Dorset County Hospital
NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust Annual Report and Accounts 2025 – 2026

Healthier lives Empowered citizens Thriving communities

Dorset County Hospital NHS Foundation Trust

Annual Report and Accounts 2025 – 2026

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

Contents

Statement from the Chair and Chief Executive

Dorset County Hospital is all about people - those who rely on our services, their families and carers, the communities we serve, and the colleagues who deliver care every day with skill, compassion and dedication. That focus has guided us throughout 2025/26, a year marked by sustained pressure across health and care services, alongside important opportunities to strengthen services and invest in the future of our hospital.

In July 2025, the publication of the NHS 10 Year Health Plan, *Fit for the Future*, set a clear national direction for the decade ahead. It outlined three fundamental shifts: moving more care from hospital settings into communities, accelerating the transition from analogue to digital, and placing greater emphasis on prevention. These ambitions reflect what patients and the public consistently tell us matters most – care that is timely, joined up and centred around individual needs – and they provide an important context for our work as an acute trust within a complex and evolving system.

Our joint strategy with Dorset HealthCare University NHS Foundation Trust (Dorset HealthCare) - Working together, improving lives - provides a strong foundation for responding to this national agenda in a way that is rooted in the needs, strengths and aspirations of Dorset's communities. Across our strategic objectives, we have continued to focus on improving quality and experience, strengthening neighbourhood-based services, supporting our workforce, and securing the long-term sustainability of care for local people.

Central to our approach is a clear commitment to listening to and involving patients, carers and communities. We know that services are most effective when they are designed with the people who use them. During the year, colleagues across Dorset County Hospital have continued to seek and respond to feedback, working with Governors, community groups and partners to improve experience, enhance equality of access and ensure our services reflect the diverse needs of the population we serve.

Our voluntary sector partners, supporters and Dorset County Hospital Charity continue to play a vital role in this work. Their contribution enhances patient experience, supports staff wellbeing and enables improvements to hospital facilities that would not otherwise be possible. We are deeply grateful for the generosity, time and commitment of our volunteers and local supporters.

Partnership working across the Our Dorset Integrated Care System, and now the wider regional cluster, continues to be essential. We work closely with University Hospitals Dorset NHS Foundation Trust (University Hospital Dorset), primary care, local authorities and voluntary sector organisations to improve patient flow, reduce unwarranted variation and support people to receive care in the most appropriate setting. Neighbourhood-based models of working are developing across Dorset as part of this system approach, and Dorset County Hospital is an important partner in this work.

Significant progress has been made this year on our New Hospital Programme developments, which represent a once-in-a-generation opportunity to transform emergency and critical care services for people in the west of Dorset. These modern, high-quality facilities will support safer care, better patient flow and improved working environments for staff, ensuring the hospital is equipped to meet growing demand now and in the years to come.

Alongside this, we have now embarked on a significant digital transformation with the launch of the Healthset electronic health record programme, which is being delivered in partnership with Dorset HealthCare, University Hospitals Dorset and Somerset NHS Foundation Trust. This shared approach will ultimately improve information sharing, reduce duplication and enhance safety for patients who move between services, while supporting more integrated working across organisations.

As with all NHS organisations, we continue to operate within a challenging financial environment. We have maintained a strong focus on productivity, efficiency and the responsible use of public resources, while keeping quality and patient safety at the forefront of decision-making.

None of this would be possible without our workforce. The challenges we face – rising demand, workforce shortages in some areas, and ongoing financial constraints – inevitably place pressure on colleagues. We want to recognise both the scale of that challenge and the extraordinary commitment shown by staff across Dorset County Hospital. Day after day, colleagues continue to provide compassionate, high-quality care in demanding circumstances, often going above and beyond to support people at their most vulnerable.

Supporting staff health, wellbeing and development remains a priority. We continue to invest in leadership, learning and opportunities to manage change, while encouraging open conversations about workload, wellbeing and improvement. Our most recent NHS National Staff Survey results remained above the average for our benchmark group in all seven NHS People Promise elements, reflecting the strength of our organisational culture even during a challenging period. Kindness and compassion – for patients, carers and for one another – will remain central as we move into what we know will be another demanding year.

Over the course of 2025/26, colleagues have celebrated a range of achievements that demonstrate how national priorities and local strategy are being translated into practical improvements for people and communities. These include:

- Opening a new patient experience and community involvement hub at the hospital;
- Praise from children, young people and parents in a national Care Quality Commission (CQC) survey for the kindness, compassion and commitment of staff;
- Completion of the £2million Fortuneswell Chemotherapy Unit transformation;
- A rating of ‘good’ from the CQC for the hospital’s Maternity Unit;
- The opening of a new sensory courtyard garden created with £50,000 from the Greener Communities Fund;
- An upgrade of the hospital’s stoma care facilities thanks to a donation by the Ducks and Drakes Cancer Trust.

We are grateful to our Governors for their continued challenge and support, to our volunteers for the time and care they give so generously, and to our partners across health, care and the voluntary sector who work with us to support people and communities every day. We also thank the patients, service users and carers who share their experiences and insights, helping us to learn and improve.

Looking ahead, the scale of ambition set out in *Fit for the Future* is significant, as are the challenges of transformation facing the wider NHS. However, we are confident that, by staying focused on people and communities, working together across organisational boundaries, and continuing to invest in our hospital and our workforce, we can deliver high-quality care and play a strong role within a sustainable local health system.

Signed

David Clayton-Smith
Trust Chair

Matthew Bryant
Chief Executive

Performance Report

Performance Overview

Purpose of the Overview
The purpose of the overview is to provide the reader with sufficient information to gain an understanding of Dorset County Hospital NHS Foundation Trust ('the Trust'), our purpose, the key risks to the achievement of our objectives and how we have performed during the financial year 2025/26. This Annual Report should be read in conjunction with the 2025/26 Quality Account.

About the Trust
Dorset County Hospital NHS Foundation Trust has a joint strategy as part of the Federation with Dorset HealthCare University NHS Foundation Trust ('Dorset HealthCare'). Our mission is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be at their best. Dorset County Hospital NHS Foundation Trust achieved Foundation Trust status on 1 June 2007 under the Health and Social Care (Community Health and Standards Act 2003). It is the main provider of acute hospital care to the residents of the west and north of Dorset, Weymouth and Portland, and increasingly serves populations in the Purbeck area.

The Trust serves a population of approximately 250,000 people but provides specialist services including Renal Services to the whole of Dorset and South Somerset. The population served has a proportion of older patients much greater than the national average (over 65 years representing 30% of the total population vs 19% for England and Wales). Dorset continues to experience an increasing total population, with 0.4% per annum forecast in the coming years, and the older population growing around 2% per annum. The main hospital opened on its current site in 1987, with major additions in 1996, and is situated centrally in the county town of Dorchester. The population served is in large part rural or coastal and has areas of marked deprivation, particularly in Weymouth and Portland.

The Trust delivers community-based as well as hospital-based services, through providing services in GP practices, in patient homes (through the Acute Hospital at Home and Discharge to Assess teams), and at community hospitals in Weymouth, Bridport, Sherborne and Blandford. The Trust works closely with primary care and social services to ensure integrated services are provided. As a Foundation Trust, Dorset County Hospital is accountable to Parliament, rather than the Department of Health, and is regulated by NHS England. We are part of the NHS and committed to meeting the national standards and targets. Our Governors and members ensure that we are accountable and listen to the needs and views of our patients.

The Trust provides the following services for patients:

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

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

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

Since 2023 the Trust and Dorset HealthCare have been working together as a group provider model (described locally as a Federation). This was agreed in 2023/24 and followed the appointment of a joint Chief Executive and Chair at the start of the year. In March 2024 we entered into a Memorandum of Understanding and since April 2024 the Federation has a single executive team working across two trusts (all posts are shared with the exception of a trust specific Chief Operating Officer and Chief Medical Officer roles) and in August 2024 the federated trusts adopted a joint strategy – Healthier Lives, Empowered Citizens, Thriving Communities.

The fundamental purpose of this group arrangement is to achieve the objectives set out in the strategy – of making the most difference we can to population health with the resources that we have by focusing on the objectives of providing safe, high-quality care, a positive environment for colleagues, contributing to strong, healthy local communities, and being sustainable – both financially and environmentally.

The arrangements by which the Trust is governed are covered in the Corporate Governance Section.

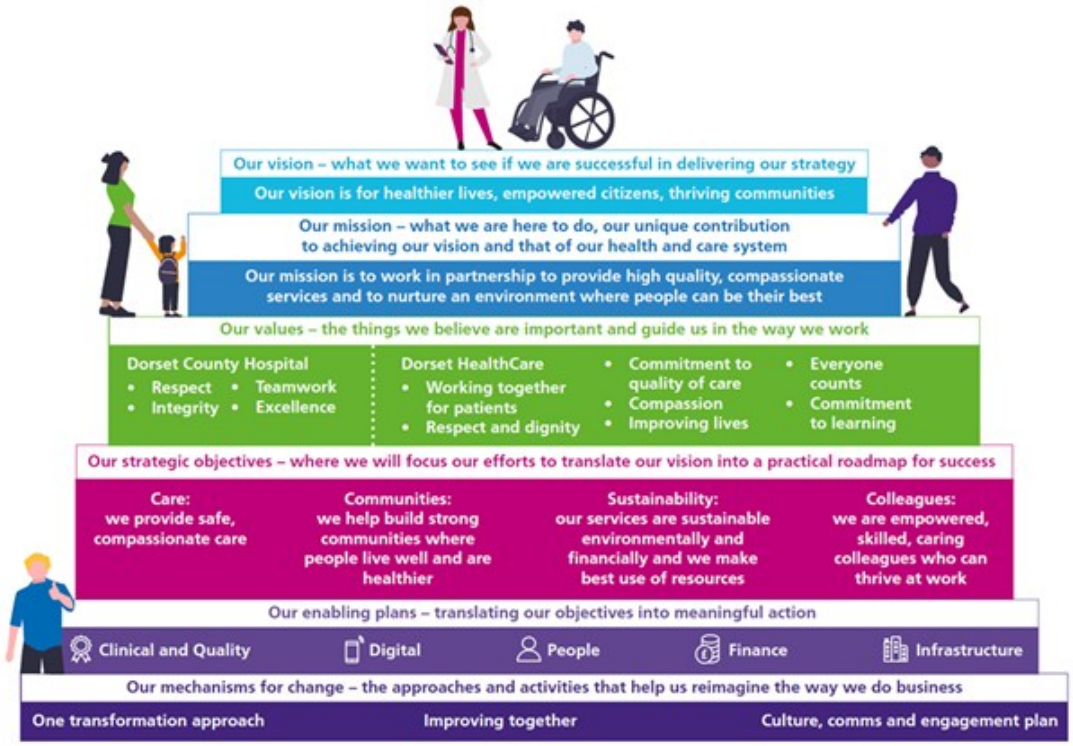
Strategy and Objectives

Our joint strategy with Dorset HealthCare, *Working Together, Improving Lives* (September 2024), sets a clear, shared direction that closely aligns with the ambitions of the NHS 10 Year Health Plan (10YP). Although developed ahead of the national plan's publication, its vision, priorities and enabling plans effectively operationalise the three shifts for the people of Dorset. Our vision – *healthier lives, empowered citizens and thriving communities* – mirrors the 10YP focus on prevention, personalisation and population health. Our mission emphasises partnership, high-quality compassionate care and a supportive, inclusive culture in which staff can thrive. Together, these create the conditions to deliver integrated, person-centred services and sustained system improvement.

The strategy commits to:

- expanding community-based, population-focused care and reducing inequalities;
- investing in digital tools that improve outcomes and user experience;
- strengthening prevention and early intervention.

The strategy is well into implementation now, turning words into action and delivery is supported by enabling plans for Clinical and Quality, People, Digital, and Estates/Infrastructure, and 10 clinical transformation priorities, including the FutureCare Programme, Planned Care Delivery, Integrated Neighbourhood Teams (INTs), Mental Health Crisis Pathways, Patient Safety Incident Response Framework (PSIRF), a single Electronic Health Record (EHR), new care pathways and strengthened co-production. Together these form a coherent, prevention-focused and digitally enabled model of care aligned to the 10YP.



Highlights of the Year

May 2025
The latest Children and Young People Survey results were released in May 2025. The positive results highlighted 99% of parents felt their child was looked after in hospital and that they were treated with dignity and respect by the staff, and 87% rated their overall hospital experience highly (7/10 or more).

May 2025

A new patient experience and community involvement hub opened at Dorset County Hospital in May. The HIVE (Health and Wellbeing, Information, Volunteering and Engagement) offers a welcoming space for patients and families to provide feedback about their experience, raise any concerns, and be signposted to various support services available in Dorset. Overseen by the Patient Experience Team, The HIVE offers a space to promote hospital initiatives, such as the volunteer service, and for drop-in information events by local organisations.

June 2025
Work to build a new £100million Emergency Department and Critical Care Unit reached a major milestone in June 2025. Contractor Tilbury Douglas started the main construction phase of works for the new state-of-the-art building which will care for patients in need of urgent and life-saving care. The building is due to open in 2027.

June 2025

The Trust's Cygnet Homebirth Team celebrated its 10th birthday. Part of the Maternity Service, the team launched in June 2015 and over that time they have delivered over 1,000 babies across Dorset. To celebrate their 10th year, the team held a birthday party in Stratton Village Hall and were joined by many of the families that they had supported over the years for afternoon tea, cake and games.

July 2025
The Chemotherapy Unit was transformed following a £2million refurbishment. Patients undergoing chemotherapy on Fortuneswell Unit now receive their treatment in a vastly improved area with new facilities. The work was carried out by LST Projects and was jointly funded by the Trust and money raised through Dorset County Hospital Charity's Chemotherapy Appeal, which included major support from the Fortuneswell Cancer Trust, local charitable trusts and the community.

August 2025
The Trust received the final instalment of a £2million donation from the HELP Appeal for a new rooftop helipad. A state-of-the-art helipad will be added on the roof of the new Emergency Department and Critical Care Unit building. It will allow patients to be transferred quickly and comfortably via a lift directly into the hospital, maintaining their privacy and dignity.

September 2025
The CQC upgraded the rating of maternity services from 'requires improvement' to 'good' following an inspection. Inspectors recognised that significant improvements in several areas had been made since their last inspection and the requirements of their recommendations had been met. The service's well-led and safe ratings were upgraded to 'good' and the overall rating was also upgraded to 'good'.

October 2025
The Microbiology Department achieved the South West Healthcare Science 2025 Community Outreach Award. Through the team's dedication, innovation, and commitment to widening access to healthcare science, they demonstrated what it means to truly inspire and engage communities.

November 2025
In November, the Trust held its first Skills Bootcamp in Health and Social Care. The four-week programme equipped learners from Dorset and Somerset with the essential skills, knowledge and behaviours needed for a successful career in the health and social care sector. Feedback from the programme was very positive.

December 2025
The Maternity Survey results praised staff for their kindness, compassion, support and high standards of care. Compared with other trusts, the Trust scored 'much better than expected' in questions focused on labour and birth. Mothers particularly praised the advice and support they received when contacting a midwife at the start of labour.

January 2026
The Trust ran a very successful staff flu vaccination campaign over the winter months, vaccinating 60% of frontline staff and 58% of all staff – exceeding our target of 54.8%. For a long period of the campaign, we were rated top in the South West for staff vaccination and within the top 10 across the country.

February 2026
In February, we launched a new service to offer patients a quicker, more comfortable alternative to a traditional endoscopy, while supporting the early detection of cancer. The capsule sponge test is a safe and effective procedure that can be delivered in just a few minutes, without the need for sedation or recovery time. Patients can be seen more quickly and comfortably, while also helping to reduce pressure on endoscopy services. This innovative service was made possible through strong collaborative working between Wessex Cancer Alliance, the Our Dorset Provider Collaborative and Health Innovation Wessex, working alongside Dorset County Hospital teams.

March 2026
Stoma care facilities were upgraded in two wards thanks to a generous charitable donation from Ducks and Drakes Cancer Trust. The bathroom improvements included new mirrors, shelving and hooks, which will enhance patients' experience at the hospital by allowing them to change their stoma bags more easily.

Performance Summary

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

Summary of operational performance

In line with national NHS reporting standards, performance metrics starting data for the year represents the April 2025 position.

The Trust's Emergency Department has seen strong performance against the four-hour standard, which has been sustained throughout the year, with expected seasonal variation. This is against a backdrop of a 10.76% increase in demand in A&E attendances. Through effective system working with other partner organisations and with tried and tested surge plans, the fluctuations in demand, seen because of seasonal variation has been managed safely. There was a continued mismatch between capacity and demand for ongoing care packages that support the safe discharge of patients. This results in patients staying in acute hospital beds when they are medically fit for discharge, causing a backlog in the Emergency Department for patients that require beds on the ward. Patient safety remains the top priority and has been maintained.

The waiting times for planned surgery have reduced in year, with the Trust reducing the number of patients waiting over 52 weeks for treatment. As well as addressing the length of wait, the Trust has also delivered a reduction in the total size of the waiting list, overachieving against the operating plan.

A reduction in the total waiting list size, was possible due to strong activity levels, service level improvements in efficiencies, and activity levels over delivered against the operating plan. This has meant that despite a growth in elective demand the Trust has been able to reduce the total incomplete referral to treatment waiting list size from 22,486 to 21,475.

The Trust has performed well against cancer wating time standards compared to previous years and while not all national performance standards have been achieved every month, the Trust has benchmarked well against other providers of a similar size and demographic. The waiting list size has fluctuated month on month, but compared to previous years it has not grown, despite an increase in referral demand.

Referral demand has increased by 4.5% compared to 2024/25 and to keep up with this demand, the Trust has responded by increasing activity using established insourcing partners and improved productivity.

Performance against the six-week diagnostic standard has been challenged throughout the year, ending with 77.4% of patients having their diagnostic test within six weeks, compared to 77.3% at the start of the year. Diagnostic services have seen an increase in demand via the emergency and elective pathways because of increase demand at the front door, increase in cancer two-week wait referrals and an increase in elective activity. The increase in demand has been managed with additional capacity through insourcing providers and Community Diagnostic Centres (CDCs).

The Trust recognises that maintaining and improving performance standards in 2026/27 will present ongoing challenges due to rising demand and the challenging financial climate. Focus on efficiency and productivity will increase further, to ensure the maximum level of activity can be delivered with every pound spent. Teams remain committed to reducing waiting times for elective pathways and to improving patient flow throughout the hospital. Work through the Our Dorset Provider Collaborative will deliver greater collaboration between Dorset County Hospital, Dorset HealthCare and University Hospitals Dorset, to utilise the capacity and available resources at a system level rather than an organisational one.

Information about the Trust's quality performance can be found in the Quality Account available on the Trust's website https://dchft.nhs.uk/about-us/trust-board/annual-reports/.

Details about the Trust's workforce performance can be found within the Staff Report.

Summary of Principal Risks

The strategic risks that challenge our achievement of our strategic objectives are identified within the Board Assurance Framework, which is reviewed regularly by the Board of Directors. The Trust's risk management processes are designed to assess the impact of all operational and strategic risks, and to ensure that they are appropriately mitigated and managed. The principal risks that we faced in 2025/26 are described in the Annual Governance Statement.

Going Concern Statement

The Trust has every confidence that services of high quality will continue to be provided now and into the future. On this basis, after making enquiries, the directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for at least 12 months from the date of this report. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Financial Performance

In 2025/26, the Trust's financial plan reflected the increased demand for NHS services, bringing with it further financial pressures due to the need to address the ongoing recovery of elective service waiting lists experienced across the country. The Dorset Integrated Care System submitted an overall breakeven plan. Within this, the Trust has submitted a planned deficit of £9.8million against its adjusted control total and technical adjustments, which is offset by surpluses across other system partners to achieve a system-wide breakeven position. To deliver this planned position, efficiencies totalling £29.1million were required.

The position before and after technical adjustments is shown in table overleaf. The adjusted control total removes in-year transactions relating to donated capital assets and impairment movements from the operating deficit, in line with accounting guidance.

Financial Performance against Plan	2025/26 Plan £ m	2025/26 Actual £ m	Variance £ m
Total income	337.9	352.0	14.1
Total expenses	(347.6)	(366.1)	(18.5)
Operating deficit	**(9.7)**	**(14.1)**	**(4.4)**
Capital donations	(0.5)	(0.5)	0.0
Donated depreciation	0.4	0.4	0.0
Impairments	0.0	4.4	4.4
Adjusted control total deficit	**(9.8)**	**(9.8)**	**0.0**

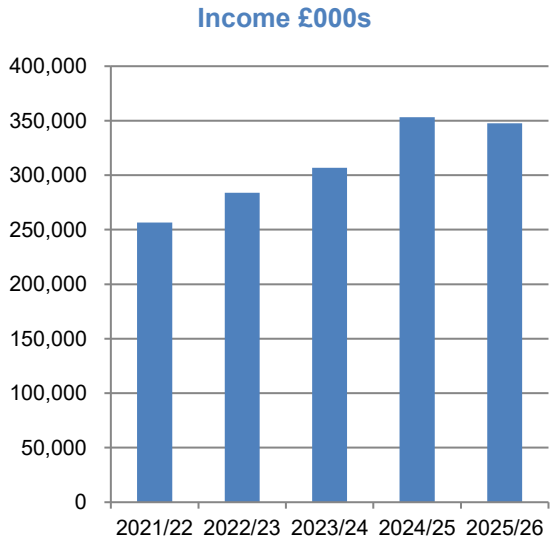
Performance Against Plan

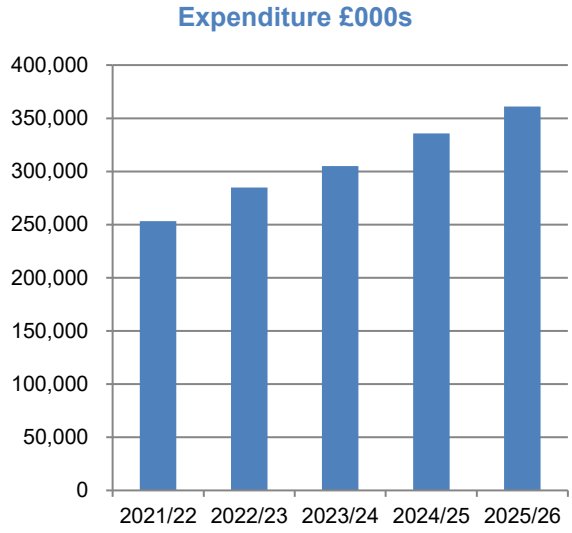
Income exceeded planned levels to the value of £14.1million. The Trust overachieved its income plan through a number of areas such as funding support for its increased activity levels, support for incurred industrial action, profits from property sales and overachievement of bank interest.

Expenditure was £18.5million above plan. There was significant pressure on expenditure budgets relating to increased activity above planned levels (a marked increase in Emergency Department attendances and support for the temporary closure of the Yeovil maternity unit), along with costs supporting industrial action, inflationary increases and impairments linked to asset revaluations and property sales.

Trends in Income and Expenditure

The charts below show the trends in income and expenditure over the five-year period from 2021/22 to 2025/26.





The income chart illustrates the movements in income over the five-year period from April 2021 to March 2026. Over the five-year period, income has seen growth of 36%. While 2025/26 shows a reduction compared to the prior year, this is attributable to £13million of non-recurrent income recognised in 2024/25; excluding this, 2025/26 reflects a further underlying increase of 2.2%. This is primarily the result of the funding received to support the

growing impact of rising inflation, increased activity levels, increased high cost of drugs funding and further growth to deliver elective recovery of services.

The expenditure chart illustrates the growth in expenditure over the five-year period, representing a 43% increase since 2021/22. In 2025/26, expenditure has increased by 7.6% compared to 2024/25. This is primarily the result of challenging costs linked to rising inflation, increased activity levels, heightened operational pressures, high cost of drugs, and challenges linked to efficiency schemes to be delivered recurrently.

Revaluation of Land and Buildings
As part of the preparation of the annual accounts, the Trust is required to assess the value of its land and buildings. This exercise is carried out at the end of the financial year. Avison Young conducted a property appraisal valuation on behalf of the Trust. Overall, there was a decrease in valuation of land and buildings of £6.1million. This included a charge to the Revaluation Reserve of £6.0million for impairments and a charge to other operating expenses in the Consolidated Statement of Comprehensive Income for impairments of £0.3million and reversals of impairments of £0.2million.

Cost Improvement Programme and efficiency plans
The Trust delivered its cost improvement plan in 2025/26 by achieving £29.1million of efficiencies. Of this, £4.9million (17%) was delivered on a recurrent basis. Efficiency delivery includes: £11.4million income received from NHS England linked to the paused shared services initiative, £2.9million from property disposal profits, and £11.8million of operational efficiency delivery against operational set targets. Overall delivery represents a significant step change for the Trust, exceeding delivery performance in prior years and reflecting substantial cost reductions from agency savings, contract renegotiations alongside improvements in income generation including bank interest.

The Trust ended the year with £27.5million cash. This was an increase of £2.3million during the year. The increase in cash is driven by receipts from property sales, agreement of an extended repayment profile on a capital loan, and a temporary rise in trade and other payables due to timing differences. These favourable movements are partially offset by the £9.8million planned deficit against the adjusted control total delivered in-year.

Charitable Funding
The Trust is fortunate to be supported by Dorset County Hospital Charity and a number of other local charities. All Dorset County Hospital Charity funds benefit the Trust. In 2025/26, the Trust received charitable grants for capital projects from the Charity of £0.5million.

Capital Expenditure
The Trust's capital plan for 2025/26 was set at £52.0million and the Trust spent £55.5million. The additional expenditure above planned levels were due to the creation of additional capital funding from the sale of Trust properties. The capital expenditure during 2025/26 was focused on completing the Stroke Unit expansion and creating an additional Hyper Acute Stroke Unit (HASU), backlog maintenance, medical equipment, investment in digital projects, and construction works on the New Hospital Programme project which is now well underway. The Trust benefitted from Public Dividend Capital external funding bids which enabled the creation of an Urgent Treatment Centre, addressed Critical Risk Infrastructure

for backlog maintenance, started work on replacement of the Trust generator, and the purchase of new medical equipment for diagnostics and surgical services.

Performance Analysis

Monitoring Trust Performance
In line with national NHS reporting standards, performance metrics starting data for the year represents the April 2025 position.

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

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

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

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

In 2025/26, the Trust has maintained the progress it made in 2024/25 with low vacancy rates thanks to the success of various recruitment strategies, particularly in nursing. This has meant the use of agency staffing has reduced further, saving money and improving the consistency of care. Theatre staffing has been a challenged area in terms of recruitment for a number of years, but a successful rolling recruitment programme has meant the vacancy factor in theatres for 2025/26 has reduced. Work with the Our Dorset Provider Collaborative is mitigating some of the outstanding risks, exploring all options to move to a more shared workforce approach across Dorset.

Moving into 2026/27, the Elective Recovery Fund (ERF) will continue. This will support the Trust in delivering the increased level of activity required for 2026/27 in order to achieve the national targets. Further efficiency and productivity improvements will be critical in delivering further performance gains.

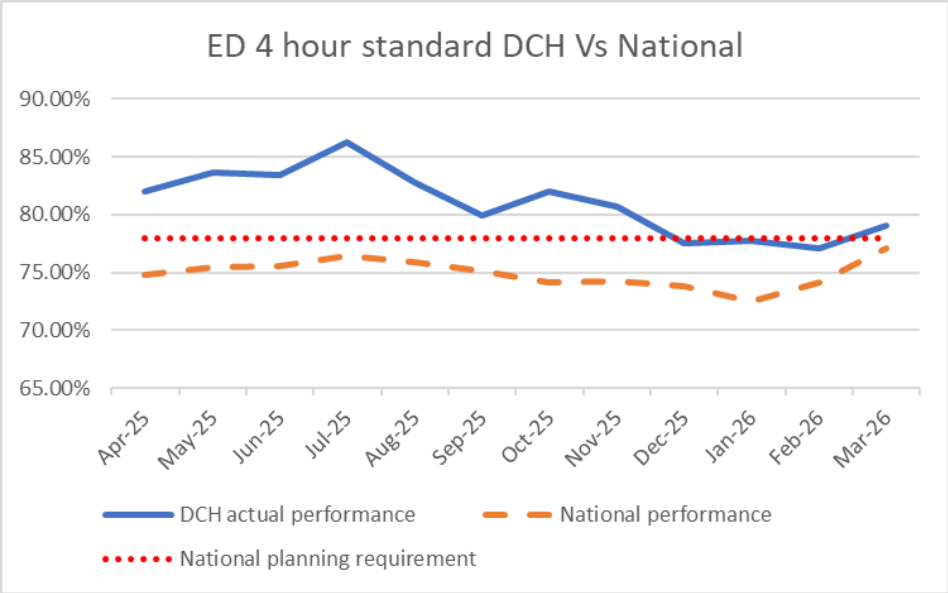
The Trust's performance trajectories were agreed as part of the 2025/26 contracting round and included the following five key performance indicators:

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

Operational Performance: The Emergency Department
In 2025/26 the Emergency Department experienced 10.76% more attendances than the previous year. This compares to 1.8% growth that was included in the operating plan. This translates to 5,862 more attendances than 2024/25, putting considerable pressure on the department and wider hospital.

