delivery partners from Social Value, Charities, Local Councils

Ellis Kara
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Dorset HealthCare University
NHS Foundation Trust

Report to	Board of Directors in Common (DHC)	
Date of Meeting	17 June 2026	
Report Title	Senior Information Risk Owner (SIRO) Annual Report 2025/26	
Prepared By	Dave Way Data Protection Officer & Information Governance Manager	
Approved by Accountable Executive	Jenny Horrabin, Joint Director of Corporate Affairs	
Previously Considered By	Information Governance Steering Group – April 2026 Strategy Transformation and Partnerships Committee in Common – May 2026	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR09 Digital SR10 Cyber Security	
Financial	No implication	
Statutory & Regulatory	Compliance with data protection law, and regulatory activity	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary

The DHC annual SIRO report is identified for inclusion on the Information Governance Group Steering Group (IGSG) Cycle of Business. It provides the Board with assurance that Dorset HealthCare University NHS Foundation Trust identifies, and addresses key information governance (IG) issues and associated risks, and undertakes all necessary activities to maintain a strong IG and cyber posture.

The information governance management framework shows the leadership, accountability within the Trust for the mandated data protection and information security activities. The NHS England on-line tool, the Data Security and Protection Toolkit (DSPT), provides the mechanism for the Trust to evidence compliance with legal and regulatory requirements.

The processing of all such data is carefully managed, and any data privacy or information security breaches are initially reported and managed through Ulysses, with serious incidents escalated to the Information Commissioner's Officer via the NHS DSPT reporting tool. The quarterly cyber security reports contain the specific details of any information security activities or concerns and are presented to IGSG and the Board.

Recommendation

The Board is requested to note:

- That we await feedback from the internal auditors on our standard of compliance to the new DSPT.
- That the mandatory IG and Cyber training stands at 92% short by 3% of the required level.
- Receive the report for **assurance**

Ulysses 10/06/2026 10:45

Senior Information Risk Owner (SIRO) Annual Report 25/26

1. Introduction

- The role of the Senior Information Risk Owner (SIRO) is to be the accountable person for the Trust in relation to the security and accessibility of all data produced and held by the Trust. Within DHC the SIRO is supported by the Data Protection Officer, Dave Way, the Digital Team primarily Andrew Harrison Digital Solution Architect and Ross Courtney IT Security Officer.
- The above named personnel are responsible for the protection of all data held and processed by the Trust and for ensuring the systems used by the Trust are secure from cyber-attack and where and if we have a data breach the Trust has plans and systems in place to protect the Trust and minimise disruption and loss of data and an ability to reinstate services and report any such breach or attack to the relevant authorities and keep the Board, the Trust and the Public informed.

2. Main narrative - SIRO Notable events in 2025/26:

2.1 Reports to the Information Commissioner's Office

- **38072** – A Nurse gathered data for their own purposes without permission, the nurse has been dismissed and the ICO has referred the case to their criminal investigations branch for investigation and possible criminal charges awaiting an update from the ICO. (From 2024/25 carried over awaiting ICO conclusion)

- **No further incidents required reporting to the ICO**

2.2 Cyber Security Incidents

- No incidents to report for 25/26

2.3 Information Governance Steering Group (IGSG):

- The SIRO chairs the IGSG meetings on a quarterly basis. The IGSG is attended by the SIRO, Deputy SIRO, Caldicot Guardian, DPO, Med Records Manager, Digital systems leads, Clinical, Training and Business and Performance representatives. The purpose of the meeting is to keep the SIRO informed of IG and Cyber matters and for those present to report on their areas of responsibility and to raise concerns. Policies and SOPs are also sent to the meeting for approval. The SIRO then takes any items for action or information to the Board.

3. Conclusion

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The Trust continues to keep the SIRO informed of how it manages its data and its systems, enabling the SIRO to make decisions and keep the Board informed of projects, risks and threats the Trust is managing and potentially facing. The DPO and IT Security Team work closely with the SIRO and the Directors to manage risk

through preventative measures and procedures and keep the Trust's systems and our patient and staff data safe. The SIRO ensures with the DPO and Cyber Security Team that they liaise with the Head of Emergency Planning to keep our business continuity plans are current and carry out exercises to test the plans.

Name and Title of Author:
Dave Way
Data Protection Officer
Dorset HealthCare University NHS Foundation Trust

Date 21/05/2026

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10/06/2026 16:10:45

Report to	Board in Common (DCH)	
Date of Meeting	17th June 2026	
Report Title	Senior Information Risk Owner (SIRO) Annual Report 2025/26	
Prepared By	Diane Gravett, Data Protection Officer	
Approved by Accountable Executive	Jenny Horrabin, Joint Director of Corporate Governance	
Previously Considered By	Strategy, Transformation and Partnership Committee	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR09 Digital, SR10 Cyber Security	
Financial	No implication	
Statutory & Regulatory	Compliance with data protection law, and regulatory activity	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary

The DCH annual SIRO report is identified for inclusion on the Information Governance Group (IGG) Cycle of Business. It provides the Board with assurance that Dorset County Hospital NHS Foundation Trust identifies and addresses key information governance (IG) issues and associated risks, and undertakes all necessary activities to maintain a strong IG and cyber posture.

The information governance management framework shows the leadership and accountability within the Trust for the mandated data protection and information security activities. The NHS England on-line tool, the Data Security and Protection Toolkit (DSPT), provides the mechanism for the Trust to evidence compliance with legal and regulatory requirements.

The processing of all such data is carefully managed, and any data privacy or information security breaches are initially reported and managed through DATIX, with serious incidents escalated to the Information Commissioner's Officer. The quarterly cyber security reports contain the specific details of any information security activites or concerns and are presented to IGG and the Board.

The DCH SIRO responsibility is with Jenny Horrabin, Joint Director of Corporate Affairs. The DCH Caldcott Guardian is Dr Rachel Wharton, Chief Medical Officer

Recommendation

Board are requested to note:

- That we await feedback from the internal auditors on our standard of compliance to the annual data security and protection toolkit.
- Receive the report for **assurance**

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Senior Information Risk Owner Annual Report 2025/26

1. Introduction

- Information Governance is the framework to ensure that an NHS organisation's information is processed legally, securely, efficiently, and effectively in accordance with the UK General Data Protection Regulations and the Data Protection Act 2018 whilst also upholding the common law Duty of Confidentiality. Good information governance practice ensures the necessary safeguards for, and appropriate use of, corporate, personal, and sensitive information through data protection and information security.

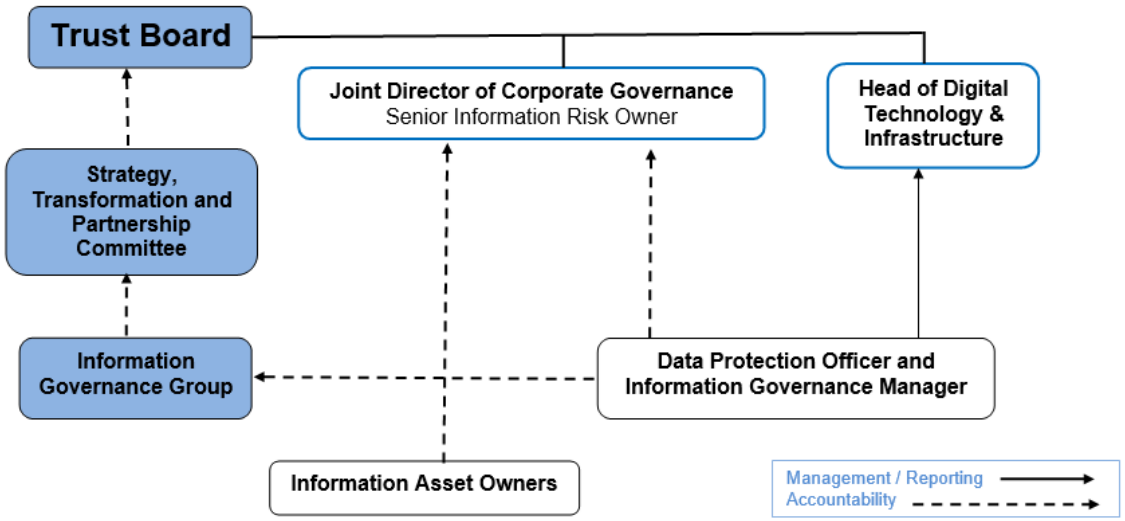
- This report is designed to provide assurance to the Strategy, Transformation and Partnership Committee that Dorset County Hospital NHS Foundation Trust is identifying and addressing key information governance issues and associated risks.

2. Leadership and accountability

- Leadership and accountability for information management is set out in the Information Governance Structure, with the Trust's Senior Information Risk Owner (SIRO), being the responsible person.

- The Joint Director of Corporate Affairs is the SIRO and is accountable to the Board, via the Strategy, Transformation and Partnership Committee, for ensuring that effective systems and processes are in place to address the Information Governance agenda, including records and document management, and is the overall owner of information risk at Dorset County Hospital.

- The Information Governance Group and Information Asset Owners are accountable to the SIRO. Information Administrators and Systems Administrators are accountable to their designated Information Asset Owner.



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Information Governance Group

- The Information Governance Group is a vital platform to ensure transparency and accountability, and to maintain engagement across the Trust.

- The data security and protection toolkit activity is reported at this meeting, as are incident reporting, health record subject access requests and records retention, information assurance including data quality, national dashboards, and information assets, and information security management framework activities including cyber security. These are all workstreams that provide assurance that the data protection and information security practices of the Trust are being managed and maintained.

3. The Role of the Senior Information Risk Owner (SIRO)

- The SIRO's role must be occupied by a Board member who will be held accountable for identifying and managing the information risks to the organisation. This includes oversight of the Trust's information security incident reporting and response arrangements.

- As data controllers we must adhere to the lawful requirements around records management and security. Article 30 of the UK GDPR requires organisations to maintain a written record of their data processing activities to demonstrate accountability if there is likely to be any risk to the rights and freedoms of data subjects or involves processing sensitive data (health). This record must detail the purposes of processing, categories of data and individuals involved, recipients, access controls, retention, and safeguards for any international data transfers.

  The SIRO is supported by Information Asset Owners (IAOs) who are divisional or care group leads and are assigned responsibility for information assets within their control. IAOs are supported throughout their department by nominated Information Asset Administrators (IAAs) and System Administrators (SAs). The Information Assurance Manager maintains the Trust's main information asset and flow register and collates assurance reports from the IAOs to provide ongoing accountability to the SIRO that the personal and sensitive information processed at DCH to provide healthcare is done so lawfully and appropriately.

4. Data Security and Protection Toolkit

- The Data Security and Protection Toolkit (DSPT) is the on-line tool provided by NHS England to enable organisations to measure their performance against the required security standards. This has become increasingly complex as NHS England works to keep the standards relevant as the digital world changes and are now based on the National Cyber Security Centre (NCSC) Cyber Assessment Framework (CAF) standards to focus more acutely on information security rather than data protection.

  BDO LLP conducted an internal audit in February and early signs of confidence are high, recommendations will be made to provide guidance to the Trust in a detailed report to the SIRO / DPO and Audit Committee once completed.

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  Work continues to meet the 2025/26 requirements in time for submission by 30th June 2026.

Personal Confidential Data
Staff must ensure that all personal confidential data is processed, stored, and transmitted securely, whether in digital or paper form, and is only shared for lawful and appropriate purposes.

Staff Responsibilities
All staff should understand their responsibilities under the Common Law of Confidentiality, UK GDPR and the Data Protection Act 2018, especially their obligation to handle information responsibly and their personal accountability for deliberate or avoidable breaches.

Information Governance and Cyber Security Training
All staff are now mandated to complete appropriate data security training every two years. The DCH level of compliance for information governance training is 92%, which is in line with Trust core elements of statutory and mandatory training. Additional ways to engage with staff and refresh their awareness are ongoing.

Managing Data Access
Personal confidential data is only accessible to staff who need it for their active role and access is removed as soon as possible once it is no longer required. We rely heavily on ESR being kept up to date, and system administration to take actions in a timely fashion. All access to personal confidential data on Digital Technology and Infrastructure (DTI) systems can be attributed to individuals.

Process Reviews
Processes and compliance to policies should be reviewed at least annually to identify and improve any which have caused breaches or near misses, or which force staff to use workarounds that compromise data security. Regular proactive audits should be scheduled and conducted however resource is not available to undertake these checks to provide assurance, instead investigations tend to be retrospective following an incident.

Responding to Incidents
Information governance related data breaches, complaints and concerns are investigated and reported to the Information Governance Group. Cyber-attacks against services are identified and resisted and NHSE CareCERT security advice is responded to promptly. Detailed information about our cyber posture is reported in the quarterly Cyber Security Report, which is presented to IGG and the Board.

Continuity Planning
A continuity plan is in place to respond to threats to data security, including significant data breaches or near misses, and it is tested once a year as a minimum, with a report to senior management. Desktop exercises are regularly undertaken to explore and raise awareness in different areas of the organisation.

Unsupported Systems
No unsupported operating systems, software or internet browsers are used within the digital estate, without appropriate documented mitigation actions. Legacy systems are those that can no longer be updated or supported by the supplier and could, therefore, introduce a risk from cyber criminals.

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Accountable Suppliers
Trust suppliers of IT services, software and hardware are held accountable via contractual clauses for protecting the personal confidential data they process and meeting the mandatory national security standards. These contracts are monitored by Procurement and DTI, and the ATAMIS procurement software is very DSPT focussed. The Procurement team undertake checks using the NHS England Digital Technology Assessment Criteria (DTAC) which has just been updated, and they work very closely with the DPO to ensure that contracts are appropriate, and data protection impact assessments are conducted whenever necessary.

Pan Dorset activities
We are working increasingly more closely with our colleagues across Dorset, and we strive to be as unified as we can be, as well as pragmatic in our approach to supporting joint ventures. Examples of recent activity are the Dorset / Somerset Epic contract for Healthset, the electronic health record, and the Optika project with the Federated Data Platform, to better support transfers of care.

5. Information Governance Issues and Risks

- The Information Governance Group monitors all data security and data protection breaches that are reported through the DATIX Reporting System. The number of IG related incidents reported remain very similar in number, type and area. There were three IG incidents reportable to the ICO in this reporting year, these were resolved satisfactorily, no reprimands were given.

- There continues to be good engagement of staff around information governance and issues are raised promptly, however, there have been a number of incidents relating to systems and suppliers. The rest are mostly simple human errors - documents left where they shouldn't be or sent to the wrong person. The remaining few are incidents of inappropriate access by experienced members of staff who know better.

6. Summary and Recommendations

- In summary, the feedback from the internal audit will inform us about ways to complete our 2025/26 Data Security Protection Toolkit submission on 30th June 2025 to best effect - the auditor has complimented us on the level of detail in our evidence so far.

- The greatest concern is the resource available to better audit, evidence and improve data protection and information security responsibilities across the Trust.

- The Group is asked to note the current position the Trust holds in relation to information governance.

Ellis,Kara
10/06/2026 16:10:45

Dorset HealthCare University
NHS Foundation Trust

Audit Committee Assurance Report for the meeting held on 29 May 2026

Chair	Nikki Rowland, Non-Executive Director
Executive Lead	Chris Hearn, Joint Chief Finance Officer
Quoracy met?	Yes
Purpose of the report	To assure the Board on the main items discussed by the Committee and, if necessary, escalate any matter(s) of concern or urgent business which the Committee is unable to conclude.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework

- Significant progress on the external audit has been made with a reduction of the expenditure recognition risk with assurance that all is on track for the extraordinary meetings in June 2026. The committee would like to pay particular thanks to the Finance team who were commended by external auditors on their responsiveness which makes the audit run more smoothly.
- Head of Internal Audit Opinion received with 'generally satisfactory with improvements required in some areas' assurance. It should be noted that the Internal Auditors have not provided any Trust with a better rating and would be unlikely to do so in the near future.
- Draft annual report was received with some recommended changes noted by the committee.
- Would like to note the improvement in the compliance on conflicts of Interest, recognising the work that has been undertaken in this space. A request on how the outsourced procurement function conflicts of interest will be monitored and assured was requested by the committee.
- 4 overdue actions, with particular concern expressed on the delays in responding to the Cyber Security audit, with the committee agreeing to seek closure more quickly than the suggested revised date initially provided.

Key issues / matters discussed at the meeting

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The committee received, discussed and noted the following reports:

Board Assurance Framework
Committee members received the 2025/26 Q4 report for assurance noting that Strategic risk for Estates (5), Finance (6) and Cyber-Security (10) met the target score therefore assuring the committee on the management processes in place. The proposed strategic risks and changes in description for 2026/27 were considered by the committee recognising that detailed discussion had also taken place amongst other Board Sub-Committees. The proposed changes to the descriptions and consolidation of 'Collaboration' and 'Transformation and Improvement' strategic risks (7

& 8) were supported in line with the agreed risk appetite, recognising some minor wording changes were still required for 2 risks to improve readability.