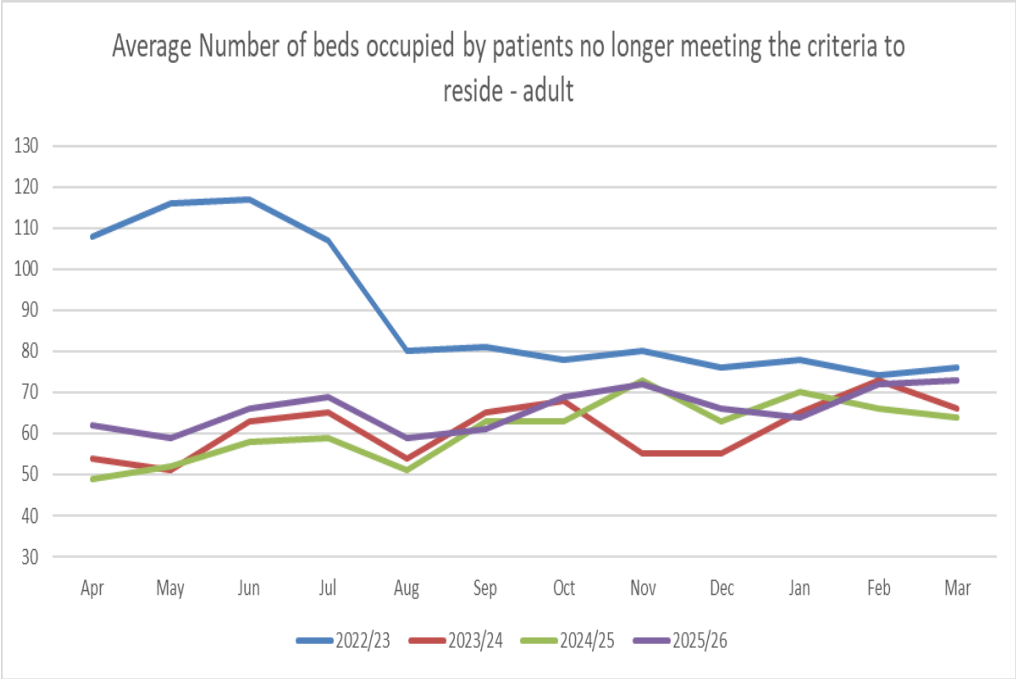
The percentage of patients that have been admitted from an ED attendance has increased to 40%; during peak times of seasonal variation (winter) this reached 42%. This is a notable change in the proportion of patients admitted compared to the previous year and represents the increasing complexity presenting at the front door and the ageing population of Dorset.

The combined Type 1 and Type 3 performance (Emergency Department and Urgent Care Centre) did achieve that national requirement of 78%, nine out of 12 months. This performance was achieved against the operational challenges that restrict hospital flow due to the continued high levels of patients with no reason to reside and the increased level of demand at the front door.



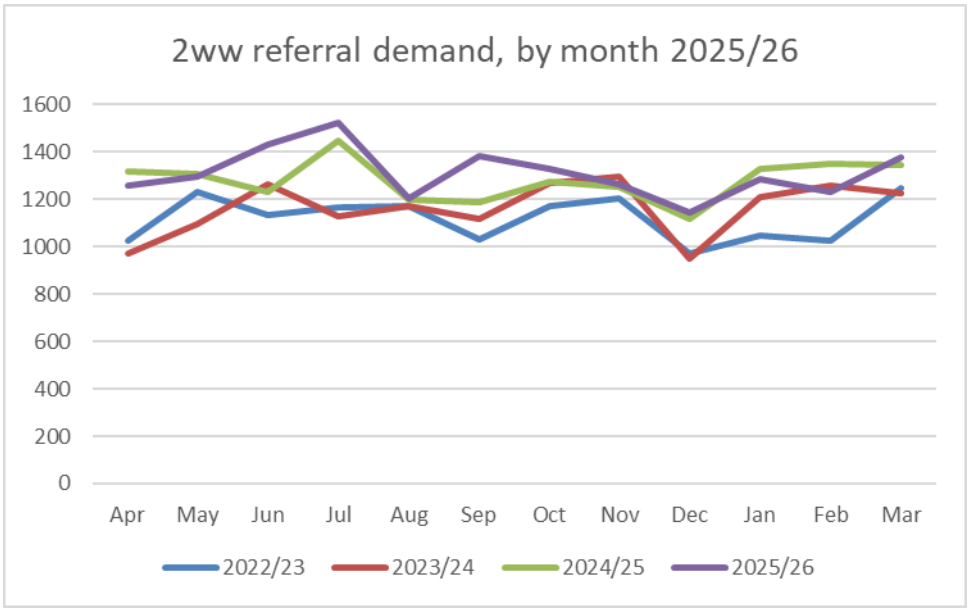
For 2025/26 the Trust continued to see the percentage of beds that were occupied by patients with 'no reason to reside' to be lower than the peak of 2022/23 but slightly increased compared to 2024/25. These are patients that are medically fit for discharge but are waiting on a care package to enable them to go home or return to an out-of-hospital care setting.

This continuation of performance, with an ageing population and increased demand at the front door, is a positive outcome and follows a multiple stranded plan, working with system partners and the local authority in a multidisciplinary way. However, the Trust and its partners recognise that if Emergency Department waits are to be improved to the constitutional standard, more needs to be done.



Operational Performance: Cancer Waiting Times

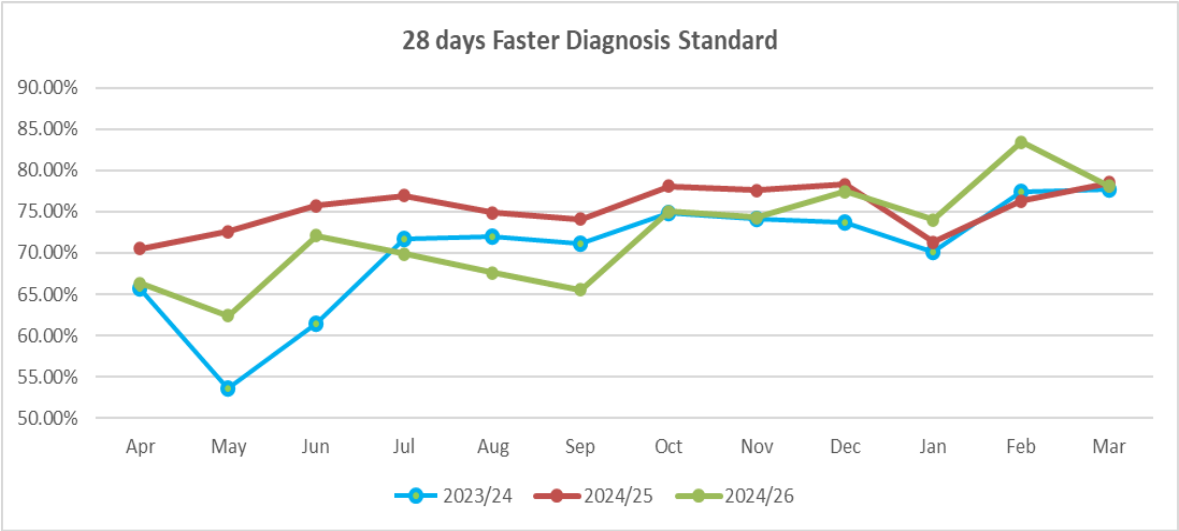
The Trust has experienced another year of increases in the demand for cancer services. The number of referrals to the two-week wait (2ww) referral pathway increased by 2.38%.



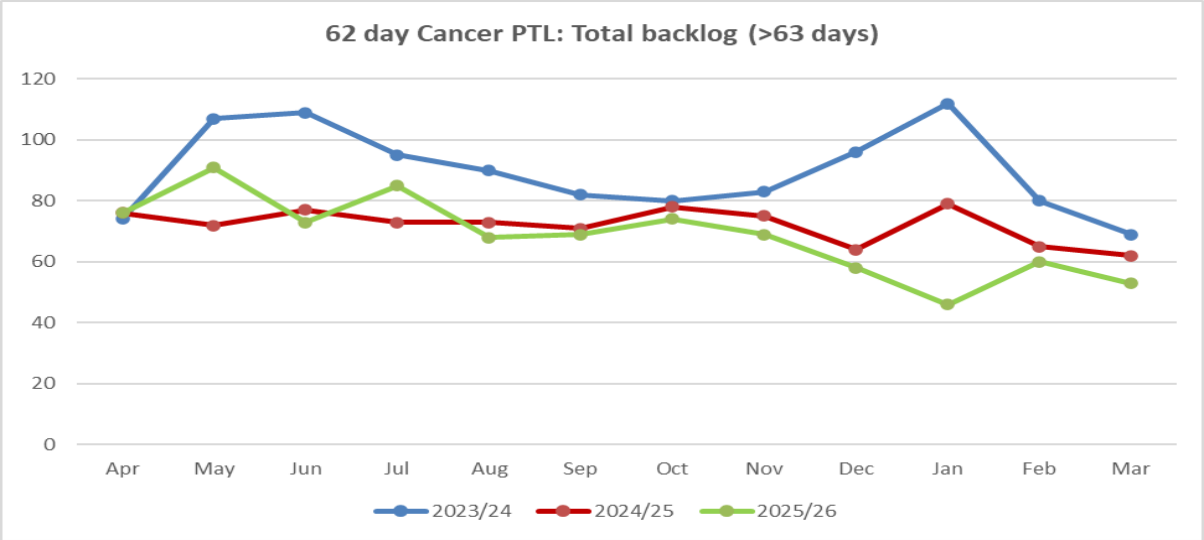
Performance against the cancer waiting time standards had a challenged start in the first half of 2025/26. This was due to demand increases, unexpected sickness and the operational

pressures of winter. In the second half of the year, cancer performance against the key metrics improved and throughout the year the Trust benchmarked well across the South West region.

Performance against the 28-day standard, which required the Trust to get to 80% of patients to be diagnosed and informed of their cancer, or non-cancer diagnosis, within 28 days of referral by March 2026, hit 80% by February 2026. Performance dropped slightly in March, achieving 77.97%.



Despite the increase in demand, the Trust has seen an overall reduction in the size of the cancer 62-day backlog. The backlog, while starting the year higher than the previous year, was smaller than it has been for the previous two years from August, for each month. Achievement of this has been due to the commitment of the clinical and administrative workforce, which supports cancer patients through their pathway in a timely manner, and supports the best clinical outcome and additional capacity.

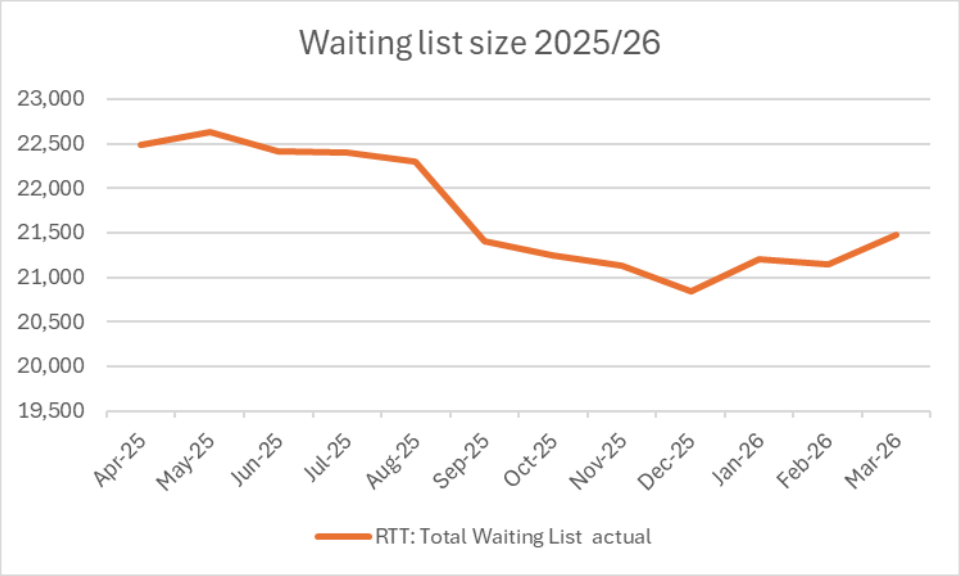


For the 2025/26 operating plan, there was a return to a focus on the 62-day referral to treatment standard, with trusts required to achieve 75% by March 2026. The Trust achieved

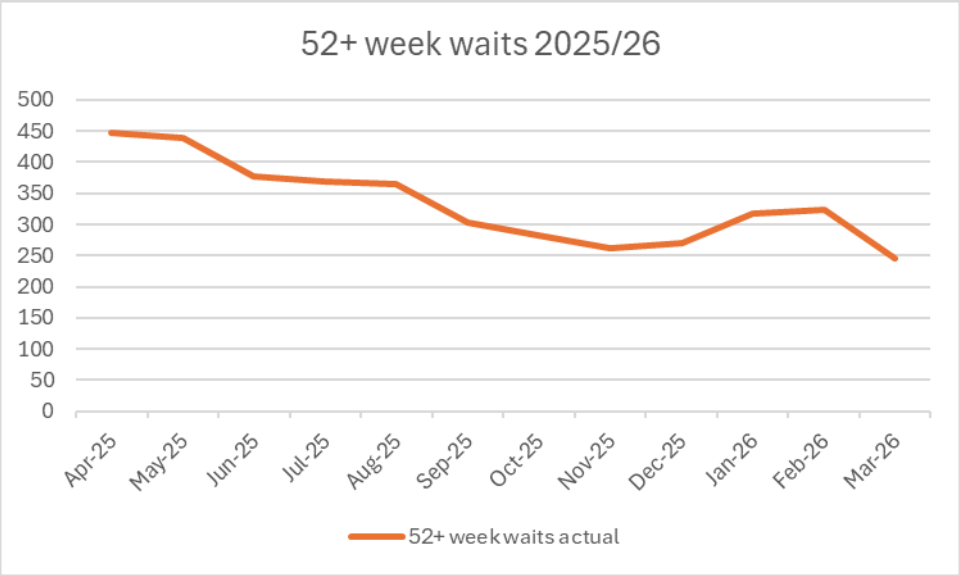
76.49% in February 2026 and 74.70% in March.

Operational Performance: Referral to Treatment Times
In response to the national elective care waiting list recovery programme, the focus for 2025/26, the Trust was required to reduce the overall size of the waiting list, reduce the number of patients waiting over 52 weeks and improve performance against the 18-week referral to treatment standard.

The total waiting list size reduced from 22,486 to 21,475 in 2025/26. This was achieved despite an increase in referrals.

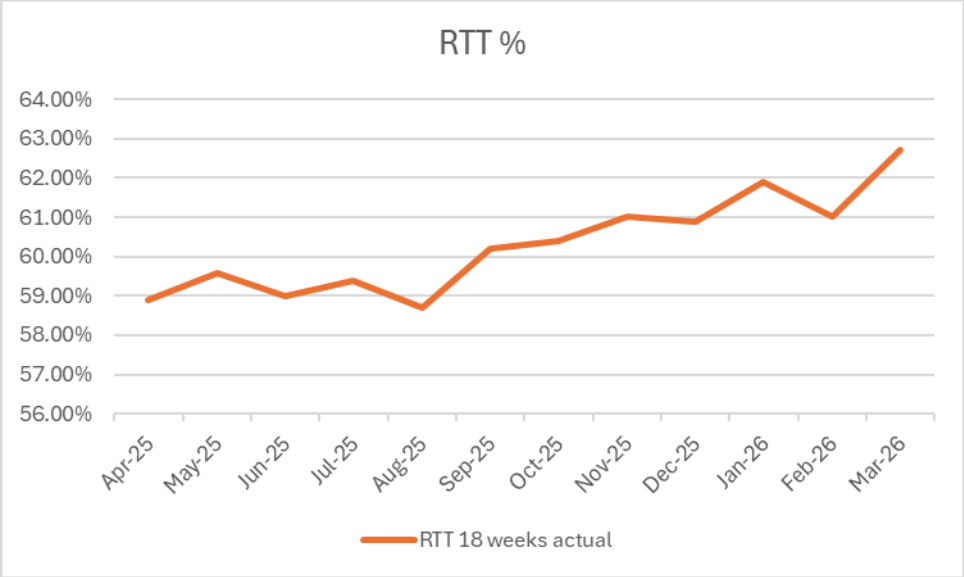


The Trust made progress in reducing the number of patients waiting over 52 weeks, from 448 to 245. This was possible with additional income earnt from over-delivering against the Elective Recovery Fund, which enabled additional activity to be delivered.

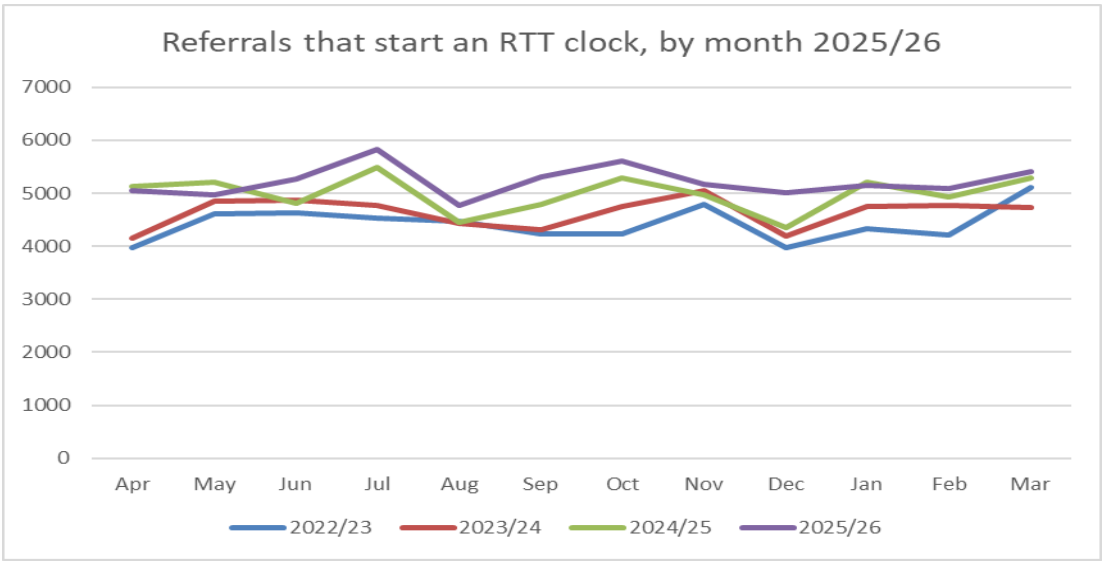


Performance against the 18-week referral to treatment standard, improved from 58.90% to

62.70% from April 2025 to March 2026. With a waiting list size and 52-week wait reduction, the improved position on the referral to treatment standard means that the Trust is starting 2026/27 in a strong position to continue to improvements in elective care performance.

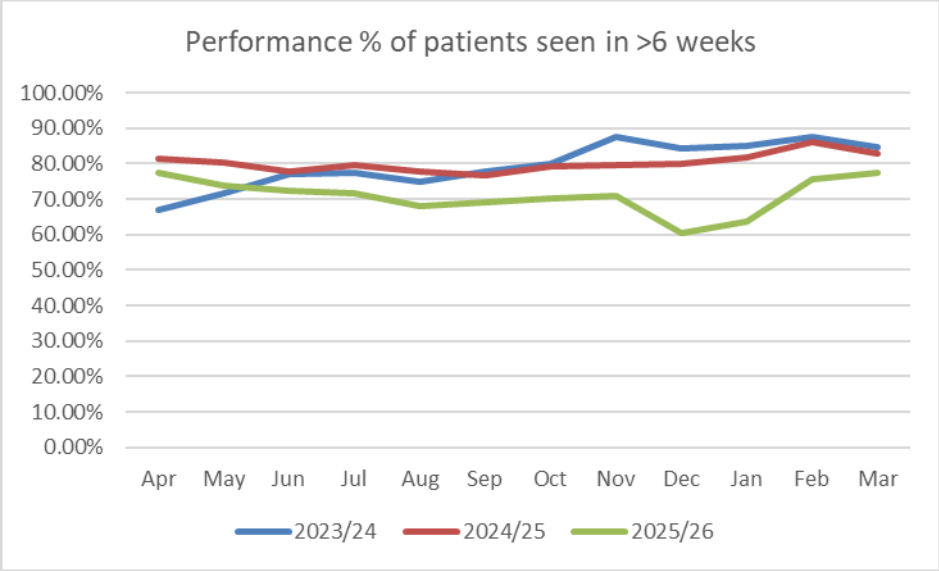


Referral volumes for the financial year 2024/25 were 4.50% up compared to 2024/25. Although this growth put further pressure on services, the Trust was pleased to see that patients were accessing the care and treatment they needed. The Trust has responded by increasing capacity within the constraints of available resources.



Operational Performance: Diagnostic Waiting Times

Diagnostic performance against the six-week waiting time standard has not performed as well when compared to the previous year, with performance below that of last year. The demand increases for both elective and non-elective pathways has put considerable pressure on diagnostic services. The Trust acknowledges that additional capacity will be required in 2026/27 to improve performance to the required standard.



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

Risk Profile of the Trust

To ensure appropriate management of the principal risks to the delivery of the Trust's strategic ambitions and priorities, particular emphasis is given to the identification and management of risk at a local level. Discussions at divisional groups are required to consider all locally held risks to encourage a culture of ensuring agreement on the identified risk score, and that mitigating actions are appropriate. Risks scoring 15+ are notified to the accountable Executive Director to review when added to the corporate risk register. The Audit Committee provides the Board with an independent and objective review of risk management systems and practice and an overview of the Trust's internal control framework.

The Board Assurance Framework was reported to the Board on a quarterly basis in 2025/26 and each strategic risk was reported to its aligned assurance committees. Chairs of Committees formally report at each meeting of the Board from a risk escalation and assurance perspective.

The main principal risks faced by the Trust during this year related to:

- The ability to deliver consistently safe, effective and compassionate care;
- Increased focus on financial controls, emphasising best value decisions;
- Robust capital prioritisation processes to ensure resources are deployed effectively and estates and new build programmes are delivered as required;
- The ability to recruit and retain staff with the right skills to deliver high quality and safe, sustainable services;
- Advancement and protection of our digital and technological capabilities to ensure deliverability of sustainable and safe services.

Although climate-related risks are acknowledged as emerging, longer-term considerations, they are currently assessed as lower in relative significance when compared with the Trust's principal risks relating to workforce capacity, quality and safety of care, and digital resilience. Climate-related risks are therefore not identified as a principal risk for the Trust. However, the need for an 'environmentally viable' estate is referenced in Strategic Risk 5 of the Board Assurance Framework.

As we enter 2026/27, the Trust remains focussed on dealing with significant operational and workforce challenges. This will include a focus on the delivery of NHS England Operational Planning Priorities.

- Improving outcomes for those accessing elective, cancer and diagnostic care by reducing waiting times and enabling faster diagnosis;
- Improving Emergency Department (ED) wait times so fewer patients need to wait more than four hours to receive treatment;
- Working collaboratively across systems to deliver on the system priorities, e.g. working with partners to transform community, urgent and emergency care to prevent inappropriate attendance at EDs and implement delivery of neighbourhood health;
- Ability to achieve financial sustainability at pace, living within our means, reducing waste and maximising productivity;
- 'Doing digital differently' by expanding our digital options and delivering improved technology offers to support delivery of safe and high-quality healthcare, such as implementing an Electronic Health Record;
- There will be a continued focus on robust risk management to ensure that any potential impacts on quality and equality are considered when discussing changes or impacts linked with the operational planning priorities within the local system context.

Within this context, we acknowledge the great opportunities in our closer integration with local partners and will continue to prioritise this and the benefits it provides in the delivery of our wider strategic objectives.

Health Inequalities
In collaboration with voluntary and statutory partners, communities and people with lived experience, the Trust has been continuing efforts to tackle health inequalities through a focused delivery of a Trust Health Inequalities Plan and participation and completion of the Equality Delivery System, ensuring services meet our population need and as an anchor institution.

Key achievements this year include:

- Delivering a perinatal vaccination programme together with Dorset HealthCare and University Hospitals Dorset, winning the Royal College of Midwives 2026 Excellence in Public Health Award;
- Completing service reviews to better understand inequities in access, experience, and outcomes of our patients through a CORE20, Inclusion Health and Learning Disability population health perspective, as part of the Equality Delivery System Framework;
- Approving the Unison Anti-racism Framework and Charter;

- Implementation of National Quality Board Equality Quality Impact Assessments and internal audit of arrangements.

Collaboration with Dorset HealthCare is key and our Joint Health Inequalities Steering Group has overseen the development and delivery of a joint plan for 2025/26. Other examples of system collaboration include in relation to how we collect, analyse and publish information related to health inequalities, detailed in the NHS Dorset's Annual Health Inequalities Report.

Further detail about the Trust's health inequalities performance can be found in the https://dchft.nhs.uk/about-us/trust-board/annual-reports/.

Environmental Performance

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

Task Force on Climate Related Financial Disclosures

TCFD Compliance Statement

The requirement is a phased approach to incorporate the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures are as interpreted and adapted for the public sector by HM Treasury. Local NHS bodies are not required to disclose scope 1, 2, and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England. These disclosures are provided below including appropriate cross refences to relevant information, with all pillars disclosed while at different stages of maturity.

To meet the requirements of the TCFD for the Trust as a public sector organisation, and to demonstrate good corporate responsibility, the report sets out how risks and opportunities relating to climate change are identified, considered and managed within its structure. Materiality assessments for sustainability priorities and risks are not undertaken by the Trust at present, but those potentially impacting supply chain, operations and greenhouse gas significance follows the broader Green Plan guidance and Sustainable procurement guidance by NHS England. The guidance application is in Phase 3 and now has a strategy pillar, expanding on risks and opportunities, impact and resilience.

Governance pillar

Board oversight of climate related issues

The Trust has in place clear governance, accountability and risk management structures related to climate related risks.

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

The Board is informed of climate related issues by the Strategy, Transformation and Partnership Committee who in turn receive assurance reports from the Sustainability and Travel Working Group. The Business Intelligence dashboard includes sustainability key performance indicators and is available to Board members and Directors, and periodic data is supplied to the Chief Finance Officer, as executive lead for sustainability. The progress of the green plan goals and targets form part of this reporting, with regular reports to the Board.

The Board has supported a joint climate change risk assessment, commissioning from May to November 2026, which will inform reviews of organisational plans and monitoring of the trusts. The Trust sets out sustainability goals as a foundation pillar of the joint strategy with sustainability being one of the Trust's strategic objectives. Additionally, climate change is identified within the Board Assurance Framework, and the Trust undertakes mitigation on the effects of flooding, heatwaves and snowstorms on our infrastructure, patients, and staff in our business continuity plans.

Management's role in assessing and managing climate related issues
The Joint Director of Estates and Facilities is updated via monthly one-to-one meetings and ad hoc discussions with the Sustainability Manager. The Director of Nursing leads the Greenspaces Group, has undertaken a masterclass in sustainability and leads across a range of committees and groups within our governance structures

A widely representative group of clinicians, managers and heads of service attend or are connected to the Sustainability and Travel Working Group where they can raise a range of climate related risks and opportunities, which forms the initial assessment and management of climate related issues, including tracking progress of the Trust's Green Plan, and developing the green travel plan with proposed assessment, management and progress to net zero targets. The purpose of the group is to guide the review of the Green Plan, to map the route to net zero in accordance with issued guidance, delivery and track strategies and policies relating to sustainability and ensure the Trust's Green Plan and future iterations are embedded into all Trust decision making and strategic developments.

Strategy pillar

Climate related risks and opportunities over the short, medium and long term
The Trust does not have a definition for short, medium and long-term climate-related risks, but these are due to be defined as part of the Climate Change and Adaption Planning work being undertaken in 2026.

The Trust commissioned a Heat and Energy Decarbonisation Plan in 2024. This decarbonisation plan with a time-related energy strategy sets out a range of actions, however these are not resourced and are reliant on identification of grant funding or private investor partnerships. The plans were used this financial year to develop business cases and undertake decarbonisation project applications in 2025/26. These are set out below.

Decarbonisation projects increasing opportunities to meet net zero emissions										
Deadline	Status	Date	Project	Funded	Funder	Description	No of x. Installed	Anticipated cost/kWh saving	Anticipated TCO2e savings	Relevance
31/03/2024	Complete	2023/24	LED	£20,000	NEEF	Replacement of Fluorescent lights with LED	307	146,200 kWh	1.54	Cost/Carbon and maintenance reduction
31/03/2025	Complete	2024/25	LED	£42,000	NEEF	Emergency LED lights	85	40,479 kWh	0.425	Cost/Carbon/ maintenance reduction
31/03/2026	In-progress	2025/26	LED		NHSE Decarb				N/A	Cost/Carbon/ maintenance reduction
31/03/2026	In-progress	2025/26	Submetering	£88,000	NHSE Decarb	First phase of high branch level submetering	30 meters, software read	10-15% anticipated energy costs and carbon		Cost/carbon/ behaviour change/identify 'vampire' draws

Impact of climate-related risks

During the winter of 2025/26 there was exceptional rainfall and the storm Chandra event on top of a saturated water table brought exceptional flooding, including a severe flood warning issued for the Upper Frome, Dorchester. There was wide disruption across South West England, due to flooded roads and railway lines, and several flooded properties in Dorset. The Trust deployed the use of 4x4s from volunteers to bring in some staff and the travel team undertook close monitoring of Dorset Council live travel updates. These events can coincide with seasonal flu with some staff unable to access the sites. In the summer of 2025/26, nationally significant amber rated concurrent droughts could lead to heat related deterioration and negatively impact on vulnerable groups such as the elderly or children while the Trust is simultaneously supporting increased tourist populations.

Climate related opportunities

Examples of opportunities defined in the draft Green Plan refresh (planned publication summer 2026) to reduce carbon that may also relate to climate risks is the Trust's work with 'hospital at home', a target to deliver 25% of outpatient care remotely and developing an Electronic Health Record to help reduce emissions, and secure mobility of records to enhance and co-ordinate delivery of care (benefits to deliver in 2028/29).

Risk Management pillar
The organisation's processes for identifying and assessing climate-related risks is set out below.

Process to identify and assess climate related risks	Remit/ frequency/risk management
Strategy, Transformation and Partnership Committee	Progress, assurance and decision recommendations from STWG on sustainability and net zero carbon progress (bi-monthly). Recommends assurance or decisions to the board
The Sustainability and Travel Working Group meetings	Quarterly, includes tracking progress of the DCH Green Plan and range of clinical and support service leads identifying and assessing climate related risks
The Joint Director of Estates and Facilities meeting with the Chief Financial Officer	Ad hoc, and includes potential for decarbonisation funding applications, towards net zero
Head of Estates and Capital Projects, the Sustainability Manager and the Sustainability Office	Ad hoc meetings on energy, with occasional references to Procurement, data/graphs of energy consumption, metering/submetering, to inform decisions
Sustainability Manager and Head of Estates and Capital Projects attend the Health, Safety, Fire and Security Meetings	Includes waste operations and climate risk to business continuity planning
Adherence to Trust policies	Sustainability Policy (2023) Sustainable Procurement Policy (2024) Waste Operations Policy (2026) Adaptation Plan (2021-2026)
Working towards guidance	Delivering a Net Zero NHS
Clinical Infection Management	Includes sustainability actions and practices
Green Theatres Group	Developing greener operations

Climate-related risks identified by the organisation
The climate-related risks for the organisation relate to materiality, considering the importance of data and evidence of climate related risks to the Trust operations and services, ensuring that we influence and follow national guidance including the NHS England Green Plan Guidance (refresh) Focus areas (2025), and the commission for a Climate Change Risk Assessment scope aligning with the CCRA following the climate adaption framework for NHS organisations in England and CCRA tool.

Managing climate-related risks
The Green Plan refresh involved a range of internal stakeholders identifying net zero climate and an adaptation focus area with commitment to a Climate Change Risk Assessment to identify risk mitigations, controls or to accept risks, determine assumptions and relate to the aforementioned framework.

The Trust has worked with University Hospitals Dorset and Dorset HealthCare to identify a consultant organisation to identify the climate related risks over the short, medium and long term. This will commence from May 2026 with a scope to look at infrastructure and service delivery, with information provided by the trusts, and is aligned with the Care without carbon climate adaptation framework and climate change risk assessment tool for NHS organisations in England. This will be a high level first step in understanding the challenges, organisational culture, and resources that can inform planning, such as the recent multiple flood events and associated impacts on public transport, roads, and housing, including patients and staff getting to the hospital sites.

The Trust works with other public sector partners in the Integrated Care System including Dorset Council who facilitate the Dorset Public Sector Decarbonisation and Ecology Group, including sustainability leads rotating chairing the meeting, and the beginning of a Dorset Climate Change Risk Assessment (CCRA) was initiated. The leads have also formed links with Bournemouth, Christchurch and Poole (BCP) Climate Forum, led by BCP Council, also developing a CCRA tool.

This work will identify climate related issues, within timeframes, to help understand how this may affect operations, strategy and financial planning, including supply chain, the physical risks and how to address risks and opportunities.

Integration into overall risk management
This is outlined in the governance and strategy pillars and the scope and commissioning that the CCRA process will engage key stakeholders, with the aim to work with business continuity and risk management, clinical and support services and the Board. Climate change impact as exemplified in recent years with significant floods and heatwaves could impact on healthcare delivery. The extent of this for consideration as a principal risk needs substantiating through data and the initial indications of the planned first level CCRA in 2026.

Metrics and target pillar
The Trust's targets and material metrics include Key Performance Indicators adopted in 2025 and are detailed in the below table. The overall emissions are not disclosed as they are derived centrally by NHS England.

Indicator	Method	Baseline year	2025/26
Compliant Green Plan Targets Achieved %, include NZC Procurement	Green Plan actions achieved across all focus areas by number of actions	2022/23	70% achieved, additional comparable actions achieved in focus areas
Carbon Footprint – decreasing in line with NHSE targets (annual)	Carbon footprint based on scope 1 and 2 emissions including energy	1990, restated from progress and data supplied by NHS England 2019/20	Carbon emissions from volatile anaesthetics have reduced over the year
National Target for Clinical waste 60:20:20 (annual)	Aim to reduce the amount of high temperature incineration waste by good utilisation of	Data available from 2025 Jan	59:26:14

Indicator	Method	Baseline year	2025/26
	correct waste streams		
EcoEarn activity – increasing (quarterly)	Staff pledge platform to gain points, and possible prizes by greener actions at work, getting to work and in everyday life, with links to ideas and actions	Baseline April 2022	Number of new members last financial year: **7** Total active members: **Av 135 monthly over the last financial year** Total members all time: **430**
Sustainable Development Assessment Tool 2 – maintain and improve score	Developed and mothballed measure of sustainable development of NHS trusts, adapted by UHD and in use by DHC and UHD.	No baseline for Trust	Not populated as extensive, no baseline and other metrics requiring allocation of officer's time

Further climate related metrics

Metrics	Comment 2025/26
Staff travel survey (SWH Green Travel Plan and inform main site Travel Plan) developed in 2024 and run annually.	Participation Single occupancy car travel (SWH travel plan)
Greener NHS - Dashboard - Returns	Anaesthetic use (scope 2 emissions) Travel, procurement (Awaiting NHSE scope 3 data) 'score' across a range of NZC actions: maintain 80%
Fleet Survey	
ERIC data	
Online greenspace surveys	Begun in 2025 for an MSc project and encompass how use of greenspaces my encourage pro-environmental behaviour, including reducing CO2e
Progress against the Estates Technical Annexe Roadmap targets	Revision with Green Plan refresh actions
Small and Medium Enterprises/Local Suppliers	
Engagement with Soil Association Process	In progress 2025/26 and funded by NHS England, to deliver 2026/27

The Trust has pledged to meet net zero carbon targets, although there is a risk of not achieving the targets without additional resources. NHS England has restated the 1990 targets to 2019/20 baseline. The revised 2019/20 baseline targets for trusts are now:

- Net Zero Carbon Footprint by 2040, reducing emissions, of 2019/20, by 47% by 2028-2032 (Scope 1 and 2);
- Net Zero Carbon Footprint Plus by 2045, reducing emissions, of 2019/20, by at least 73% by 2036-2038 (Scope 3).

The Trust has reduced scope 1 and 2 emissions by 1,333 tCO2e[2] since 2019/20, with a challenging target of 3,555 reduction and 444 tCO2e per annum for scope 1 and 2. Scope 3 data is awaited from Greener NHS Dashboard. These are absolute targets, not intensity based, and this metric approach may be redefined in 2026/27.

The Trust has not made any public reports, announcements, commitments, pledges or goals specific to scope 1, 2, or 3 beyond the pledges set out in the Green Plan.

The joint Green Plan refresh was in development during 2025/26 so progress on the first Green Plan was closed at 70% achieved, with organically arising actions completed.

Metrics and Targets: Environmental Performance
Responsible use of environmental resources

Electricity
The Trust is supplied grid electricity by EDF. Electricity produced by the Combined Heat and Power Engine is captured under gas usage figures. For all figures ranges used are not absolutes. There are 20 electricity meters supplying to various buildings on the site and Albany Court accommodation, six British Gas meters supplying electricity to the buildings in Charlton Down. During 2025/26 steps were instigated to reduce the number of fiscal meters.

Total Consumption of Electricity (kWh) 2022/23-2025/26

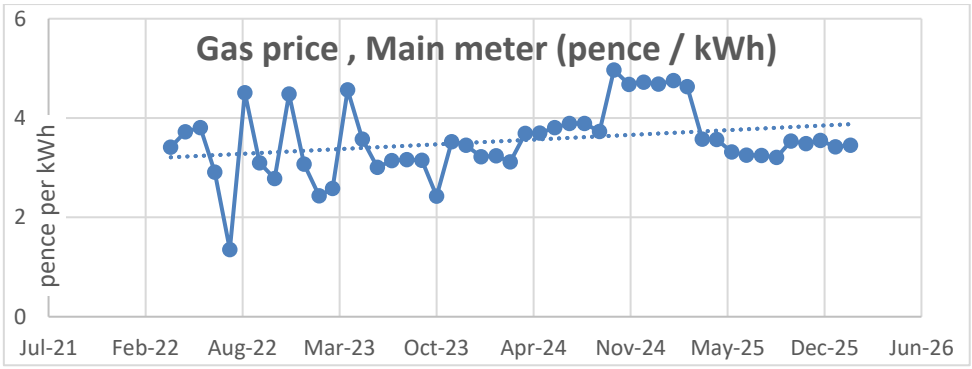
	kWh consumed
FY 22/23	2.5 – 3 GWH
FY 23/24	3 – 3.5 GWH
FY 24/25	2.5 – 3 GWH
FY 25/26	3.5 – 4 GWH

Please note that the 2024/25 figures reported in the 2024/25 Annual Report and Accounts were based on estimated meter readings which have since been confirmed. The above data for 2024/25 is now correct. Data for 2025/26 may fluctuate as previous bills in year have been based on estimated readings; final figures will be included in the 2026/27 Annual Report and Accounts.

Gas
Out of 20 gas meters in total, eight belong to bronze service from Total Energies with automated meter reading; the rest are standard NHH meters. Unlike electricity, gas prices vary monthly and are not constant throughout the financial year.

Gas pricing for the main site (pence/kWh):

[2]A **tonne of CO2** represents the physical mass of carbon dioxide released into the atmosphere, providing a standardised way to quantify emissions from human activities such as driving, electricity use, or industrial processes for organisations to track emissions, the tonne, is metric, not US. This is expressed as CO2 equivalent (CO_2e) as other greenhouse gases like methane (CH4) and nitrous oxide (N2O) have stronger warming effects than CO_2. This converts the impact of all greenhouse gases into the amount of CO2 that would produce the same warming over a 100-year period, using a factor called **Global Warming Potential (GWP).**



To enable like-for-like comparison, the below table includes 11 months of data for each financial year, excluding March in all cases. While gas usage was similar to FY2023/24 and higher than FY2024/25, overall costs FY2025/26 remain lower, as the average unit gas price is lower.

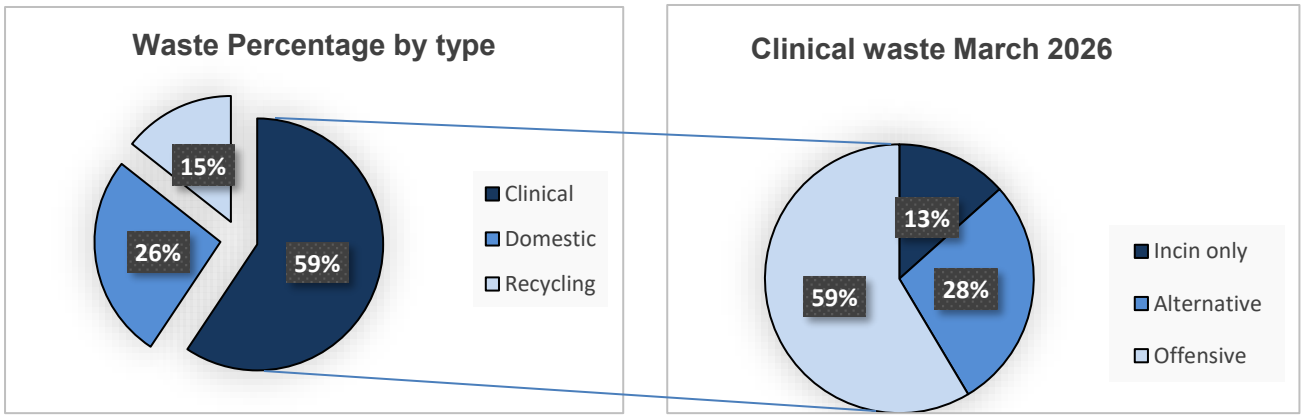
Average Gas prices and consumption (range) main site

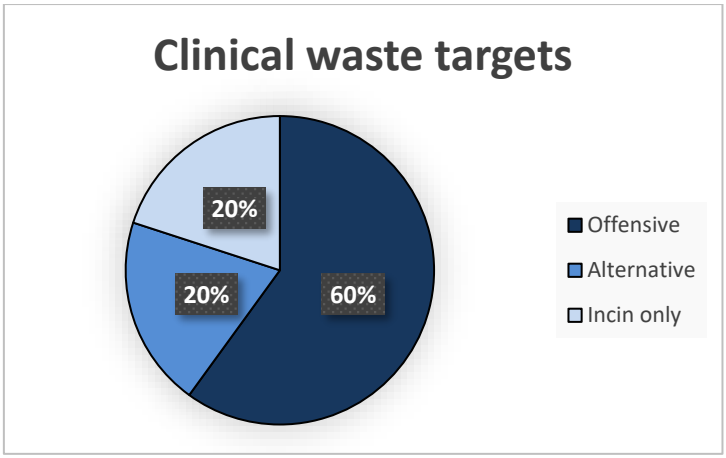
	Average price per unit for Main site (pence)	KWH	£
FY22/23	2.97	19 to 20 GWH	800K – 900K
FY23/24	3.04	22.5 to 23.5 GWH	900K – 1M
FY24/25	4.14	20 to 21 GWH	950K – 1.5M
FY 25/26	3.13	22.5 to 23.5 GWH	850K – 950K

Please note that the 2024/25 figures reported in the 2024/25 Annual Report and Accounts were based on incomplete billing data which has since been corrected. The above data for 2024/25 is correct and the data for 2025/26 is based on actual readings, not estimates.

Carbon emissions

Anaesthetics are at 459tC02e carbon emissions from natural gas equates to 4,194 tonnes, to the end of February 2026 (BEIS GHG emission conversion factors). Gas usage tonnes, tp the end of January 2026 (Greener NHS Dashboard). CHP Carbon emissions are included in the natural gas emissions.





Rehoming scheme

Rehoming service (office furniture, filing cabinets, bins, trolleys, cabinets, medical locking cabinets)	Quantity rehomed (tonnes)	Value	Disposal costs avoided	T(CO2e) avoided
April 2025 – January 2026	9.25	Approx. £100,000	£1,834	8.56

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

Food and nutrition

The public and staff restaurant recycling station, a type of 'still great plates' available to staff with a short-term need and measurement of food waste continues, with work underway on sustainable durable serviceware for wards. The Trust has secured support from NHS England to undertake Soil Association Bronze standard and continues to work with local suppliers where possible. A hospital charities grant, following funding by a patient's family member, has seen the development of a kitchen garden and a survey of the bird feeder livestream from Devon Wildlife trust. The Trust has used Bridge Roots coffee in our restaurants for over two years, with a traceable origin, environmental and conservation standards including rainforest alliance, shade grown methods allowing wildlife support and natural ecosystem. The company also collaborates with Project Waterfall bringing clean water to coffee farming communities.

Water

The older estate is prone to roof and water system leaks at times. Staff can report water leaks through EcoEarn and claim green points. We also have sensor taps which help minimise water consumption. Greener Theatres actions include use of hand sanitiser after initial scrubbing, rather than repeat scrubbing. Work to undertake more regular water meter reading is underway.

Greener theatres and anaesthetics

In line with the guidelines and standards from NHSE, we have moved completely from

desflurane and decommissioned the manifolds for nitrous oxide. The anaesthetic gas CO_2e emissions are at 459 tonnes compared to 657 tonnes and 599 tonnes for previous years (data acquired from Greener NHS dashboard, with details limited to 10 months as available).

Despite the rise in nitrous oxide and Entonox consumption in the previous financial year, the Trust continues to see a pronounced reduction in emissions from volatile anaesthetic agents, which form part of scope 1 emissions, with a consistent downward trend evident over the last two years reflecting actions by Green Theatres Group, anaesthetists, medical gases and estates and facilities.

Medical gases, while useful, are scope 1 emissions, as direct emissions from the organisation's operations have a high global warming potential. Emissions from volatile anaesthetics, Entonox, and total anaesthetic emissions are trending downwards from 2018/19 to 2025/26.

Green Travel Plans

NHS England Green Plan refresh guidance, available from 5 February 2025, states that Green Travel Plans should be integrated to Green Plans from December 2026. Green Travel Plans incorporate scope 2 (business travel) and scope 3 (staff commute) emissions, with actions during 2025/26:

- Main site Green Travel Plan scope and task and finish group established;
- Staff Travel Survey was initially a requirement of South Walks House Travel Plan but is now conducted annually and includes all staff. A survey in summer 2024, received 288 responses, setting a benchmark, and was repeated in summer 2025, with 330 responses;
- Annual fleet data survey, as part of Greener NHS data collection;
- Working closely with Dorset Council transport team, including communication on cycle improvements and potential grants for cycle shelters, to consider in the Green Travel Plan;
- Bicycle Users Group Teams channel including notifications of cycle works;
- Low carbon travel options available on internal StaffNet with plans to add to webpages.

Dorset NHS Lift share

- Number of members: 96 (2025/26);
- Historic savings are £30,838, 23.29 tonnes of CO2e reductions and 105,646 miles reduced as a part of lift sharing;
- Forecasted 12 months savings figures are £11,694, eight tonnes of CO2e reductions and 40,063 miles to be expected to be saved in next 12 months.

Green spaces

The Trust is working to improve its greenspaces for health and wellbeing benefits via a multidisciplinary Greenspaces and Gardens Group, led by the Director of Nursing, which meets bi-monthly. The Sustainability Manager has explored the assessment of greenspaces and nature-based activities, including the impact of time in nature on the likelihood of pro-environmental behaviours, conversations nationally and regionally on nature-based activities in an acute setting and a quality improvement project and showcasing 'HealthybyNature' at a

recent Quality Improvement conference.

Nature and wellbeing
The Trust's Nature Recover Ranger came into post in June 2025, with the Trust as hosts and partners of the Healthy by Nature Project. The ranger is delivering greenspace improvements and engaging staff, patients, visitors and local community with nature for health and wellbeing. There are 23 members of the staff and volunteers gardening group, with up to five regular participants and tasks running each month, and ad hoc sessions as needed.

The ranger has supported the next stage of the sensory garden project, the first phase funded by the Greener Communities Fund, supported by the local horticultural college and stakeholders. This was further supported by a Dobbies in the Community grant, who contributed 1,000 bulbs planted by staff and volunteers, supporting pollinator species, adding value to greenspaces. Local fundraising and the hospital Charity supported over 50 herbs being planted by volunteers outside Damers Restaurant and the staff Pride Networkand Greenspaces Group are working on an inclusion garden plan. Patient nature-based activities are taking place weekly, with clinical or activity leader support, and collaborative monthly activities with patients on the Mary Anning and Stroke Units working with Arts in Hospital, Dementia and Chaplaincy Teams.

Social, Community and Human Rights Issues
The Trust takes its responsibilities towards the community it serves very seriously and recognises the responsibility it has to:

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

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

The Trust's Social Value Pledge is available on the hospital's website - https://www.dchft.nhs.uk/about-us/social-value/ - and presents the Trust's commitments to helping to improve the overall wellbeing of the community. The Trust has a Social Value Annual Plan, aligned to the Trust's strategy.

In 2026/27 we will be developing a joint Social Value Annual Plan across the Trust and Dorset HealthCare.

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

Charitable Activities

Dorset County Hospital Charity
The Charity's purpose is to raise funds to enhance patient care and staff welfare at the Trust; providing support that is above and beyond the NHS budget. Dorset County Hospital Charity's Business Plan details fundraising plans, budgets and opportunities. These include a major £2.5million capital appeal supporting enhancements to the new Emergency Department and Critical Care Unit and a focus on building the charity's income to improve the charity's financial sustainability and the contribution it makes to enhance patient care and staff welfare.

Friends of Dorset County Hospital
The Friends of Dorset County Hospital fundraise in support of the hospital, providing funds which benefit patient care. During the reporting period the Friends have expanded the regular trolley rounds to inpatient areas; continued the funding and supply of comfort bags to patients who have been admitted without essentials for personal care; and donated a significant sum to the Emergency and Critical Care Appeal. Their ongoing funding support is greatly valued by the hospital.

Volunteering and Community involvement
The Volunteer Service continues to play a vital role in enhancing patient experience, with over 200 volunteers contributing across a wide range of roles, with over 15,000 volunteer hours contributed this year. Over the past year, the service has focused on continuing the expansion and developing the Activity Volunteer Team in partnership with the Dementia Team and Arts in Hospital Team. Volunteers have delivered a broad programme of therapeutic activities, from cooking sessions and arts and crafts to games and music, making a significant positive impact to patient wellbeing.

Complementing this work, six therapy dogs and Activity Volunteers now regularly visit patients, bringing comfort and connection across the hospital. Healthy Stay volunteers continue to provide essential mealtime and hydration support and Greet and Guide volunteers remain a key part of the hospital's welcome and wayfinding offer. The Young Volunteer Programme has continued successfully, with a more focused intake this year to ensure high-quality training and support. The team has also sustained strong relationships with external partners, including local schools, youth organisations, voluntary organisations

and Yeovil Freewheelers Blood Bikes.

Last year saw the introduction of mandatory NHS England volunteer data reporting, contributing to a national understanding of volunteering in the NHS.

Priorities for 2026/27 include sustaining the current service, further developing the Activity Volunteer role aligned with the Trust's quality priorities, expanding end-of-life care volunteer support, and continuing collaborative work with clinical teams to identify new volunteering opportunities. The upcoming renewal of the Better Impact volunteer management system will also be a key operational focus.

Partnership with voluntary sector organisations

- The Friends of Dorset County Hospital continue to provide a daily trolley shop service and fundraising support;
- Yeovil Freewheelers Blood Bikes deliver urgent samples and equipment and now support medication delivery to recently discharged patients, enabling earlier discharges;
- Your Voice - Experience of Care Council: Membership is constituted from volunteers and Governors together with members of the Patient Experience Team. Ongoing engagement provides valuable insight to support service improvement;
- Healthwatch Dorset: Shared reports and feedback help identify themes and opportunities for improvement;
- Maternity and Neonatal Voices Partnership (MNVP): provides structured engagement and feedback, including from inclusion health and seldom heard groups, on service delivery and improvements to maternity services.

Human Rights

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

Modern Slavery Act 2015

The Trust is fully committed to ensuring compliance with the Modern Slavery Act 2015 and requires all its large suppliers to demonstrate the steps they are taking to ensure that slavery and human trafficking is not taking place in any of its supply chains or in any part of its business. We also require all contractors to agree to the NHS terms and conditions for the provision of goods and services, and by doing so they are confirming that they comply with all relevant laws and guidance and using the good practice guidelines. Our Modern Slavery Statement has been approved by the Board and is published on the Trust website at https://dchft.nhs.uk/about-us/procurement/modern-slavery-statement/.

Anti-Bribery

The Bribery Act 2010, which came into force on 1 July 2011, aims to tackle bribery and corruption in both the public and private sectors.

Bribery can be defined as ‘giving someone a financial or other advantage to encourage them to perform their functions or activities improperly or reward them for having done so’.

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

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

Overseas Operations
The Trust has no overseas operations.

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

Signed

Matthew Bryant
Chief Executive
23 June 2026

Accountability Report

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

Directors' Report

Board of Directors Profiles

Chair

David Clayton-Smith – first term 01/05/2023 – 30/04/2026, second term 01/05/2026 – 30/04/2029

David is a vastly experienced chair and non-executive director, working in a broad range of non-executive roles in both the public and private sectors, most recently focusing heavily on health. David has held non-executive director roles at Frimley Health NHS Foundation Trust and has been Chair at East Sussex Healthcare NHS Trust, as well as the NHS Sussex and NHS Surrey Primary Care Trusts. From 2019-22, David was Independent Chair at the Buckinghamshire, Oxfordshire, Berkshire West Integrated Care System. He was also an Independent Chair at Epsom and St Helier NHS Trust. David's executive career was spent in marketing roles across the retail and hospitality sector.

Chief Executive Officer

Matthew Bryant – appointed 01/04/2023

Matthew joined Dorset County Hospital and Dorset HealthCare Trusts in March 2023 as their first joint chief executive officer. He had previously worked for Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust where he was Chief Operating Officer for hospital services. He led the Somerset health and care system boards for planned and unplanned care and previously led surgical and medical services at the Royal Devon and Exeter NHS Foundation Trust, as well as leading the Trust's work to improve care for frail older people. Over a 28-year career in the NHS he has worked with hospital, community and mental health services, commissioning organisations, cancer networks and helped to establish the Peninsula Medical School in the South West. Matthew was Senior Independent Trustee at Hospiscare, the palliative care provider based in Exeter for a number of years and is currently a trustee on the board of the NHS Alliance.

Non-Executive Directors

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

Following a career in local government, Margaret established her own consultancy providing strategic advice on transformation, regeneration and Corporate Social Responsibility programmes, with a focus on embedding issues of diversity inclusion into 64 mainstream delivery. Margaret's clients extend across all three sectors and have included Nike UK, Unilever, Lloyds Banking and the Football Association. Margaret spent several years

involved in training Metropolitan Police Service officers in diversity and inclusion. She has held a number of advisory roles including Chair for the charity IMPACT and advisory Board member for Choice FM Radio. Margaret is currently a Trustee of Over the Wall, a charity providing breaks for children facing serious health challenges and is the founder of the Foodbank DoorSteppers, an organisation she established in response to COVID-19. In 2023 Margaret graduated from the Tavistock Institute, London with an MA in Consulting and Leadership in Psychodynamic and Systemic Approaches.

Eiri Jones – first term 01/01/2022 – 31/12/2024, second term 01/01/2025 – 31/12/2027 Deputy Chair from 01/09/2022. Joint Non-Executive Director with Dorset HealthCare University NHS Foundation Trust from 23/09/2024.
Eiri Jones joined the Trust in January 2022. Eiri is a Registered Adult and Children's Nurse; has an MA in Professional Development; and is a QI practitioner who has supported several organisations with improvement work. Eiri has clinical, managerial and executive leadership knowledge and skills gained during a career spanning nearly 50 years. Eiri has held senior and board positions in a range of trusts in England and Wales and has also held regional (Trust Development Authority), national (Welsh Government and State of Qatar) and regulatory (Nursing and Midwifery Council) appointments. Her most recent full-time role was as the Regional Director for Getting it Right First Time (GIRFT) in the South West region. She is a Clinical Non-Executive Director in Salisbury Foundation Trust, where she was recently Interim Chair at the Trust.

Claire Lehman – first term 18/07/2023 – 17/07/2026. Joint Non-Executive Director with Dorset HealthCare University NHS Foundation Trust from 18/05/2025.
Dr Lehman joined the Trust as a Non-Executive Director in 2023 and became a Joint Non-Executive Director with Dorset HealthCare in 2025. Since 2023 Claire has been a Non-Executive Director at South Western Ambulance Service NHS Foundation Trust and previously served as a Non-Executive Director at Great Western Hospitals NHS Foundation Trust. Claire has a keen interest in optimising population health and addressing health inequalities. She is a keen advocate for empowering patients and their support networks.

Stuart Parsons – first term 01/12/2021 – 30/11/2024, second term 01/12/2024 – 30/11/2027
Stuart is a fellow of the Association of Chartered Certified Accountants, having qualified whilst working at Eldridge-Pope Brewery in the centre of Dorchester. He has more than 30 years of experience in commercial finance and has held senior positions in a number of sectors including telecoms, logistics, equipment rental, asset management and engineering services. Before retirement he held the position of Group Commercial and Finance Director for Briggs Equipment UK Limited based in Staffordshire. His roles have included international businesses across Northern Europe and Russia.

Stephen Tilton – first term 01/06/2020 – 31/05/2023, second term 01/06/2023 – 31/05/2026
Stephen qualified as a Chartered Accountant with Price Waterhouse and is a Fellow of the ICAEW. He has held a series of senior executive roles in the financial services sector specialising in regulation, risk and governance, including over 10 years as director of legal and compliance at a global private equity firm. He joined the Trust having spent nearly four years as a Non-Executive Director at Worcestershire Health and Care NHS Trust where he

chaired the Audit and Charitable Funds Committees and was a member of the Quality and Safety Committee.

David Underwood – first term 01/03/2020 – 28/02/2023, second term 01/03/2023 – 28/02/2026, extended to 28/02/2029, subject to annual review. Senior Independent Director from 01/09/2022. Joint Non-Executive Director with Dorset HealthCare University NHS Foundation Trust from 23/09/2024.
David is an experienced senior leader having worked first at the Civil Aviation Authority as an Air Traffic Control Scientist and Research Manager before joining the Met Office, in 1998, to lead their Civil Aviation Business. Over 20 years with the Met Office David undertook a range of senior executive roles including Group Head of Public Sector Business, Deputy Director of Technology and Information Systems and latterly Deputy Director of High-Performance Computing. In addition to his executive roles David has more than 10 years non-executive leadership experience gained in the fields of Environmental Business, Further Education (serving on the Board of Exeter College) and most recently as a Non-Executive Independent Advisor to the Royal Devon and Exeter NHS Foundation Trust with regard to their MyCare Technology enabled Transformation Programme.

Executive Directors
Joint Chief Financial Officer: Chris Hearn – appointed 01/02/2024 (Chief Finance Officer from 03/10/2022)
Chris joined the Trust in October 2022 from Dorset HealthCare University NHS Foundation Trust, where he was Director of Operational Finance. During his time in the NHS, Chris has worked in a number of senior finance roles within acute, mental health and community trusts, and prior to this has experience across a variety of technical and commercial finance roles within a large FMCG organisation. Chris is a Fellow of the Institute of Chartered Accountants in England and Wales (ICAEW), having qualified with PwC London.

Joint Chief Nursing Officer: Dawn Dawson – appointed 01/04/2024
Dawn is a highly motivated, confident and enthusiastic clinical executive with extensive and varied executive leadership experience in community, mental health, secondary care, and system settings. Her focus is on strategic thinking, combined with collaborative high trust leadership. Dawn is a registered nurse with an extensive clinical background having worked across acute, community and the mental health sector. Her commitment is to create an empowered culture in which all colleagues strive to deliver safe, high quality, compassionate care every day. Dawn has a broad academic background, which includes psychology, law, legal practice, post-compulsory education, strategic system leadership, and business administration. Dawn is a Chartered Member of the Chartered Management Institute and a qualified executive coach. Dawn was awarded a visiting professorship from Bournemouth University in 2021.

Joint Director of Corporate Affairs: Jenny Horrabin – appointed 11/03/2024 (non-voting)
Jenny was appointed Joint Executive Director of Corporate Affairs for Dorset HealthCare and Dorset County Hospital on 11 March 2024. She is a qualified accountant and chartered company secretary. She worked in audit and assurance for over 20 years in the public and private sector, before moving into a Company Secretary role in the NHS in 2012. She joined the trusts from Coventry and Warwickshire Partnership NHS Trust, having previously worked

in senior governance and corporate affairs roles in two Clinical Commissioning Groups. She is an active member of the NHS Company Secretaries Network and a member of the HFMA Audit and Governance Committee. She is also a trustee of a charity and an Audit Committee Member at Citizen Housing.

Joint Chief People Officer: Nicola Plumb – appointed 01/02/2024. (Interim Joint Chief People Officer from 01/05/2023).
Nicola is passionate about the NHS and has spent her career in the public sector since graduating from Durham University with a Politics degree in 2000. Nicola has held a variety of communications and development roles in the NHS and Department of Health including working at NHS Bournemouth and Poole, Communications Advisor to the NHS Chief Executive and working as Head of Brand for NHS England.