Corporate Risk Register
The committee received a detailed summary of the Risk Register report for assurance with an agreed cross-referral to the Quality committee for an update on progress with risk reference 1273 relating to the prescribing of valproate. The committee noted that the current high scoring risk relating to the CAMHS new build will reduce in the next edition of the report as it becomes operationally ready.

Internal Audit – Progress Report, Follow-up Report and Strategic and Operational Plan
The completion of the following audits were highlighted in the **progress report** to committee:

- Data Security and Protection Toolkit (advisory)
- Equality & Quality Impact Assessments (design substantial, effectiveness moderate)
- Appraisal Processes (design substantial, effectiveness moderate)

Findings were accepted and progress against the milestones will be monitored.

The 2026/27 **Internal Audit Plan** has been approved following minor amendments at JEMT.

Four overdue actions were presented in the **Internal Audit Follow-up Report** arising from three 2025/26 audits, with revised dates to come back to committee in relation to concerns on progress against the Cyber Security Supply Chain Management Audit relating to controls of access for third party users.

Head of Internal Audit Opinion
The committee received the head of internal audit opinion for assurance which was 'generally satisfactory with improvements required in some areas.' No audits received 'no assurance' or 'limited assurance', and no areas of concern were raised.

External Audit Progress Report
A verbal update was provided for assurance. Significant progress has been made including the reduction of the expenditure recognition risk, and no concerns were raised. Delivery is on track for the extraordinary Audit Committee meeting in June 2026. The committee gave special thanks to the Finance team for meeting all requests in a timely manner and equally to the external audit team.

Counter Fraud Progress Report

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The committee received the Q4 progress report for assurance noting a high number of completed investigations during the period, with no open cases at the end of the year and the improvement in compliance with recording conflicts of interest.

Draft Annual Report and Accounts (including annual governance statement)
The committee noted the current progress on the Annual Report with discussion and request for rewording of descriptions of the counter-fraud and external audit functions, with a cross-referral to the People and Culture Committee on approaches to increasing staff-side Trust membership. The committee requested further commentary in the report that explains the low performing score against 'effectiveness and experience' in the 'NHS oversight framework' section.

NHS Code of Governance, NHS Provider Licence, and Fit and Proper Persons Compliance
The committee noted the report for assurance with one proposed amendment in the code of governance to reflect comments on the timeliness of papers received in the annual committee effectiveness review. There was also commitment from the Non-Executive Directors to support training in authoring committee papers in the most informative and effective way.

Managing Conflicts of Interest (including gifts and hospitality) Compliance
The committee received the report for assurance and requested further assurance on how conflict of interest compliance for the outsourced procurement service will be managed and assured.

Decisions made at the meeting

- Approval of the Internal Audit plan for 2026/27 (final)

Issues / actions referred to other committees / groups

- Referral to the Quality Committee for an update on progress with risk reference 1273 relating to the prescribing of valproate.
- Referral to People & Culture Committee on approaches to increasing staff-side Trust membership (relating to the content of the membership section of the annual report)

Quoracy and Attendance						
	29/05/2026					
Quorate?	Y					
Nikki Rowland	Y					
Eiri Jones	Y					
Dave Underwood	Y					

Ellis Smith 10/6/2026 15:10:53

Dorset County Hospital
NHS Foundation Trust

Audit Committee Assurance Report for the meeting held on 1 June 2026

Chair	Stuart Parsons
Executive Lead	Chris Hearn, Chief Finance Officer Jenny Horrabin, Director of Corporate Affairs
Quoracy met?	Y
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Receipt of the Board Assurance Framework and Corporate Risk Register with updates as described below • Head of internal audit opinion for 2025/26 with a rating of "generally satisfactory with improvements required in some areas". • Positive feedback from external audit regarding the DCH Finance Team and their responsiveness in the year end audit process • Receipt of the draft Annual Report and Accounts and Annual Governance Statement, which were felt to provide a fair and balanced view • Confirmation of compliance with NHS Code of Governance, NHS Provider Licence, and Fit and Proper Persons
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: Further to an open action, an update on FOI compliance to be provided to the next meeting **Board Assurance Framework**, noting that: • The highest risks for the trust remain SR1, SR3, SR5, SR6, and SR9 • SR6 (finance) score has reduced from 20 to 16 due to the reduction in likelihood • Discussion around the outstanding actions for SR3 and SR6 • The revised wording for strategic risks was reviewed and broadly agreed with. **Corporate Risk Register**, noting: • Some scores were increasing due to operational pressures • The limitations of the reporting system were discussed with the new risk management system expected to provide improved reporting abilities and therefore additional assurance for the committee. Work ongoing to consider how to include current mitigations in the report, as opposed to historic. **Internal Audit progress, follow up, and annual reports**, noting:

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	Data Security and Protection Toolkit (DSPT) audit provided a moderate risk assessment and high confidence level. Receipt of the final internal audit plan for 2026/27and follow up reports with no outstanding issues. Head of internal audit opinion for 2025/26 with a rating of "generally satisfactory with improvements required in some areas". This is the second highest rating and replaces the previous rating of 'moderate'. **External Audit Update** noting a positive year-end audit with thanks extended to the DCH Finance Team for their responsiveness to audit queries. The final external audit report will be presented to the 22nd June Audit Committee, with no VFM weaknesses anticipated. **Counter Fraud Strategic and Operational Plan** and **Counter Fraud Reports** noting a request for increased resource in the 2026/27 plan which was being discussed with CH due to the cost impact. The progress report noted that work during Q4 has focused on investigating allegations of fraud, and completing a thematic fraud risk assessment in relation to AI enabled fraud. One new report of suspected fraud was received during Q4. **Draft Annual Report and Accounts 2025/26 (incl. Annual Governance Statement)** were received and felt to provide a fair and balanced view. Discussions around how assurance could be provided with regards to the accuracy of performance information, with an action arising to address this. The final report would be presented to extraordinary Audit Committee and Board meetings on 22nd June. **NHS Code of Governance, NHS Provider Licence, and Fit and Proper Persons Compliance** confirming compliance for all three elements for 2025/26. **Managing Conflicts of Interest, and Gifts and Hospitality Compliance** update provided, with an action referred to People and Culture Committee in Common regarding how to ensure that the outstanding individuals who have not made a declaration do so.
Decisions made at the meeting	• Approval of Review of Strategic Risks • Approval of the Internal Audit Annual Report and Opinion • Approval of the Counter Fraud Strategic and Operational Plan
Issues / actions referred to other committees / groups	• Referral to People and Culture Committee in Common to consider how to ensure that the outstanding individuals who have not made a declaration do so.

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Quoracy and Attendance						
	01 Jun 2026	25 June 2026 (Extraordinary)	03 Aug 2026	30 Nov 2026	01 Feb 2027	30 Mar 2027
Quorate?	Y					
Stuart Parsons	Y					
Dave Underwood	Y					

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Dorset County Hospital
Dorset HealthCare

Mental Health Legislation Committee in Common (MHLCiC) Assurance Report for the meeting held on Thursday 28th May 2026

Chair	Andreas Haimböck-Tichy
Executive Lead	Lucy Knight
Quoracy met?	Yes
Purpose of the report	To assure the Board on the main items discussed by the Committee and, if necessary, escalate any matter(s) of concern or urgent business which the Committee is unable to conclude.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Patient stories are now being presented to the Committee which gives a practical insight in terms of how the Legislation is applied and how it is making a difference. • Memorandum of Understanding is in place and is making a difference in terms of cross-agency working. • In depth report on the deaths of detained patients and the learning gained from those sad events. • Positive progress on the Section 132 reporting. • Improved dashboard, Mental Health Legislation Team were acknowledged for their dedication and improved reporting.
Key issues / matters discussed at the meeting	Discussion around the use of force and restrictive practices being listed as reporting ad hoc to the Committee. It is a quarterly report that goes via the Quality Governance Group, but CMO felt it should come to MHLAC regularly. This will be reviewed. **Patient Story:** A complex patient story was shared with the Committee involving the long-term use of the Mental Health Act (MHA), a Community Treatment Order (CTO) and the Deprivation of Liberty Safeguards (DOLS). The patient was in a residential care setting, and the Community Mental Health Team (CMHT) had worked with the care home to ensure that the least restrictive practice was in place for this patient. CTO was important as this gave the power to recall to patient to hospital for treatment, which happened twice. This was an example of positive use of the CTO and an approach to working with partner agencies to reduce restrictions and work towards the patient's best interest and quality of life. There was some discussion around how the learning from this case could be shared across the CMHTs. Positive points were flagged around working with the residential home and the patient. **Corporate Risk Register Assigned Risks** No risks identified that meet the threshold for committee consideration.

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MHL Committee Annual Report:
Committee noted:

- Met four times, two of which were quorate as a joint committee (joint from July 2025) – there were some issues with quoracy on the Dorset County side, so the membership was reviewed and the Director of Corporate Affairs added to the attendees and the meeting has been quorate since then.
- Progress has been monitored via the action tracker.
- Assurance report submitted to Board after each Committee meeting.
- Committee has been regularly attended by Non-Executive Directors for both organisations and other Executives and staff as required.
- Standing agenda items are included on the workplan.
- Following review, Committee has discharged its responsibilities.
- Noted Terms of Reference had already been agreed by Board, due to timings of this Committee, so presented here for completeness. Agreed.
- Noted poor response rate to effectiveness survey, 2 respondents, as such the results could be misleading. ACTION: agreed to re-run the survey at 6 months will all Committee members encouraged to respond.

Policies Relevant to the Work of the Committee

- Noted this was an historic report.
- Monthly process in place to review and chase any policies that are overdue, and those due for renewal in the next 6 months.
- New Intranet due to be launched in Dorset HealthCare in July, so a further cleanse and chase will take place before items are uploaded on to the new system.
- On the new intranet, metatags will be added to each policy for better search functionality.
- Noted the difficulty in getting multi-agency policies agreed.

Memorandum of Understanding (MOU): Escalation of patients detained under DOLS or MHA
Memorandum of Understanding has arisen out of the tricky interface between the Mental Capacity Act (MCA) and the Mental Health Act (MHA), particularly in acute hospitals. There is a difficulty of interprofessional interactions around patients in acutes that are ineligible for DOLS but also don't meet the requirement for a detention under the MHA. These problems are occurring all over the country. The MOU was originally developed in the north of England, but this has been adapted to Dorset.

MOU provides a clear pathway for escalation where there is an agreement around which legal framework to use for people in acute hospitals. It provides a step by step if there is a disagreement on which framework to

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use, and what happens if resolution isn't reached and how to escalate via a three-step process.

DHC and DCH Mental Health Legislation Assurance Dashboards
HealthCare:

- Covered quarter 4 data.
- Noted special cause variation around the MHA at Royal Bournemouth Hospital (RBH), which means that we are seeing less use of the MHA at RBH.
- Noted lower use of the MHA across all providers.
- One incidence of a patient passing away whist under detention, which was reported to CQC at the time of occurrence.
- One incidence of an under 18 being admitted to an adult environment. Adolescent patient was not admitted to an adult ward, but they were admitted to the health-based placed of safety. Being transparent, this was also notified to the CQC, although it was not a requirement to do so, so that they were aware that an under 18 was within one of our adult facilities but was not interacting or spending time with adult patients.
- Two instances of Sections lapsing.
- Continued increased compliance with ensuring manager's hearings, which have been scheduled following renewal of a Section 3 or renewal or extension of a community treatment order, are held in the current period of detention, rather than falling into the next period of detention.
- Starting to see a slight increase in terms of urgent applications for DOLS. This is being monitored.
- Light touch review requested around the delays in the S136 detentions, and whether there are any clinical concerns.
- Noted the almost mirror images of reduced MHA detentions and the increase in DOLS applications and detentions.

<u>Presentation on Attendance at Hearings:</u>

- Committee had previously raised concerns over the low levels of attendance at Mental Health hearings.
- Noted we have more CTO, or reviews by hospital managers, than Section 3.
- CTO hearings outnumber Section 3 significantly. Hospital Manager hearing referrals are made automatically when a CTO or Section 3 is renewed.
- September to February data was reviewed, and detailed 113 hospital hearings had taken place, 82 of which involved patients subject to a CTO.
- Patient attendance at these hearings are between 5% and 37%.
- Patients are more likely to attend Section 3 hearings, rather than a CTO hearing. Patients are more likely to attend a hearing that relates to an in-hospital detention.

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- Work has been undertaken by the MHA Office to encourage patient attendance at manager's hearing and tribunals.

Dorset County:

- Issue with a Section 5. Requested completed by a resident doctor, but the patient had not been moved from the Emergency Department to the patient administration system as an admission, which would render the 5:2 not valid.
- Increase in numbers during February and March, we saw a high number of admissions from eth Weymouth and Portland area, and these are associated with complexity and safeguarding concerns. Work is being undertaken around high intensity users for calls to see if we can mitigate the need for an ED attendance.
- Psychiatric Liaison Team is undertaking an audit to review the patients that were coming straight to ED and not accessing mental health services at a local level. That information will be reviewed by the Mental Health and Learning Disabilities Group.
- Psychiatric Liaison are also looking at the contacts of those patients in the two weeks prior to attending ED, and whether there was a missed opportunity for earlier intervention.
- One under 18 was detained on Kingfisher, originally under a Section 2 and then a Section 3.
- Discussion was had around the resident doctors and the use of a Section 5:2 to ensure paperwork is completed correctly after some anomalies were found. So many resident doctors rotate after four months, so it Is not the right solution to train them all in systems they will infrequently use. We are looking at training our ED Resident doctors and locally employed doctors as they rotate less.
- Dashboard is regularly presented to the Mental Health and Learning Disability Group which is also attended by CAMHS and Psychiatric Liaison colleagues which is working well and gives an opportunity to look at operational issues affecting both organisations.
- There was a planned review of 9 cases following attendances at ED being undertaken in a multi-agency, multi-professional clinical case review to look at joint learning and to see how we may be able to manage patients more effectively together.
- One case will be reviewed via the Right Care, Right Person process, which related to a patient that was bough to ED, but should have gone for a S136 assessment.

Deaths of Detained Patients: MHA Learning Summary

- Cases were managed in accordance with the required procedures, including notifying the CQC, internal reporting via the risk management system and application of Duty of Candour.
- Person 1 died by suicide whilst on Section17 leave. A key issue identified was an administrative error resulting in the patient being

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recorded incorrectly as informal rather than detailed. The review found that this error did not impact the outcome, and the patient would have been granted leave regardless of legal status.

- Learning identified:
  - Clarity of roles and responsibilities of Approved Clinicians particularly Consultant Practitioner Approved Clinicians.
  - Strengthening staff induction and training in MHA powers (notably Section 23 discharge)
  - Finalisation and implementation of Multi=Professional Approved Clinician (MPAC) guidance.
  - The need for improved understanding of risk assessment in neurodiverse patients, supported by a planned thematic review.
- Person 2 died from cocaine toxicity with underlying coronary artery disease. The review identified no issues or learning related to MHA detention.

Improving Section 132 Reporting - Progress Report

- This Section places a legal duty on hospital managers to ensure that patients detained under the Act are informed, both orally and in writing of their legal authority for their detention, their right to appeal to the Mental Health tribunal, their right to legal representation and advocacy, the role of their nearest relative and other safeguards available to them.
- DHC historically have recorded Section 132 rights on paper forms completed by nursing staff which were then sent to the Mental Health Legislation Office. This process was burdensome, prone to delays and dependent on manual handling.
- To improve efficiency and compliance this process has now been embedded directly into the RiO electronic patient record. This enables some pre-population of data, such as patient and ward details.
- Enables real-time visibility of rights attempts and provides clear dashboards showing the same.
- Benefits have been improved compliance, and better data quality, enhanced patient experience, stronger governance and environmental benefits.

Mental Health Act Care Quality Commission (CQC) Inspections Assurance Report (including individual reports following inspections)

- Three actions in relation to Herm ward have been closed.
- One action has been granted an extension to the deadline date to enable sufficient time for staff to complete training.
- Progress has been made on one action in relation to the removal of dormitory accommodation. Committee note that there remains a risk that the deadline may not be met with this action as there have been delays with securing planning permission.
- Remaining final action was on track.