Chief Operating Officer: Anita Thomas – appointed 04/10/2021
Anita joined the Trust in 2000 as an Administration Manager. Since then, she has worked in a variety of roles across the Trust including Head of Health Records, Transport and Waste, Head of Access and Administration, Associate Director for Cancer and Access Services, Deputy Chief Operating Officer, Head of Transformation and Performance Improvement and Divisional Manager for Urgent and Integrated Care. Anita has a degree in History (Warwick), Masters in Developing and Leading Services (School of Health and Social Care, Bournemouth University), completed the 2015 NHS Leadership Academy Nye Bevan Programme - NHS Leadership Academy Award in Executive Healthcare Leadership as well as Quality Improvement and Service Redesign (NHSI QSIR Programme) and has been a Teaching Faculty Member Associate since 2017.

Chief Medical Officer: Rachel Wharton – appointed from 01/04/2025
Rachel has been working as an Emergency Medicine Consultant at the Trust since 2009. As well as her Emergency Medicine training, Rachel also spent time in Australia doing paediatric and neonatal retrieval and worked in pre-hospital care with the London HEMS service. Rachel has enjoyed several leadership positions within the Trust – most notably as the first Lead for Locally Employed Doctors. Rachel has supplemented her leadership experience with academic studies at Masters Level. Rachel was appointed as the Chief Medical Officer in January 2025 on an interim basis.

The following were also Board Members during the year:

Frances West – first term 23/09/2024 – 30/01/2026 (Joint Non-Executive Director with Dorset HealthCare University NHS Foundation Trust)

Nick Johnson – Joint Chief Strategy, Transformation and Partnerships Officer: appointed 01/02/2024 to 31/08/2025. Deputy Chief Executive from 01/04/2023. (Director of Strategy, Transformation and Partnerships from 01/02/2016).

Managing Conflicts of Interest
The Trust has a clear policy to ensure we comply with the NHS England's guidance on 'Managing conflicts of interest in the NHS'. All staff are required to declare the following interests (financial or otherwise) to ensure they are not compromised and that we act with transparency and openness in everything we do: clinical private practice; any gifts,

hospitality or donations received; outside employment; significant shareholdings and other ownership interests; sponsorship arrangements, and events or posts they attend or hold.

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

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

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

Political Donations
Dorset County Hospital NHS Foundation Trust has not made any political donations during 2025/26.

Better Payment Practice Code Compliance
The Trust has adopted the Better Payment Practice Code, which requires all undisputed invoices to be paid by their due date, or within 30 days of receipt of goods or a valid invoice. The application of this policy resulted in a supplier payment period of 51 days for the Trust's trade payables as at 31 March 2026 (2025: 50 days). The Trust incurred interest and compensation charges of £760 during 2025/26 (2024/25 £879) under the Late Payment of Commercial Debt (Interest) Act 1998. The performance of the Trust in complying with the Code were as follows:

	2025/26		2024/25	
		Value		Value
	Number	£000	Number	£000
Trade payables				
Total bills paid in year	**59,232**	**130,243**	60,000	126,382
Total bills paid within target	**55,322**	**122,374**	57,501	118,938
Percentage of bills paid within target	**93%**	**94%**	96%	94%
NHS payables				
Total bills paid in year	**1,297**	**23,959**	1,456	12,749
Total bills paid within target	**1,038**	**19,062**	1,204	11,106
Percentage of bills paid within target	**80%**	**80%**	83%	87%

Income Disclosure
The Trust has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by

the Health and Social Care Act 2012), by ensuring the income from the provision of goods and services for the purposes of the health service in England are greater than income from the provision of goods and services for any other purposes. The income from provision of goods and services for any other purpose was £1.1million which represents 0.32% of total Trust income. The Trust's financial planning process ensures the requirement is maintained in the future and that any income for other purposes is contributing a profit for reinvestment into health services in England.

Disclosures relating to the CQC and NHS England Well Led Framework
Information relating to the Well Led framework can be found in the Corporate Governance Report and the Annual Governance Statement sections of this report.

Patient Care
The Trust works closely with the Council of Governors, system health and care partners and local voluntary sector and community leaders to gather information and feedback on service delivery and redesign, including seeking out and formalising co-production and co-design opportunities.

Examples of liaison and development of improvements related to healthcare targets include:

- Progress on compliance with Accessible Information Standards;
- Reduction in catheter associated infections as part of the Dorset System Hydration Project;
- Liaison with the Dorset Carers Forum on carers support and use of the carers digital flag, Carer's Passport and Dorset County Hospital based weekly Carers' Cafés hosted in The HIVE;
- Co-design and ongoing engagement with the Your Future Hospital Collaborative aiming to ensure patients are admitted to the right place, at the right time, to be cared for by the appropriate specialty. Specific focus is being given to discharge planning, communication and processes;
- Initiation of an in-reach service from Dorset Youth Association to support early intervention for children and young people with social, emotional and mental health needs.

The Trust is fully compliant with the registration requirements of the CQC and underwent inspection of Maternity Services in May 2025 for the inspection domains of Safe and Well Led with a rating of 'Good'. Comprehensive inspection of Urgent and Emergency Care Services and Medicine (including Elderly Care) Services was undertaken during the period with a draft report awaited at the time of reporting. No immediate concerns were escalated and local improvements to medical workforce in the Emergency Department, environmental improvements for children in the Emergency Department and upgrade to door entry system in escalation areas were noted for action.

In conjunction with commissioners and system partners, the Trust is a co-author and signatory on Memorandums of Understanding for both Children and Young People and Adults where discharge arrangements and suitable services to meet the needs of complex patients has led to avoidable delays. These have provided formalised structures to support collaboration and multi-agency working for the benefit of patients and to reduce extended

lengths of stay.

A commissioner led review of Same Sex Accommodation policies and procedures commenced as a result of high levels of breach reports, predominantly in specialist services such as critical care and renal services. This work has resulted in a small improvement compared to 2024/25, however national guidance from NHS England is still awaited following the UK Supreme Court ruling in April 2025 to further inform policy application. In the meantime, work continues on improvements to patient flow, elimination of corridor care and expediting discharge from critical care to eliminate the risk of mixed sex breaches and reliance on temporary escalation spaces.

There have been no new or significantly revised services in the year, however the Trust responded positively and robustly to the closure of Yeovil District Hospital Maternity and Neonatal Services and worked collaboratively throughout the period with Somerset Foundation Trust, the Maternity and Neonatal Voices Partnerships in Somerset and Dorset and system partners.

Service improvements have been delivered in relation to staff survey feedback and reports of violence and aggression against staff including formal adoption of the UNISON Anti-racist Framework and Trust enrolment in Cohort 9 of the National Enhanced Therapeutic Observation of Care (ETOC) Exemplar programme. Improvements include policy review and implementation, training and education and improved reporting to ensure appropriate action and interventions are implemented.

Work has continued to develop the Creative Health Programme with charity funded developments with Bournemouth Symphony Orchestra, Arts in Hospital and the NHS Ranger to deliver a range of therapeutic activities for patients and staff. This builds on the Quality Priorities for Patient Activity Programmes and Active Hospital, including upgrades and improvements to outside spaces. Expansion of the Creative Health programme, including initiatives such as Operation Jackanory in Paediatric Services led by the Knowledge and Library Team, form theatre and poetry reading is supported with recent funding secured for staff training and wellbeing opportunities.

Patient Information

Over the past year, the Patient Experience Team has strengthened how patient and carer information is produced and shared. Processes for creating and reviewing patient information leaflets have been streamlined and Health Literacy Champions now review patient information and provide structured feedback.

Patient information processes have been brought together under the Communication with Patients Policy, which aligns translation and interpretation services, health literacy, and the Accessible Information Standards. This ensures information is clear, inclusive, and accessible.

The team continues to promote the Carer's Passport Trust-wide, collaborating with voluntary and community sector partners to improve identification of carers at earlier points in the patient journey. This year, the offer was extended into the Emergency Department. Engagement with Primary Care Network carers leads, and local carers groups in Weymouth

and Portland is helping identify what works well and where further improvement is needed. This collaborative insight will shape co-designed improvements through 2026/2027.

Complaints Handling
The Trust continues to strengthen its complaints handling processes through the centralised Complaints and Patient Advice and Liaison Service (PALS) Team, ensuring that all concerns are recorded, investigated and responded to within required timeframes.

Over the past year, the Trust has embedded the Patient Experience Policy that adopted the Parliamentary and Health Service Ombudsman (PHSO) NHS Complaint Standards. This introduced an enhanced early resolution standard, focused on timely engagement and swift problem-solving. Complaints that cannot be resolved early now progress to a Closer Look Investigation, led by dedicated investigators who maintain clear communication with those raising concerns.

Alongside restructuring the team, staff training has been expanded to build confidence and consistency in responding to complaints. Additional improvements include streamlined processes, strengthened support for Care Groups through regular coordination meetings, and new tools such as the Early Resolution Summary Form to ensure accurate documentation.

Learning from complaints continues to drive quality improvement, with recent examples such as reviewing bowel preparation guidance for consistency of advice and improving the application guidance for chemotherapy cold-caps. Ongoing work to refine complaint theming and develop a Learning and Improvement Board will further support Trust-wide learning and enhanced patient experience.

Patient and Public Involvement and Engagement
The Trust has continued to develop strong partnerships with local and regional organisations to enhance patient experience and support community engagement. This includes working with:

- Primary Care Networks (PCNs) to share approaches to supporting carers and improving continuity of support across services;
- Defence Medical Welfare Service (DMWS) and the Royal British Legion, particularly in relation to supporting the Armed Forces and Veteran community;
- Dorset Royal British Legion (RBL) fund care packs for veterans whilst inpatients. These are coordinated through the Dementia Team who support staff in identifying and responding to the needs of veteran patients.

A major development for 2025/26 was the opening of The HIVE, the new patient experience and community involvement hub. Funded by the DCH Charity and opened in May 2025, The HIVE brings together health and wellbeing information, volunteering, engagement activity, and community-based support. The HIVE is an accessible, welcoming space enabling people to connect, seek advice, and contribute to thriving local communities. Partners such as LiveWell Dorset, First Point and the Defence Medical Welfare Service (DMWS), amongst others, regularly promote and offer their services from The HIVE.

The Patient Experience Team brings together complaints, PALS, volunteering, and patient and public engagement services to provide a unified approach to improving patient experience across the Trust.

Over the past year, team restructuring has strengthened cross-working and improved service delivery, supporting the Trust's mission to provide high-quality, compassionate care. The team acts as a central point for concerns, advice, and feedback, supported by over 200 volunteers, and monitors performance through Experience of Care Committee and the Quality Committee, analysing complaints, concerns, compliments and Friends and Family Test (FFT) feedback to identify themes and drive improvement.

Engagement structures have expanded, including the Accessible Information Standards Group, and plans to launch the Patient Experience Learning Network and relaunch the Armed Forces Community Steering Group in 2025/26.

The team oversees national patient surveys and implements action plans based on findings, while also increasing opportunities for public feedback through initiatives such as Care Opinion.

Friends and Family Test activity remains largely paper-based while we are awaiting digital upgrades, with continued efforts to improve accessibility and response rates. Real-time feedback continues to provide valuable insights, often enabling rapid resolution of concerns.

Wider patient and public engagement has included events with carers, armed forces groups, blind and partially sighted communities, and local wellbeing initiatives, as well as strengthened collaboration with Trust Governors to extend community involvement.

Ongoing work to improve carers' support, promote the Carer's Passport, and enhance identification of carers and veterans ensures that the Trust continues to respond to the needs of its local communities.

NHS Patient Surveys

The team works closely with Business Intelligence to oversee the national survey programme (inpatients, maternity, children and young people, urgent and emergency care, cancer). Results are reviewed at the Experience of Care Committee, with action plans developed for areas requiring improvement. Areas for improvement are reported via the Quality Governance framework and summarised in the Annual Quality Account.

Stakeholder Relations

One of our strategic principles is that patients, service users, carers and communities are at the heart of everything we do and are an equal partner in the way we plan and deliver care, aligning with the Integrated Care System's aims. This includes actively involving individuals in shaping services and empowering them in their own health and wellbeing.

We also collaborate widely with others to innovate, bringing new equipment, ideas and ways of working to our frontline staff. Dorset partners include local councils, the police, fire and rescue service, and Bournemouth and Health Sciences Universities. Across Wessex we partner with Health Innovation Wessex and Wessex Health Partners who introduce and

support us with new research and innovations. These collaborations ground our work in local need and connect us to a wealth of connections and resources.

Our close working relationships with University Hospitals Dorset and primary care partners are crucial for ensuring seamless service delivery.

The Our Dorset Provider Collaborative (ODPC)
Provider collaboratives are partnerships that bring together two or more NHS trusts (public providers of NHS services including hospitals and mental health services) to work together at scale to benefit their populations.

In Dorset we have established the Our Dorset Provider Collaborative (ODPC) formed of the Trust, Dorset HealthCare, University Hospitals Dorset and the Dorset General Practice Alliance (whose membership includes all GP practices in Dorset).

The goals of the ODPC are:

- Improving population health and healthcare;
- Tackling unequal outcomes and access;
- Enhancing productivity and value for money;
- Helping the NHS to support broader social and economic development.

During 2025/26 the ODPC has overseen a number of programmes of work in line with the agreed objectives below:

Programme	Purpose	Achievements 2025/26
Shared corporate services	Efficiencies and economies of scale for the system in shared support functions such as procurement and estates/facilities services.	Board agreements across the three provider trusts to establish a single procurement service hosted by UHD, overseen by a joint procurement board to be established later in 2026.
Workforce	Better recruitment, retention and deployment of staff.	Maintained consistency across nursing bank and agency rates of pay and usage, reducing reliance on temporary staffing improving quality of care for patients.
Single services modelling	Reductions in unwarranted variations for patients and greater resilience across the Dorset system.	Joint recruitment to hard-to recruit to consultant posts in some services, working across clinical networks to align best practice.
Vertical integration and Integrated Neighbourhood Team work	Reductions in health inequalities and supporting greater efficiency of services for patients.	Neighbourhood teams established across Dorset, prioritising patients with most need. Developing access to diagnostics closer to people's homes for respiratory services, improved diagnostic tools for gastroenterology patients and

Programme	Purpose	Achievements 2025/26
		collaborating for best practice in hospital at home services.
Integrated digital services	Economies of scale, improved patient care and reductions in health inequalities.	Development of a single digital strategy for Dorset and procurement of a single Electronic Health Record.
Shared operational services oversight	Economies of scale, improved patient care	Overseen the work of the One Dorset Pathology and Community Diagnostic programmes.

Integrated Neighbourhood and Community Teams

At its heart the Neighbourhood Health programme is about how health and care teams, the voluntary sector and communities work together and change the way care is delivered to:

- Ensure better co-ordinated care for individuals with reduced fragmentation and duplication;
- Increase the focus on proactive and preventative care helping people build their knowledge, and confidence to make healthier lifestyle choices and feel better able to manage their own health;
- Adopt a holistic approach that considers an individual's medical needs alongside their physical, social and emotional needs;
- Bring care as close to home as we possibly can, and co-design services that are based on, and meet the needs of, local communities.

The system-wide Neighbourhood Health programme is jointly led by Dorset HealthCare and the Dorset General Practice Alliance (DGPA) and consists of partners from across the Dorset health and care system, including primary, community and secondary care health services, local authority services including social care, community development and public health, and the voluntary, community and social enterprise (VCSE) sector.

There are 18 neighbourhoods across the Dorset system aligned to the current Primary Care Network footprints. Integrated Neighbourhood Teams have been established for each neighbourhood, and each team has a leadership group with representatives from across the health and care system, supported by delivery facilitators who help coordinate and progress the work.

This year has seen a significant focus on building the local teams, with colleagues in primary care, community health and social care services, getting to know who is in the team and what they do, and identifying and addressing barriers that can make collaborative working more difficult, leading to duplication, delays, or people being passed between services and experiencing multiple referrals.

Work to streamline local systems and processes and integrate care around individuals has already started to improve both the experience and outcomes for people who rely on our services, while also making it easier for staff across organisations to work together effectively and provide more joined-up support.

In August 2025 the programme successfully secured social investment funding from Macmillan Cancer Support. This funding is helping to build additional capacity and support greater integration of care around individuals.

This funding has supported neighbourhoods to continue to build their local teams, progress work that reflects their local priorities and develop new ways of working including:

- Pathway changes being developed to support people living with frailty, mental health issues and cancer;
- Integrated Primary Care and Community Nursing Teams;
- Service developments around group clinics, women's health, obesity and leg clubs;
- Supporting care homes to reduce unnecessary admissions;
- Work with the voluntary sector around social prescribing and making connections into community groups;
- Work with secondary care colleagues to support people who are high intensity users of unplanned services and improve proactive care for those living with long-term conditions.

Signed

Matthew Bryant
Chief Executive

Remuneration Report

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

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

In line with Article 21 of the General Data Protection Regulation (GDPR) directors have been offered the opportunity to review the information being disclosed about themselves and the opportunity to object to such disclosures. No such objections have been received.

Annual Statement on Remuneration
As Chair of the Remuneration Committee, I am pleased to present the Remuneration Report for 2025/26.

The purpose of the Remuneration Committee is to make recommendations to the Board of Directors in relation to the appointment and remuneration of the Chief Executive Officer and Executive Directors. The Committee also reviews and makes recommendations regarding the Board of Directors' skill mix and balance, taking into account future challenges, risks and opportunities facing the Trust and the skills and expertise that the Board of Directors requires in order to meet these. The Remuneration Committee also ensures adequate succession planning arrangements for the executive team are in place. In the reporting year the Remuneration Committee met on three occasions. Each of these meetings were held as a committee in common with the Dorset HealthCare University NHS Foundation Trust Remuneration Committee. The following topics were discussed:

- Very senior managers (VSM) pay framework and remuneration;
- Review of remuneration for the Interim Chief Medical Officer;
- Proposal for the appointment process for the appointment of the Deputy CEO;
- Committee annual report, effectiveness review, and terms of reference;
- A review of ongoing arrangements for the executive team, including capacity review and future arrangements for the executive team including arrangements for the vacant Joint Chief Strategy, Transformation and Partnerships Officer post;
- Extension of the Interim Chief Medical Officer post holder;
- Appointment of a Joint Chief Digital Information Officer to the Trust Board.

The decisions made at those meetings were taken within the context of the Trust's federated working with Dorset HealthCare, and included the creation of a joint executive role, in the form of the Chief Digital Information Officer.

Signed

David Clayton-Smith
Trust Chair and Remuneration Committee Chair

Senior Managers' Remuneration Policy

The Trust's senior management remuneration policy requires the use of benchmark information and the Trust makes reference to and complies with the NHS Very Senior Managers Pay Framework. Responsibility for setting senior managers' remuneration sits with the Remuneration Committee, as outlined in the terms of reference. On this basis staff have not been consulted on the senior managers' remuneration policy.

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

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

Future Policy Table

The Trust's remuneration policy in respect of each of the above is outlined in the below.

	Salary (Fees and Salary)	Pension and Benefits
Purpose and Link to Strategy	• Helps to recruit, reward and retain • Reflects competitive market level, role, skills, experience and individual contribution	• Help to recruit and retain • NHS Pension scheme arrangements provide a competitive level of retirement income
Operation	Base salaries are set to provide the appropriate rate of remuneration for the job, taking into account relevant recruitment markets, business sectors and geographical regions. The Remuneration Committee considers the following parameters when reviewing base salary levels: • NHS Very Senior Managers Pay Framework • Pay increases for other employees across the Trust • Economic conditions and governance trends • The individual's performance, skill and responsibilities through appraisals • Base Salaries at NHS organisations of similar size are benchmarked against Dorset	Executive Directors are eligible to receive pension and benefits in line with the policy for other employees. Executive Directors are entitled to join the NHS Pension Scheme, which from April 2015 is a Career Average Revalued Earnings scheme. Where an individual is a member of a legacy NHS defined benefit pension scheme section (1995 or 2008) and is subsequently appointed to the Board, they retain the benefits accrued from these schemes. The principal features and benefits of the NHS Pension

	Salary (Fees and Salary)	Pension and Benefits
	County Hospital NHS Foundation Trust • Base Salaries are paid in 12 equal monthly instalments via the regular monthly employee payroll • The Executive Directors do not receive performance related pay.	Scheme are set out in a table in the Remuneration Report. Pension related benefit is the annual increase in pension entitlement accrued during the current financial year from total NHS career service.
Opportunity	The Remuneration Committee ensures levels of remuneration are sufficient to attract, retain and motivate directors of the quality needed to run the organisation successfully but avoid paying more than is necessary though using benchmarking and the NHS Very Senior Managers Pay Framework. National and Local benchmarking data, including the NHS Very Senior Managers Pay Framework recommendation was reviewed by the Remuneration Committee who reviewed the relative position of each Executive.	The maximum Employers' contribution to NHS Pension Scheme is 23.78% (14.38% paid by the Trust and 9.4% is paid by NHS England) of base salary for all employees including Executive.
Performance Conditions	None, although performance of both the Trust and the individual are taken into account when determining whether there is a base salary increase each year. The individual receives an annual appraisal to review performance and set objectives.	None
Performance Period	Annual Appraisal covers a 12-month period	None

Differences in Remuneration for Other Employees

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

The structure of the reward package for the wider employee population is based on the national NHS remuneration frameworks for Medical, Dental and Non-Medical Staff. Non-Medical Staff remuneration is in line with the Agenda for Change Framework, which assesses remuneration in line with the framework for Medical and Dental Staff remuneration.

All staff are eligible to join and participate in the NHS Pension Scheme.

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

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

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

Policy on Remuneration of Non-Executive Directors

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

Annual Report on Remuneration

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

Senior Managers Service Contracts

The table below contains contract information on the Trust's senior managers for the financial year 2025/26.

Name	Title	Current Tenure	Notice Period
Non- Executive Directors			
David Clayton-Smith	Chair	01/05/26 – 30/04/29 (second term)	3 months
Eiri Jones	Non-Executive Director, Deputy Chair	01/01/25 – 31/12/27 (second term)	3 months

Name	Title	Current Tenure	Notice Period
Margaret Blankson	Non-Executive Director	01/01/24 – 31/12/26 (second term)	3 months
Claire Lehman	Non-Executive Director	18/07/23 – 17/07/26 (first term)	3 months
Stuart Parsons	Non-Executive Director	01/12/24 – 30/11/27 (second term)	3 months
Stephen Tilton	Non-Executive Director	01/06/23 – 31/05/26 (second term)	3 months
David Underwood	Non-Executive Director	01/03/26 – 28/02/29 (extension to second term, subject to annual review)	3 months
Frances West	Non-Executive Director	23/09/24 – 30/01/2026 (first term)	3 months
Executive Directors			
Matthew Bryant	Chief Executive	Commenced 01/04/23	6 months
Dawn Dawson	Joint Chief Nursing Officer	Commenced 01/04/24	6 months
Chris Hearn	Joint Chief Financial Officer	Commenced 03/10/22	6 months
Jennifer Horrabin	Joint Director of Corporate Affairs	Commenced 11/03/24	6 months
Nick Johnson	Deputy Chief Executive/Joint Chief Strategy, Transformation and Partnerships Officer	Commenced 01/02/16 Left the Trust 31/08/2025	6 months
Nicola Plumb	Joint Chief People Officer	Commenced 01/05/23	6 months
Anita Thomas	Chief Operating Officer	Commenced 04/10/21	6 months
Rachel Wharton	Interim Chief Medical Officer	Commenced 01/04/25	6 months

Remuneration Committee

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

The Committee, formerly known as the Remuneration and Terms of Service Committee was renamed the Remuneration Committee from 12 August 2025.The committee's attendance record is set out in the table below:

Name	Attendance/Meetings eligible to attend
David Clayton-Smith (Trust Chair) (Chair)	3/3
Margaret Blankson	2/3
Eiri Jones (Deputy Chair)	2/3
Claire Lehman	2/3
Stuart Parsons	3/3
Stephen Tilton	1/3
David Underwood	3/3
Frances West (to 30 01 26)	2/2

Expenses of Governors and Directors

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

	2025/26		2024/25	
	Number receiving expenses / total	£'00	Number Receiving Expenses / total	£'00
Governors	2 / 28	277	2 / 28	129
Chairman and Non-Executive Directors	2 / 9	392	2 / 9	299
Executive directors	5 / 8	1,777	8 / 9	3,073
Total expenses		2,446		3,501

The following sections of the Remuneration Report are subject to audit

The total remuneration of Directors and senior managers for 2025/26 was £860,398 (2024/25: £877,400).

Total Remuneration of Directors 2025/26	Note	Salary	Taxable Benefits	Pension Related Benefits	Total Remuneration	Recharges Salary	Recharges Taxable Benefits	Recharges Pension	Remuneration net of Recharges
Name and Title		(Bands of £5,000)	(To nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(To the nearest £100)	(Bands of £2,500)	(Bands of £5,000)
		£000'	£	£000'	£000'	£000'	£	£000'	£000'
David Clayton-Smith, Joint Chairman	1	40 - 45	-	-	40 - 45	-	-	-	40 – 45
David Underwood, Joint Non-Executive Director	2	20 - 25	-	-	20 – 25	(10 -15)	-	-	10 – 15
Stephen Tilton, Non-Executive Director		10 - 15	-	-	10 – 15	-	-	-	10 - 15
Margaret Blankson, Non-Executive Director		10 - 15	-	-	10 – 15	-	-	-	10 - 15
Stuart Parsons, Joint Non-Executive Director		10 - 15	-	-	10 – 15	-	-	-	10 - 15
Claire Lehman, Joint Non-Executive Director	3	20 - 25	-	-	20 – 25	(10 - 15)	-	-	10 - 15
Frances West, Joint Non-Executive Director*	4	-	-	-	-	5 – 10	-	-	5 - 10
Eiri Jones, Joint Non-Executive Director	5	25 - 30	-	-	25 – 30	(10 – 15)	-	-	10 - 15
Matthew Bryant, Joint Chief Executive Officer*	6	-	-	-	-	125 - 130	-	122.5 – 125	245 - 250
Nick Johnson, Joint Chief Strategy, Transformation and Partnership Officer / Deputy CEO	7	70 - 75	-	12.5 - 15.0	85 - 90	(35 - 40)	-	(5.0 - 7.5)	40 - 45

Total Remuneration of Directors 2025/26 (continued)	Note	Salary	Taxable Benefits	Pension Related Benefits	Total Remuneration	Recharges Salary	Recharges Taxable Benefits	Recharges Pension	Remuneration net of Recharges
Name and Title		(Bands of £5,000)	(To nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(To the nearest £100)	(Bands of £2,500)	(Bands of £5,000)
		£000'	£	£000'	£000'	£000'	£	£000'	£000'
Rachel Wharton, Chief Medical Officer		215 - 220	-	110.0 – 112.5	325 - 330	-	-	-	325 – 330
Chris Hearn, Joint Chief Financial Officer*	8	135 - 140	-	37.5 - 40.0	175 – 180	(45 - 50)	-	(12.5 – 15.0)	115 - 120
Anita Thomas, Chief Operating Officer		145 - 150	-	52.5 - 55.0	200 - 205	-	-	-	200 – 205
Dawn Dawson, Joint Chief Nursing Officer*	9	-	-	-	-	85 – 90	-	22.5 – 25	105 - 110
Nicola Plumb, Joint Chief People Officer*	10	-	-	-	-	80 - 85	-	27.5 - 30.0	110 – 115
Jennifer Horrabin, Joint Director of Corporate Affairs*	11	-	-	-	-	70 – 75	300	45.0 – 47.5	115 - 120

The individuals with an asterisk (*) are charged to the Trust by Dorset HealthCare University Hospital NHS Foundation Trust (DHUFT) which reflects the Joint Board arrangement between Dorset HealthCare University Hospital NHS Foundation Trust and Dorset County Hospital NHS FT (DCHFT).

Notes

1 – Postholder as Joint Chairman for DCHFT and DHUFT and paid individually by both Trusts.
2 – Postholder as Joint Non-Executive Director for DCHFT and DHUFT.
3 – Postholder as Joint Non-Executive Director for DCHFT and DHUFT from 18 May 2025.
4 – Until 31st January 2026
5 – Postholder as Joint Non-Executive Director for DCHFT and DHUFT.
6 – Postholder as Joint Chief Executive Officer for DCHFT and DHUFT and post is shared on 50:50 basis full salary banding £250,000 – £255,000.
7 – Postholder as Joint Chief Strategy, Transformation and Partnership Officer / Deputy CEO for DCHFT and DHUFT and post is shared on 50:50 basis until the 31 August 2025.
8 – Postholder as Joint Chief Financial Officer for DCHFT and DHUFT and post is shared on 50:50 basis full salary banding £180,000 - £185,000. Postholder transferred to Dorset HealthCare University Hospital NHS Foundation Trust payroll from the 1 January 2026.
9 – Postholder as Joint Chief Nursing Officer for DCHFT and DHUFT and post is shared on 50:50 basis full salary banding £170,000 - £175,000.
10 – Postholder as Joint Chief People Officer for DCHFT and DHUFT and post is shared on 50:50 basis full salary banding £165,000 - £170,000.
11 – Postholder as Joint Director of Corporate Affairs for DCHFT and DHUFT and post is shared on 50:50 basis full salary banding £140,000 - £145,000.