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Decisions made at the meeting	Nil
Issues / actions referred to other committees / groups	Nil

Quoracy and Attendance				
	28/05/2026			
Quorate?	DHC Y | DCH Y			
Andreas Haimböck-Tichy (DHC)	Y			
Dawn Dawson (or deputy)	Y			
Lucy Knight (DHC)	Y			
Rachel Wharton (DCH)	Y			
Margaret Blankson (DCH)	Y			
Nikki Rowlands (DHC)	Y			
Suresh Ariaratnam (DHC)	Y			
Stuart Parsons (DCH)	Y			
Jenny Horrabin	N			

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Report to	Board of Directors (DCH & DHC)	
Date of Meeting	17 June 2026	
Report Title	Annual Governance and Board Effectiveness Review	
Prepared By	Jenny Horrabin, Joint Director of Corporate Affairs	
Approved by Accountable Executive	Jenny Horrabin, Joint Director of Corporate Affairs	
Previously Considered By	N/A	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	Board effectiveness includes effective oversight of strategic risks	
Financial	No specific implications	
Statutory & Regulatory	Compliance with statutory and regulatory requirements reported	
Equality, Diversity & Inclusion	Included within NHS Code of Governance and Leadership Competency Framework	
Co-production & Partnership	Included within NHS Code of Governance	

Executive Summary

- This paper outlines the assessments of compliance that have taken place that collectively inform our annual review of board effectiveness.
- During 2025/26 DHC and DCH operated with Committees in Common and from October 2025 have operated a Board in Common. All Board Development during the year has been undertaken jointly and the corporate governance arrangements are mirrored across both organsiations. Therefore, this report applies to DHC and DCH with differences highlighted where they occur.
- Below are listed the reviews undertaken during the year that collectively allow us to conclude on our board effectiveness.
  - The NHS Code of Governance
  - The NHS Provider License
  - Provider Capability Assessment
  - Advanced Foundation Trust Application (DHC only)
  - BDO Well Led Review (coaching conversations)
  - The Annual Governance Statement 2025/26
  - Fit and Proper Person Test, Leadership Competency Framework and Board Member Appraisal Guidance and Board Development Programme
  - Committee Annual Report, Committee Effectiveness Reviews and Committee Terms of Reference
  - Annual Board Effectiveness Review

- For both DHC and DCH we have declared compliance under the 'comply or explain' rules related to statutory and regulatory requirements, in particular the NHS Code of Governance and NHS Provider Licence. This was reported to the respective Audit Committees on 29 May 2026 (DHC) and 1 June 2026 (DCH).
- The Committee reviews have confirmed that the Committees are compliant with their Terms of Reference and the annual effectiveness reviews have provided positive feedback on the

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effectiveness of the Committees with a small number of areas for improvement, with consistent themes across Committees. The results of these were reported to Committees in March 2026 (with the exception of the Mental Health Legislation Committee and the Remuneration Committees which will be reviewed at the next meetings of each) and to Board in April 2026. The Terms of Reference for Committees have been reviewed and were approved at Board in April 2026.

- There is a full Joint Board Development Programme in place, and this covers strategy, accountability and culture and leadership. This is complemented by individual training and a central record is maintained of this.
- In April 2025 NHS England published 'Board Member Appraisal Guidance'. NHS England » Board member appraisal guidance. The appraisal process for 2024/25 was completed in accordance with the guidance and the process for 2025/26 is currently in progress and will be undertaken in accordance with the guidance, with completion within expected deadlines.
- During the year NHS England introduced the Provider Capability Assessment. Each Trust was required to self-assess their capability against six domains. NHS England » Assessing provider capability: guidance for NHS trust boards
  - DHC self-assessed as 'compliant' across all six domains. The Trust was subsequently assessed by NHS England as 'Green'. This was consistent with the Trusts self-assessment.
  - DCH self-assessed as 'compliant across four domains and 'partially compliant' across two domains. The Trust was subsequently assessed by NHS England as 'Amber-Green'. This was consistent with the Trusts self-assessment.
- Towards the end of 2024/25 and into 2025/26 the Trusts Internal Auditors undertook an advisory piece of work framed around the CQC well led framework and in particular held coaching conversations with Directorates and Senior Leaders. Positive feedback was provided and was presented to Board in September 2025 as part of a Board Development session.
- In November 2025 DHC were selected by NHS England to be a wave 1 applicant for Advanced Foundation Trust. This process was undertaken between December 2026 and March 2026 and included a robust internal review, building on the Provider Capability Assessment. This was subject to external review by NHS England including a detail review of evidence submissions, observations of Committee and Board and a Board-to-Board Meeting with NHS England. The Trust submission based on our self-assessment was compliant with all 'Board statement'. Positive feedback has been provided at all stages with no areas of concern reported to the Trust. The outcome of the process is awaited.
- At the end of the year an annual Board Effectiveness Survey was completed. This anonymous survey provided Board Members with the opportunity to comment on board effectiveness across six areas. The responses rates were 64% for DHC and 71% for DCH. The results were presented at the Board Development Session on 12 May 2026.
- The Annual Governance Statement (AGS) included as part of the Annual Report has concluded that there are no significant internal control issues for either DHC or DCH. The draft reports have been reviewed by respective Audit Committees on 29 May 2026 (DHC) and 1 June 2026 (DCH).
- The results of this annual assessment were presented and considered as part of a Board Development Session held on 12 May 2026.
- The conclusion of this review is that DCH and DHC Boards continue to operate effectively.

Recommendation

The Board is asked to confirm that the annual review of Board effectiveness has been completed through the reviews described in this report.

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Annual Governance and Board Effectiveness Reviews - June 2025

Dorset Healthcare University BHS Foundation Trust (DHC) and Dorset County Hospital NHS Foundation Trust (DCH)

1. Introduction

This paper outlines the assessments of compliance that have taken place that collectively inform our annual review of board effectiveness.

During 2025/26 DHC and DCH operated with Committees in Common and from October 2025 have operated a Board in Common. All Board Development during the year has been undertaken jointly and the corporate governance arrangements are mirrored across both organisations. Therefore, this report applies to DHC and DCH with differences highlighted where they occur.

Below are listed the reviews undertaken during the year that collectively allow us to conclude that we have robust governance arrangements in place and the DCH and DHC boards have operated effectively.

- The NHS Code of Governance
- The NHS Provider License
- Provider Capability Assessment
- Advanced Foundation Trust Application (DHC only)
- BDO Well Led Review (coaching conversations)
- The Annual Governance Statement 2025/26
- Fit and Proper Person Test, Leadership Competency Framework and Board Member Appraisal Guidance and Board Development Programme
- Committee Annual Report, Committee Effectiveness Reviews and Committee Terms of Reference
- Annual Board Effectiveness Review

2. The NHS Code of Governance

The NHS Code of Governance sets out a common overarching framework for the corporate governance of trusts, reflecting developments in UK corporate governance and the development of integrated care systems. The new version of the code applies from April 2023. The full code can be found at NHS England » Code of governance for NHS provider trusts. Set out in five sections, the code describes principles of good governance and the provisions (based on the principles) with which provider trusts must 'comply or explain'.

A self-assessment has been completed that provides assurance of compliance with the NHS Code of Governance for 2025/26. Both trusts are fully compliant.

The full self-assessment to demonstrate compliance with the NHS Code of Governance was presented to the respective Audit Committees on 29 May 2026 (DHC) and 1 June 2026 (DCH).

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Area – NHS Code of Governance	DHC	DCH
Board Leadership and Purpose		
Division of Responsibilities		
Composition, Succession and Evaluation		
Audit, Risk and Internal Control		
Remuneration		
Publicly Available Information		

3. The NHS Provider License

The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future.

A new NHS Provider licence was issued on 31 March 2023. The requirements relating to certification of the licence requirements was removed from the provider licence with effect from 1 April 2023. NHS England does not routinely monitor and assess compliance against each of the individual licence conditions, although there is an expectation that providers should periodically self-assess. In the majority of cases compliance can be assured through reference to existing plans/strategies.

A self-assessment has been undertaken and this provides assurance to the Board that the trust is compliant with all licence conditions. The full licence with all conditions can be found at PRN00191-nhs-provider-licence-v4.pdf (england.nhs.uk).

License condition CoS7 – Availability of Resources, requires that the trust will have access to the necessary resources for the forthcoming 12-month period and to declare any limitations. The Annual Governance Statement within the Annual Report considers the factors impacting the availability and efficient use of resources and outlines the sources of internal and external assurance the trust has received on the use and availability of resources. This informs the Chief Executive's view of the adequacy of the trust's systems of internal control and provides assurance to the Board of compliance with license condition CoS7.

The trust must also review whether their governors receive enough training and guidance to carry out their roles. The induction, training and guidance arrangements are mirrored across DCH and DHC and included:

- Induction training
- Governor handbook
- Regular development events and workshops each year (these are individual trust and joint events)

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- Regular updates and information on key areas
- Offered training provided through the NHS Providers Governwell programme.

The training provided is regularly reviewed and refreshed through annual reviews of the induction and business programmes and through feedback after the development days and other events. Governors also have access to specialist expertise to provide appropriate and objective guidance including the corporate governance team, communications team in relation to membership and engagement and human resources and external support for the Council of Governors' Nomination and Remuneration Committee.

The full self-assessment to demonstrate compliance with the NHS Provider License was presented to the respective Audit Committees on 29 May 2026 (DHC) and 1 June 2026 (DCH).

4. Fit and Proper Persons Test, Leadership Competency Framework and Board Member Appraisal Guidance

NHS England (NHSE) published a new Fit and Proper Person Test (FPPT) Framework in August 2023 following the Kark review undertaken in 2019. The framework is applicable to executive and non-executive directors, alongside guidance for chairs on implementation. The Board received a detailed briefing on the enhanced requirements to ensure that members of the Board were 'fit and proper' and are of 'good character' in September 2023 with the NHSE expectation of full implementation of the guidance by 31 March 2024.

During the year the trust ensured compliance with the framework and submitted the required confirmation of compliance return to NHSE by the 30th June 2025.

We are currently in the process of undertaking our annual review of the Fit and Proper Person Checks and these will be completed by the deadline of 30th June 2026 enabling the trust to submit the Chair's statement of compliance to NHSE by that time.

The Kark review (discussed above) also recommended the implementation of a competency framework for board members which is aligned to NHS England's People Promise. The Leadership Competency Framework aims to promote diversity and high-quality care provision and is based on wider industry best practice.

The framework is for chairs, chief executives and all board members in NHS systems and providers, as well as serving as a guide for aspiring leaders of the future. It is designed to:

- support the appointment of diverse, skilled and proficient leaders
- support the delivery of high-quality, equitable care and the best outcomes for patients, service users, communities and our workforce
- help organisations to develop and appraise all board members
- support individual board members to self-assess against the six competency domains and identify development needs.

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Appraisals have been undertaken in accordance with the Leadership Competency Framework, and we have reported compliance with this to NHS England during the year.

In April 2025 NHS England published 'Board Member Appraisal Guidance'. NHS England » Board member appraisal guidance. The appraisal process for 2025/26 will be undertaken in accordance with the guidance.

We are required to confirmation completion of the Chairs and Non-Executive Directors appraisals to NHS England and these were reported in accordance with the agreed deadlines during the year (for 2024/25 appraisals) and have been scheduled to meet the required reporting deadlines for 2025/26 appraisals.

There is a full Joint Board Development Programme in place, and this covers strategy, accountability and culture and leadership. This is complemented by individual training and a central record is maintained of this.

We have in place a Succession Plan for Non-Executive Directors. This includes a skill matrix and references the Workforce Race Equality Standards (WRES) and Workforce Disability Standards (WDES).

5. Board Development Programme

There is a full Joint Board Development Programme in place, and this covers strategy, accountability and culture and leadership. For 2025/26 the Development Plan has been aligned to domains in the Insightful Board Guidance and the Provider Capability Assessment. The completed Board Development Plan for 2025/26 is included at Appendix One.

The outline for plan for 2026/27 is included at Appendix Two. The plan is kept undergoing to ensure board development evolves in response to the environment in which we operate.

We recognise that there may be occasions when the DCH and DHC Boards have different development needs and where this is the case Board specific sessions will be undertaken. This did not occur in 2025/26.

The Board Development Plan is supplemented through individual training and by individual committee sessions. Each Committee has four 'informal' sessions per year which provides the opportunity for Committee specific development sessions.

6. Committee Annual Report, Committee Effectiveness Reviews and Committee Terms of Reference

The Committee reviews have confirmed that the Committees are compliant with their Terms of Reference and the annual effectiveness reviews have provided positive feedback on the effectiveness of the Committees with a small number of areas for improvement, with consistent themes across Committees. The results of these were reported to Committees in March 2026 (with the exception of the Mental Health Legislation Committee and the Remuneration Committees which will be reviewed at the next meetings of each) and to Board in April 2026. The terms of Reference for Committees have been reviewed and were approved at Board in April 2026.

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Area – Committee Effectiveness	Annual Effectiveness Review	Discharged Responsibilities	TOR and Work Plan Reviewed
Audit Committee – DCH/DHC			
Remuneration Committee – DCH/DHC			
Strategy Transformation and Partnerships Committee in Common			
People and Culture Committee in Common			
Quality Committee in Common			
Finance and Performance Committee in Common			
Mental Health Legislation Committee in Common			

7. Well Led – Coaching Conversations

Towards the end of 2024/25 and into 2025/26 the Trusts Internal Auditors undertook an advisory piece of work framed around the CQC well led framework and in particular held coaching conversations with Directorates and Senior Leaders. Positive feedback was provided and was presented to Board in September 2025 as part of a Board Development session.

8. Provider Capability Assessment

During the year NHS England introduced the Provider Capability Assessment. Each Trust was required to self-assess their capability against six domains. NHS England » Assessing provider capability: guidance for NHS trust boards.

As part of the NHS Oversight Framework (NOF), NHS England assessed NHS trusts capability. As a key element of this, NHS boards were asked to assess their organisation's capability against a range of expectations across 6 areas.

This is designed to strengthen board assurance and help oversight teams take a view of NHS trust capability based on boards' awareness of the challenges their organisations face and subsequent actions to address them. The purpose of this is to focus trust boards' attention on a set of key expectations related to their core functions as well as encourage an open culture of 'no surprises' between trusts and oversight teams. NHS England regional teams then used the Trusts self-assessment and other evidence to derive a view of the organisation's capability.

Ellis Kay
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The DCH and DHC self-assessments were approved by the Boards in October 2025 and the outcome of the NHSE review was received in February 2026 and reported to the next scheduled Board meeting.

- DHC self-assessed as 'compliant' across all six domains. The Trust was subsequently assessed by NHS England as 'Green'. This was consistent with the Trusts self-assessment.
- DCH self-assessed as 'compliant across four domains and 'partially compliant' across two domains. The Trust was subsequently assessed by NHS England as 'Amber-Green'. This was consistent with the Trusts self-assessment.

Area – Provider Capability Assessment	DHC	DCH
Self-Assessment		
Strategy Leadership and planning	Confirmed	Confirmed
Quality of Care	Confirmed	Confirmed
People and Culture	Confirmed	Confirmed
Access and Delivery of Services	Confirmed	Confirmed
Productivity and Value for Money	Confirmed	Partially Confirmed
Financial Performance and Oversight	Confirmed	Partially Confirmed
NHSE Assessment	**Green**	**Amber/Green**
Consistent	√	√

9. Annual Board Effectiveness Review

At the end of the year an annual Board Effectiveness Survey was completed. This anonymous survey provided Board Members with the opportunity to comment on board effectiveness across six areas. The responses rates were 64% for DHC and 71% for DCH. The results were presented at the Board Development Session on 12 May 2026. The detailed survey results have been shared with DCH and DHC Board Members and an overview is provided in the table below.

Respondents	DHC	DCH
Self-Assessment	**9 (64%)**	**10 (71%)**
Board Focus		
Board Team Working		
Board Impact		
Board Engagement		
Board Process and Meetingss		
Financial Performance and Oversight		

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There were comments in both reports relating to the length of papers for Committee and Board and this was consistent with the feedback from NHS England as part of the DHC Advanced Foundation Trust assessment process.

We recognise that in creating Committees in Common and a Board in Common there will be an inevitable increase in the volume of papers to ensure the business of both trusts is appropriately covered. However, we know there is more we can do to streamline the papers and to improve the quality of the executive summaries.

There is a Board Paper Improvement Plan in place and report writing training for executives and senior leaders has been commissioned. In the first half of 26/27 we are expecting to see an improvement in the board papers and will be introducing a maturity framework for board reporting to drive improvements and move from information heavy to insight driven. It is also recognised that whilst there have been significant improvements in the timeliness of papers over the last two years there are occasions when late papers are circulated – this is primarily due to awaiting latest data and when it does occur board members are notified. Actions to further improved are included in the Board Paper Improvement Plan.

10. Advanced Foundation Trust Assessment (DHC only)

In November 2025 DHC were selected by NHS England to be a wave 1 applicant for Advanced Foundation Trust. This process was undertaken between December 2025 and March 2026 and included a robust internal review, building on the Provider Capability Assessment. The DHC Board approved the Board Certification Statements in December 2025 prior to submission to NHS England in January 2026. This included specific statements relating to board effectiveness and effective governance arrangements.

This was subject to external review by NHS England including a detail review of evidence submissions, observations of Committee and Board and a Board-to-Board Meeting with NHS England. The Trust submission based on our self-assessment was compliant with all 'Board statement'. Positive feedback has been provided at all stages. The Trust were successful in this application which was confirmed at the end of May 2926.

Area – Advanced Foundation Trust Self-Assessment	DHC
Outcome	**Successful**
Strategy Leadership and planning	
Quality of Care	
People and Culture	
Access and Delivery of Services	
Productivity and Value for Money	
Financial Performance and Oversight	

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11. Annual Governance Statement

The Annual Governance Statement is a mandatory requirement for the Annual Report and provides a statement by the Chief Executive Officer of their review of the governance systems and processes in place across the trust to ensure effective control and mitigation of risks. NHS England's Annual Reporting Manual sets out guidance and mandatory text requirements of the statement.

The statement discusses the systems of internal control in place across the trust and the trust's capacity to handle risks alongside reviews of efficiency and effectiveness and the use of resources. The concluding declaration is informed by a variety of sources of feedback and assurance including the views of internal auditors who have provided a 'moderate' level of assurances regarding the trust's systems of internal control.

No significant internal control issues have been identified for the year ended 31 March 2026 for DHC and DCH. The statement also includes assurance on condition CoS7 of the NHS Provider Licence, as referenced above.

The draft Annual Governance Statement was presented to the respective Audit Committees for review on 29 May 2026 (DHC) and 1 June 2026 (DCH). The final draft will be presented to the Audit Committee and Board for approval in June 2026 in accordance with national reporting deadlines.

12. Conclusion and Recommendations

The Board is asked to confirm that the annual review of Board effectiveness has been completed through the reviews described in this report.

Ellis,Kara
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Appendix One: Overview – Joint Board Development 2025/26

Dates and Time Available	Subject	Domain	Purpose	Exec Lead	Status
May 2025 – 1 Day	Children and Young People Future Care	Strategy and Quality	Strategy System and Partnership Working	Dawn Dawson, CNO Eiri Jones, NED Rachel Small / Anita Thomas, COO	Complete
July 2025 – 1 Day	Patient Safety Incident Response Plan Strategic context and next steps Maternity Colleague wellbeing and support	Quality Strategy Quality People	 Culture and Leadership Strategy	Niche and Dawn Dawson, CNO Matthew Bryant, CEO Dawn Dawson, CNO Nicola Plumb, CPO	Complete
Sept 2025 – 1 Day	Strategic context and next steps Well Feedback (BDO Review) Risk Appetite Provider Capability Assessment and the Insightful Board	Strategy Leadership Leadership Leadership	 Strategy Culture and Leadership Skills and Knowledge	Matthew Bryant, CEO Ayesha Janjula (BDO) Jenny Horrabin, DoCA / BDO (Ellen Fielding) Jenny Horrabin, DoCA	Complete
Nov 25 – 1 Day	Financial Planning (inc WTE) Creating an Anti-Racist Organisation	Finance People	Skills and Knowledge Culture and Leadership	Chris Hearn, CFO Nicola Plumb, CPO	Complete

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Dates and Time Available	Subject	Domain	Purpose	Exec Lead	Status
Dec 25 – 90 mins	Freedom to Speak Up – Board Briefing	Leadership People	Culture and Leadership	David Clayton-Smith Russ Parkinson	Complete
Jan 26 – 1 Day	Alex Petts – Part of Joint Board Development Programme lead by River Leadership – focussed on Advanced Foundation Trust and what this means for DCH and DHC	Leadership	Board Dynamics	Alex Petts, River Leadership	Complete
Mar 26 – 1 Day	Mental Health Services and Transformation	Leadership, Quality Strategy	Skills and Knowledge	Rachel Small	Complete

1) Part of externally delivered Board Development Programme delivered by River Leadership

Ellis Kara
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Appendix Two: Overview – Joint Board Development Plan 2026/27

Quarter	Subject	Domain	Purpose	Status
Q1 May 2026	Well Led	Quality Leadership	Skills and knowledge	Complete
Q2 July 2026 September 2026	Board development / board dynamics (1) Health Inequalities Quality Improvement Engagement Approach SEND Reforms Mental Health Legisalation	Leadership and Culture Strategy Quality Productivity and VFM People and Culture Access and Delivery of Services	Board dynamics Strategy System and Partnership Working	Planned
Q3 November 2026	Frail elderly, Future Care and Integrated Neighbourhood Team	Strategy Quality Access and Delivery of Services	Strategy System and Partnership Working	Planned
Q4 January 2027 March 2027	Digital (including Cyber, Caldicott)	Strategy and Leadership	Strategy System and Partnership Working	Planned
	Board development / board dynamics (1)	Strategy and Leadership	Board dynamics	Planned

1.Part of externally delivered Board Development Programme delivered by River Leadership

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Dorset County Hospital
NHS Foundation Trust

DCH Charitable Funds Committee Assurance Report for the meeting held on 19.5.26

Chair	Dave Underwood, NED
Executive Lead	Chris Hearn, Chief Finance Officer
Quoracy met?	**Yes**
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• The Capital Appeal (ED/CrCU) has now crossed the £1.9M mark and we expect to near £2M during the Summer.

Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: • **CFC Minutes (31.3.26)** – ensure Members and In Attendance recorded separately moving forward. Minutes approved. • **CFC Actions (31.3.26)** – All actions completed or in progress. • **BI Report**: report on DCHC charity spend 23/24 and 24/25 mapped against care areas and DIIS health inequality data to be reviewed by committee (ex-committee) and feedback observations. • **DCH Charity Financial Reports 25/26 (M12 Yr End)** – reports were received. Total income as of end Mar 2026 £855,899. Unrestricted funds were £607,493 providing a surplus of £334,493 against the approved reserves target of £273,000. • **DCHC Credit Card proposal:** for virtual credit card facility for DCH Charity presented and approved. • **DCHC Risk Register review (6mth):** all key risks reviewed and current risk ratings approved. • **DCHC Policies: Fundraising Policy (updated)** and **Donation Acceptance/Refusal Policy** reviewed and approved. • **£2.5M Capital Appeal (ED/CrCU) report (May 2026)** – report received. £1.85M income and pledges received as of May 2026. Gala Dinner raised £300K (net of costs). Additionally, committee agreed to transfer further £70K to the Appeal Fund from the second interim distribution (£150K) from the major legacy. Appeal total now heading towards £2M. • **Fundraising & Communications report** – overview of current key fundraising activities and communications. Please see report enclosed.

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	• **Lillian Martin legacy** – Email from lead charity re-land management issues from Knight Frank to be circulated to committee for response. Awaiting update re-payment of c£30K from sale of parcel of land. • **AOB:** • **DCHC Appeal (ED/CrCU) – Philanthropy Board:** objective to set up a Philanthropy Board building on the success of the Gala event, working with members of the Appeal committee. Proposal and terms of reference to be circulated for approval.
Decisions made at the meeting	• **DCHC Credit Card proposal:** for virtual credit card facility for DCH Charity presented and approved. • **Capital Appeal (ED/CrCU):** committee agreed to transfer further £70K to the Appeal Fund from the second interim distribution (£150K) from the major legacy.
Issues / actions referred to other committees / groups	• None

Quoracy and Attendance					
	19.5.26				
Quorate?	Y				
Dave Underwood	Y				
Chris Hearn	N				
Jo Howarth	N				
Anita Thomas	N				
Margaret Blankson	Y				
Stephen Tilton	Y				

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Dorset County Hospital
Dorset HealthCare

Report to	Board of Directors in Common (DHC & DCH)	
Date of Meeting	17 June 2026	
Report Title	Estates and Facilities Compliance Report	
Prepared By	David McLaughlin, Director of Estates & Facilities	
Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	Finance and Performance Committee in Common - May	
Action Required	**Approval**	-
	Assurance	Y
	Information	-

Alignment to Strategic Objectives	Describe how this paper contributes to our strategic objectives
Care	Compliance risk affects the safety of our patients
Colleagues	Impacts the safety of our people working within our buildings
Communities	N/A
Sustainability	N/A
Implications	Describe the implications of this paper for the areas below
Board Assurance Framework	SR5 - Estates
Financial	Currently Mitigated within delegated budget
Statutory & Regulatory	Statutory requirement to comply
Equality, Diversity & Inclusion	N/A
Co-production & Partnership	N/A

Executive Summary

Background
This paper details the status of Estates and Facilities Statutory Compliance within the Trust, the areas where we have a good picture, or where levels of Compliance fall below the expected level, along with the context for this.

Within this paper, Compliance measurement data has been drawn using the following data sources:

- MiCad CAFM system
- MiCad IPR Compliance system and front-page dashboards
- Compliance Tracker
- PAM report

This paper is for information and assurance; it also details the mitigations where we have known compliance gaps.

Statutory Compliance
Estates maintenance, inspections, and servicing tasks falling under the category of Statutory Compliance are either completed in-house using directly employed labour (DEL), or via a specialist contractor, depending on the nature and specialism of the task.
Several tools are in place to monitor and report on compliance across the two delivery strategies and against each element. There are however some differences in the tools used for this across the 2 Trusts. The list below gives details of the methodology used in each Trust:

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Dorset HealthCare (DHC)

- **IPR system dashboard –** Statutory compliance documents are uploaded into the MiCad IPR system against the relevant building when received. An expiry date is then set, at which point if we haven't received the latest document the element will revert to non-compliant. A set of front-page graphs are shown giving a compliance percentage against each element. This system allows us to quickly see how many non-compliant areas we have and what the applicable locations are. Within DHC this is our main tool for monitoring statutory compliance against our buildings.
- **Quarterly DEL Planned Maintenance KPI Compliance report –** Within DHC, the compliance manager produces a quarterly DEL Planned Maintenance KPI report. This report is issued to all operational managers with the Estates team, to allow them to monitor performance in terms of planned maintenance delivered by our in-house teams. The report gives an aggregate set of data and graphs for each planned maintenance category – statutory, mandatory and best practice. The report then drills down percentages against each individual maintenance team – electrical, mechanical, building, and water hygiene.
- **PAM report –** The premises Assurance Model (PAM), is undertaken annually for each Trust and is mandated for all NHS Trusts across the country. Undertaken by an external consultant, this audit is focused on assurance that Trusts are effectively managing and maintaining their portfolio, with a heavy focus on statutory compliance. The report covers a range of areas including Estates (Hard FM services), Facilities (Soft FM services), Health & Safety, Fire Safety, Sustainability and more.
- **Micad FM system –** Data from the Micad FM system is extracted to analyse PPM completion within each criticality.

Dorset County Hospital (DCH)

- **Compliance Tracker –** The compliance tracker is a master spreadsheet document which works in much the same way as the IPR compliance system. All statutory tasks and assets are loaded into this spreadsheet, with the date of the last statutory maintenance or examination carried out. Each element is linked to a front-page graph giving a percentage of compliance against each element. Once the expiry date elapses, the element is then reflected as non-compliant.
- **PAM report –** The premises Assurance Model (PAM), is undertaken annually for each Trust and is mandated for all NHS Trusts across the country. Undertaken by an external consultant, this audit is focused on assurance that Trusts are effectively managing and maintaining their portfolio, with a heavy focus on statutory compliance. The report covers a range of areas including Estates (Hard FM services), Facilities (Soft FM services), Health & Safety, Fire Safety, Sustainability and more.

Premises Assurance Model (PAM)

- The Premises Assurance Model (PAM) assessment and submission for 2025 have now been completed. For the first time, this has been undertaken by an external specialist partner with the scores now receipted by both Trusts. Details of the assessment outcome scores are contained under the relevant compliance reports for each Trust within this document.

Implications of non-compliance

- The safety of our patients, visitors and staff is reliant on a compliant Estate. Our Statutory Compliance comes in many forms including, but not limited to:
- Fire
- Ventilation
- Cleaning Standards
- Water management
- Electrical
- Pressure Systems
- Lifts and Lifting Equipment
- Catering hygiene
- Asbestos management
- Working at Height

Ellis Karen
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Failure to maintain robust systems increases risks of catastrophic failure, possibly resulting in injury or worse to our patients, staff or visitors. There are also risks around loss of service continuity where plant or equipment may fail.

- Any non-compliance which results in an incident could see legal cases brought against the Trust or those responsible to maintain the asset at the statutory levels.
- Also, reputational damage is likely in the event of an incident caused by non-compliance to statutory legislation.

Due to these risks, Estates and Facilities have in place audit and tracking processes which will be used to provide assurance to committee, and as part of this process, any significant risk will be identified, escalated and mitigated as far as reasonably possible immediately.

Recommendation

The Board is requested to receive the report for assurance

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1 Introduction

Estates and Facilities routinely populate and monitor several audit and measurement tools to understand and track compliance, these tools include a Statutory Compliance Tracker, quarterly DEL Planned Maintenance report and IPR system compliance dashboards. The External Premises Assurance Model Audit was completed for 2025. This was undertaken by an external partner, and outcome scores have been included for each Trust compliance report and now includes status updates on actions identified. The detail within this report is based on actual recorded compliance where documentary evidence is tangible, there are no estimated or assumed figures.

Please note, that there will still be occasions where a backlog of receipted documentation has not yet been uploaded and administrated to the IPR system to enable the elements to be updated. In this situation, whilst we would technically remain compliant where this is the case, due to the works being completed, until we can satisfactorily evidence the required documentation they will not be included in our measurement, and these items will remain as 'non-compliant'.

2 Statutory Compliance by Trust

2.1 Dorset HealthCare (DHC)

Report information and data provided by Simon Deery – Estates Compliance Manager

Compliance overall

The most recent quarterly DEL Planned maintenance KPI compliance report continued to show strong figures against statutory maintenance tasks. Mandatory and best practice tasks also remain strong, but an increase in planned maintenance tasks following receipt and uploading of revised asset data for the Trust has meant more PPM allocations in these categories.

IPR reported compliance also continues to show consistent scores. This has remained stable following improved processes for uploading documentation and ensuring that external planned maintenance contractors are managed consistently to ensure they are meeting KPI delivery targets.

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Areas of noted improvement

Fire Risk Assessments – Several fire risk assessments were showing as overdue for review in the system. Following close collaboration with our colleagues in the fire safety team, we have receipted a number of updated risk assessments which were completed by the due dates but hadn't reached our team for uploading; these have now been added against the relevant buildings. The few remaining outstanding RAs are currently being processed for uploading.

Water Safety – Several water risk assessments were slightly overdue for their routine review. These have now been addressed by our in-house water hygiene team. For smaller sites we also have the skillset within this team to undertake a complete risk assessment ourselves without the need to deploy a contractor. This process has proved to be very useful, especially with several smaller maintained leasehold properties which we have taken on. A small number of larger sites are now due for new risk assessments to be completed, and this has been arranged with our approved contractor and a final date will be confirmed imminently.

Health & Safety Risk Assessments – A new dashboard has now been added to the IPR to include all Estates Risk Assessments. These were reviewed as part of the process to ensure that they were up to date, and we now have a live monitoring tool to ensure these do not become overdue for their review in future. The RA dashboard sits at 100% compliant.

Energy Performance Certificates (EPC) – A slight backlog in uploading the latest EPC documents and associated recommendation reports meant that these dashboards were showing an inaccurately low level of compliance. Several reports have now been collated and uploaded to the IPR system meaning we now have a much stronger picture in this area.

Areas requiring further improvement

PSSR – A review of assets examined under the category of PSSR by our contractor, Allianz Engineering, has uncovered several erroneous items. Items requiring examination under the statutory PSSR requirements are clearly labelled as such, however there are some items which are being examined but are not required to be under these regulations. The compliance team continue to work at removing these erroneous assets from the examination schedule. There are still situations present where communication from the contractor and estates, to arrange an inspection visit, is poor. This can result in the engineer not being able to access an asset when they attend site.