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

Total Remuneration of Directors 2024/25 (continued)	Note	Salary	Taxable Benefits	Pension Related Benefits	Total Remuneration	Recharges Salary	Recharges Taxable Benefits	Recharges Pension	Remuneration net of Recharges
Name and Title		(Bands of £5,000)	(To nearest £100)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(To the nearest £100)	(Bands of £2,500)	(Bands of £5,000)
		£000'	£	£000'	£000'	£000'	£	£000'	£000'
Prof Alastair Hutchison, Chief Medical Director	6	195 - 200	-	0	195 - 200	-	-	-	195 - 200
Rachel Wharton, Chief Medical Officer	7	40 - 45	-	42.5 – 45.0	85 - 90	-	-	-	85 – 90
Chris Hearn, Joint Chief Financial Officer	8	165 - 170	-	45.0 - 47.5	210 - 215	(80 - 85)	-	(22.5 - 25.0)	105 - 110
Anita Thomas, Chief Operating Officer		140 - 145	-	97.5 - 100.0	240 - 245	-	-	-	240 – 245
Dawn Dawson, Joint Chief Nursing Officer*	9	-	-	-	-	80 – 85	-	75.0 – 77.5	160 - 165
Nicola Plumb, Joint Chief People Officer*	10	-	-	-	-	80 - 85	700	22.5 - 25.0	105 – 110
Jennifer Horrabin, Joint Director of Corporate Affairs*	11	-	-	-	-	65 – 70	500	77.5 – 80.0	140 - 145

The individuals with an asterisk (*) are charged to the Trust by Dorset HealthCare University Hospital NHS Foundation Trust (DHUFT) which reflects the Joint Board arrangement between Dorset HealthCare University Hospital NHS Foundation Trust and Dorset County Hospital NHS FT (DCHFT).

Notes

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

There have been no annual performance related or long-term performance related bonuses paid during the year 2025/26 or 2024/25.

There have been no payments for loss of office during 2025/26 or 2024/25.

There have been no payments to past senior managers during 2025/26 or 2024/25.

Fair Pay Multiple Statement

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

The banded remuneration of the highest-paid director in the Trust in the financial year 2025-26 was £215,001 – £220,000 (2024-25, £185,001 - £190,000). The change between years saw a 16% increase (2024-25: 21% reduction) which relates to Chief Medical Officer post becoming full time from 1 April 2025.

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

For employees of the Trust as a whole, the range of remuneration in 2025/26 was from £250,001 - £255,000 to £10,001-£15,000 (2024-25 £290,001 - £295,000 to £10,001 - £15,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is an increase of 1.4% (2024/25: reduction of 4%). In 2025/26, 13 (2024/25: 24) employees received remuneration in excess of the highest-paid director. Remuneration was in the banding range of £365,000 to £370,000 (2024/25: £290,000 to £295,000).

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

	25th Percentile		Median		75th Percentile	
Year	**25/26**	24/25	**25/26**	24/25	**25/26**	24/25
Salary Component of pay	**£26,598.00**	£24,071.00	**£37,796.00**	£32,324.00	**£46,580.00**	£44,962.00
Salary Component: pay ratio for highest paid director	**8.18**	7.86	**5.75**	5.85	**4.67**	4.21
Total Pay & Benefits excluding Pension benefits	**£26,598.00**	£25,674.00	**£35,498.22**	£32,334.14	**£47,461.65**	£45,535.32
Pay and benefits excluding pension: pay ratio for highest paid director	**8.18**	7.37	**6.13**	5.85	**4.58**	4.15

*Prior year fair pay multiple includes Non-executive directors (NEDs) which are now outside the scope of the fair pay multiple and not included in 2025/26 fair pay multiple.

Pension Arrangements

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

No CETV will be shown for pensioners or senior managers over National Pension Age (NPA). This is age 60 in the 1995 Section, age 65 in the 2008 Section or SPA or age 65, whichever is the later, in the 2015 Scheme.

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

	Real Increase in pension at retirement	Real Increase in lump sum at retirement	Total accrued pension at retirement at 31/03/2026	Related lump sum at retirement at 31/03/2026
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)
	£000	£000	£000	£000
Matthew Bryant, Chief Executive*	12.5 – 15.0	22.5 – 25.0	95 – 100	245 – 250
Nick Johnson, Deputy Chief Executive/Director of Strategy, Transformation and	0 – 2.5	0	20 – 25	0 – 5

Partnerships+				
Anita Thomas, Chief Operating Officer*	2.5 – 5.0	0 – 2.5	50 – 55	120 – 125
Chris Hearn, Chief Financial Officer	2.5 – 5.0	0	25 – 30	0 – 5
Nicola Plumb, Chief People Officer*	2.5 – 5.0	0 – 2.5	55 – 60	15 – 20
Rachel Wharton, Chief Medical Director	5.0 – 7.5	7.5 – 10	55 – 60	130 – 135
Dawn Dawson, Joint Chief Nursing Officer	2.5 – 5.0	0	10 – 15	0 – 5
Jennifer Horrabin, Joint Chief Director of Corporate Affairs*	5 – 7.5	5 – 7.5	45 – 50	110 – 115

	Cash Equivalent Transfer Value at 01/04/2025	Cash Equivalent Transfer Value at 31/03/2026	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£000	£000	£000	£000s
Matthew Bryant, Chief Executive*	1,798	2,116	249	-
Nick Johnson, Deputy Chief Executive/Director of Strategy, Transformation and Partnerships+	235	277	8	-
Anita Thomas, Chief Operating Officer*	1,049	1,142	56	-
Chris Hearn, Chief Financial Officer*	264	316	25	-
Nicola Plumb, Chief People Officer*	814	897	48	-
Rachel Wharton, Chief Medical Director*	1,043	1,194	112	-
Dawn Dawson, Joint Chief Nursing Officer*	155	214	37	-
Jennifer Horrabin, Joint Chief Director of Corporate Affairs*	919	1,050	99	-

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

+ Postholder as Joint Chief Strategy, Transformation and Partnership Officer / Deputy CEO for DCHFT and DHUFT and post is shared on 50:50 basis until 31 August 2025 with the disclosed increase in pension benefits apportioned to reflect the period during which they were a senior manager of the Trust.

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount

rates for calculating unfunded public service contribution rates that was extant on 31 March 2023. HM Treasury published updated guidance on 27 April 2023. The factors used to calculate a CETV increased, following this guidance and will affect the calculation of the real increase in CETV. This guidance will be used in the calculation of 2025/26 CETV figures.

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

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

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

Matthew Bryant
Chief Executive

Staff Report

People Strategy

The Trust employs over 3,500 staff in a huge variety of roles and with a wealth of knowledge and expertise. Attracting, developing and retaining a highly engaged workforce is essential to delivering high quality care and support for our patients.

Our Joint People Plan 2025-28, across Dorset HealthCare and Dorset County Hospital, forms one of five enabling strategies that support our joint strategy, 'Working Together, Improving Lives'. We are operating in an exceptionally challenging financial environment and our People Plan focuses on the key areas that will enable us to maintain a sustainable workforce and at the same time support service and workforce transformation. The Plan works specifically towards the 'Colleagues' objective in the joint strategy.

Progress made in 2025/26 includes:

- Introduction of Sexual Safety Charter and associated mandatory training;
- Launch of new joint staff recognition scheme;
- Launch of Joint Culture and Belonging Group;
- Agreed adoption of the Anti-Racism Charter across both trusts;
- Supporting large transformation projects.

As we look forward to the coming year our focuses will be to target our resources where they are really needed and will make a tangible difference:

- Targeted support to transformation programmes;
- Delivery of our workforce operational plan including reducing temporary staffing spend;
- Deliver the integration of our People Services;
- Continuing to deliver high quality people services and service improvement.

Ensuring our work has a positive impact on patient care is paramount. We know that when colleagues feel valued, supported and included, they are better able to deliver the outstanding care our patients deserve.

Employment Policies

The Trust maintains a comprehensive suite of employment policies designed to provide clear guidance to staff and ensure compliance with our legal and regulatory obligations. All policies are reviewed on a cyclical basis to ensure they remain current, effective and aligned with best practice, and they are made available to staff via the Trust intranet.

The Trust remains committed to collaborative working with Dorset HealthCare. During 2025/26, we strengthened this partnership by developing several joint policies, including Death in Service, Terminal Illness and a review of the Flexible Working Policy. We have also aligned principles with a review of the Probationary and Performance Management Policies to support implementation of legal changes within the Employment Rights Act to support greater consistency in approach across both organisations.

Appraisal Process
During 2025/26, we have enhanced the simplified 'appraisal on a page' form and policy, by launching 'Making the most of your appraisal' workshops for all staff. Together with the 'Meaningful Appraisals' module for line managers, delivered within the Management Matters Programme, these developments continue to promote more effective and meaningful appraisal conversations, supporting an emphasis on staff wellbeing, career progression, performance and personal development. We are connected into NHS England (NHSE) who are designing a national approach to appraisal through a set of principles, to be launched during 2026, and will incorporate the principles into our policy and processes.

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

Period covered: January to December 2025

Figures converted by DH to Best Estimates of Required Data Items			Statistics Produced by NHS Digital from ESR Data Warehouse	
Average FTE 2025	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
3,370	33,037	9.8	1,230,025	53,594

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

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

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

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

Recruitment and Retention
The past 12 months have seen ongoing pressures on recruitment with national shortages of some professionally qualified staff. Work has also been undertaken to increase productivity in support services, with some vacant roles being held pending review/removal. These challenges mean that the overall vacancy rate for the Trust has doubled this past year to 6.8%. Recruitment of clinical staff remains a high priority to ensure good quality care and reduce the need for agency and bank worker expenditure.

Working in collaboration is a key pillar for the People Plan and the Trust has continued to work closely with other NHS Trust colleagues, and in particular with Dorset HealthCare, as we develop the federated model to enhance recruitment and selection activity and promote

Dorset as a place to live and work.

The Trust's turnover rate for 1 April 2025 - 31 March 2026 was 8.63% (headcount % based on a rolling 12-month period). Turnover has reduced and is within the Trust's acceptable range of 8% - 10%. Turnover data is reported to the Board (via the integrated corporate dashboard) and the People and Culture Committee and is available on the NHS workforce statistics website https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics.

Locally, workforce plans continue to be refined, supporting delivery of new services such as the new ED and Critical Care Unit (the New Hospital Programme), stroke services expansion, and other schemes to support flow, admission avoidance and to reduce reliance on temporary staffing.

The Trust set an ambitious Whole Time Equivalent (WTE) reduction target in 2025/26 to reduce staffing (substantive and temporary) by 232 WTE. In-year developments and service pressures, including the temporary transfer of maternity services from Yeovil, meant that this target was not achieved. A substantive reduction of 23 WTE was achieved in year, through a combination of turnover and a Mutually Agreed Redundancy Scheme.

Equity, Diversity, Inclusion and Belonging (EDIB)
Our commitment to equity, diversity, inclusion and belonging (EDIB) continues to shape how we support colleagues and develop organisational culture. In partnership with Dorset HealthCare, we have launched a Joint Inclusion and Belonging Strategy (2024–2026), setting a shared direction of travel for inclusive practice throughout staffs' time with us, from recruitment and onboarding through to development, progression and transition.

Our work remains grounded in national and legal frameworks, including the Equality Act 2010, the Public Sector Equality Duty, the Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES), and the Equality Delivery System (EDS2). These frameworks provide an important foundation for accountability, but our ambition goes further; to build an organisation where inclusion and belonging are embedded in everyday practice, decision-making and leadership.

During 2025/26, further progress has been made in strengthening the Trust's EDIB approach through a more data-informed and strategically aligned programme of work. This includes the publication of the Joint Gender, Ethnicity and Disability Pay Gap Report, which for the first time brought together statutory Gender Pay Gap reporting with Trust-wide Ethnicity and Disability Pay Gap analysis. While the wider report brings together analysis across all three pay gap areas, the statutory Gender Pay Gap submission remains specific to the Trust. The current report is available here https://dchft.nhs.uk/about-us/equality-diversity-inclusion-and-belonging/. For Dorset County Hospital, this represents an important step forward in understanding patterns of inequality more fully and in creating a stronger evidence base for action on representation, progression and workforce experience.

A gender breakdown report by headcount for our staff is as follows:

	Male	Female
Directors	6	8
Other Senior Managers	60	159
Employees	1,149	3,344

In line with the Code of Governance for NHS Providers, Dorset County Hospital reviews the ethnic diversity of its Board and senior managers in relation to the Trust's workforce and the communities it serves. This review happens annually, under Workforce Race Equality Standard (WRES) indicator 9.

At 31 March 2026, one of the Trust's 14 Board members was recorded as Black and Minority Ethnic (BME), as defined for WRES reporting, and 13 were recorded as White. Within the voting membership of the Board, one of 13 members was recorded as BME and 12 as White. Executive Board membership was recorded as 0 BME and six White, while Non-Executive Board membership was recorded as one BME and seven White.

BME representation on the total Board was therefore 7.14%, compared with 23.67% of the Trust's overall workforce. Voting Board membership was 7.69% BME and Executive Board membership was 0% BME.

For the purpose of this disclosure, other senior managers are reported using AfC Band 8C and above data. Current data shows that one of 34 individuals in these roles was recorded as from an ethnic minority background, approximately 3%. This remains below both the Trust's overall workforce profile and the local Dorset population benchmark.

The Board's ethnic profile is closer to the ethnic profile of the local Dorset population than to the Trust's overall workforce profile. However, the Trust recognises that Board and senior manager representation does not yet reflect the ethnic diversity of the workforce overall. This remains an area of continued focus. The Trust will continue to monitor Board and senior manager diversity through WRES reporting, pay gap reporting, EDS 2022 and the Inclusion and Belonging Action Plan, supporting continued focus on inclusive recruitment, progression, leadership development and succession planning.

Alongside this, the Board approved the Joint Anti-Racism Framework, marking an important step in strengthening the Trust's collective approach to race equity and anti-racist practice. The Trust also signed the UNISON Anti-Racism Charter, further signalling its commitment to embedding anti-racist principles in leadership, accountability and organisational practice.

Conscious inclusion training has continued to support greater awareness and accountability across the organisation. In addition, conscious inclusion and inclusive leadership training are now mandatory for colleagues with line management responsibilities, reflecting the Trust's expectation that inclusive leadership is a core part of management practice rather than an optional area of development.

Work has also continued to strengthen the use of Equality Impact Assessments (EIAs) in strategic planning and policy development. Revised guidance has supported more

consistent application, helping to identify where decisions may affect different groups in different ways and reinforcing the importance of equitable and evidence-based decision-making.

Staff Networks remain central to our EDIB ambitions. Over the past year, their contribution has grown through closer engagement in policy review, feedback mechanisms and strategic discussion. Alongside this, the introduction of an anonymous reporting route linked to Freedom to Speak Up and sexual safety concerns represents a tangible step towards improving psychological safety, confidence to raise concerns, and colleague trust.

The Organisational Development Team have launched the 'Introduction to Neurodivergent Colleagues' workshop as part of our ongoing commitment to building an inclusive and supportive workplace culture. The programme is designed to increase understanding of neurodiversity in the organisation and to equip both managers and staff with the knowledge and confidence to support neurodivergent colleagues effectively. We continue to run dignity and respect sessions, covering protected characteristics and considering unacceptable behaviour, and how to challenge it.

Our Compassionate Leadership Programme has inclusive leadership at its heart and promotes the importance of valuing diversity and modelling inclusive practices.

The Trust is committed to ensuring equality for all employees and job applicants. We recognise and celebrate the value of a diverse workforce and are dedicated to supporting the individual needs of our people so they can perform at their best and sustain their employment in the long term.

To uphold this commitment, the Trust has a range of supportive policies and processes, including:

- Reasonable Adjustments Policy – ensuring that employees and applicants can access the support they need to thrive in their roles;
- Employee Passport – enabling staff to record and communicate their adjustment needs consistently and confidently;
- Sickness Absence Management Policy – providing a framework for supporting employees whose health needs may change over time;
- Inclusive Recruitment Practices – embedding accessibility and fairness from the point of advert through to appointment.

In addition, Without Limits is the staff network representing the voices of disabled employees, colleagues with long-term health conditions, and unpaid carers at Dorset County Hospital. The network plays a vital role in shaping an inclusive culture and ensuring that lived experience informs Trust policy and practice.

Partnership Working

The Trust is committed to open and transparent communication with employees. Our strong and constructive partnership with recognised Trade Unions supports meaningful engagement with staff and ensures their views are represented in decisions that affect them.

We maintain regular formal and informal engagement with Trade Union representatives,

enabling constructive dialogue, consultation on key initiatives and the collaborative resolution of workplace matters.

Health and Wellbeing
Employee wellbeing continues to be a key focus. Resources and information available for staff on the intranet were reviewed and enhanced, giving staff greater access to support when they need it.

Our employee assistance programme provision from Vivup is available to staff 24/7, 365 days a year. This is enhanced with an on-site counselling provision which staff can access through a clinical triage process provided by Vivup.

Financial support for staff has continued to be a priority due to the ongoing economic environment. We work closely with the Money and Pensions Service, and staff can be referred confidentially to foodbanks. We offer free food to staff which would otherwise go to waste from our restaurant.

The network of 80+ Health and Wellbeing (HWB) Coaches continue to provide a valuable peer support network across the Trust. The coaches are provided with specific training to support colleagues through wellbeing conversations and given knowledge to signpost to further help if required and have accessed additional training opportunities such as Suicide First Aid conversations.

We launched a 2026 Inclusion and Wellbeing Calendar which includes a monthly theme, guiding Trust-wide communications and events, supporting a culture of wellbeing, belonging and inclusion.

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

Raising awareness of the need to counter fraud and corruption is communicated via a variety of methods, including leaflets, counter fraud newsletters and notices, staff bulletins, staff awareness presentations, induction training and the Trust's intranet. Our Local Counter Fraud Service (LCFS) undertake several proactive workstreams throughout the year to support the Trust's commitment to this area and have in the last year attended site for awareness sessions and swiftly responded to requests from the Trust for specialist investigations.

Staff Experience and Engagement
The NHS Staff Survey was issued to all staff between 1 October and 28 November 2025. Our overall response rate decreased from 46.4% to 43.5% in 2025 but has fluctuated over the last five years from a high of 46.8% in 2021 to a low of 41% in 2023. The current rate 43.5% is just below the median for our benchmarking group, which is 47%.

Staff were offered the option to fill out the survey online or by physical survey. The decline in response rate is in line with the national picture, and we will continue to review our approach

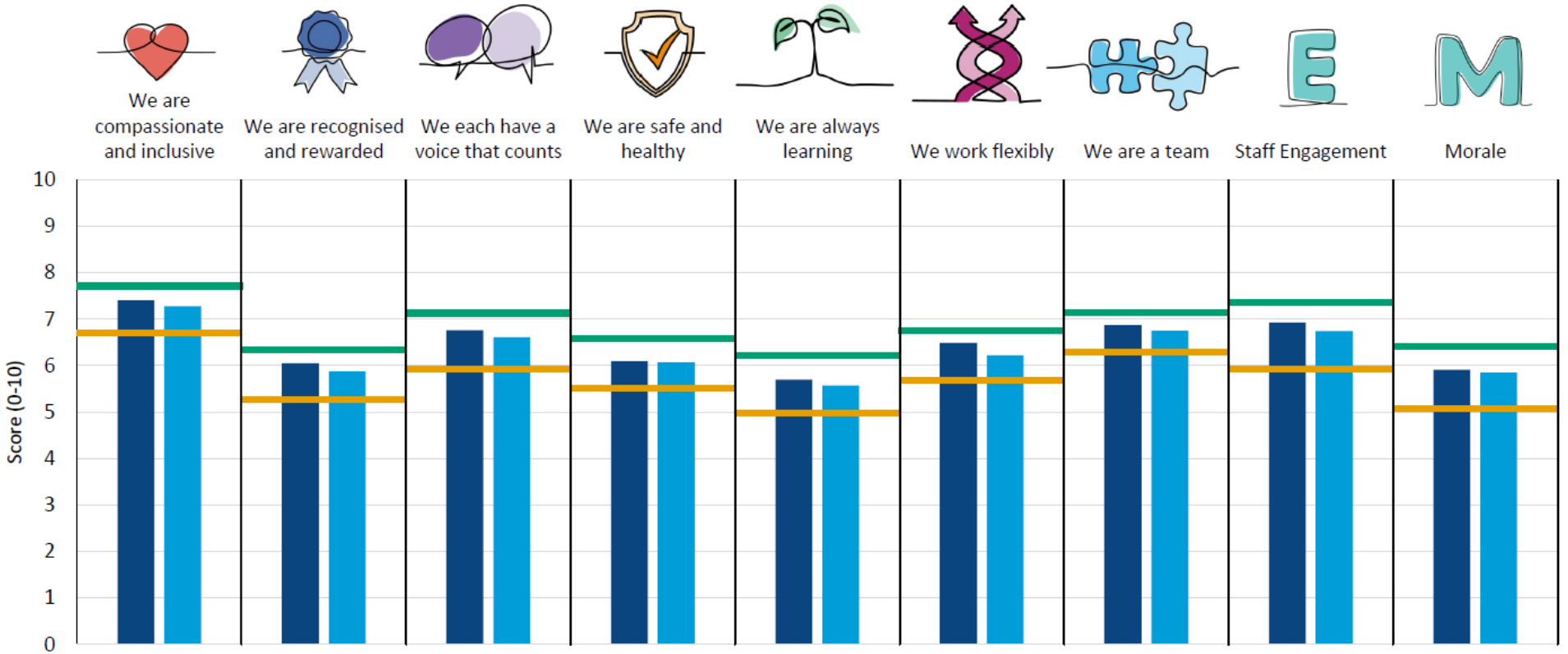
to improve the number of respondents next year.

The survey is mapped against the seven elements of the People Promise, and against two themes of staff engagement and morale. The high-level summary is as follows:

	Improved	Declined	Stayed the same
Against sector benchmark average score	Above average in all seven People Promise elements and both themes of staff engagement and morale.	N/A	N/A
7 People Promise elements and 2 themes against last year's score	We have improved in two of the People Promise elements: 'We are safe and healthy' and 'we work flexibly'.	We have decreased in five of the seven People Promise elements and both 'staff engagement' and 'morale' themes.	N/A
21 reportable sub-scores under each element or theme against last year's score	We have improved in 6 sub-scores: Burnout; Negative experiences; Appraisals; Support for work-life balance; Motivation; and Work Pressure.	We have decreased in 15 sub-scores.	N/A

The movements are marginal and are broadly in line with the national picture. Our primary approach to acting on the survey findings is to continue to embed ownership of the results and actions within teams and services, as well as engaging with key organisation-wide groups and forums to identify cross-cutting themes for action. Additionally, in the coming year an integrated Staff Voice reporting framework will be introduced, which will bring together insight from a range of existing listening and engagement mechanisms, including the NHS Staff Survey, National Quarterly People Pulse Survey, Freedom to Speak Up, Staff Side engagement, Staff Governors, workforce metrics and wider organisational engagement activity. The framework aims to strengthen organisational learning, support Board oversight of workforce culture and engagement, improve visibility of colleague experience and support more responsive organisational action.

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



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.40	6.05	6.76	6.09	5.70	6.49	6.87	6.92	5.91
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	1618	1620	1603	1609	1547	1611	1616	1621	1622

Widening Participation

Skills Bootcamp in Health and Social Care

In 2025 we delivered a highly successful Skills Bootcamp in Health and Social Care, a government-funded training programme designed for adults aged 19+ across Dorset and Somerset which offers a hands-on learning experience in clinical environments to prepare learners for a career in the industry. Participants receive a guaranteed job interview with local employers upon completion, and our first cohort of learners all completed and attended interview, with 71% succeeding in being offered a role or a place in the talent pool.

Supported Internships

Dorset County Hospital has continued to expand its Supported Internship provision in partnership with local education providers, with Employ My Ability newly added to our programme offer. The initiative provides meaningful 26-week work placements for young people with physical, mental, or learning disabilities who may face barriers to employment. In 2025/26, the Trust has offered eight placements across the organisation, strengthening our commitment to inclusive employment pathways and supporting young people to develop the skills and confidence needed for long-term work opportunities.

Functional Skills

At Dorset County Hospital we strive to develop an individual's educational achievements to expand opportunities to pursue their chosen career pathway, and to assist staff to reach their full potential. We offer free functional skills delivered by Skills and Learning Adult Education in English, Digital Skills and Maths – 35 staff are currently on the programme. We have expanded our capacity to include staff from Dorset HealthCare.

Work Experience Placements

In 2025/26, the Trust delivered 250 workplace experiences, expanding our Year 10 offer significantly and maintaining our high level of engagement across the area. We also participated in the county's Modern Work Experience pilot, delivering a Key Stage 3 experience to 60 students, aimed at sparking early career inspiration. We achieved the Silver Quality Standard Award (QSA) for work experience from NHS England, and this year also saw delivery of our first Teacher Encounters event, developed with the Dorset Careers Hub, giving educators direct exposure to NHS roles so they can better guide students.

Supporting Introduction to Programmes

The Widening Participation Team have worked collaboratively with our medical education, support worker development and Non-Medical Undergraduate Education Team this year to increase the number of 'introduction to' programmes with successful programmes for future aspiring healthcare professionals looking at nursing, medicine and allied health professional careers. Across all programmes, between 95% and 100% of participants stated they wished to continue a career in healthcare.

Apprenticeships

During 2025/26, 70 staff enrolled onto apprenticeship programmes spanning Levels 2 (GCSE equivalent) to 7 (Masters equivalent). We currently have 202 apprentices, our highest number of learners to date, reflecting a growing demand for apprenticeship study routes. 62 learners have completed their programmes in 2025. Year on year completions rose by 24%, delivering a 59% improvement overall since 2024. This has been achieved

through robust completion planning, whilst maintaining a stable flow of new enrolments as apprentices successfully complete.

We continue to work with system partners across Dorset to deliver annual Registered Nurse Degree Apprentice cohorts, supporting long-term workforce planning and sustainability.

Healthcare Support Worker Development
The nationally recognised Care Certificate continues to be delivered to all new Healthcare Support Workers joining the Trust. Our comprehensive education programme incorporates the full Care Certificate standards alongside the essential training required for the healthcare support worker role. Feedback from participants and their line managers is considered in programme development to ensure the curriculum remains relevant, and responsive to workforce needs.

During 2025 over 100 healthcare support workers were supported through the Support Worker Induction and Care Certificate programme. The average completion time remains nine weeks, well within the Trust's 12-week expectation. Professional development of our support worker workforce is a key priority. Over the past year, 43 members of staff have successfully completed the Supporting Learners in Practice course. Additionally, staff wishing to progress onto Level 2 or Level 3 Healthcare Apprenticeships are provided with structured guidance and support to facilitate their development. We are also seeing sustained growth in healthcare support workers progressing into professional careers across nursing, midwifery, therapies, and medicine.

Non-Medical Undergraduate Education
Our Non-Medical Undergraduate Education Team monitor educational quality assurance and educational governance of our clinical learning environments. The focus for 2025 has been to increase clinical placement capacity and educator capability for allied health professional undergraduate students. Capacity modelling, early planning, and engagement with therapy practice educators, has resulted in a 70% increase in physiotherapy placements and 125% increase for occupational therapy. Placement capacity for nursing and midwifery remained stable and in line with demand from universities.

Preceptorship and Overseas Educated Staff Support
The Preceptorship Programme is a 12-month development programme for all non-medical newly qualified registered healthcare professionals. The programme is fully aligned to the national frameworks for nurses, AHPs and midwives and continues to meet expectations of the National Preceptorship Interim Quality Mark. In 2025 we have delivered four programmes to 64 newly registered clinical staff. At the end of the preceptorship year, we encourage all preceptees to undertake our in-house Management Matters Programme alongside the NHS Leadership Academy Edward Jenner Programme. We have been innovative in our approach to move from analogue processes to digital by developing a digital portfolio for all our preceptorship programmes. This has improved accessibility and monitoring of completion and supports our commitment to environmental sustainability. We continue to retain and support over 300 clinical staff from overseas who contribute to our organisation. We have seen an increase in the number of healthcare support workers we have recruited who are registered nurses in their country of origin. In 2025 we were able to support eight staff to complete their Objective Structured Clinical Examination (OSCE)

programme, achieving a 100% pass rate with seven of the eight staff securing registered nurse positions in the organisation.

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

Consultancy

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

	2025/26 - £000s
Finance	25
HR, Training & Education	6
Organisation & Change Management	4
Property & Construction	6
Strategy	22
Technical	19
Total	**82**

Reporting High Paid Off-payroll Arrangements

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

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

For any off-payroll engagements as at 31 March 2026, for more than £245 per day and that last for longer than six months	Number of engagements
Number of existing engagements as of 31 March 2026	1
Of which, the number that have existed:	
For less than one year at time of reporting	Nil
For between one and two years at the time of reporting	Nil
For between two and three years at the time of reporting	1
For between three and four years at the time of reporting	Nil
For 4 or more years at the time of reporting	Nil

All off-payroll workers engaged at any point during the year ended 31 March 2026, for more than £245 per day	Number of engagements
Number of new engagements during the year ended 31 March 2026	388
Of which…	
Not subject to off-payroll legislation	386
Subject to off-payroll legislation and determined as in-scope of IR35	2
Subject to off-payroll legislation and determined as out-of-scope of IR35	Nil
Number of engagements reassessed for compliance or assurance purposes during the year	Nil
Of which; No of engagements that saw a change to IR35 status following review	Nil

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026	Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	Nil
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	16

The Trust has made no payments for off payroll arrangements to individuals through their own companies during 2025/26.

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

Average number of employees (WTE basis)

	Average for year ended 31 March 2026		
	Total number	Permanent number	Other number
Medical and dental	447	442	5
Administration and estates	585	584	1
Healthcare assistants and other support staff	963	963	-
Nursing, midwifery and health visiting staff	1,112	1,057	55
Nursing, midwifery and health visiting learners	42	42	-
Scientific, therapeutic and technical staff	297	294	3
Healthcare science staff	91	90	1
Social care and staff	-	-	-
Other	-	-	-
Total	3,537	3,472	65
Of which: Engaged on capital projects	48	48	-

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

Employee Expenses

	Total £000	Permanent employed £000	Other total £000
Salaries and Wages	175,263	172,070	3,193
Social security costs	22,238	22,238	-
Apprenticeship levy	870	870	-
Pension cost – NHS pensions	20,648	20,648	-
Pension cost – Employer contributions paid by NHSE	13,477	13,477	-
Pension cost – other	24	24	-
Termination benefits	322	322	-
Temporary staff – Agency/contract staff	5,749	-	5,749
Total Gross Staff Costs	**238,591**	**229,649**	**8,942**
Included within; costs capitalised as part of assets	3,847	3,847	-

Exit Packages

2025/26 Exit package cost band	Number of Compulsory redundancies	Number of Other departures agreed	Total number of exit packages by cost band
< £10,000	-	29	29
£10,001 - £25,000	-	4	4
£25,001 - £50,000	-	1	1
£50,001 - £100,000	1	1	2
> £200,000	-	-	-
Total number of exit packages by type	1	35	36
Total resource cost (£000)	60	262	322

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

The payments included in ‘Other departures’ agreed for 2025/26 are 31 in respect of contractual payments made in lieu of notice and four mutually agreed resignations (MARS) contractual costs (2024/25: 25 payments for lieu of notice and three payments for mutually agreed resignations (MARS). Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pension scheme. Ill-health retirement costs are met by the NHS pension scheme and are not included in this table.