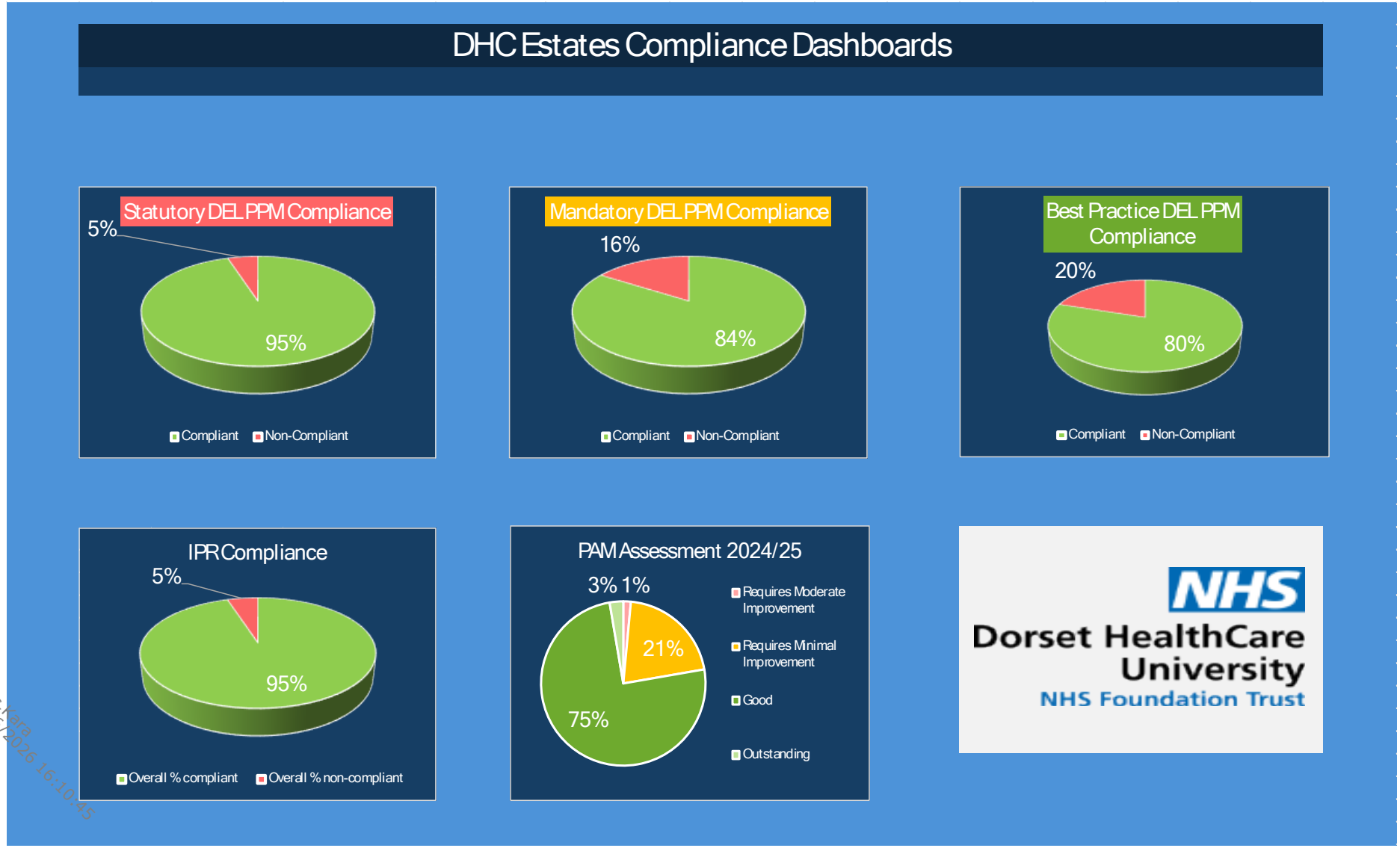
PAT – Following a review of this element, several improvement strategies have been identified. It is now intended that all PAT documentation for full site testing will be added to the IPR compliance system. This will enable a clearer snapshot of compliance to be gained and easily identify any overdue areas. Currently, each site is tested in its entirety on an annual basis, but certain categories of electrical equipment do not require such frequent testing due to lower risk characteristics. The Compliance Manager (also the Chair of the DHC Electrical safety Group), intends to review this process and provide a rationale paper detailing an improved approach to this. The benefits of this would see less assets needing to be tested annually and significant reduction in contractor spend year on year. Importantly though, there would be no reduction in terms of safety or risk. It is intended that any such revision to our processes will be jointly tabled via the Electrical safety Group and ratified

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across all key stakeholders, including the Health and Safety team. This action will be progressed once the migration to the new Singu FM system is completed.

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DHC Compliance Dashboards



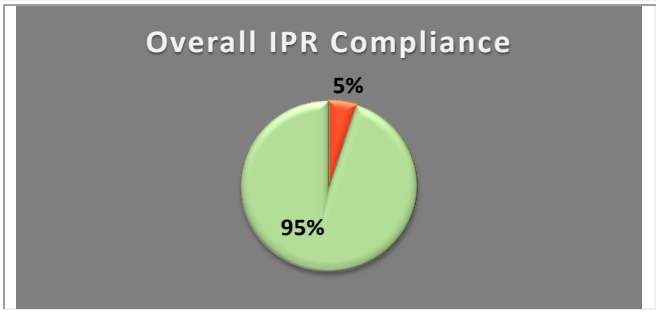
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IPR Compliance Q4

IPR Element	Compliance Percentage Level	Number of non-compliant elements
Asbestos Re-inspection Reports	100 %	0
Electrical Installation Condition Reports (EICR)	98 %	2
Lightning Protection Systems – Inspection and Testing	100 %	0
Lifts – LOLER Thorough Examinations (6 Monthly)	93 %	2
Lifts – LOLER Thorough Examinations (Annual)	100 %	0
Fire Doors - Inspections	100 %	0
Portable Fire Extinguishers - Servicing	80 %	21
Fire and Smoke Damper Inspections	91 %	1
External Fire Escape Staircases (Structural Examinations)	100 %	0
Fire Alarm Service (3 Monthly)	98 %	1
Fire Alarm Service (6 Monthly)	96 %	2
Medical Gas Pipeline Systems (MGPS)	100 %	0
Gas Appliance Servicing - (Domestic Hot Water Generators)	100 %	0
Gas Appliance Servicing - (Catering Appliances)	100 %	0
Gas Appliance Servicing - (Space Heating Appliances)	100 %	0
Gas Appliance Servicing – (Laundry Appliances)	100 %	0

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IPR Element	Compliance Percentage Level	Number of non-compliant elements
Gas Appliance Servicing – (Heating Boilers)	100 %	0
Kitchen Ventilation Extract Systems	100 %	0
Local Exhaust Ventilation	100 %	0
Pressure Vessels – Thorough Examinations	72 %	5
UPS (Medical Locations) - Servicing	50 %	1
Water Risk Assessment	94 %	6
Theatre Re-verification	100 %	0
Standby Generators – Major Servicing and Load Bank Test	100 %	0
Standby Generators – Intermediate Servicing	81 %	3
Energy Certificate Recommendation Reports	96 %	2
Display Energy Certificate	94 %	3
Fire Risk Assessment	92 %	9
Estates H&S Risk Assessments	100%	0

Item	Total	Overall IPR Compliance Level
Total number of individual compliance elements	1058	
Total number of compliant individual elements	1000	
Total number of non-compliant individual elements	58	

Elements falling below 80%

UPS (Medical Locations) - Servicing – These were slightly overdue by around a month. Since the Q4 report was extracted, these have now been addressed by our contractor.

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PSSR – Issues identified with no access to plant due to the contractor failing to adequately plan and communicate with estates. We are working through the areas with no access to plan a reattendance for these to be picked up.

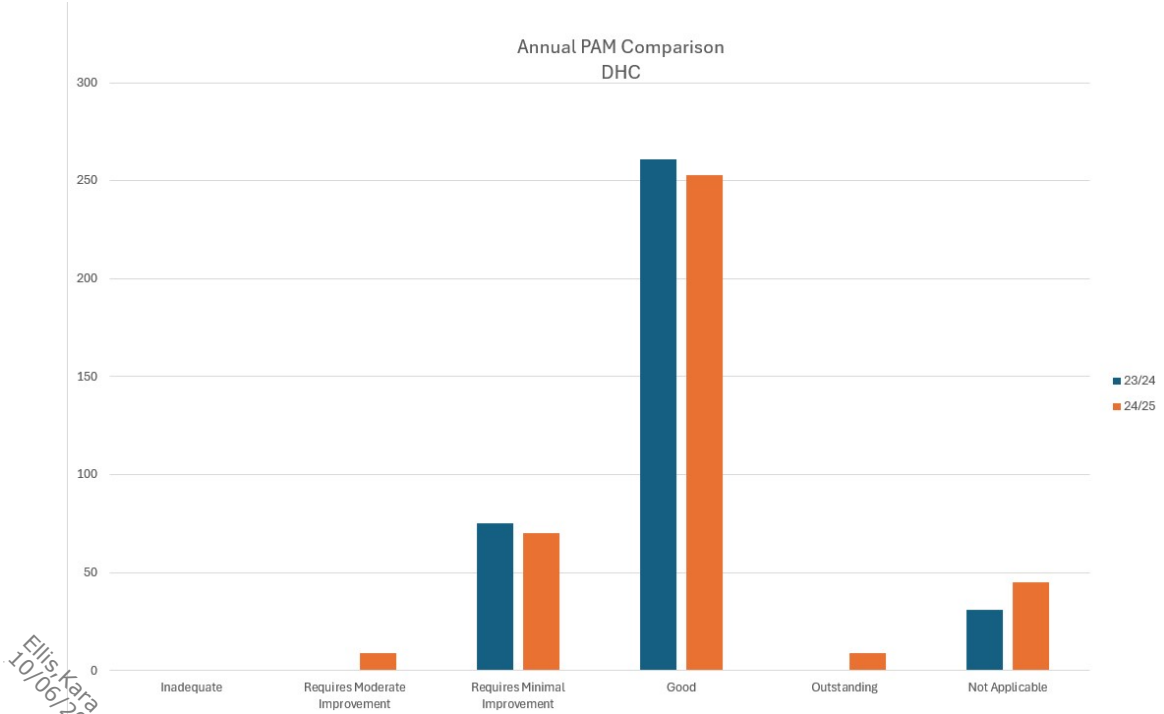
Premises Assurance Model (PAM) Assessment

The original PAM Assessment outcome scores for DHC are detailed in the table below. A comparison score is given against the previous assessment undertaken in 2023/24. Note: Current numbers of actions have now been reduced with an update on these actions provided further on in this section.

	Inadequate	Requires Moderate Improvement	Requires Minimal Improvement	Good	Outstanding	Not Applicable
23/24	0	0	75	261	0	31
24/25	3	27	70	253	9	45

The Compliance Team now have a live action tracker in place to track progress on all actions picked up the most recent PAM assessment. Regular routine meetings are now in place between DHC and DCH, alongside relevant stakeholders for each area. These meetings allow for updates to be provided and added to the action tracker.

The table below gives a graphical comparison of our current position and the previous year's PAM Assessment.



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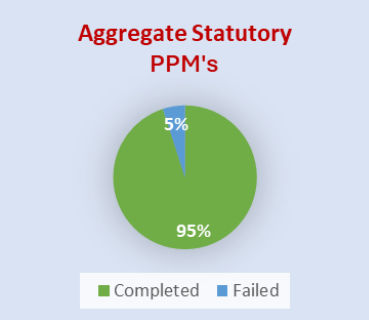
PAM Actions update

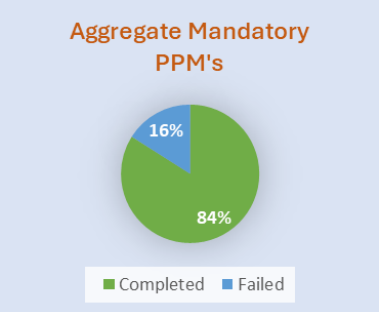
The PAM actions update is shown at the bottom of the report as this is part of the federated working with both trusts working together as a single team to close out any issues.

DEL Planned Maintenance (Estates)

The table below shows the total amount of jobs completed and failed within each of the three PPM categories in Q4; this is aggregated across all trade disciplines. A percentage is then given for the level of compliance against each. For Q4, statutory planned maintenance compliance sat at 95%, level with the benchmark target.

PPM Category	Total Jobs Completed	Total Jobs Failed	Compliance Level*
Statutory	4139	232	95 %
Mandatory	1891	349	84 %
Best Practice	1960	496	80 %







Reactive Works (Estates)

Reactive job requests are split across five SLA response priority categories, dependent upon the criticality and urgency of the work being requested. The table below sets out these response categories:

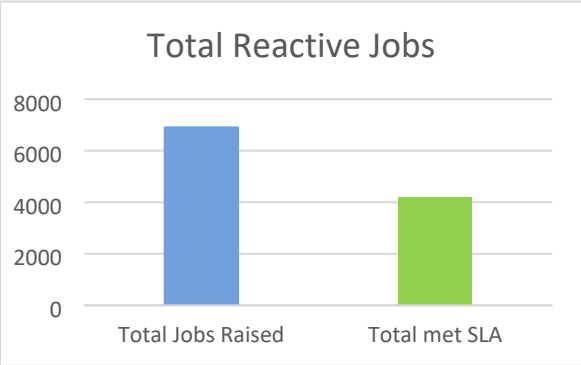
Priority response category	Target SLA response time
Emergency – 2 Hour response	Attendance within 2 hours of receiving call request. For emergency situations.
Priority – 1 Working Day	Attendance within same day of receiving call request. For high priority situations.
Urgent – 3 Working Days	Attendance within 3 working days of receiving call request. For other urgent situations, but where a same day response is not necessary.
Routine (default) – 5 Working Days	Attendance within 5 working days of receiving call request. This is a standard routine default response where urgency level permits
28 Days	Attendance within 28 days of receiving call request. This category is for other non-critical works such as minor new works requests

Ellis,Kara
10/06/2026 09:10:43

All Reactive Requests

In Q4 a total of 6905 reactive requests were received by the service desk. Of these,

61% were responded within the SLA timeframes.



The figures in the above table are drilled down into the individual response priority categories as follows:

Emergency – 2 Hour response

In Q4 a total of 58 Emergency – 2-hour response requests were received by the service desk. Of these, 59% were responded within the SLA timeframe.

Note: A significant portion of jobs that are being classed as Emergencies do not fall into the criteria set out in the Priority Classification table. Work continues with the service desk team to limit the emergency calls to better use available resource.

Priority – 1 Working Day

In Q4 a total of 479 Priority – 1 working day response requests were received by the service desk. Of these, 62% were responded within the SLA timeframe.

Note: A significant portion of jobs that are being classed as Priority – 1 Day do not fall into the criteria set out in the Priority Classification table. Work continues with the service desk team to limit the emergency calls to better use available resource.

Urgent – 3 Working Days

In Q4 a total of 109 Urgent – 3 working day response requests were received by the service desk. Of these, 65% were responded within the SLA timeframe.

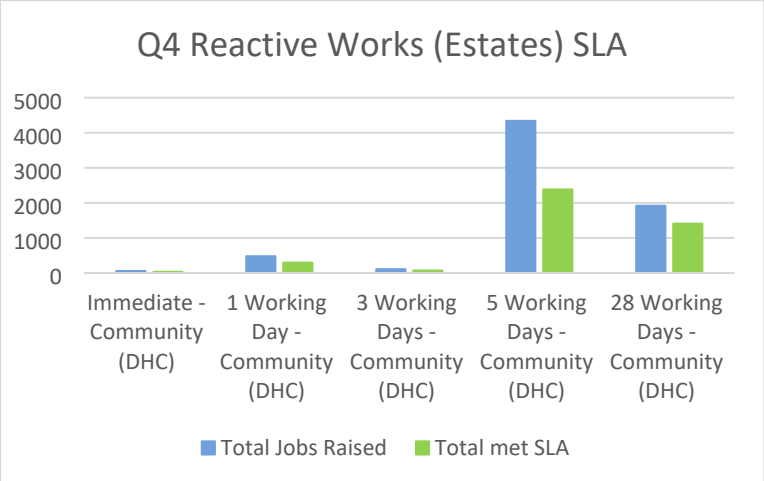
Routine (default) – 5 Working Days

In Q4 a total of 4340 Routine (default) – 5 working day response requests were received by the service desk. Of these, 55% were responded within the SLA timeframe.

28 Days

In Q4 a total of 1919 28 Days response requests were received by the service desk. Of these, 74% were responded within the SLA timeframe.

Ellis Kirk
10/06/2026 16:10:45



3.2 Dorset County Hospital (DCH)

Report information and data provided by Andrew Kersley – Estates Compliance and Asset Officer

Compliance overall

Various improvements have been made to the compliance tracker to give further control of compliance and evidence of that. The Technical Compliance Tracker continues to be updated at routine intervals to reflect the changing picture of items delivered, and remedial works undertaken. Also, the past performance of the system is being analysed to look to give assurance over the 12 months. Some compliance areas are being looked at so that the whole area does not go out of compliance on the same date so this will smooth some of the spikes in the system. The Compliance tracker is being updated to clearly show the Statutory compliance and splitting down to highlight additional areas. Overall compliance is currently running at 71% but this is due to a combination of additional areas being added to the tracker and awaiting documentation for some areas that were inspected within the required timescale. When the documentation has been evidenced and recorded the compliance level becomes 86%. The tracker is not updated until evidence documentation is provided, to ensure a 'closed loop'.

Compliance Tracker

The table below shows the current status of the compliance tracker on 11 May 2026. There are a couple of notable areas of concern, but some of the areas have only just been loaded into the tracker so those areas are not fully developed yet. This will lead to the compliance percentage being lower while the evidence is gathered to properly populate that area.

Ellis,Kara
10/06/2026 16:10:45

Asset Area	No. Of Assets	Compliant	Non-Compliant	% Compliancy
PSSR	59	56	3	95%
LOLER	57	53	4	93%
LOLER Lifts	15	15	0	100%
LOLER Hoists	60	58	2	97%
LEV	4	4	0	100%
Ventilation Reverifications	22	15	5	75%
Ventilation 6 Monthlies	59	35	24	59%
Water Hygiene	11	11	0	100%
Water Hygiene - Legionella	233	214	19	92%
Water Hygiene - Pseudomonas	309	236	73	76%
Lightning Conductors	4	4	0	100%
Fixed Wire Testing	337	122	215	36%
PAT	19623	19623	0	100%
Generators	2	0	2	0%
UPS Inspections	38	31	7	82%
Asbestos	95	68	27	72%
EPC	19	19	0	100%
Ladders	46	46	0	100%
Window Restrictors	1349	459	890	34%
F Gas	160	125	35	78%
F Gas (Mortuary)	13	13	0	100%
F Gas (Lab Fridges)	32	32	0	100%
F Gas (Drug Fridges)	89	89	0	100%
F Gas (Blood Fridges)	15	15	0	100%
F Gas (Catering)	40	15	25	38%
Gas Safe	112	41	71	37%
Medical Gases	328	3	325	1%
Emergency Lighting	1866	1098	768	59%
Fire Extinguishers	578	114	454	20%
Fire Blankets	229	186	43	81%
Fire Suppression	6	6	0	100%
Smoke Detectors	92	89	3	97%

Ellis,Kara
10/06/2026 16:20:45

Asset Area	No. Of Assets	Compliant	Non-Compliant	% Compliancy
CO Monitors	49	48	1	98%
Dry Riser	8	0	8	0%
Fire Alarm	26	23	3	88%
Fire Dampers	573	212	361	37%
Smoke Vents	35	35	0	100%
FRA	70	21	49	30%
Fire Doors	1681	296	1385	18%
Totals:	**28342**	**23097**	**5033**	**71%**

Complete	A/W Evidence	Incomplete	A/W Contractor

A new category has been added to the tracker showing that the contractor is awaited on site. There are a large number of categories that are awaiting external contractors so that we can ensure compliance. It is worth noting the categories that this applies to as it shows that the compliance department

The Gas Safe area runs on an 11 month cycle but this time there are some issues as the Damers Court and Albany Court sites have now moved to PRIME. These are a large number of assets so have a large effect on the compliance in this area. Documentation has been requested from PRIME and have D&B have been booked to attend the other Gas installations on our site.

The generators are a slightly different case this year. We have booked a service on the South Wing generator and are awaiting the contractors on site to complete this. The North Wing generator is being replaced this year and the project this currently undergoing design reviews. There was a question whether the generator should be serviced as it was being removed. It has been decided to do a lite service this year to ensure that the generator remains fully operational until it is replaced.

We are also awaiting paperwork for a number of areas that have been inspected. These include Fire Dampers, Dry Risers, Fire Extinguishers and Fire Blankets. Once these are received the numbers will show a large change.

Fire Risk Assessments continue to progress, with external accommodation now completed and internal clinical areas being assessed by the Fire Officer using ZetaSafe. The Trust is considering transitioning these inspections to the SINGU system. In parallel, an external agency has been commissioned to produce a comprehensive fire and evacuation strategy for the entire DCH main site, including NHP.

Ellis Kara
10/06/2026 14:10:03

Fire compartmentation and fire door works for Phases 1–3 have commenced for FY 25/26. Phase 1 (South 3) fire-stopping is largely complete, with some areas requiring deferred access or risk-based management. Sixteen fire doors for Level 3 South are in production for

installation in May 2026. Future phases will address SCBU, Maternity and Main Theatres, CrCU, staircases, roof voids, and hospital streets on a risk-based schedule through 2029/30.

Fire alarms are now monitored via the BI Gateway, with direct reporting through Switchboard teams, and no major incidents have been recorded. There are currently 43 active fire-related risks on the corporate register, three open incidents under investigation, and 13 risks managed and tolerated. TVF has completed servicing of all fire extinguishers, with replacements ordered where required; future servicing will transition to DHC under an SLA. Quarterly update meetings with DWFRS continue, with no new actions arising from the most recent review.

Fire Doors

The fire doors have been subject to a maintenance regime where doors that do not require inspection have been monitored. Now working with both the Fire Brigade and an external consultant a new fire strategy is being implemented and the maintenance regime is being overhauled. Fire doors have been inspected in a 6 month program in High risk areas, including Streets and entrances to wards. This is carrying on while the review is ongoing. Doors are also being replaced on South Level 3 in improve the compartmentation on that area. The doors will continue to be inspected using the risk based approach and this will lead to a bespoke system where doors will be inspected on requirements and this will give further assurance of compliance.

There are a small number of areas that are incomplete. However, these are generally all being worked on, usually by the in-house team. Most of these areas are showing an improvement over the last few months and although this is generally slower due to a lack of resource will result in full compliance.

This shows that although the system does have a lower percentage compliance this does not tell the whole story. The current system is loaded against full compliance and there are spikes where a whole area goes from full compliance to complete non-compliance within the space of a month. We need to find a way to smooth these spikes to give a more measured view of compliance.

Fixed Wire testing (EICR)

This has in the past been a major issue. Now inspection and testing as been commenced. This will close this area once the paperwork is received. The testing of the entire site will potentially take a considerable amount of time so this may impact on the receipt of certification.

Emergency Lighting

Now this area is subject to federated working there is considerable movement. The system is not only being tested but is also being repaired. There are a rather large number of units that need to be updated but the improvement in the compliance is encouraging.

Ellis Kelly
10/06/2026 14:10:43

Premises Assurance Model (PAM) Assessment

The PAM Assessment outcome scores for DHC are detailed in the table below. A comparison score is given against the previous assessment undertaken in 2023/24.

	Inadequate	Requires Moderate Improvement	Requires Minimal Improvement	Good	Outstanding	Not Applicable
23/24	2	56	134	125	1	63
24/25	3	59	86	155	24	57

The PAM submissions for both DCH and DHC were completed this year by an outside consultancy. This gives a good impartial verification of the scores that are given.

There has been work completed by both trusts working through the action tracker of all of the “Requires Moderate Improvement” and “Inadequate”. This has been done on a risk based methodology completing the “Inadequate” areas first.

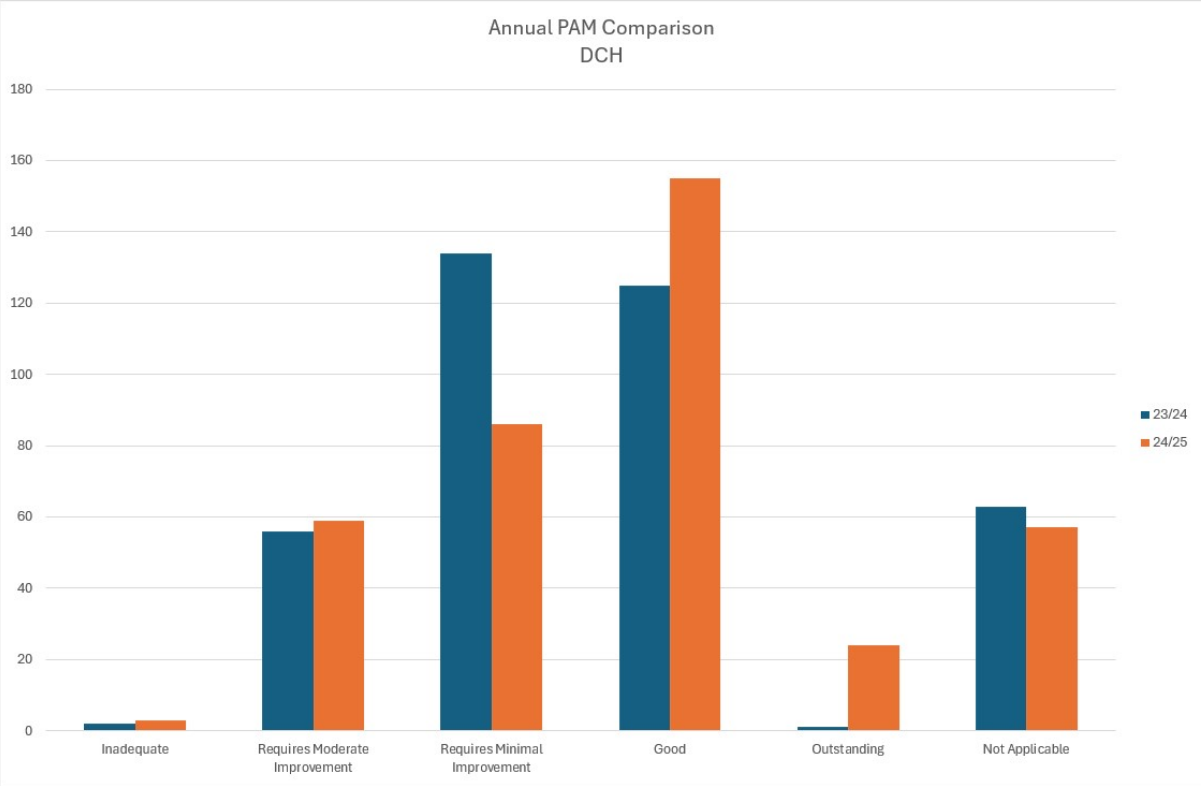
These were mainly paperwork based errors with missing policies or other documentation. The DHC errors were some documentation that was not supplied to the auditor in time. These have since been seen by the team and therefore the action’s closed.

The DCH “Inadequate” actions were regarding missing policies that had not been created by the team. These have now been created and proofread by the Estates Officers. These are now being passed to the relevant safety groups to be ratified. This then closes out those inadequate areas.

Looking at other improvement areas within the action plan there have been opportunities for federated working between the 2 Trusts and these chances have been taken. These have resulted in some collaborative schemes that will benefit both trusts. These include a joint catering review looking at how this can be dealt with by both trusts and potential joint working opportunities. It has also lead to opportunities to share best practice between the trusts.

The table below gives a graphical comparison of our current position and the previous year’s PAM Assessment.

Ellis,Kara
10/06/2026 16:10:45



The window for submitting PAM for this year has just opened and the data and evidence collection for this year will begin shortly.

A close check will be made on each of the areas within the action plan to ensure that there have been improvements are progressing as expected.

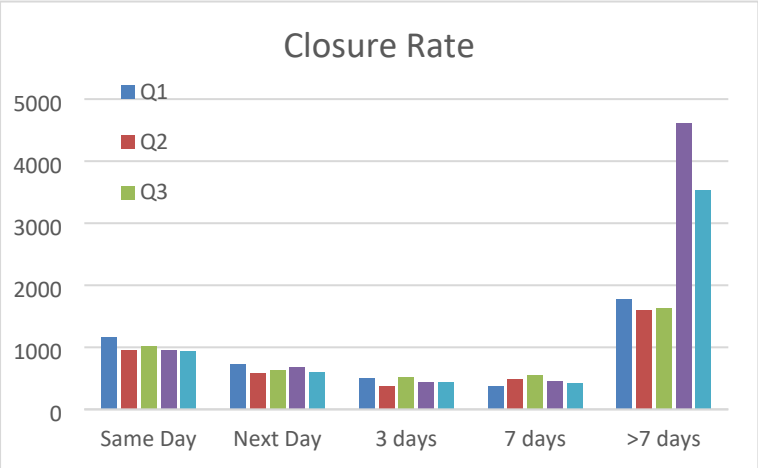
The action plan regarding the inadequate areas is shown below

Question	Area	Comment	Action	Progress
SH 7.1	Natural Gas and specialist piped systems: Policy & Procedures	No Natural Gas Policy or procedure	New policy written to cover this	The policy will be ratified at the next H&S meeting
12.1	Lifts, Hoists and Conveyance Systems: Policy & Procedures	Develop and publish Policy and procedures as per the HTM.	Policy from DHC revamped to include DCH	New policy to be ratified at the next safety group meeting
13.1	Pressure Systems: Risk Assessment	Review and approve Pressure Systems Policy and procedures. Develop Safe System of Work (SSoW) Pressure Systems.	Policy and SSoW written to cover this issue	Policy will be ratified following consultation regarding roles

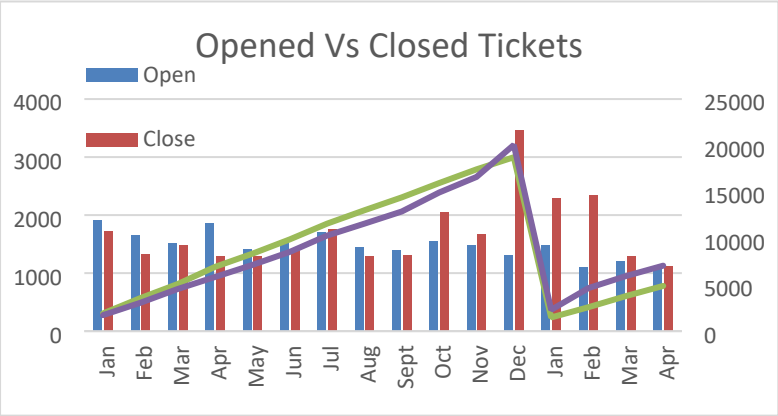
Ellis,Kara
10/06/2026 16:10:45

Reactive Works (Estates)

The graph below shows a comparison between the closure rates of reactive jobs, against their priority categories, across the quarters of the year: It shows that there is little difference in closure rates between either different quarters of the year or even different years.



The graph below shows a comparison between reactive jobs open versus reactive jobs closed across the quarters of the year: As can be seen there is little correlation between the open and closed jobs each month. The large number of closures between October 2025 and February 2026 are a result of work done to clear the MICAD system prior to the introduction of the SINGU system.



4 Conclusion

Both Trusts continue to work towards aligning their reporting methodology. This is a result of closer working and a federated approach. Whilst there are still some disparities in this, the use of the technical tracker versus the IPR compliance module provides the same reporting outcomes in terms of accurately monitoring individual building / area compliance. DCH are working towards setting up their IPR system to reflect that of DHC. The process of moving DCH to the IPR tracking system is on hold as there is a project in progress to align the software used by both trusts and transform this to a single instance.

Ellis Kaur
10/06/2026 16:10:45

Time is also being taken to align the ERIC and PAM submissions. This will then be able to align the Trusts further and provide further assurance of compliance and continuing improvement.

Both Trusts have seen tangible improvements overall in terms of statutory compliance and ensuring that no areas are not considered and left in a state of non-compliance.

KPI delivery for reactive works will be more of a focus when the SINGU system is fully implemented and this will show the reactive delivery of both teams against the SLA's for both trusts.

The trusts are both currently collating information for the ERIC submissions to take place. Once collected the performance of the trusts can be benchmarked and this can be used to look at various schemes that may be used in both trusts to generate improvements across both estates and see where potential savings may be found.

PAM will begin to be collated after this. There is a change to this years submission in that instead of there being a range of possible responses there is now only as Yes or No response. Following last years submission a new structure has been put in place to ensure that all paperwork is up to date and available as evidence for the submission. This will ensure that building on last years result we will have further successes and show that both trusts are continuously improving.

5 Recommendations

The Board in Common is requested to:

- Receive the report for assurance

6 Appendix A

This details the actions regarding the "Requires Moderate Improvement" from the PAM submission.

DCH had 59 questions that required moderate improvement and DHC had 27 questions.

Of these areas, 22 (26%) have now been completed. A further 41 (48%) are currently progressing and will be closed out in turn. 24 areas (28%) are subject to joint working between DCH and DHC.

Joint working and reviews between the 2 trusts covers catering, that is undergoing a full review and BIM (Building Information Modelling). This is a new concept to the department and will require further information to fulfil this requirement. There were a number of policies and other paperwork that was required and these have been either closed out or awaiting ratification to complete the issue.