Corporate Governance Report

Code of Governance for NHS Provider Trusts
The Code of Governance for NHS Provider Trusts was published in October 2022 and has applied since 1 April 2023, replacing the former NHS Foundation Trust Code of Governance issued by Monitor.

The Code provides a single overarching framework for NHS provider governance, reflecting developments in UK corporate governance and integrated care systems. Providers are required to comply with its provisions or explain any departures on a comply-or-explain basis.

Compliance with the Code
NHS Foundation Trusts are required to include specific disclosures in their annual reports to meet the requirements of the Code of Governance for NHS Provider Trusts. Dorset County Hospital has applied the principles of the Code on a comply-or-explain basis.

The Board of Directors implements the Code through key governance documents, including:

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

A comprehensive self-assessment of compliance with the Code was completed in April 2025 and 2026 to inform the Annual Report and Annual Governance Statement. The Trust is fully compliant with the Code.

During the year, new Non-Executive Directors were appointed across Dorset County Hospital and Dorset HealthCare, informed by the skills matrix. A joint succession plan was developed and was shared with the Council of Governors' Nominations and Remuneration Committee.

There are no areas of non-compliance, and the Trust is fully compliant with all provisions relating to the publication of information.

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

Board of Directors
The Board of Directors is responsible for setting the Trust's strategy and overseeing its operations, ensuring compliance with the Trust's Constitution, the NHS Provider Licence,

and all statutory and contractual requirements. Details of Board composition, terms of office and remuneration are set out in the Directors' Report and Remuneration Report.

Dorset County Hospital and Dorset HealthCare moved to a Board in Common in October 2025.

Board members undertake annual appraisals, including self-assessment, peer review and feedback from Governors and external stakeholders. These are undertaken to establish performance objectives for the coming financial year. The Trust Chair's appraisal is led by the Senior Independent Director and submitted to NHS England.

The Board regularly reviews its skills, expertise and experience needed within the Board to ensure it remains balanced and effective in meeting the Trust's ongoing requirements.

Attendance at Trust Board Meetings 2025/26

* indicates extra-ordinary meetings
^ indicates a Board meeting held in common with Dorset HealthCare University NHS Foundation Trust. From October 2025 all Board meetings were routinely held in common with Dorset HealthCare University NHS Foundation Trust.

P1 = Public P2 = Private	08 Apr 2025		29 Apr 2025	10 Jun 2025		26 Jun 2025	12 Aug 2025		07 Oct 2025		22 Oct 2025	04 Nov 2025	09 Dec 2025		26 Jan 2026	10 Feb 2026		03 Mar 2026	25 Mar 2026
	P1	P2	P2*^	P1	P2	P2*^	P1	P2	P1	P2	P2*^	P2*^	P1^	P2^	P2*^	P1^	P2^	P2*^	P2*
Non-Executives																			
David Clayton-Smith	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Margaret Blankson	A	A	✓	✓	✓	A	✓	A	✓	✓	A	A	✓	✓	✓	✓	✓	✓	A
Eiri Jones	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A
Claire Lehman	✓	✓	✓	✓	✓	✓	A	A	-	-	-	-	✓	✓	✓	✓	✓	✓	✓
Stuart Parsons	A	A	A	✓	✓	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	A
Stephen Tilton	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	A	A	A	✓	A	A	✓
Dave Underwood	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Frances West (to 30 01 26)	✓	✓	✓	A	A	✓	✓	✓	✓	✓	A	✓	✓	✓	✓				
Executives																			
Matthew Bryant	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dawn Dawson	✓	✓	✓	✓	✓	✓	A	A	A	A	A	A	A	A	✓	✓	✓	✓	✓
Chris Hearn	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jenny Horrabin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nick Johnson (to 31 08 25)	✓	✓	✓	✓	✓	✓	✓	✓											
Nicola Plumb	✓	✓	✓	✓	✓	✓	A	A	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓
Anita Thomas	✓	✓	A	✓	A	A	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	A	✓
Rachel Wharton	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Committee attendance

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

Audit Committee
During the year the Audit Committee Terms of Reference were reviewed in accordance with the 2024 Healthcare Financial Managers Association NHS Audit Committee Handbook.

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

The purpose of the committee is to maintain oversight of the Trust's systems of internal control, governance and quality safety on behalf of the Board of Directors, seeking assurances from non-executive Committee chairs, supported by executive directors.
The internal audit function is provided by a third-party provider of internal audit services, BDO LLP, which reports to the Audit Committee. The Audit Committee monitors the internal audit work programme and receives regular reports and assurances on the adequacy of controls in place. The Audit Programme facilitates and informs the Head of Internal Audit Opinion that is included within the Trust's annual report each year.

External auditors review the plan of work, risks and mitigations and provide recommendations on areas where further mitigations or improvement could be made. They undertake a formal audit of the Trust's accounts and annual report each year which includes scrutiny of: Management Override of Controls, Valuation of Land and Buildings and Fraudulent recognition of non-pay expenditure. External auditors have not provided any non-audit services in year.

The committee considered the Annual Report and Audited Accounts for 2025/26 at a meeting held on 1 June 2026 and concluded that there were no significant risks requiring action pursuant to the Corporate Governance Code.

Non-Executive Director Members Attendance at the Audit Committee 2025/26	
Name	**Attendance/Meetings eligible to attend***
Stuart Parsons (Committee Chair)	6/6
Stephen Tilton	5/6
Dave Underwood	6/6

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

Quality Committee
From April 2025 the Trust's Quality Committee has operated as a committee in common with

the same committee from Dorset HealthCare. The purpose of the committee is to maintain oversight of quality, safety, clinical governance and patient and carer experience on behalf of the Board, as well as to oversee, monitor and review the governance arrangements underpinning the planning and delivery of care according to the CQC key lines of enquiry for assessing healthcare services

Committee members attendance 2025/26 (including extraordinary meetings)	
Name	**Attendance/Meetings eligible to attend**
Dawn Dawson	7/8
Eiri Jones (Committee Deputy Chair)	8/8
Claire Lehman (Committee Chair)	8/8
Stuart Parsons	8/8
Anita Thomas	7/8
Rachel Wharton	6/8

Finance and Performance Committee

The Finance and Performance Committee continues to operate as a committee in common with the same committee from Dorset HealthCare. The Committee advises, supports and assures the Board on matters related to financial and operational performance., enabling strategies, business cases, expenditure, procurement and financial plans in line with the Standing Financial Instructions and Scheme of Delegation and oversight of compliance in respect of estates, health and safety (including fire and water) and emergency Preparedness, Response and Resilience, Subsidiary Companies and Joint Ventures.

Committee member attendance 2025/26 (including extraordinary meetings)	
Name	**Attendance/Meetings eligible to attend**
Chris Hearn	9/10
Nick Johnson	2/4
Anita Thomas	8/9
Stephen Tilton	8/9
David Underwood (Committee Chair)	10/10
Frances West	7/9
Rachel Wharton	5/9

People and Culture Committee

The People and Culture Committee continues to operate as a committee in common with the same committee from Dorset HealthCare. The Committee advises, supports and assures the Board on matters related to the production and delivery of strategies and plans related to people, culture and organisational development; overseeing key performance indicators relevant to the scope of the work of the committee; and matters related to equality, diversity and inclusion, annual reporting and compliance with regulatory and legislative requirements.

Committee members attendance 2025/26	
Name	**Attendance/Meetings eligible to attend**
Margaret Blankson	4/6
Dawn Dawson	5/6

Eiri Jones (Committee Chair from (31 01 2026)	6/6
Nicola Plumb	4/6
Frances West (Committee Chair to 30 01 2026)	4/5
Rachel Wharton	3/6

Strategy, Transformation and Partnerships Committee

The Strategy, Transformation and Partnerships Committee continues to operate as a committee in common with the same committee from Dorset HealthCare. The Committee advises, supports and assures the Board on matters related to oversight of delivery of the Trust's strategic objectives and priorities and the One Transformation Approach (consisting of four portfolios: Neighbourhood Health and Wellbeing; Mental Health Inpatient Flow; Unplanned Care Flow and Working Together); maintaining oversight of the programmes of work in respect of digital; New Hospital Programme and quality improvement and ensuring alignment with the strategic objectives and priorities and the One Transformation Approach; and maintaining oversight of all collaboratives and partnership arrangements, ensuring alignment with the strategic objectives and priorities and the One Transformation Approach.

Committee members attendance 2025/26	
Name	**Attendance/Meetings eligible to attend**
David Clayton-Smith (Committee Chair)	6/6
Dawn Dawson	5/6
Chris Hearn	6/6
Nick Johnson	2/2
Claire Lehman	4/6
Nicola Plumb	6/6
Dave Underwood	6/6
Frances West	5/5

Mental Health Legislation Committee

In April 2025 the Boards of Dorset County Hospital NHS Foundation Trust and Dorset HealthCare approved a decision to develop a Mental Health Legislation Committee in Common, which became operational in July 2025. The role of the committee is to scrutinise assurances that Dorset County Hospital NHS Foundation Trust is operating and will continue to operate in accordance with the law and best practice in relation to the rights of mental health services users.

Committee members attendance 2025/26	
Name	**Attendance/Meetings eligible to attend**
Margaret Blankson	2/3
Dawn Dawson (or nominated deputy)	2/3
Jenny Horrabin	2/2
Stuart Parsons	2/3
Rachel Wharton	0/3

Effectiveness Evaluation

The Board of Directors continued its programme of staff, patient and carers stories at each formal meeting, providing direct feedback from staff, patients and carers. During January

and February 2026, the Board undertook a comprehensive review of committee performance to strengthen assurance, communication and escalation arrangements.

This review supported the further development of federated governance across the Trust and Dorset HealthCare, with the establishment of five Committees in Common and shared annual work plans clearly distinguishing joint and Trust-specific business. Committee effectiveness evaluations, along with updated terms of reference and 2026/27 work plans, were completed and reported to committees and the Board in March and April 2026 respectively. Governance structures, continue to be reviewed as arrangements mature. The Audit Committee and Remuneration Committee have remained Trust specific.

The Board met in public on alternate months, with Joint Board Development workshops held in the intervening months.

Strategic risks within the Board Assurance Framework (BAF), and the Risk Appetite Statement, were reviewed and agreed in November 2025, with each strategic risk assigned to a committee for a quarterly review. The full BAF is presented to Audit Committee and Board to maintain overall oversight.

Well-Led Review
NHS Foundation Trusts are strongly encouraged to undertake an independent external review against the CQC's Well Led Framework every three to five years, according to their circumstances

Dorset County Hospital NHS Foundation Trust underwent a comprehensive formal external review of its compliance with the requirements in 2021, and the development and improvement actions identified at that time have been completed. During 2025/26 a Well Led review was undertaken by the Trusts Internal Audit provider, with a focus on the quality statements well led conversations at a Board and Divisional level.

Further details about how the Trust is well led can be found in the Directors' Report section of this report and the Annual Governance Statement.

Care Quality Commission
The Trust is fully compliant with the registration requirements of the CQC and underwent inspection of Maternity Services in May 2025 for the inspection domains of Safe and Well Led with a rating of 'Good'. A comprehensive inspection of Urgent and Emergency Care Services and Medicine (including Elderly Care) Services was undertaken during the reporting period with a draft report awaited at the time of reporting.

Information Governance
Significant work has continued in year to maintain information governance compliance requirements across the Trust and to ensure compliance with the Data Security and Protection Toolkit requirements. Further discussion of information governance activity throughout the year can be found in the Annual Governance Statement.

Council of Governors

The Council of Governors represents the interests of the populations and communities served by the Trust and partner organisations. The Council of Governors has a duty to hold non-executive directors to account individually and collectively for the performance of the Board of Directors, providing feedback on the Trust's performance to stakeholder organisations and members. The Chair of the Council of Governors is also the Chair of the Board of Directors and is responsible for the performance of non-executive directors.

The Council of Governors receive the Annual Report and Accounts and has responsibility for conducting an Annual Members' Meeting. Below is a full list of the Governors' statutory duties is detailed in the Constitution which can be found at https://dchft.nhs.uk/about-us/freedom-of-information/publication-scheme/

The table below lists all the Governors in 2025/26 and the constituencies they represent, and the number of meetings attended from the maximum they could have attended, depending upon time of appointment or leaving the Council.

Governors Terms of Office and Attendance at Council of Governors' meetings 2025/26
Elected Governors

Constituency	Name	Current Tenure	Attendance at Council of Governor meetings/Meetings eligible to attend*
West and South Dorset	Jean Pierre Lambert	09/07/2024-08/07/2027 (first term)	5/5
West and South Dorset	Kathryn Harrison (Lead Governor)	01/10/2023-30/09/2026 (second term)	5/5
West and South Dorset	David Taylor	01/10/2023-30/09/2026 (first term)	1/5
West and South Dorset	Mike Byatt	09/07/2024-08/07/2027 (second term)	3/5
West and South Dorset	Alan Clark	09/07/2024-08/07/2027 (first term)	5/5
West and South Dorset	Anne Link	09/07/2024-08/07/2027 (first term)	5/5
West and South Dorset	Judy Crabb	26/09/2024-25/09/2027 (second term)	5/5
West and South Dorset	3 x Vacancies		
North and East Dorset	Lynn Taylor	29/05/2025-08/07/2027 (second term)	4/4
North and East Dorset	Simon Bishop	01/10/2023-30/09/2026 (third term)	5/5
North and East Dorset	Maurice Perks	26/09/2024-25/09/2027 (third term)	4/5
North and East Dorset	Carol Manton	26/09/2024-25/09/2027 (first term)	5/5
North and East Dorset	1 x Vacancy		
South Somerset and the rest of England	1 x Vacancy		

Staff	Midhun Paul	01/10/2023-30/09/2026 (first term)	2/5
Staff	Max Deighton	26/09/2024-25/09/2027 (first term)	3/5
Staff	Jan Wagner	18/08/2025-25/09/2027 (first term)	4/4
Staff	1 x Vacancy		

* The Council of Governors met on the following dates in 2025/26: 22 April, 18 August, 17 November, 21 January (extraordinary and in common with DHC), 09 March.

Appointed Governors

Organisation	Name	Current Tenure	Attendance at Council of Governor meetings/Meetings eligible to attend*
Friends of DCH	Paul Kent	15/08/2025- 14/08/2028 (first term)	2/4
Coastland College	Kate Wills	01/07/2025-30/06/2028 (first term)	2/4
Dorset Mental Health Forum	Becky Aldridge	17/11/2025-16/11/2028 (first term)	3/3
People First	Laura Kerr	01/08/2025- 31/07/2028 (first term)	4/4
Two Harbours Healthcare	Sharlina Sallehuddin	09/03/2026-08/03/2029 (first term)	1/1
Dorset Council	Rory Major	24/06/2024-23/06/2027(first term)	0/5

* The Council of Governors met on the following dates in 2025/26: 22 April, 18 August, 17 November, 21 January (extraordinary and in common with DHC), 9 March.

Governors who left during the year

Constituency/ Organisation	Name	Leaving Date	Attendance at Council of Governor meetings/Meetings eligible to attend*
Age UK	Terri Lewis	11/09/2025	0/2
Friends of DCH	Barbara Purnell	30/06/2025	0/1
Staff	Jack Welch	01/09/2025	2/2

Governor Activities

Over the past year, the Council of Governors has continued to play an active and important role in shaping the Trust's work and ensuring the voices of local people are heard. Governors met at least four times during the year, with meetings held both in person and online to make them as accessible as possible. These meetings were open to the public and advertised on the Trust website, helping to keep the work transparent and visible to local communities.

At the formal quarterly Council of Governor meetings Governors heard from the Non-Executive Directors, who shared updates on key areas of the Trust's performance. The Joint Chief Executive, Joint Chief Finance Officer and other Executive Team members also

joined regularly to provide insight into the Trust's priorities, challenges and achievements throughout the year.

A wide range of topics came to the Council for discussion. Governors learned about the Trust's plans for 2025/26, including work to explore opportunities for income from non-NHS activities. They were briefed on the Quality Priorities and the annual NHS Staff Survey results. They received service presentations from the Patient Experience Team and about the Fit for the Future: 10 Year Health Plan for England (the NHS 10 Year Plan). These sessions helped Governors stay close to what is happening across the organisation.

Governors continued to observe many of the Trust's Board committees, including the committees that operate jointly with Dorset HealthCare. The Governor observers then provide a report at the Council of Governor meeting about the committee effectiveness. Governors are also invited to observe public Board meetings. This level of involvement helps Governors build a detailed understanding of how the Trust is run and gives them confidence when holding Non-Executive Directors to account.

Governors helped plan and host the Annual Members Meeting (AMM) which took place in the Education Centre of Dorset County Hospital in September 2025 and was open to all Trust members.

Throughout the year, Governors stayed engaged with the people they represent, holding pop-up events around the hospital and actively engaging with community groups within their constituencies, helping to raise awareness of the Trust's work and strengthen local connections. Staff Governors continued to meet regularly with colleagues across the Trust, ensuring staff voices are clearly heard in Council discussions, especially when concerns are raised about services or about the experience of staff and patients.

Working collaboratively has been an important theme this year. A joint workshop was held with Governors and Non-Executive Directors from both Dorset County Hospital and Dorset HealthCare offering a valuable opportunity to strengthen relationships and share perspectives across the two organisations.

Governors appointed the external auditor for a further three-year term and were directly involved in the recruitment and re-appointment of Non-Executive Directors as part of the ongoing federation between the two trusts. Details of the activity of the Governors' Nominations and Remunerations Committee are given below.

There are several mechanisms in place that enable effective engagement between the Board of Directors and the Council of Governors, including:

- Governors overserving at Board committees and bi-annual meetings with committee chairs and the nominated Governor observer;
- Attendance of both Executive and Non-Executive Directors at Council of Governors meetings;
- A standing invitation for the Lead Governor to observe confidential Board of Directors meetings;
- By asking questions at Council of Governors meeting, public Board meetings, and via

the Corporate Governance Team;
- A joint workshop for Governors and Non-Executive Directors;
- Participation in quality walkarounds, with executive and Non-Executive Directors.

In the event of any disagreement between the Council of Governors and the Board of Directors, the Trust's Constitution specifies a Dispute Resolution Process (Annex 6). This mechanism provides a formal framework for addressing disagreements should they arise. This process has not been invoked during the reporting year.

Nomination and Remuneration Committee (Council of Governors' sub-committee)
The Nomination and Remuneration Committee is a sub-committee of the Council of Governors. Its responsibilities include the appointment of Non-Executive Directors and determining their rates of remuneration. The terms of reference for the Nomination and Remuneration Committee can be found on the Trust website Council of Governors | Dorset County Hospital. During the reporting year, the committee met on two occasions, and one of these meetings was held as a Committee in Common with Dorset HealthCare. An overview of the outcomes is provided below:

- Reappointment of Frances West, Joint Non-Executive Director for a second three-year term;
- Review of the Trust Chair's appraisal and remuneration and recommended an uplift to the Chair's remuneration;
- Approval to commence a recruitment campaign for one joint and two Dorset County Hospital Non-Executive Directors;
- Reappointment of the Trust Chair for a second three-year term;
- Extension of the second term of David Underwood for a further three-year term subject to annual review.

All recommendations made by the Committee to the Council of Governors were subsequently approved.

Attendance at Nomination and Remuneration Committee 2025/26		
Role	**Name**	**Attendance/Meetings invited to or required to attend***
Trust Chair	David Clayton-Smith	2/2
Non-Executive Director, and Senior Independent Director	David Underwood	1/1
Non-Executive Director, Dorset County Hospital Deputy Chair	Eiri Jones	1/1
Appointed Governor – Dorset Mental Health Forum	Becky Aldridge	0/1
Public Governor – North and East Dorset	Simon Bishop	2/2
Public Governor – North and East Dorset	Lynn Taylor	1/1
Public Governor – West and South Dorset	Judy Crabb	1/1
Public Governor – West and South Dorset	Kathryn Harrison	1/2
Public Governor – West and South Dorset	Jean-Pierre Lambert	2/2
Public Governor – West and South Dorset	Anne Link	2/2

Staff Governor	Jack Welch	1/1
Staff Governor	Jan Wagner	0/1

*The Nomination and Remuneration Committee met on the following dates in 2025/26: 30 July, 22 December (in common with DHC)

Council of Governors' Register of Interests

Dorset County Hospital NHS Foundation Trust is required to maintain a record of the details of company directorships and other significant interests held by Governors which may conflict with their responsibilities.

The Trust maintains a Register of Interests for Executive Directors, Non-Executive Directors, Governors and senior members of staff. The Register of Declarations of Interest for our Council of Governors is available on the Trust website Council of Governors | Dorset County Hospital or on request from the Joint Director of Corporate Affairs.

Director Attendance at Public Council of Governor Meetings during 2025-26		
Date of Meeting	**Executive Attendance***	**Non-Executive Attendance****
22 April 2025	Joint Chief Executive Officer Joint Chief Nursing Officer Joint Director of Corporate Affairs Joint Chief Financial Officer Deputy CEO and Director of Strategy Transformation and Partnerships Chief Medical Officer	David Clayton-Smith (Chair) Stuart Parsons
18 August 2025	Joint Chief Financial Officer Deputy CEO and Joint Director of Strategy Transformation and Partnerships Joint Chief Nursing Officer Joint Director of Corporate Affairs Chief Medical Officer	David Clayton-Smith (Chair) David Underwood Stuart Parsons Stephen Tilton
17 November 2025	Joint Chief Executive Officer Joint Chief Financial Officer Joint Chief Nursing Officer Joint Chief People Officer Chief Medical Officer Joint Director of Corporate Affairs	David Clayton-Smith (Chair) David Underwood Eiri Jones Frances West
21 January 2026 (extraordinary, confidential, and in common with DHC)	Joint Chief Financial Officer Joint Director of Corporate Affairs	David Clayton-Smith (Chair) Eiri Jones (Deputy Chair)
09 March 2026	Joint Chief Executive Officer Joint Chief Financial Officer Joint Chief Nursing Officer Joint Chief People Officer Chief Medical Officer Joint Director of Corporate Affairs	David Clayton-Smith (Chair) Eiri Jones Claire Lehman

* Executives are invited to the Council of Governors on a routine basis and attend the Council of Governors as requested to present relevant reports. Governors also have the right to request members of the executive team attend the meetings under paragraph 10C of Schedule 7 to the NHS Act 2006, but the Council of Governors has not exercised this right during 2025/26.

** In addition to the Chair's attendance, Non-Executive Directors are invited to attend Part One Council of Governor meetings on a routine basis and present to the Council of Governors on a rota basis.

Membership

Foundation trusts have a responsibility to engage with the communities they serve and listen to community views when planning services. Dorset County Hospital has two types of membership: *public* and *staff.* Staff automatically become members unless they choose to opt out. The Trust also encourages people living within its constituency boundaries to register as public members. Being a member demonstrates support for the Trust and the services it provides and offers opportunities to share views that help shape services to meet patient needs. Members can also self-nominate to stand as a Governor or vote for Governors who represent their constituency. Membership is open to people ages 16+ years who are resident in England. Registration as a member can be via a membership application form, online at www.dchft.nhs.uk or by phoning 01305 255419.

The Council of Governors has established a Membership Committee which meets on a quarterly basis to keep the membership development strategy under review and to oversee membership communications, events and recruitment. All Governors sit on this committee. The Trust membership constituency boundaries changed during 2025/26, being reduced from five constituencies to three. The Constituency boundaries changed from East Dorset, North Dorset, West Dorset, Weymouth and Portland, and South Somerset and the Rest of England. The new constituencies are drawn with minor amendments from the parliamentary boundaries established in 2023 (former Local Authority areas) and are now called North and East Dorset, South and West Dorset and South Somerset and the Rest of England.

Governors have continued to engage with the Trust membership and with members of the public by holding pop-up stands within the hospital and to meet staff, patients, and visitors. The Governors have also attended, by appointment, other organised groups to engage with the people in attendance such as a mother and baby group and a veterans group. During these informal interactions, Governor's fulfil the statutory requirement to canvass the opinion of the members and the public by listening to what matters most to people regarding their healthcare and their experiences of the NHS. At these sessions, Governors display information boards with useful content, including updates on the New Hospital Programme and other key Trust initiatives. As Governors interact with attendees, they record feedback and summarise this into reports submitted to the Council of Governors and the Experience of Care Committee. Through these interactions, Governors develop a broad understanding of members' and the public's views, ensuring they can effectively represent this voice at Council of Governors meetings and Governor/ Non-Executive Director workshops.

The Trust has also continued to keep in contact with its members via the Trust's website, social media and the publication of the Governor newsletter, an e-bulletin to enable to Governors to communicate directly with the membership. Through these mechanisms the Governors are able to update the membership and constituents on how they have discharged their responsibilities.

The tables below show the number of members in each constituency area:

Constituency Numbers 2024/2025	
East Dorset	201
North Dorset	226
South Somerset and the Rest of England	87
West Dorset	1046
Weymouth and Portland	602
Total Public Members	2162
Staff members	3950
Total	6112

Constituency numbers with new constituency boundaries 2025/2026	
North and East Dorset	281
West and South Dorset	1757
South Somerset and the Rest of England	86
Total Public Members	2124
Staff	2788*
Total	4912

*Please note, the number of members in the staff constituency in 2025/26 is significantly lower than previous years, due to improved reporting in line with the constitutional criteria for the membership of the constituency.

NHS Oversight Framework

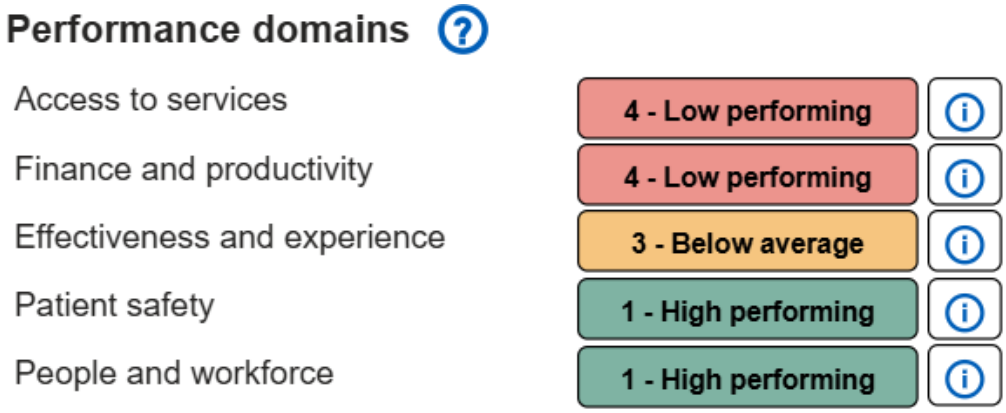
NHS England's *NHS Oversight Framework 2025/26* is the framework for assessing health systems including providers. It promotes transparency. Improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five segments.

Segmentation indicates performance and whether improvement is required, from high performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

a) Its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity);
b) considering financial override which may limit a segment to be no better than 3;
c) contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality), and;
d) capability assessments which consider the organisation's leadership and governance.

The Trust was placed within segment 3, with the narrative stating 'below average and/or financial deficit. Quarter 4 data for 2025-26, published on 11 June 2026, as below: (NOF Acute Dashboard - NHS England public data gateway)



Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Dorset County Hospital NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS England.

NHS England has given Accounts Directions which require Dorset County Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Dorset County Hospital NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the *Department of Health and Social Care Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy, and;
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's

auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Matthew Bryant
Chief Executive
23 June 2026

Annual Governance Statement 2025/26

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Dorset County Hospital NHS Foundation Trust ('the Trust') to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place at Dorset County Hospital NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

The Trust has maintained a robust system of internal control throughout the year; revising how it both responded to the sustained operational pressures and ensured that the Board and Council of Governors remained fully briefed on the Trust's operational pressures and response. The Board of Directors has maintained oversight of the risks to delivery of strategic priorities and progress in key areas of programmed work where this has been possible.

Capacity to handle risk

Leadership of Risk Management

The Trust has continued to develop risk management processes within the organisation. These processes are overseen by coherent and comprehensive management structures and roles. The Trust's risk management strategy outlines the Trust's approach to risk management throughout the organisation, including identifying the accountability arrangements and the tools and resources to manage these. The Risk Management Strategy has been reviewed during the year as we move to a shared Risk Management Strategy with Dorset HealthCare University NHS Foundation Trust ('Dorset HealthCare).

Successful risk management starts with the setting of Trust's objectives to direct the safe delivery of services and care to patients, promote and deliver sustainable population health, protect the business and reputation of the Trust and make the Trust a place that staff want to work.

The Board of Directors determines the balance required between achieving the Trust's objectives and avoiding risk altogether. This is reflected in the risk appetite statement agreed by the Board which was reviewed and approved during the year as we move towards a shared risk management approach with Dorset HealthCare. The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities (desirable risk) and threats (undesirable risk). The Trust aims to mitigate those risks to acceptable levels through risk management policies and processes by making the most of opportunities and reducing the impact of threats.

Non-Executive Directors are aware of their responsibilities in relation to risk management and chair all Board committees, applying independent judgement in relation to risk management issues and satisfying themselves that the Trust's systems of risk management are robust and defensible. All Board committees have defined terms of reference setting out responsibilities for risk management where appropriate.

The Chief Executive Officer has overall responsibility for effective risk management in the Trust. High level operational responsibility for risk management has been delegated to the Chief Nursing Officer. All executive leads have a specific responsibility for the identification and prudent management of risks within their sphere of accountability and are responsible, where required, for the provision of specialist advice to the Board. This recognises that all Executive Directors are subject matter experts and have specific responsibilities for interpreting and applying national policy, legislation and regulations in their specific areas of responsibility and expertise.

The Chief Nursing Officer has designated staff responsible for:

- the risk management process (the development of risk management strategy and policy, administration of risk management systems and oversight of clinical risk exposures facing the Trust, ensuring the provision of risk management training, supporting divisions and localities, carrying out checks within and across divisions and localities to monitor the management of risk and triangulating lessons for learning from clinical risks ensuring defects, alerts or changes in practice are conveyed to frontline teams promptly);
- monitoring the quality of services against CQC standards and progress against the Trust's quality priorities, advising on and escalating risks relating to regulatory standards and patients.

The Director of Corporate Affairs has responsibility for the Board Assurance Framework, working with executive leads assigned to each identified strategic risk. Quarterly updates are provided to Committees and Board.

Risk Management Training

Effective implementation of the strategy facilitates the delivery of a quality service and, alongside staff training and support, provides an improved awareness of the measures needed to prevent, control and contain risk. To achieve this, the Trust:

- ensures all staff and stakeholders have access to a copy of the Risk Management Framework;

- produces a register of risks across the Trust that is subject to regular review at Divisional level, by the Senior Management Team, Board committees and the Board;
- communicates to staff any action to be taken in respect of risk issues;
- has developed policies, procedures and guidelines based on the results of assessments and identified risks;
- ensures that training programmes raise and sustain awareness throughout the Trust of the importance of individual responsibility in identifying and managing risk;
- ensures that staff have the knowledge, skills, support and access to expert advice necessary to implement the policies, procedures and guidelines associated with the strategy;
- monitors and reviews the performance of the Trust in relation to the management of risk and the continuing suitability and effectiveness of the systems and processes in place to manage risk;
- Corporate risks are linked to the Board Assurance Framework, and they are also linked to any supporting information to evidence where and how the risk has arisen and how the risk score has been determined.

Risk training forms part of the Trust induction programme for clinical and non-clinical staff and is also included in preceptorship and junior doctor training.

The Risk and Control Framework

The Trust recognises that effective risk management is essential to continuously improving the quality of care. All staff play a vital role in identifying, assessing and managing risks. This is supported through proactive risk assessment and the review of adverse events, complaints, inquests and legal claims. The Trust fosters a fair and consistent culture that promotes openness and encourages staff to acknowledge and learn from mistakes.

The Trust has in place clear policies and systems for identifying, evaluating and monitoring risk. These include:

- The Risk Management Framework;
- Trust policies and procedures;
- Service, Care Group, Divisional and Corporate Risk Registers that contain both clinical and non-clinical risks together with the Board Assurance Framework;
- Designated appointments to support the Board and staff in the management of risk.

Trust-wide risk profiling is undertaken on an on-going basis, and managers are required to ensure that risk assessment and audit is undertaken within their areas of responsibility. Outcomes are recorded within the Trust's risk management system and managers are responsible for ensuring that findings are acted upon and adequately monitored. Audit of the centralised system ensures that managers review assessments as required.

The Trust's Incident Management and Review Policy requires staff to report all adverse incidents, both actual and potential (near misses), and sets out the methodology and responsibilities for assessing and evaluating the risks. The impact of a risk will dictate at which level of the organisation the risk event is investigated and reported, with the lowest category (green) being managed at a local level and the highest (red) managed at executive level with reports being made to the Board and statutory external agencies.

The Trust has well developed business continuity plans in place and an established Incident Coordination Centre (ICC) that can be stood up when required in order to respond to pressures arising from increasing urgent and emergency care demands. The ICC has been activated a number of times throughout the year in order to maintain safety throughout periods of industrial action, periods of increased staff absences due to increased cases of respiratory infections and industrial action, poor patient flow through the hospital and adverse weather conditions.

Corporate Governance Framework
The Trust continued to develop and refine its governance arrangements in year during 2025/26

Dorset Healthcare University NHS Trust and Dorset County NHS Foundation Trust Boards approved the establishment of a federated model of collaboration during 2023/24. The aims of this approach include improving quality of care and population health for patients, and providing a better experience, including new development opportunities, for staff.

In addition to the Joint Chair, Chief Executive and other Executive Director posts established during 2023/24, since April 2024 we have had a single executive team working across the two Trusts and all posts are shared with the exception of a trust specific Chief Operating Officer and Chief Medical Officer roles. There have been no gaps in Board capacity during the year, with a conscious decisions made where posts were not recruited to or interim arrangements in place in the context of federated working across the two Trusts.

Our shared governance was developed during 2024/25 with the establishment of some ‘Committees-in-Common’ and shared Non-Executive Director posts. We have continued to develop and strengthen this during 2025/26 with the creation of two additional Committees-in-Common from April 2025 (Quality Committee in Common and Mental Health Legislation Committee in Common) and a Board in Common from October 2025. There were clear transition plans in place as we moved to the new governance arrangements.

The Trust has a strong governance framework that provides clear reporting lines from operational services to the Board. These structures ensure that the Board’s responsibilities are effectively discharged and that it’s work is conducted with openness and transparency. A review of the governance reporting structures was also undertaken during the year to ensure these are clearly documented and understood. This was published in a Governance Manual that is available to all staff.

The Standing Orders, together with the Scheme of Delegation, Reservation of Powers, and Standing Financial Instructions, form the core of the Trust’s governance framework. The Scheme of Delegation defines the responsibilities retained by the Board and those delegated to its committees, while the Standing Financial Instructions provide essential controls for managing the Trust’s financial affairs. Collectively, these documents support effective governance, internal control and risk management, and promote efficient, transparent and compliant operations. The Standing Orders were reviewed and approved in April 2025 as part of the Constitution review.

The Board has an ongoing role in reviewing the governance arrangements to ensure that the Trust continues to reflect the principles of good governance. The effectiveness of the system of internal control has been subject to ongoing review by the Board against the measures detailed within this section. Membership and attendance of the Board and the committees is routinely monitored and attendance for the period is included in the Directors' Report.

The Board held six meetings in public during the year. Governors routinely attended and members of the public were invited to attend.

During the year, Board agendas have focused on safety and quality, strategy, people and culture, and performance and governance. Each public meeting also included a patient or staff story to support learning and assurance.

All Board members receive an annual appraisal undertaken by the Chief Executive or the Chair as appropriate. During 2025/26 the Leadership Competency Framework and Board Member Appraisal Guidance were used as the frameworks for these appraisals.

One Joint Non-Executive Director was extended beyond the end of their second term under exceptional circumstances due to their expertise during 2025/26. This will be reviewed annually for a maximum of three years. The Trust Chair was also reappointed for his second term during the year. In addition, one Joint Non-Executive Director was reappointed for their second term in the year but subsequently left during the financial year.

The Non-Executive Director skills matrix has been reviewed and updated and is used to inform recruitment and succession planning. Our Succession Plans include consideration of the skills required to deliver our strategic ambitions and Fit for the Future: 10 Year Health Plan for England.

Throughout the year, the Board undertook a structured development programme focused on key strategic priorities, including strategy formulation, risk appetite, the Board Assurance Framework, partnership working and the delivery of high-quality, safe care. Joint Board Development sessions with Dorset HealthCare and Dorset County Hospital continued throughout the year, with the programme regularly refined to reflect national developments and emerging priorities.

The work of the Board is supported by the following formal committees that it has established (see table). Each committee is chaired by a Non-Executive Director, with the duties and responsibilities of each committee clearly articulated in the Terms of Reference that include explicit accountability arrangements and reporting relationships. All Committees in Common are chaired by Joint Non-Executive Directors, with the exception of the Mental Health Legislation Committee which is chaired by a Non-Executive Director from Dorset HealthCare as the lead Mental Health Legislation Administration across both Trusts.

An annual evaluation of effectiveness of each committee has been completed, with the results reported to the committee and the Board.

Committees	Chair as at 31 March 2026
Audit Committee*	Stuart Parsons
Remuneration Committee *	David Clayton-Smith
Finance and Performance Committee **	David Underwood
Strategy, Transformation and Partnerships Committee **	David Clayton-Smith
People and Culture Committee**	Frances West (until end of January 2026) Eiri Jones (From February 2026)
Quality Committee**	Claire Lehman
Mental Health Legislation Assurance Committee**	Andreas Haimboeck-Tichy

*Denotes statutory Committee

**Committee in Common with Dorset HealthCare

These and other committees keep the Board informed of significant risks and provide both the Board and me with necessary assurance, playing a critical role in ensuring that risk management systems and processes are in place and are effective.

Following each meeting the Chair of each committee reports to the Board and outlines the most important aspects of the agenda, and any issues that need to be brought to the attention of the Board and providing assurance on the discharge of the responsibilities delegated to the committee.

Assessment against the CQC and NHS England Well Led Framework is undertaken through the work of the Quality Committee (via the Quality Governance Group) and the Senior Leadership Group. In addition, BDO LLP (the Trusts Internal Audit provider) undertook a review of preparedness on the well led framework with coaching sessions held with senior leaders. This work was undertaken across 2024/25 and 2025/26 and was reported via a Board Development session in September 2025.

The Board considers statements relating to compliance with this condition of the NHS Provider Licence on an annual basis as part of a self-certification process. Annual compliance with the principles of the Code of Governance for NHS Providers is reviewed as part of the required disclosure which appears in this annual report. The principal risks to compliance with the NHS Provider Licence Section 4 (governance) relate to the oversight metrics set out in the appendices to the NHS Oversight Framework. These metrics are monitored by the Board through its Integrated Performance Report and Finance Reports.

Strategic Risks

The Joint Strategy ‘Working together, improving lives’ was approved in 2024/25, alongside a shared set of strategic risks for both Trusts. These risks were reviewed during 2025/26 to ensure they continued to reflect the key challenges across the federation.

Although the strategic risks are jointly defined, each Trust maintains its own Board Assurance Framework (BAF) with risk scores, controls, assurances and actions tailored to its organisational context.

Each strategic risk is assigned to an Executive Director and a designated Board committee. Committees review their allocated risks regularly, and both the Audit Committee and the Board carry out quarterly reviews of the full BAF. This ensures that mitigating actions remain effective and that risks are framed appropriately in line with the operating environment.

The BAF provides a consolidated view of strategic risks, the controls in place, and the assurances supporting those controls. It highlights any risks that may affect delivery of strategic ambitions, priorities or in-year objectives.

Strategic risks and their associated risk appetite statements were reviewed in November 2025. No changes were required, although they continue to be monitored to ensure alignment with the Trust's current position.

The strategic risks as at 31 March 2026 are shown in the table below:

Board Assurance Framework Overview
Strategic Risk
SR1: Safety and Quality - If we are not able to deliver the fundamental standards of care in all of our services, we will not be providing consistently safe, effective and compassionate care.
SR2: Culture - If we do not achieve a culture of compassion and empowerment and engagement, we will not have a motivated workforce with the required capacity and skills to improve patient outcomes and deliver safe care.
SR3: Workforce Capacity - If we are not able to recruit and retain the required number of staff with the right skills, we will not be able to deliver high quality and safe sustainable services within our resources.
SR4: Capacity and Demand - If we do not meet current and expected demand and achieve local and national measures and targets within available resources, we may face regulatory action and patients' outcomes will be adversely affected.
SR5: Estates - If we do not have an estate that is fit for purpose and economically and environmentally viable, we will be unable to provide the right places for our staff to deliver high quality services to the communities that we serve.
SR6: Finance - If we do not deliver on our financial plans, including the required level of savings, this will adversely impact our ability to provide safe sustainable services, and will impact upon the overall ICS position.
SR7: Collaboration - If we do not have effective and positive partnerships within the ICS then we will not be able to shape decision and deliver the transformation required.
SR8: Transformation and Improvement - If we do not seek and respond to the views of our communities to co-produce and continuously improve and transform our services, we will not contribute to the reduction of health inequalities within our communities.
SR9: Digital Infrastructure - If we do not advance our digital and technological capabilities, including achieving our EHR ambition, we will not deliver the innovative and sustainable services, the delivery of safe services could be compromised.
SR10: Cyber Security - If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date, then we are at increased risk of a cyber security incident.

Compliance with the Code of Governance for NHS Providers

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

- The NHS Constitution;

- Standing Orders and Standing Financial Instructions;
- Scheme of Delegation and Matters Reserved for the Board;
- Code of Conduct – Board of Directors and Council of Governors.

A self-assessment has been completed to provide assurance on compliance with the NHS Code of Governance for 2025/26. The Trust is fully compliant. We continue to strengthen our governance arrangements, particularly as we further develop our shared governance arrangements across the Trust and Dorset HealthCare.

Compliance with the new NHS Provider Licence

NHS England reviewed the NHS Foundation Trust Licence conditions in 2023, extending their requirements to all NHS providers and updating them to reflect wider system compliance expectations. In quarter 4, the Trust completed a comprehensive assessment of its compliance with the revised Provider Licence conditions to ensure adherence to the updated standards.

The Trust can assure itself of compliance with NHS Licence section 4 requirements through the following mechanisms that have been deployed during 2025/26:

- The Board has maintained a strong emphasis on quality and safety in its meeting agendas to ensure that these remain the focus of decision making and planning;
- The Board has an executive lead for quality and clear accountability structures are in place for a quality agenda that is integrated into all aspects of the organisation's work;
- The Board has continued to undertake visits to wards to meet with staff and gain feedback on an intermittent basis where service operational pressures have allowed. Governor participation in these visits has continued and Governors have continued to observe Board and committee meetings where feedback has been shared;
- The Board has continued to deliver optimal emergency waiting times, and elective, diagnostic and cancer care to patients;
- The Board has maintained appropriate oversight of regulatory and compliance regimes through robust incident management arrangements in line with regional and national guidance and support.

The Trust is compliant with the NHS Provider Licence.

The Trust must also review whether their Governors receive enough training and guidance to carry out their roles. The Governors receive:

- Induction training;
- Regular development events each year;
- Regular updates and information on key areas;
- Training provided through the NHS Providers GovernWell Programme.

Governors also have access to specialist expertise to provide appropriate and objective guidance including the Corporate Governance Team, the communications team in relation to membership and engagement and human resources and external support for the Council of Governors' Nominations and Remuneration Committee.

This year the Governors have also taken part in joint workshops with the Non-Executive Director and Governors from Dorset HealthCare.

Declarations of Interest
The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months as required by the Managing Conflicts of Interest in the NHS guidance.

During 2025/26, the Conflict of Interest Policy was relaunched following a review and alignment with Dorset HealthCare, with reporting to the Audit Committee on an annual basis.

All staff within the Trust graded at Agenda for Change pay scale Band 8d/equivalent very senior manager grade or above, or that are classed as 'decision makers' are required to declare any interests in line with national guidance, on an annual basis. This does not negate the need for all staff to declare an interest if they have one.

The Register of Interests is reviewed by the Audit Committee and published on the Trust website. The Trust uses an automated process to seek appropriate declarations using the Electronic Staff Record and regular notifications are made to appropriate staff where declarations have not been made.

Quality Governance
The Chief Nursing Officer is the executive lead for quality and safety governance, supported by the Chief Medical Officer, the Chief Operating Officer and the Director of Nursing and Quality. The Trust has maintained oversight of key quality performance and activity metrics throughout the year. The Quality Committee in Common has continued to scrutinise quality governance arrangements and performance in the Trust and provide assurance to the Board. The Quality Committee in Common met bi-monthly during the year and maintained oversight of CQC registration requirements through routine reporting.

The Trust Quality Governance Group, reporting to the Quality Committee in Common, provides greater oversight of the breadth of quality governance reporting. Quality performance is also monitored by NHS Dorset Integrated Care Board at regular relationship and system level meetings.

The Quality Committee in Common has delegated responsibility to oversee the Trust's clinical and quality governance arrangements. It provides a clear vision for clinical governance within the Trust. It sets clear performance standards and holds the divisions, corporate functions and, where relevant, other Trust-wide groups to account for the delivery of the clinical and quality governance agenda.

The Trust is fully compliant with the registration requirements of the CQC and underwent inspection of Maternity Services in May 2025 for the inspection domains of Safe and Well Led with a rating of 'Good'. A comprehensive inspection of Urgent and Emergency Care Services and Medicine (including Elderly Care) Services was undertaken during the period with a draft report awaited at the time of reporting. The annual Quality Account for 2025/26 has been developed in accordance with The National Health Service (Quality Accounts)

Regulations 2010 and national guidance, led by the Director of Nursing. Stakeholders receive a draft version of the report for comment, with feedback received included in the final version. These include the Council of Governors, the Health Oversight and Scrutiny Committees of Dorset Council, Healthwatch Dorset and NHS Dorset Integrated Care Board.

The Trust's quality priorities underpin quality governance and are reviewed and updated annually. They outline the Trust's priority areas of focus for quality, and progress is monitored 'from ward to board'. Data included within the Quality Account is based on the descriptors set out in national guidance and is subject to data quality checks as part of the Trust's data quality assurance process. The Quality Committee in Common and the Quality Governance Group have a key role in monitoring the content of the Quality Account, the determination of quality priorities, and the ongoing monitoring thereof, and in providing assurance to the Board of Directors.

All Trust policies and procedures are produced in line with best practice. The effectiveness of policies in ensuring quality of care provided is monitored through a variety of mechanisms including:

- as part of the Patient Safety Incident Response Framework;
- by undertaking audits;
- by monitoring incidents, coroner cases, complaints and clinical litigation data.

Should the Trust wish to explore a particular aspect in the quality of care in more detail a focused 'deep dive' review will be undertaken. The Trust-wide clinical audit programme includes topics from priority areas such as regulatory inspection reports, NICE guidance and contractual requirements.

The Trust uses an online incident management system (Datix) for reporting all types of incidents (clinical and non-clinical). The system enables real-time notifications of incidents to be sent to identified members of staff. The notification and distribution rules are coordinated and disseminated using incident type and severity to ensure that the correct people are made aware when an incident has occurred and its potential significance.

All staff are encouraged to report when things have, or could have, gone wrong. At the heart of the Trust's Risk Management Framework is the desire to learn from incidents and near misses, complaints, inquests and claims, to continuously improve management processes and clinical practice. The primary focus is to achieve a culture that gives staff the confidence to speak honestly about something that didn't go to plan and to report issues.

The Patient Safety Incident Response Framework (PSIRF) was introduced from autumn 2023. It sets out a fundamentally different approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The Trust is in dialogue to actively manage risks with key public stakeholders. Examples of this dialogue include:

- Participation in the Dorset Integrated Care Partnership, the Dorset Health and Care Partnership;

- Working collaboratively with NHS Dorset Integrated Care Board;
- Engaging with Healthwatch Dorset;
- Consulting the Council of Governors on key issues and risks;
- Holding public engagement events, including an annual members' meeting;
- Interaction at various levels with Higher Education institutions;
- Membership of clinical networks;
- Membership of research networks;
- Regular relationship meetings with the CQC.

Safe Staffing

The Trust completes an annual workforce plan as part of the wider operational and financial planning process. The Trust has a wide range of actions and initiatives in place to tackle our immediate and medium-term workforce pressures and a comprehensive plan in place that details the actions and initiatives we will take to deliver our four key strategic objectives. Focusing on recruitment, retention, staff wellbeing and workforce planning is essential for us to meet these challenges. Assurance is provided to the Board, via the People and Culture Committee in Common and Quality Committee in Common, that short, medium, and long-term workforce strategies and safe staffing systems are in place.

In order to ensure safe staffing, three times daily safe staffing meetings are held with the Matrons of the Day, the Safer Staffing Lead and the Temporary Staffing Team. These are held in conjunction with fortnightly Safe Staffing Meetings chaired by the Director of Nursing together with the use of Allocate Safecare to monitor patient acuity, dependency and staffing levels; bi-annual audit of staffing levels using the Safer Nursing Care Tool (SCNT); quarterly audits of neonatal staffing levels, and use of Birth Rate Plus to monitor staffing levels in Maternity Services. The Trust has completed a self-assessment and is assured that it complies with the Developing Workforce Safeguard recommendations through:

- Formal adoption of the NQB 2016 guidance in safe staffing policies and procedures;
- Bi-annual audit of safe staffing levels using the Safer Nursing Care Tool and subsequent reporting to the Trust Board;
- Development of the Safe Staffing governance framework to ensure evidence of compliance with professional judgement, triangulation with quality and safety risks, and daily decision making with clear lines of escalation, as well as describing the ward to board safeguards in place;
- Monthly review of ESR people performance, workforce modelling, establishments and clinical models of care to inform strategic plans and ensure operational delivery;
- Leadership from the Associate Director, Allied Health Professions and a Safe Staffing Fellow, and from the Joint Head of Nursing, Professional Practice and Workforce, to strengthen the leadership of workforce planning, development and delivery of priorities;
- Development of ward level dashboards detailing key nursing, quality and staffing metrics to inform local and Trust-wide areas for improvement.

A Trust commissioned review of safe staffing arrangements and compliance with developing workforce safeguards was undertaken by NHS England in the reporting period with a number of improvements identified to further strengthen arrangements. These include job

planning and developing annual establishment reviews for non-ward-based teams including community services.

Other areas of internal control
The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past 12 months, as required by the Managing Conflicts of Interest in the NHS guidance. During the year we have reviewed our processes and policies, and these were re-launched during 2025/26 with reporting of compliance to the Audit Committee on an annual basis.

As an employer with staff entitled to membership of the NHS pension scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments on the effects of climate change and severe weather and have developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency and Effectiveness of the Use of Resources
Each member of the Board is aware of their responsibility to spend public money effectively. All budget managers have a responsibility to manage their budgets and systems of internal control effectively and efficiently. This message has also been communicated throughout the organisation so that all staff are aware of their responsibilities. The Trust incorporates Equality Quality Impact Assessments into its cost improvement programme to ensure that efficiency measures continue to support high-quality, value-for-money services.

The Audit Committee receives reports from internal and external audit and counter fraud, on the work undertaken to review the Trust's systems of control including economy, efficiency and effectiveness of the use of resources. Action plans are agreed from these reports to improve controls where necessary.

The Trust's internal auditors have undertaken a programme of work to provide independent assurance on the adequacy and effectiveness of systems of control across a range of financial and organisational areas including those identified in the Board Assurance Framework. All internal audit reports have been reported to the Audit Committee throughout the year and are reflected in the Head of Internal Audit's 'Annual Opinion', which is included within this report.

The Head of Internal Audit's 'Annual Opinion' has concluded that: "*Our opinion is: Generally satisfactory with improvements required in some areas. Overall, the controls in*

the areas we examined were found to be suitably designed and operating effectively to achieve the specific risk management, control and governance arrangements and value for money. However, there are some areas where weaknesses and/or non-compliance were identified and, therefore, may put the achievement of objectives at risk. No audits received 'no assurance' or 'limited assurance', and no high significance findings were raised."

In line with the National Audit Office's Code of Audit Practice, external auditors review the Trust's arrangements for securing economy, efficiency and effectiveness. Their assessment for the year identified no significant risks or weaknesses.

Information Governance
Staff are required to report all actual or suspected information security incidents through the Trust's electronic reporting system, where risks are assessed using the Trust's risk matrix.

The Information Governance Manager/Data Protection Officer leads the operational delivery of the Data Security and Protection Toolkit (DSPT) and works closely with Head of Digital Technology and Infrastructure, the cyber security lead, and the Information Assurance Manager to ensure compliance with DSPT requirements and other regulatory obligations.

Any information governance related risks reported through Datix have auto generated notifications to the Data Protection Officer. Incidents that are reportable to the Information Commissioner's Office are done so as soon as possible and within the 72-hour window via the DSPT incident reporting tool.

The Trust has an Information Governance Group, chaired by the Senior Information Risk Owner, or their deputy, and is attended by the Caldicott Guardian. Escalation from this group is via the Strategy, Transformation and Partnership Committee, and then to Board.

In line with the duty of candour, the Trust informs service users if a breach occurs involving their personal information.

Data quality and governance
Work has continued to strengthen the existing processes around data quality throughout the year, building on the data quality processes and procedures that have been in place for some time in the Trust. Current processes and procedures, as well as recent initiatives to improve data quality, include the following:

- **Data Quality:** The Trust monitors and reports on data quality using the Commissioning Data Sets (CDS) Data Quality Dashboards published by NHS England. The Information Assurance Manager reports the Trust's performance at the bi-monthly meetings of the Information Governance Group. A variety of tools is used both by the Data Quality team and by staff Trust-wide to improve these figures including targeted queries and Power BI reports designed by the Business Intelligence Team. The emphasis is on continuous improvement and data quality being the responsibility of all staff.

- **Information Assurance:** In line with the Data Security and Protection Toolkit (DSPT) work continued to ensure the Information Asset and Flows Register is populated accurately and comprehensively. The wider value to the organisation of the information recorded in the Register has been recognised and consequently a secure way of sharing some of the data is underway. Training and support in the roles of the Information Asset Administrators (IAA), System Administrators (SA) and Information Asset Owners (IAO) is provided. These are key roles across the Trust in supporting a robust mechanism to monitor and control data quality measures for all Trust information systems, this has included more emphasis on non-clinical information assets.

- **Governance:** Information assurance, incorporating data quality, is reported through the Information Governance Group, chaired by the SIRO with escalation to the Strategy, Transformation and Partnership Committee. The Digital Transformation and Assurance Group (DTAG), chaired by the Joint Chief Digital Officer also receives key performance indicators (KPI) relating to key data quality metrics as part of the broader and regular KPI reporting across all digital services.

- **Information Dashboards:** The performance dashboards have been kept under review and a process of continual development and improvement has been implemented. Increasingly, the committees of the Board have been receiving performance dashboards in SPC format. Specific dashboards are available for respective Board committees and divisional services.

- **Ownership:** Improving ownership of data quality issues continues to be an objective for the Trust. The Trust conducts an annual DSPT audit to ensure compliance, this requires information asset ownership, and responsibilities are agreed and supported at executive level and cascaded through divisional directors and managers who hold staff accountable.

- **Regular audit and external assurance:** In addition to the annual DSPT audit, other data quality audits are conducted in a number of areas including mortality, specialist clinical coding areas (on a regular, randomly selected basis as per national best practice recommendations), in addition to departmental clinical audits. Key issues are discussed at the Clinical Effectiveness Group to ensure a culture of continuous data quality improvement.

- **Information Systems:** As more information is captured in our information systems and business processes change accordingly, it is important to understand the data quality implications from any systems change. In recognition of this the Information Assurance Team of three, including the Information Assurance Manager, continue to work closely with system managers and key business users to address any data quality issues. Where data quality issues are identified, they are rectified quickly with feedback to users of source systems to reinforce the importance of accuracy and completeness in recording of patient data.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors has overall responsibility for the activity, integrity and strategy of the Trust and receives reports from the chairs of each of the Board committees, including the Audit Committee and Quality Committee.

The role of the Audit Committee is to provide the Trust Board with independent assurance that adequate processes of financial and corporate governance, risk management, audit and internal control are in place and working effectively. The Terms of Reference were reviewed and updated during the year in line with the Healthcare Financial Management Association NHS Audit Committee Handbook. It oversees the establishment and maintenance of an effective system of governance, risk management and internal control throughout the organisation.

The Committee is chaired by a Non-Executive Director and all members of the Committee are independent Non-Executive Directors. The Committee agrees the annual plans for internal and external audit and reviews the work and findings of internal audit and external audit and provides a conduit through 2025/26 was undertaken by BDO LLP who produce an annual internal audit plan, produced in discussion with the Trust to enable high level scrutiny of the effectiveness of the processes and procedures that the Trust has in place. The Committee also maintains oversight of the Trust's counter fraud arrangements.

The Quality Committee is chaired by a Non-Executive Director. The Committee meets bi-monthly and receives reports related to quality governance arrangements underpinning the planning and delivery of care and the management of clinical risks and risks relating to the delivery of the Trust’s strategic objectives addressing the quality of services. This included monitoring ongoing compliance with the CQC’s fundamental standards for quality and safety and clinical outcomes and effectiveness.

Clinical audit is primarily a quality improvement tool but is also used to provide assurance of compliance with best practice standards and contractual requirements. The Trust’s clinical audit plan is built on the rolling programme of audits already in place and incorporated all statutory and mandatory requirements for clinical audit.

During this year, NHS England developed the ‘Provider Capability Assessment’ which underpins the NHS Oversight Framework (NOF). This is intended to both strengthen board assurance and help regional oversight teams take a view of boards’ grip and awareness of the challenges their organisations face and their track record of addressing them. NHS

England's view of a trust's capability will, alongside each trust's NOF segment, inform their relationship with the organisation and inform any necessary support actions.

As part of the process the Trust had to first self-assess against a set of criteria across six domains:

- Strategy, leadership and planning;
- Quality of care;
- People and culture;
- Access and delivery of services;
- Productivity and value for money;
- Financial performance and oversight.

Following the assessment process, Dorset County Hospital NHS Foundation Trust was allocated an overall capability rating of 'Amber/Green' for 2025/26. This matched the self-assessment undertaken by the Trust prior to submission.

Based upon these inspections, reviews, and the opinions issued by our auditors on the system of internal control, I can confirm that the arrangements the Trust has in place for the discharge of statutory functions are effective.

Conclusion
The Trust has experienced a number of challenges during the year, with the required focus, the most significant of which was the financial position.

No significant internal control issues have been identified for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Matthew Bryant
Chief Executive
23 June 2026

The Accountability Report was approved by the Board of Directors on 22 June 2026 and signed on its behalf by Matthew Bryant, Chief Executive.

Matthew Bryant
Chief Executive
23 June 2026

Independent Auditor's Report to the Council of Governors of Dorset County Hospital NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Dorset County Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2026 which comprise the Group and Trust Statements of Comprehensive Income, Group and Trust Statements of Financial Position, Group and Trust Statements of Changes in Taxpayers' Equity and Group and Trust Statements of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Group and the Trust as at 31 March 2026 and of the Group's and the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2026 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Group and the Trust's services or dissolve the Group and the Trust without the transfer of their services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Group and the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Group's and the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Group and the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud
To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Group's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Group's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve financial performance targets delegated to the Trust by NHS England
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the Group's accounting policies

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls in particular the risk that Group management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the mainly block nature of the funding provided to the Group and the Trust during the year. We therefore assessed that there was limited opportunity for the Group and the Trust to manipulate the income that was reported**.**

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to completeness of expenditure around year end, in response to possible pressures to meet financial performance targets.