Ellis,Kara
10/06/2026 16:10:45

DCH SubCo Ltd Assurance Report
for the meeting held on 20 May 2026

Chair	Stephen Tilton
Executive Lead	Anita Thomas, Claire Abraham, Nick Jones (DCH SubCo Directors)
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• This was Stephen Tilton's last meeting as chair. Board members extended their thanks to Stephen for his contributions to the company over the last six years. The Trust needs to appoint a replacement chair for the company • Reflections from recent experiences of working with Trust colleagues as part of the expansion is that training is required for Trust staff to understand that the company is a separate organisation to the Trust, and not simply a different department. It is important that the distinction between the two entities (the company and the Trust) is maintained. A governance structure for the company is in development and will be shared with the Trust to support this training, possibly through senior leadership group meetings.
Key issues / matters discussed at the meeting	• Finance Report to end of March, noting profit performance £31,000 behind the plan of £98,000. Overspend relates to increased operating expenses linked to the increased footprint and preparations for increased activity as part of the new contract. The Board recognised that this is part of the transition phase and is expected to continue in the short term, but that performance is expected to improve in the coming months. The SubCo Board will receive an update on the Q1 position ahead of the next Board meeting in August to maintain oversight. The Board is confident that it continues to be a going concern. • Performance Report and Review of Risk Register, Incidents and Complaints and Mitigating Actions noting: ○ All KPIs continue to be met, except for waste costs in March 2026 which totalled £315.50. There have been some dispensing errors following the expansion relating to increased activity and new staff. This would continue to be monitored closely and training provided where needed. ○ Reflection that whilst some risks had been resolved by the expansion, it causes some other risks which would continue to be monitored and address. ○ A dispensing error had previously been reported to the Board. It was clarified that the resulting £3,600 stock written-off was a

Ellis Kara
10/06/2026 16:10:45

	dispensing error that had left the pharmacy and therefore could not be returned. ○ Expanded KPIs are in development to provide additional information about operational performance, beyond the contractual KPIs. ○ No new complaints or incidents in quarter. • Board Effectiveness Review and Terms of Reference, noting that: ○ Members reflected positively on the working of the Board, recognising that this was a time of change in the organisation with footprint and service expansion, and that the governance arrangements for the company would be expanded in alignment with this, and will include a new management group. ○ The Trust needs to appoint a successor to ST as he is leaving the Trust at the end of May ○ Approval of the Board Effectiveness Review and Terms of Reference • Expansion update including Review of Performance Monitoring Indicators: ○ Plans to launch the expanded pharmacy service on 1st June were to be delayed, as the recruitment of a locum second pharmacist had not been successful and this posed a risk to fulfilling the expansion. Recruitment plans were in place with the intention of targeting the cohort of pharmacist who would become qualified this summer, with a locum in the interim. ○ 125 patients out of the total 1050 have now transferred from the Trust to Fortuneswell pharmacy (totalling approximately 35% of all transfers given the variation in frequency of prescription deliveries for those patients). ○ Over the counter (OTC) sales were in development, with work ongoing to determine the appropriate profit margins for OTC pricing. Authority was delegated to CL to decide margins for OTC pricing following this work. ○ Approval of the updated contractual KPIs between the Trust and SubCo. Operational and performance KPIs were to be drawn up by management group ○ The full report is appended for Finance and Performance Committee in Common information.
Decisions made at the meeting	• Approval of the Board Effectiveness Review and Terms of Reference • Authority delegated to CL to decide margins for OTC pricing • Approval of the updated contractual KPIs between the Trust and SubCo
Issues / actions referred to other committees / groups	• Nil

Ellis,Kara 10/06/2026 11:10:43

Report to	Finance and Performance Committee in Common	
Date of Meeting	27 May 2026	
Report Title	Update on expansion of Fortuneswell Pharmacy (May 2026)	
Prepared By	Nick Jones	
Accountable Executive	Nick Jones	
Previously Considered By	DCH SubCo Ltd. Board, 20 May 2026	
Action Required	**Approval**	N
	Assurance	N
	Information	Y

Executive Summary

This report was presented to DCH SubCo Board on 20th May 2026 and is presented to Finance and Performance Committee in Common for information only.

The report provides an update on the expansion of Fortuneswell Pharmacy including:

- Update on Pharmacist recruitment, including locum cover
- Provide assurance on the transition of services
- Update on governance and KPIs
- Update on logistics and home deliveries

Recommendation

Members are requested to:

- Receive the report for **information**

Ellis Kara
10/06/2026 16:10:45

Update on expansion of Fortuneswell Pharmacy (May 2026)

1. Introduction

1.1. Dorset County Hospital have requested that Fortuneswell Pharmacy expand the services they provide to the Trust, and following negotiations between the Trust and the SubCo a plan was agreed.

1.2. Building work was completed earlier this financial year, and following approval at the SubCo Board additional recruitment has taken place.

1.3. A working group has been established consisting of key members of the Trust's Pharmacy team, and the SubCo team to agree the timeline and order of transfer of services, following the phase agreement the SubCo Board approved (appendix 1).

2. Main narrative

2.1. **Recruitment**

2.2. Recruitment of all roles is now complete with the exception of the second Pharmacist. The second Pharmacist post has been advertised three times with no success. A hold on recruiting for a fourth time was put in place to review the advert, and find a more opportune moment to recruit.

2.3. Unsuccessful candidates of the Pharmacy Department in the Trust have been contacted, with some interest in applying for the role. The role has been readvertised w/c 11th May with this in mind.

2.4. Delays in the recruitment of a locum Pharmacist has occurred due to procurement challenges and uncertainty of framework rules. Whilst a locum pharmacist had been identified unfortunately the candidate withdrew and so we have had to go back out to locum agencies. To note, this will delay the transfer of outpatients.

2.5. **Transfer of services**

2.6. The next phase of homecare and outpatients have been agreed with the working group taking into account some of the current challenges

2.7. Delays in the recruitment of the locum Pharmacist has delayed the transfer of services

2.8. Current activity transfer numbers are:

a. 125 patients out of the total 1050 have now transferred and received their first delivery (deliveries between 8-16 weekly)

b. c15% of outpatient scripts have been transitioned to Fortuneswell Pharmacy, which represents around 30% of services

2.9. The formal launch has been delayed due to the staffing delays, with the new target date of 1st June 2026.

2.10. **Logistics/Home Deliveries**

2.11. The Trust Logistics team have informed us that they have recruited to a permanent driver, and are interviewing for 2 as & when drivers imminently to support the expansion plans

Ellis,Kara
10/06/2026 16:10:45

2.12. The Trust Logistics team have informed us that they are sourcing an additional van via U Drive to trial different types of van to support the expansion of cold chain products

2.13. FP10 repatriation has begun slowly, targeting areas that are transferring over such as Gastroenterology

2.14. **Over the counter sales**

2.15. The Fortuneswell team are working with suppliers to stock a small number of over the counter sales as per the request from the Trust. The till is now operational, and stock is being procured ready for the formal launch of the Pharmacy.

2.16. The Board is requested to approve the margin levels as (to be discussed verbally as awaiting further information)

2.17. **Governance**

2.18. The new Management Board is awaiting Terms of Reference, and then it is expected to have it's inaugural meeting in June 2026. Key initial focus will be:

a. Ensuring separation of Trust and SubCo business e.g. emails, risks, incidents, procurement
b. Oversight of near misses, incident monitoring and risk
c. Oversight of policies and procedures
d. Activity monitoring and KPIs
e. Business Continuity Plans
f. Oversight of financial monitoring

2.19. **KPIs**

2.20. The contractual KPIs between the Trust and SubCo have been proposed by the Trust, and have been included in this meeting pack for SubCo Directors approval (Appendix 2)

2.21. Alongside the contractual KPIs, it is proposed that the SubCo monitors additional KPIs via the Management Group. These have not been finalised yet and will be presented alongside the Q1 review of contracts. They are expected to include:

a. Stretch targets on key contractual KPIs
b. Over the counter sales targets
c. Workforce indicators such as sickness rates, appraisal rates, requirements for backfill/bank/agency usage
d. Budgetary controls

2.22. **Update on contracts and SLA**

2.23. Discussions between the Trust and SubCo are ongoing around the contractual changes and updated SLA requirements associated with the expansion of services. As agreed in April's SubCo Board meeting, there will be a review of Q1 2026-27 which will then support a more robust contract and SLA, and therefore the Directors are asked to approve this approach.

2.24. Given the Trust has a logistics team, and the SubCo will benefit from the adaptability of that team the proposal is that the outlined costs are passed through to the Trust through the SLA, and that the Trust will perform the logistics service on our behalf.

Ellis,Kara
10/06/2026 16:10:45

3. Recommendations

3.1. The Board / Committee is recommended to:

a. Receive the report for **information**

Name and Title of Author: Nick Jones, Director
Date 12/05/2026

Ellis,Kara
10/06/2026 16:10:45

Dorset County Hospital
NHS Foundation Trust

Report to	Board in Common (DCH)	
Date of Meeting	17 June 2026	
Report Title	DCH SubCo Ltd Performance Report Q4	
Prepared By	Andrew Harris	
Accountable Executive	Anita Thomas, Claire Abraham, Nick Jones (DCH SubCo Ltd Directors)	
Previously Considered By	DCH SubCo Ltd. Board, 20 May 2026 Finance and Performance Committee in Common, 27 May 2026	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Executive Summary

- Activity continues at similar levels to the preceding 12 month period, which has been reduced since June 2023 to match capacity limitations. Transition of services to the expanded Fortuneswell Pharmacy began in March 2026.
- All KPIs are currently green for the year to date, with the exception of waste costs which for June 2025 which totalled £3,639.46 (including £3,600 of stock dispensed in error) and for March 2026 which totalled £315.50.
- The new build Fortuneswell opened on Friday 11th July – The risk register will be fully reviewed following this to reflect the new premises.

Recommendation

Members are requested to:

- Receive the report for **assurance**

Ellis Kara
10/06/2026 16:10:45

Performance Report

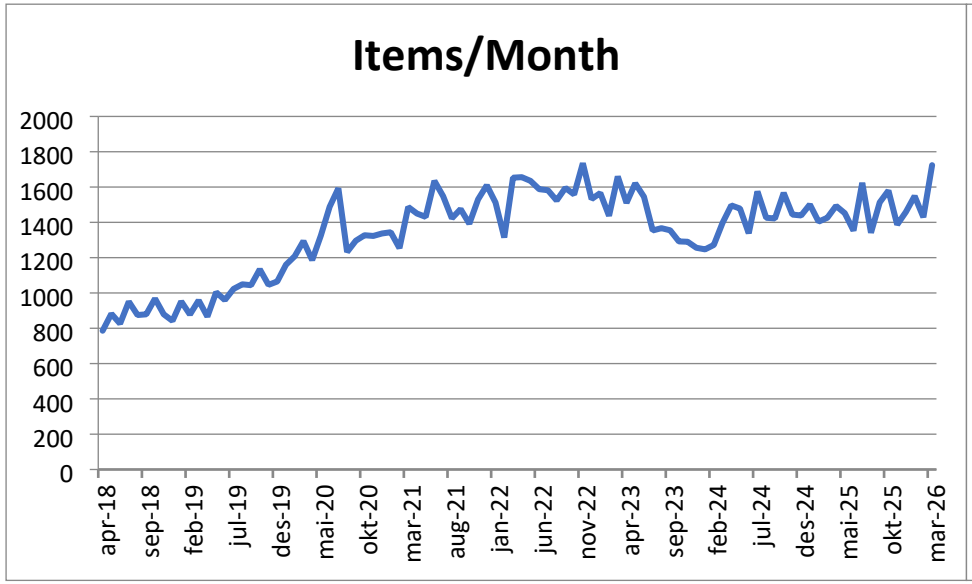
Andrew Harris
Superintendent Pharmacist
Apr 2026

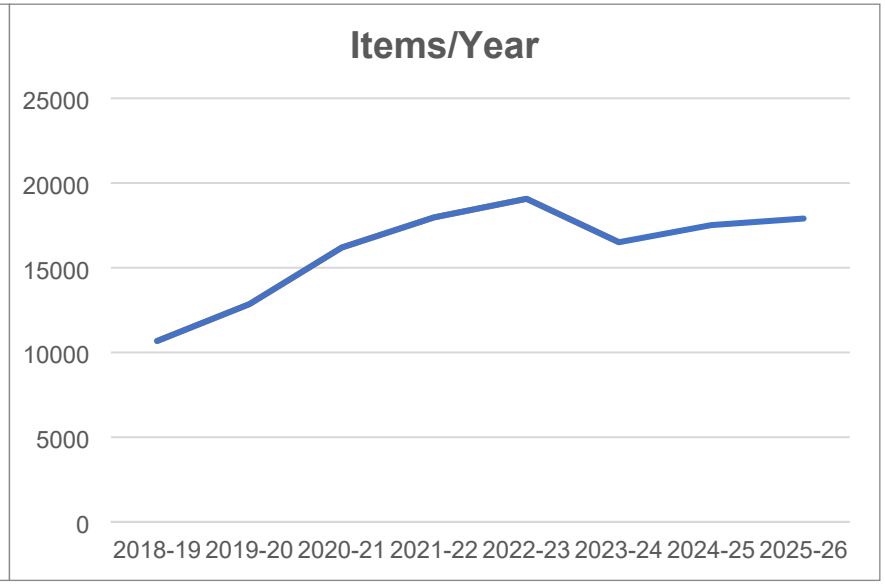
Key Performance Indicators (KPIs)

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total Number of Customers per Month	179	137	141	161	127	194	194	157	152	187	168	205
Total Items Dispensed	1493	1452	1353	1624	1341	1513	1580	1387	1459	1549	1429	1724
Average Items/day	74.7	72.6	61.5	70.6	67.1	68.8	68.7	69.4	69.5	73.8	71.5	78.4
No. of same day Prescriptions	194	202	137	221	235	217	199	195	182	253	211	252
No. of Advance Prescriptions	501	424	505	520	419	531	559	484	507	506	498	676

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Activity levels from April 2018 to current:





Fortuneswell Pharmacy has returned to cancer only related activity which is reflected in the reduced activity from August 2020, though cancer related activity is now climbing.

Fortuneswell Pharmacy has returned to cancer only related activity which is reflected in the reduced activity from August 2020, though cancer related activity is now climbing.
A review of dispensing activity was undertaken in June 2023 in conjunction with the Chief Pharmacist and Lead Cancer Nurse to identify activity that could be relocated elsewhere (main hospital pharmacy or community pharmacy) to manage the increasing workload. Since March 2026, some of this workload has been repatriated to Fortuneswell Pharmacy, as well as beginning the expansion of services, starting with renal homecare.

All contractual KPIs year ended March 2026 are green.

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Performance measure	Key Performance Indicator	Target performance	Green	Amber	Red	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep–25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Rate of dispensing errors detected post issue	Number of errors made per total volume of prescriptions dispensed that have LEFT the department	<2.0%	<1.0%	1.0-2.0%	>2.0 %	0.00%	0.00%	0.22%	0.23%	0.23%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Near Miss Monitoring	Number of errors made per total volume of prescriptions dispensed that have NOT LEFT the department	<2.0%				0.94%	1.10%	1.03%	0.86%	1.04%	0.93%	0.76%	0.72%	0.69%	0.77%	0.98%	1.16%
Availability of service	Responsible Pharmacist Availability	0	0 to 45 mins	45 to 90 mins	> 90 mins	0	0	0	0	0	0	0	0	0	0	0	0
Availability of medicines	The % of prescription items dispensed in full at the first time of presentation excluding manufacturer can't supply	98%	100% - 98%	97.9% - 96%	< 95.9 %	99.73 %	99.59 %	99.93 %	99.94 %	99.85 %	99.93 %	99.94 %	99.93 %	99.86 %	99.81 %	99.93 %	99.59 %
MHRA Recall Assurance	100% of all SABs alerts, MHRA and Company-Led recalls are managed in accordance with Class status	100%				100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
All Mosaiq advance prescription preparedthe day in advance of collection	The completion time should bethe day in advance of collection/ delivery to chemotherapy nurses.	>90%	100% - 90%	89.9% - 80%	<80 %	93.4%	91.0%	97.4%	92.9%	95.2%	97.0%	99.1%	97.5%	91.5%	97.6%	92.7%	95.9%

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The waiting time for dispensing prescriptions, during a monthly period shall be: (i) 30 minutes or less in respect of 95% of all prescriptions; and (ii) 20 minutes or less in respect of 80% of all prescriptions	The time taken for a patient to wait for their prescription from the time they present it to the Pharmacy.	(i) 30 minutes or less in respect of 95% of all prescriptions (ii) 20 minutes or less in respect of 80% of all prescriptions	For (i) Greater than or equal to 95% For (ii) Greater than or equal to 80%	For (i) 80% - 94.9% For (ii) 65% - 79.9%	For (i) Less than 80% For (ii) Less than 65%	(i) 100% (ii) 95.2%	(i) 99.2 % (ii) 95.3%	(i) 99.0% (ii) 98.0%	(i) 100% (ii) 99.3%	(i) 100% (ii) 97.1%	(i) 99.3% (ii) 97.3%	(i) 100% (ii) 99.1%	(i) 100% (ii) 96.0%	(i) 98.4% (ii)92.0%	(i) 98.1% (ii) 95.7%	(i) 99.2% (ii) 95.5%	(i) 99.4% (ii) 92.3%
Index of customer satisfaction	The patient overall satisfaction level		100% of Customers to be offered Customer Feedback Survey Monthly Reporting on KPIs to record; Total Number of Customers per Month Completion / Uptake Rate (%)			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of complaints	The number of upheld complaints		1 or fewer complaints per quarter	2 or fewer complaints per quarter	Over 2 complaints per quarter	0	0	0	0	0	0	0	0	0	0	0	0
Number of non-agreed non-formulary items supplied	Number of items that appear on total non-formulary supply report	0%	0% - 0.049%	0.05% - 0.099%	> 0.1%	0	0	0	0	0	0	0	0	0	0	0	0
Controlled drug management	Correct procedure against SOPs followed at all times	100%	No Tolerance			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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Provision of financial, clinical and management information	financial, clinical and management information to be provided within 5 working days following the end of the previous month	100%	100% - 99%	98.9% - 97.5%	< 97.5 %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Waste/Expiry management *	Waste Costs below £200 per month - Stock waste to be managed	<£200	<£200			£5.87	£0.00	£3639.46	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£68.66	£315.50

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Month End Stock Value £k (i/c VAT)	363	447	384	342	367	375	351	532	431	457	472	583

Incidents
1 dispensing error left the department on 17th June. No harm to patient. £3,600 of stock had to be written off.

Complaints
Nil

Keys Risks

- The original business was for a dedicated Cancer Services Outpatient Pharmacy with an estimated dispensing activity of ~700 items per month. Activity has steadily increased over the two year period and is now 1,400 per month, double the anticipated level of activity in the original business case. There is now a risk the Outpatient Pharmacy would no longer meet the General Pharmaceutical Council (GPhC) premises standards if re-inspected. **Some of this has been resolved with moving into the new build Fortuneswell Pharmacy on Thursday 10th July, and the risk register needs updating accordingly.**
- HM Treasury commenced a consultation in August 2020 on "VAT and the Public Sector: Reform to VAT refund rules". This has significant implications for the Public sector including the NHS which if the recommendation is implemented, would permit full refunds of the VAT incurred on all goods and services during the course of non-business activities (full refund model). This represents a significant risk to the long term sustainability of the subsidiary company.

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Report to	Board in Common, Part 1 (DCH)	
Date of Meeting	17 June 2026	
Report Title	DCH SubCo Ltd. Board Effectiveness Review 2025/26 and Terms of Reference	
Prepared By	Abi Baker, DCH Corporate Governance Manager (SubCo Company Secretary)	
Approved by Accountable Executive	Anita Thomas, Director	
Previously Considered By	DCH SubCo Ltd. Board 20 May 2026 Finance and Performance Committee in Common, 27 May 2026	
Action Required	**Approval**	Y
	Assurance	Y
	Information	N

Executive Summary

The purpose of the report is to present the outcome of the DCH SubCo Ltd annual review of board effectiveness and to seek approval of the forward work programme for 2026/27 and any proposed revisions to the Terms of Reference arising from the review recommendations.

Public sector good governance practice determines that Boards of Directors should undertake an annual review of their effectiveness to inform changes to their terms of reference, priorities and work programmes for the forth coming year, so demonstrating effective leadership and supporting the development and delivery of the company's overall objectives.

In previous years the effectiveness review has been conducted by way of an online survey, with a limited response rate. This year, Board members were emailed and asked to share their thoughts on the below prompts; they could either return feedback by email or in a call with the Company Secretary.

- The focus of the Board in Board meetings
- The impact of the Board on the company
- The frequency and length of Board meetings
- The knowledge and skills on the Board
- The quality of papers in allowing the Board to effectively perform its role
- Anything else you wish to share

Three out of four Board members provided feedback, and this is summarised and analysed below.

Feedback

Members reflected positively on the working of the Board, recognising that this was a time of change in the organisation with footprint and service expansion, and that the governance arrangements for the company are likely to change in alignment with this.

The focus of the Board:

- The Board has a defined focus and performs well. The Board is aware of current and future company developments and members are engaged in the meetings.
- The Board has struggled to know how much detail it needs to be aware of, with some areas being fairly high level, but other areas being more granular. The new Management Group will help with this.
- The focus has rightly been on the ongoing expansion. It would be good to create time for the Board to periodically have a development session or similar, to take stock, reflect on the direction of travel and to consider if there is anything that could be done differently

The impact of the Board:

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- The Board makes a positive impact and has the right balance of being proactive and reactive. The addition to the Board of the Trust's Chief Pharmacist will support this.

The frequency and length of Board meetings:

- Is appropriate at present. The introduction of a new management group will continue to support this. Frequency and length of meetings can be kept under review as the expansion develops.

The knowledge and skills on the Board

- Very good with a wide range of different and complementary areas of expertise
- The addition of board level pharmacy experience is positive
- Knowledge and skills have always been rich and will get richer with the addition of NJ & AT
- A great deal of organisational knowledge will be lost when ST leaves
- Training on the roles and responsibilities of directors will be beneficial for new board members, and as a refresher for existing members

The quality of papers in allowing the Board to effectively perform its role

- Papers are generally good quality and appropriately succinct
- A greater emphasis on risk would be beneficial; work is ongoing in this regard with the expansion of services
- The expansion offers an opportunity to make board reports mature and proactive (vs reactive) including forecasting information, visuals, and a review of KPIs in performance and finance.

Other comments

- Additional time for the board to meet and reflect (beyond the usual meeting agenda) on whether we could or should be doing anything differently, rather than assume the status quo, particularly in light of service expansion.
- The time commitment and competing priorities of substantive Trust roles can make it hard to prioritise company matters. Additional time outside of Board meetings to give dedicated, focussed time to the company would be helpful.
- Operational staff could be excused from part of the Board meeting, to allow for confidential discussions to take place.

The Board is asked to consider the following recommendations for development of the Board

- Periodically dedicating part of the Board meeting to development discussions regarding direction of travel, whether anything could be done differently etc.
- Creation of a Management Group and associated delegated authorities, as previously discussed
- Arranging training on the roles and responsibility of directors, as previously discussed
- Developing the maturity of board reports, with refreshed KPIs and forecasting information
- Operational staff to be periodically excused from part of the Board meeting, to allow for confidential discussions

Last year's review identified one area for development relating to the appointment of a fourth director, which has now been completed.

SubCo Board Terms of reference

Minor updates have been made to the terms of reference, removing the reference to 'cancer' outpatient pharmacy services (in light of the expanded services offered), removing reference to contract and SLA length for simplicity, and adding the establishment of a Management Group. These amendments are clearly marked in the attached.

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At the DCH SubCo Board meeting held 20/05/2026, Board members agreed to the above recommendations to develop the Board further and approved the revised Terms of Reference and workplan for 2026/27.

Finance and Performance Committee in Common meeting 27/05/2026
At the Finance and Performance Committee in Common meeting held 27/05/2026, committee members agreed to the above recommendations to develop the Board further and approved the revised Terms of Reference for 2026/27.

DCH SubCo Management Group Terms of reference
Also attached for approval is a set of Terms of Reference for a new DCH SubCo Management Group. In light of the ongoing expansion of the company the Board intends to create a management group with delegated authority from the company board. The Board Terms of Reference (below) set out that the powers delegated to the DCH SubCo Board cannot be further delegated without approval of the Shareholder (DCHFT).

The management group will offer increased operational oversight and senior decision making of the company to support the ongoing expansion. The group will report in to each meeting of the DCH SubCo Board.

Due to the timing of meetings, the terms of reference have been approved by the DCH SubCo Ltd Board virtually and will be returned to the next formal meeting for completeness. It was not possible for these to be presented to Finance and Performance Committee in Common. However, approval from the Trust Board is sought at this stage to ensure that this key management group can begin to meet and support the operations of the company.

Recommendation

Finance and Performance Committee in Common is asked to:

1. Receive the effectiveness evaluation for **Information** and
2. **APPROVE** the reviewed DCH SubCo Board Terms of Reference and
3. **APPROVE** the new Management Group Terms of Reference.

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Terms of Reference

DCH SubCo Limited Board of Directors

Constitution

The Board of Directors of DCH SubCo Ltd (the Board) is the key operational decision making body for the company and has delegated authority from the sole shareholder, Dorset County Hospital NHS Foundation Trust, to make operational decisions as outlined within the Business Plan in line with the company's Articles of Association and financial limits established within the shareholder's Standing Financial Instructions.

Authority

DCH SubCo Board is invested with the delegated authority to act on behalf of the shareholder. The limit of such delegated authority is restricted to the areas outlined in the Articles of Association and matters reserved to Dorset County Hospital NHS Foundation Trust Board of Directors as the corporate shareholder. DCH SubCo Board is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are requested to co-operate with the Board in the conduct of its inquiries.

DCH SubCo Board is authorised by the shareholder to obtain independent legal and professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary.

DCH SubCo Board is authorised to establish sub-committees and working groups to support its work subject to Terms of Reference that shall be approved by the Board, but shall not delegate the powers conferred upon it by these Terms of Reference to any other body without the express authorisation of the Shareholder.

Purpose

The purpose of DCH SubCo Board is to review key contract and performance indicators, any safety and governance concerns and financial performance relating to DCH SubCo activity as a provider of ~~Cancer~~ outpatient pharmacy services. Contract review meetings between DCH SubCo and the shareholder will take place on a quarterly basis and be reported to DCH SubCo Board at the following meeting. DCH SubCo Board will monitor the ~~5 year~~ contract for the provision of outpatient pharmacy services to the shareholder and monitor the ~~3 year~~ Service Level Agreement for the provision of services from the shareholder to DCH SubCo.

The Board will keep under review the operating model and take commercial decisions regarding the employment of staff, their terms and conditions of employment and medicines procurement arrangements, ensuring best value for money.

DCH SubCo Board will be responsible for delivery of the DCH SubCo growth strategy.

Membership

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As stated in the Articles of Interest, the Board shall be appointed by the shareholder and will comprise the following as Directors of DCH SubCo Ltd:

- At least one Non-Executive Director – Chair

- At least two Directors

The Corporate Governance Manager (DCHFT) will be in attendance as the Company Secretary.

The Fortuneswell Superintendent Pharmacist will be in attendance at Board meetings.

Deputies

DCH SubCo Directors may appoint an alternative person to exercise Director's powers / carry out duties provided this is notified in writing or at a meeting of Directors and must be approved by the shareholder.

Quorum

DCH SubCo Board shall be deemed quorate if there is representation from three Directors. A duly convened meeting of the Board at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Board. No decisions will be made should a meeting not achieve quorum.

Frequency of Meetings

The Board shall meet at least once each quarter. Members the Board must attend at least three of all meetings each financial year but should aim to attend all scheduled meetings.

Duties

The Board has the following duties and functions:

To monitor:

- service contracts with suppliers in order to ensure best value for money
- the contract and performance indicators with DCHFT
- financial performance ensuring a positive year end position is reported for the benefit of the shareholder and that the company remains a going concern.
- to maintain and report on mitigations to identified risks contained within the business plan (Changes to VAT / NHSE model / reductions in cancer drug spending)
- the outpatient lease arrangement
- directly employed staff terms and conditions, making recommendation on changes to the shareholder for approval where this may be necessary
- oversee the development of the company's annual report and accounts ensuring that this is independently audited and submitted to Companies House in a timely manner
- to mitigate risks as these are identified, escalating to the shareholder where necessary
- ensure that the shareholder is assured of the effective governance arrangements in place within DCH SubCo
- to review the Terms of Reference annually

Reporting

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The Chair of DCH SubCo Board will report in writing to the shareholder's Finance and Performance Committee meeting that follows the Board meeting via an Escalation Report. This report will summarise the main issues of discussion and attention will be drawn to any issues, risks or decisions that require escalation to the shareholder for a decision.

DCH SubCo Board will receive reports from the sub-committees that it formally establishes that record key issues and decision making and escalation of risks and issues for the Board's attention. The Board has established the following sub-committees:

- Contract Review Group
- Management Group

Administration

The Board will be serviced by the DCHFT Corporate Governance Manager who will agree the agenda and Board Work Programme with the Chair.

Review

These Terms of Reference will be reviewed annually unless there is a requirement to do so earlier.

Appraisal

DCH SubCo Board will carry out an annual appraisal of its performance and effectiveness in line with the requirements of the public sector Audit Committee Handbook 2024 and will report this to the Board of Directors and shareholder annually.

Approved by DCH SubCo Board of Directors – 20 May 2026

Ratified by the Shareholder Board – xxx

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June 2026

Terms of Reference
DCH SubCo Limited Management Group

Constitution
The DCH SubCo Ltd Board ("the Board") and the Dorset County Hospital NHS Foundation Trust Board ("the Shareholder") hereby resolves to establish the DCH SubCo Ltd Management Group ("the Group") as the key operational management body for the company. The Group has delegated authority from the Board and the Shareholder to make operational decisions specifically delegated to it via these Terms of Reference, and in line with the Scheme of Delegation.

Authority
The Group is invested with the delegated authority to act on behalf of the Board and the Shareholder. The limit of such delegated authority is restricted to the areas outlined in these Terms of Reference, and in line with the Scheme of Delegation. The Group is empowered to investigate any activity within its Terms of Reference, and to seek any information it requires from staff, who are requested to co-operate with the Group in the conduct of its inquiries.

Purpose
The purpose of DCH SubCo Management Group is to oversee the company's day to day operational matters to ensure the effective running of Fortuneswell Pharmacy, including monitoring activity levels and key performance indicators, oversight of incidents, risk management, and business continuity planning, oversight of operational budgets and operational policies.

Membership and Attendance
Membership of the group will comprise:

- The directors of the Board (with the exception of the company chair)
- Fortuneswell Pharmacy Superintendent Pharmacist
- Fortuneswell Pharmacy Dispensary Manager

Additional individuals will be required to attend the group as requested, including but not limited to:

- Trust Financial Controller
- Trust HR and/or recruitment
- Trust Logistics Manager
- Trust IT
- Trust Pharmacy

Meetings of the Group will be chaired by one of the DCH SubCo Ltd Directors.

Quorum
The Group shall be deemed quorate if there is representation from:

- One director
- One member of the Fortuneswell Pharmacy Management Team

A duly convened meeting of the Group at which a quorum is present shall be competent to exercise all or any of the authorities, powers and duties vested in or exercised by the Group. No decisions will be made should a meeting not achieve quorum.

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Additional attendees are not members of the group and do not count towards to quorum.

Frequency of Meetings
The Group shall meet at least monthly. Members the Group must attend at least 10 of all meetings each financial year but should aim to attend all scheduled meetings.

Duties
The Group has the following duties and functions:

- To monitor activity levels within the company, including contractual and operational KPIs, prior to review at Board
- To oversee and monitor near misses, incident monitoring and the risk register. To mitigate risks as these are identified, escalating to the Board where necessary
- Oversight of operational budgets including approval limits in line with the Scheme of Delegation
- To ensure workforce management in line with agreed terms and conditions including offers of support and performance management as required
- To ensure Business Continuity Plans are appropriate and in place
- With the exception of those reserved for Board approval, the Group is responsible for oversight and approval of operational and HR policies and standard operating procedures.
- Working with the Contract Review Group as a communication forum between the company and the Shareholder, particularly in relation to any issues of ensuring separation of Trust and SubCo business
- To review the Terms of Reference annually

Reporting
The Chair of the Group will report in writing to the DCH SubCo Ltd Board meeting that follows the Group meeting via an Escalation Report. This report will summarise the main issues of discussion and attention will be drawn to any issues, risks or decisions that require escalation to the Board for a decision.

Administration
The Group will be serviced by the pharmacy administration team who will agree the agenda with the Chair.

Review
These Terms of Reference will be reviewed annually unless there is a requirement to do so earlier.

Approved by DCH SubCo Board of Directors – 04 June 2026

Ratified by the Shareholder Board – xxx

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