We performed procedures including:

- Identifying journal entries to test at the Group level based on risk criteria and comparing the identified entries to supporting documentation. These included those posted by senior finance management, those posted to unusual accounts, and journal entries with unusual characteristics compared to the total journal population.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- inspecting a sample of payments made in the period around 31 March 2026, to determine whether expenditure had been recognised in the correct accounting period and whether accruals were complete.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations
We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer and other management (as required by auditing standards), and from inspection of the Group's and the Trust's regulatory and legal correspondence and discussed with the Accounting Officer and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Group is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Group is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the nature of the Group's and the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation
Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report
The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports
In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26.

Accounting Officer's responsibilities
As explained more fully in the statement set out on page 92, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Group and the Trust or dissolve the Group and the Trust without the transfer of their services to another public sector entity.

The Audit Committee is responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources
Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources
As explained more fully in the statement set out on page 92, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and

related statutory guidance, having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters
We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES
This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT
As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO’s audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Dorset County Hospital NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.

Duncan Laird
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE
24 June 2026

Foreword to the Accounts

Dorset County Hospital NHS Foundation Trust

These accounts, for the year ended 31 March 2026 have been prepared by Dorset County Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Matthew Bryant
Chief Executive
23 June 2026

Statement of Comprehensive Income for the year ended 31 March 2026

		Group		Trust	
		2025/26	2024/25	**2025/26**	2024/25
	Note	**£000**	£000	**£000**	£000
Operating income from patient care activities	3	321,703	319,740	321,703	319,740
Other operating income	4	25,943	33,548	26,069	33,636
Operating expenses	6	(360,924)	(335,581)	(361,114)	(335,782)
Operating (Deficit)/Surplus		**(13,278)**	**17,707**	**(13,342)**	**17,594**
Finance costs:					
Finance income	10	1,419	874	1,400	856
Finance expenses	11	(750)	(755)	(750)	(755)
PDC dividends charge		(4,448)	(4,829)	(4,448)	(4,829)
Net finance costs		**(3,779)**	**(4,710)**	**(3,798)**	**(4,728)**
Gains on disposal of assets	12	2,919	20	2,919	20
Corporation tax expense		(16)	(31)	-	-
(Deficit)/Surplus for the year		**(14,154)**	**12,986**	**(14,221)**	**12,886**
Other comprehensive income will not be reclassified to income and expenditure:					
Impairment of property, plant & equipment		(6,043)	(1,447)	(6,043)	(1,447)
Revaluation gains on property, plant & equipment		3	109	3	109
Total comprehensive (expense)/income for the year		**(20,194)**	**11,648**	**(20,261)**	**11,548**

The notes on pages 121 to 160 form part of these accounts.

Statement of Financial Position as at 31 March 2026

		Group		Trust	
		31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	Note	**£000**	£000	**£000**	£000
Non-current assets					
Intangible assets	14	25,383	17,158	25,383	17,158
Property, plant and equipment	15.4	188,868	168,587	188,768	168,587
Right of use assets	16	19,434	20,167	19,434	20,167
Trade and other receivables	18.1	931	591	931	591
Total non-current assets		**234,616**	**206,503**	**234,516**	**206,503**
Current assets					
Inventories	17	6,316	5,090	5,830	4,810
Trade and other receivables	18.1	20,973	21,491	20,838	21,387
Non-current assets held for sale	34	-	-	-	-
Cash and cash equivalents	19	27,464	25,165	26,742	24,410
Total current assets		**54,753**	**51,746**	**53,410**	**50,607**
Current liabilities					
Trade and other payables	20	(46,801)	(34,209)	(46,051)	(33,696)
Borrowings	21	(2,186)	(6,676)	(2,186)	(6,676)
Provisions	22	(45)	(51)	(45)	(51)
Other liabilities	23	(2,238)	(1,669)	(2,238)	(1,669)
Total current liabilities		**(51,270)**	**(42,605)**	**(50,520)**	**(42,092)**
Total assets less current liabilities		**238,099**	**215,644**	**237,406**	**215,018**
Non-current liabilities					
Borrowings	21	(28,618)	(25,496)	(28,618)	(25,496)
Provisions	22	(186)	(249)	(186)	(249)
Total non-current liabilities		**(28,804)**	**(25,745)**	**(28,804)**	**(25,745)**
Total assets employed		**209,295**	**189,899**	**208,602**	**189,273**
Financed by taxpayers' equity:					
Public dividend capital		206,946	167,356	206,946	167,356
Revaluation reserve		39,774	48,189	39,774	48,189
Income and expenditure reserve		(37,425)	(25,646)	(38,118)	(26,272)
Total taxpayers' equity:		**209,295**	**189,899**	**208,602**	**189,273**

The financial statements on pages 116 to 160 were approved by the Board on 22 June 2026 and signed on its behalf by:

Matthew Bryant
Chief Executive
23 June 2026

Statement of Changes in Taxpayers' Equity

Group	Total £000	Public Dividend Capital (PDC) £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers' equity at 1 April 2025	**189,899**	**167,356**	**48,189**	**(25,646)**
Deficit for the year	**(14,154)**	-	-	(14,154)
Net impairments on property, plant and equipment	**(6,043)**	-	(6,043)	-
Revaluations on property, plant and equipment	**-**	-	-	-
Revaluations on right of use assets	**3**	-	3	-
Transfer to retained earnings on disposal of assets	**-**	-	(2,375)	2,375
Public Dividend Capital received	**39,590**	39,590	-	-
Taxpayers' equity at 31 March 2026	**209,295**	**206,946**	**39,774**	**(37,425)**
Taxpayers' equity at 1 April 2024	**164,873**	153,978	49,546	(38,651)
Surplus for the year	**12,986**	-	-	12,986
Net impairments on property, plant and equipment	**(1,447)**	-	(1,447)	-
Revaluations on property, plant and equipment	**103**	-	103	-
Revaluations on right of use assets	**6**		6	
Transfer to retained earnings on disposal of assets	**-**	-	(19)	19
Public Dividend Capital	**13,378**	13,378	-	-
Taxpayers' equity at 31 March 2025	**189,899**	**167,356**	**48,189**	**(25,646)**

Trust	Total £000	Public Dividend Capital (PDC) £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers' equity at 1 April 2025	**189,273**	**167,356**	**48,189**	**(26,272)**
Deficit for the year	**(14,221)**	-	-	(14,221)
Net impairments on property, plant and equipment	**(6,043)**	-	(6,043)	-
Revaluations on property, plant and equipment	**-**	-	-	-
Revaluations on right of use assets	**3**	-	3	-
Transfer to retained earnings on disposal of assets	**-**	-	(2,375)	2,375
Public Dividend Capital	**39,590**	39,590	-	-
Taxpayers' equity at 31 March 2026	**208,602**	**206,946**	**39,774**	**(38,118)**
Taxpayers' equity at 1 April 2024	**164,347**	153,978	49,546	(39,177)
Surplus for the year	**12,886**	-	-	12,886
Net impairments on property, plant and equipment	**(1,447)**	-	(1,447)	-
Revaluations on property, plant and equipment	**103**	-	103	-
Revaluations on right of use assets	**6**	-	6	-
Transfer to retained earnings on disposal of assets	**-**	-	(19)	19
Public Dividend Capital	**13,378**	13,378	-	-
Taxpayers' equity at 31 March 2025	**189,273**	**167,356**	**48,189**	**(26,272)**

The Revaluation Reserve consists of £39,761k (£48,175k at 31 March 2025) relating to property, plant and equipment and £13k (£14k at 31 March 2025) relating to right of use assets.

Information on reserves

Public Dividend Capital
Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the Public Dividend Capital dividend.

Revaluation Reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and Expenditure Reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows for the year ended 31 March 2026

	Group		Trust	
	2025/26	2024/25	**2025/26**	2024/25
	£000	£000	**£000**	£000
Cash flows from operating activities				
Operating (deficit) / surplus	(13,278)	17,707	(13,342)	17,594
Non-cash income and expenses				
Depreciation and amortisation	14,209	12,418	14,204	12,418
Impairments and reversals	4,467	22	4,467	22
Income recognised in respect of capital donations (cash and non-cash)	(511)	(473)	(511)	(473)
Decrease / (Increase) in trade and other receivables	298	(160)	330	(79)
Increase in inventories	(1,226)	(1,312)	(1,020)	(1,265)
Increase in trade and other payables	5,996	3,709	5,743	3,117
Increase / (Decrease) in other liabilities	569	(338)	569	(338)
(Decrease) / Increase in provisions	(71)	21	(71)	21
Corporation tax paid	(31)	(35)	-	-
Net cash generated from operations	**10,422**	**31,559**	**10,369**	**31,017**
Cash flows from investing activities				
Interest received	1,373	836	1,354	819
Purchase of intangible assets	(11,970)	(3,652)	(11,970)	(3,652)
Purchase of property, plant and equipment	(36,043)	(19,231)	(35,938)	(19,231)
Sales of property, plant and equipment	5,976	7	5,976	7
Receipt of cash donations to purchase capital assets	511	473	511	473
Net cash used in investing activities	**(40,153)**	**(21,567)**	**(40,067)**	**(21,584)**
Cash flows from financing activities				
Public Dividend Capital received	39,590	13,378	39,590	13,378
Movement in loans from Department of Health	(219)	-	(219)	-
Capital element of lease liability repayments	(1,950)	(1,498)	(1,950)	(1,498)
Interest paid	(97)	(97)	(97)	(97)
Other interest	(1)	(1)	(1)	(1)
Interest element of lease liability repayments	(771)	(589)	(771)	(589)
PDC Dividend paid	(4,522)	(4,825)	(4,522)	(4,825)
Net cash used in financing activities	**32,030**	**6,368**	**32,030**	**6,368**
Increase in cash and cash equivalents	**2,299**	**16,360**	**2,332**	**15,801**
Cash and cash equivalents at 1 April	25,165	8,805	24,410	8,609
Cash and cash equivalents at 31 March	**27,464**	**25,165**	**26,742**	**24,410**

Notes to the Financial Statements

1 Accounting policies and other information

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the DHSC GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below.

These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting Convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1 Critical accounting judgements and key sources of estimation uncertainty

In the preparation of the financial statements, the Trust is required to make estimates and assumptions that affect the application of accounting policies and the carrying amounts of assets and liabilities. These estimates and assumptions are based on historical experience and other factors that are considered to be relevant. Actual outcomes may differ from prior estimates and the estimates and underlying assumptions are continually reviewed.

The key sources of estimation uncertainty which have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities are:

Valuation of land and buildings
Land and buildings are included in the Trust's statement of financial position at current value in existing use. The assessment of current value represents a key source of uncertainty. The Trust uses an external professional valuer to determine current value in existing use, using modern equivalent asset value methodology and market value for existing use for non-specialised buildings.

Of the £123.0 million net book value of land and buildings subject to valuation, £112.7 million relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced.

It is possible that the inflation will affect the Trust's future assessment of what would be required in a modern equivalent asset, but as yet there is insufficient information to indicate what the impact of this will be.

Depreciation of property, plant and equipment and amortisation of computer software
The Trust exercises judgement to determine the useful lives and residual values of property, plant and equipment and computer software. Depreciation and amortisation is provided so as to write down the value of these assets to their residual value over their estimated useful lives.

1.2 Consolidation

1.2.1 Subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves of the subsidiary are included as a separate item in the Statement of Financial Position.

DCH appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust (including where they report under UK FRS 102) or where the subsidiary's accounting

date is not coterminous. The amounts consolidated are drawn from the financial statements of DCH SubCo Ltd. Intra-entity balances, transactions and gains/losses are eliminated in full on consolidation.

The Trust wholly owns DCH SubCo Ltd which forms part of the consolidated accounts. DCH SubCo Ltd provides outpatient pharmacy services. Its turnover for the period ended 31st March 2026 was £6.1m and its gross assets at 31 March 2026 totalled £1.6m.

The Trust has established that, as it is the corporate trustee of Dorset County Hospital NHS Foundation Trust Charitable Fund, it effectively has the power to exercise control of this charity so as to obtain economic benefits. However the assets, liabilities and transactions are immaterial in the context of the Trust and therefore it has not been consolidated. Details of balances and transactions between the Trust and the charity are included in the related parties' notes.

1.2.2 Joint Ventures

Arrangements over which the Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

The Trust has one joint venture DCH Estates Partnership LLP OC418519, which is a commercial partnership with Partnering Solutions (Dorset) Ltd (Interserve Prime) creating a Strategic Estates Partnership. No assets or transactions have taken place during 2025/26.

1.3 Income

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The DHSC GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or service is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare in the form of fixed payments to fund an agreed level of activity.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual

usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure, it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.4 Expenditure on employee benefits

1.4.1 Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.4.2 Pension costs

Payments to defined contribution pension schemes (including defined benefit schemes that are accounted for as if they were a defined contribution scheme) are recognised as an expense as they fall due.

NHS Pension Scheme:

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employer, GP practices and other

bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the employer's pension contributions payable to that scheme for the accounting period.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill health. The full amount of the liability for the additional costs are charged to operating expenses at the time the Trust commits itself to the retirement regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

The Foundation Trust does not have any employees that are members of the Local Government Superannuation Scheme and therefore, does not pay employer contributions into this scheme.

1.4.3 Termination Benefits

Staff termination benefits are provided for in full when there is a detailed formal termination plan and there is no realistic possibility of withdrawal by either party.

The Trust ran a Mutually Agreed Resignation Scheme (MARS) during 2025/26 and 20/25. The MARS payment is fixed at ½ month's salary for each full year of reckonable service up to a cap of 12 month's salary. Furthermore, there is a minimum payment of 3 month's salary for 1 – 5 years reckonable service and a salary cap of £80,000 for high earners (pro-rata for part time staff).

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised to the extent that they have been received and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except when it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Property, plant and equipment

1.6.1 Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- individually it cost at least £5,000; or
- collectively has a cost of at least £5,000 and individually a cost of more than £250;
- the assets are functionally interdependent, with broadly simultaneous purchase dates, which are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building includes a number of components with significantly different asset lives, e.g. hospital wings, then these components are treated as separate assets and depreciated over their own useful economic lives (UEL).

The component parts of each significant Trust building are depreciated as a group, as permitted by IAS 16, unless a component has a significantly different UEL and is deemed by the Trust to be significant, in which case it is depreciated separately over its own economic useful life.

1.6.2 Measurement

Valuation: All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.
Fair values are determined as follows:

- Non-specialised buildings – market value for existing use
- land and specialised buildings – Modern equivalent asset value

All land and buildings are revalued using professional valuations in accordance with accounting standard IAS 16 Property, Plant and Equipment every five years. A three-year interim valuation is also carried out. Additional valuations are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period.

Professional valuations are carried out by the Trust's external valuer (Avison Young). The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23 borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

Until 31st March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. Indexation ceased from 1st April 2008. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An item of property, plant and equipment, which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5. The last full valuation survey was assessed by the valuer of Avison Young at 31 March 2024 with a Desktop Valuation 31 March 2026.

<u>The Key factors impacting on the land and property valuation</u>
The valuation involves estimation techniques and in arriving at their opinion of the useful economic life and value of a building, the Trust's property valuation takes into account the following aspects:

- Physical obsolescence - the age, condition and the probable costs of future maintenance.
- Functional obsolescence - the suitability of the properties for their present use and the prospect of continuance or use for an alternative purpose. Another potential cause of functional obsolescence is legislative change, for example, statutory and regulatory compliance, including compliance with sustainability and energy legislation.
- Economic obsolescence - the extent of any loss in value resulting from external economic factors.
- Environmental Factors **-** where the existing use has been considered in relation to the present and future characteristics of the surrounding area, local and national planning policies and restrictions likely to be imposed by the planning authority on the continuation of the use.
- Change of use - any identified present of future change of use of a building.

The valuation has been prepared in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the HMT Treasury Financial Reporting Manual (FReM), compliant DHSC Group Accounting Manual (GAM), and to comply with IFRS, specifically with regard to IAS 16 'Property, Plant and Equipment'.

The valuer's opinion of Fair Value was primarily derived using the Depreciated Replacement Cost (DRC) approach to value the specialised operational assets, and for non-specialised assets an Existing Use Value (EUV) basis as defined in the RICS Valuation – Professional Standards at UK VPGA 6.

Where assets are "specialised" the DRC for the Modern Equivalent Asset (MEA) methodology has been employed. An MEA has been determined based upon a single build programme on a cleared site to modern design and arrangement/adjacencies. The valuer has applied information provided by the Trust during consultation as to how a new MEA might be designed. Moreover, the valuer has analysed similar modern facilities presently being developed, where site densities, building arrangement, number of stories and bed provision can be analysed and adjusted as appropriate to the subject Trust.

In arriving at the replacement build cost rates used in the DRC valuations, the Valuer relies on BCIS and other published costs data supplemented where available by knowledge of recent build costs incurred by the Trust of constructing general and specialised healthcare accommodation. The indices are shown in the table below:

Indices	BCIS (TPI)	Location Factor
2023/24	390	106
2025/26	410	101
National Factor	1051	
Local Factor		0.953
Combined Factor		1.002

Floor areas
The Trust uses a MICAD database/repository for its estate data, including plans and floor areas. The system is updated on an ongoing basis to reflect new build and disposals and other updates reflecting remeasurement to maintain data quality. Floor areas are supplied by the Trust to the valuer to inform the valuation. Differences between the floor areas held by the Trust and the valuer are investigated and resolved to a de minimums of no impact on the value.

Land Values
Land has been assessed to Current Value, interpreted as EUV, having regard to the cost of purchasing a notional replacement site in the same locality, equally suitable for the existing use and of the same size, with normally the same physical and locational characteristics as the actual site, other than characteristics of the actual site that are irrelevant, or of no value, to the existing use. Where the use is too specialised to categorise in market terms, the land has been valued assuming the benefit of planning permission for development for a use, or a range of uses, prevailing in the vicinity of the actual site.

Sensitivity of Assumptions
A sensitivity analysis of these assumptions allows the Trust to understand the impact on materiality, given the estimation uncertainty implicit in the valuation. The table below setting out at a high level the sensitivity of the valuation of the main hospital site to movements in each of these key assumptions, using a 5% tolerance. 31 March 2024 balances have been used as the baseline to derive these values, as the valuation indices were applied to these balances in arriving at the 31 March 2026 valuation.

	Build Cost Index	Obsole-scence Factor	Land Value /Acre
Baseline Adjustment Factor	1.051	(1.015)	1.00
Assumption value (£m)	2.3	(12.7)	0
Sensitivity (+5%) (£m)	5.0	0.6	0.2
Sensitivity (-5%) (£m)	(5.0)	(0.6)	(0.2)

Revaluation gains and losses: Revaluation gains are recognised in the revaluation reserve, except where; and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenses.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned; and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of other comprehensive income.

Impairments: In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits, or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) impairment charged to operating expenses; (ii) the balance in the revaluation reserve attributable to that asset before impairment.

An impairment that arises from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenses to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is

transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

1.6.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that the future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.7 Intangible assets

1.7.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; and where the cost of the asset can be measured reliably.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

Expenditure on development is capitalised only where all of the following have been demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset is identified;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

1.7.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the definitions of IAS 40 Investment Properties or IFRS 5 Assets Held for Sale.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

1.8 Depreciation and amortisation

Freehold land is considered to have an infinite life and is not depreciated. Properties under construction are not depreciated until brought into use.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

The following table details the useful economic lives currently used for the main classes of assets:

Asset class	Min Life Years	Max Life Years
Buildings exc. dwellings	4	84
Plant & machinery	3	15
Information technology	3	15
Furniture & fittings	5	10
Intangible assets	3	15

Property, plant and equipment which have been re-classified as 'held for sale' cease to be depreciated upon the re-classification.

Right-of-use assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

1.9 Donated assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.10 De-recognition

Assets intended for disposal are reclassified as 'Held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for

recognition as 'Held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

1.11.1 Trust as lessee

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

1.11.2 Trust as lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic

rate of return on the Trust's net investment outstanding in respect of the leases.

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.12 Inventories

Inventories are valued at the lower of cost and net realisable value using the 'first-in first-out' formula. These are considered to be a reasonable approximation to fair value due to the high turnover of stocks.

The Trust receives inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.13 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of that amount. The amount recognised in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

Term	Years	Nominal rate	Prior year rate
Short	Up to 5	3.64%	4.03%
Medium	After 5 up to 10	4.22%	4.07%
Long	After 10 up to 40	5.32%	4.81%
Very long	Exceeding 40	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.50%	2.60%
Year 2	2.00%	2.30%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 2.95% in real terms (prior year: 2.40%).

1.15 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 22.2 but is not recognised in the Trust's accounts.

1.16 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk-pooling schemes under which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of any claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular

claims are charged to operating expenses as and when the liability arises.

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, these are disclosed where an inflow of economic benefits is probable. The Trust currently has no contingent assets to disclose.

Contingent liabilities are not recognised, but are disclosed in note 25 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public dividend capital

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services (GBS) 111 and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) approved expenditure on current year COVID-19 capital assets, (iv) assets under construction for nationally directed schemes and (v) any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing net relevant assets.

In accordance with the requirement laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.19 Financial assets and financial liabilities

1.19.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The DHSC GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

1.19.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and financial liabilities are classified as subsequently measured at amortised cost.

1.19.3 Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

1.19.4 Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.19.5 De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.20 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Corporation Tax

Section 148 of the Finance Act in 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of Foundation Trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year. In determining whether or not an activity is likely to be taxable a three-stage test may be employed:

- The provision of goods and services for purposes related to the provision of healthcare authorised under section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt;
- Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax;
- Only significant trading is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

The majority of the Trusts activities are related to core healthcare and are not subject to tax.

Private patient activities are covered by section 14(1) of the Health and Social Care (Community Health and Standards) Act 2003 and not treated as a commercial activity and are therefore tax exempt; and
Other trading activities (including car parking and staff canteens) are ancillary to the core activities and are not deemed to be entrepreneurial in nature.

However, the Trust's commercial subsidiary is subject to corporation tax, and this has been included in the group accounts.

1.22 Foreign currencies

The Trust's functional currency and presentational currency is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of transaction.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However they are disclosed in Note 29 to the accounts in accordance with the requirements of the HM Treasury's Financial Reporting Manual.

1.24 IFRS Standards, amendments and interpretations in issue but have not yet been adopted

The DHSC GAM does not require the following standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £123m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for some of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore, the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £112.7m at 31 March 2026. The Trust currently is unable to quantify the impact on its financial statements at this time.

1.25 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with general payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.26 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.27 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.28 Going concern

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

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

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

The Trust has submitted a planned breakeven position for 2026/27 with a closing cash position of £16.6 million.

The Trust has contracts with national and local commissioners for 2026/27 and is planning to deliver services for the going concern period, Board of Directors have made no decision to discontinue any operations, transfer services or significantly restructure the organisation. The regulator (NHS England) have not issued any communications that impact the Trusts going concern requirements.

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

2. Segment analysis

The Trust has considered the requirements in IFRS 8 for segmental analysis. Having reviewed the operating segments reported internally to the Board, the Trust is satisfied that it is appropriate to aggregate these as, in accordance with IFRS 8: Operating Segments, they are similar in each of the following respects:

- The nature of the products and services;
- The nature of the production processes;
- The type of customer for their products and services;
- The methods used to distribute their products or provide their services; and
- The nature of the regulatory environment.

The Trust therefore has just one segment, "healthcare". Analysis of income by different activity types and sources is provided in note 3.

3. Income from patient care activities

3.1 Analysis by activity

	Group		Trust	
	Year ended 31 March 2026	Year ended 31 March 2025	**Year ended 31 March 2026**	Year ended 31 March 2025
	£000	£000	**£000**	£000
Aligned payment & incentive (API) income - Variable*	75,609	60,580	75,609	60,580
Aligned payment & incentive (API) income - Fixed*	206,179	227,603	206,179	227,603
High costs drugs income from commissioners	20,701	12,516	20,701	12,516
Other NHS clinical income	4,041	3,941	4,041	3,941
Private patient income	1,096	1,299	1,096	1,299
Additional pension contribution central funding**	13,477	12,905	13,477	12,905
Other clinical income	600	896	600	896
Total	**321,703**	319,740	**321,703**	319,740
Income commissioner requested services	320,007	317,545	320,007	317,545
Income non-commissioner requested services	1,696	2,195	1,696	2,195
Total	**321,703**	319,740	**321,703**	319,740

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the NHS Payment system documentation. https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**The employer contribution rate for NHS pensions increased from 20.6% to 23.7% (excluding administration charge) from 1 April 2024. Since 2019/20, NHS providers continued to pay over contributions at the rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Commissioner-requested services are services which local commissioners believe should continue to be provided locally if any individual provider is at risk of failing financially. Any organisation providing a commissioner-requested service must continue offering the service unless it can obtain agreement from NHS Improvement and the commissioners to stop. It cannot dispose of relevant assets used to provide the service without NHS Improvement consent and it must pay into a risk pool that will fund services in the event of financial failure.

3.2 Analysis by source	Group		Trust	
	Year ended 31 March 2026	Year ended 31 March 2025	**Year ended 31 March 2026**	Year ended 31 March 2025
	£000	£000	**£000**	£000
NHS - Foundation Trusts	412	395	412	395
NHS - NHS England	29,906	53,625	29,906	53,625
NHS - ICBs	289,506	264,118	289,506	264,118
NHS - other	145	69	145	69
Local authorities	38	-	38	-
Department of Health and Social Care	2	-	2	-
Non NHS - private patients	1,096	1,299	1,096	1,299
Non NHS - overseas patients	25	11	25	11
NHS Injury Scheme	548	199	548	199
Non NHS - other	25	24	25	24
Total	**321,703**	319,740	**321,703**	319,740

NHS Injury Scheme income relating to the 2025/26 financial year is subject to a provision for doubtful debts of 24.62% (2024/25: 24.45%) to reflect expected rates of collection.

The Group and Trust overseas patient income for the year amounted to £25k (2024/25 £11k). Cash received amounted to £8k (2024/25 £4k) in respect of current and previous years' income.

The amounts written off in respect of current and prior years amounted to £nil (2024/25 £nil).

4. Other operating income

	Note	Group Year ended 31 March 2026 £000	Group Year ended 31 March 2025 £000	Trust Year ended 31 March 2026 £000	Trust Year ended 31 March 2025 £000
Research and development		1,416	1,190	1,416	1,190
Education and training		9,042	9,189	9,042	9,189
Education and training - notional income from apprenticeship fund		934	856	934	856
Received from NHS Charities: Cash donations		511	473	511	473
Received from NHS Charities: Contributions to expenditure		84	111	84	111
Non-patient care services to other bodies		10,532	18,199	10,658	18,279
Staff recharges		508	468	508	468
Operating leases - Minimum lease receipts	5	107	105	107	113
Car parking		863	435	863	435
Catering		801	737	801	737
Pharmacy sales		161	83	161	83
Staff accommodation rentals		687	730	687	730
Non-clinical services recharged to other bodies		4	9	4	9
Clinical excellence awards		35	83	35	83
Other income generation schemes		94	77	94	77
Other income		164	803	164	803
Total		**25,943**	33,548	**26,069**	33,636

5. Operating lease income and future receipts

Lease receipts recognised as income in year:	Group Year ended 31 March 2026 £000	Group Year ended 31 March 2025 £000	Trust Year ended 31 March 2026 £000	Trust Year ended 31 March 2025 £000
Minimum lease receipts	107	105	107	113
Total minimum lease payments	**107**	105	**107**	113
Of which:				
Income generated from owned assets	**107**	105	**107**	113
Future minimum lease receipts due:				
Not later than one year	80	105	80	113
Later than one year and not later than five years	-	105	-	113
Total	**80**	210	**80**	226

6. Operating expenses

	Note	Group Year ended 31 March 2026 £000	Group Year ended 31 March 2025 £000	Trust Year ended 31 March 2026 £000	Trust Year ended 31 March 2025 £000
Employee expenses	7.1	234,744	220,171	234,610	220,081
Employee expenses - Non-executive directors		145	151	145	151
Purchase of healthcare from NHS and DHSC bodies		8,668	8,645	8,668	8,645
Purchase of healthcare from non-NHS and non-DHSC bodies		12,449	11,671	18,616	17,493
Supplies and services - clinical (excluding drug costs)		25,652	24,322	25,652	24,322
Supplies and services - general		3,037	3,040	3,037	3,040
Drug costs		29,374	28,325	23,560	22,811
Inventories written down (net, incl. drugs)		240	65	236	64
Consultancy costs		82	61	74	55
Establishment		2,039	1,786	2,039	1,786
Premises - Business rates payable to Local Authorities		1,711	1,515	1,711	1,515
Premises - Other		10,728	10,504	10,728	10,504
Transport (business travel only)		427	453	427	453
Transport (other)		389	417	389	417
Depreciation on property, plant and equipment		11,163	11,295	11,158	11,295
Amortisation on intangible assets		3,046	1,123	3,046	1,123
Impairments net of (reversals)	13	4,467	22	4,467	22
Movement in credit loss allowance		17	(6)	17	(6)
Change in provisions discount rate		(2)	-	(2)	-
External audit - statutory audit services*		151	146	145	140
Internal audit costs - (not included in employee expenses)		115	115	115	115
Clinical negligence - NHS Resolution (premium)		7,397	7,195	7,397	7,195
Legal fees		122	77	122	77
Insurance		133	138	131	138
Research and development		24	61	24	61
Training courses and conferences		714	629	714	629
Education and training - notional expenditure funded from apprenticeship fund		934	856	934	856
Lease - short term lease (<= 12 months)		21	19	21	19
Car parking and security		439	888	439	888
Losses, ex gratia & special payments		7	2	7	2
Other services		1,388	1,106	1,388	1,106
Other		1,103	789	1,099	785
Total		**360,924**	335,581	**361,114**	335,782

*no other remuneration was paid to the auditor, except for the amounts disclosed above

7. Employee expenses and numbers

7.1 Employee expenses

	Group		Trust	
	Year ended 31 March 2026	Year ended 31 March 2025	**Year ended 31 March 2026**	Year ended 31 March 2025
	£000	£000	**£000**	£000
Staff & executive directors	231,742	217,322	231,608	217,232
Research and development staff	1,144	1018	1,144	1018
Education and training staff	1,781	1,574	1,781	1,574
Redundancy	60	242	60	242
Early retirements	17	15	17	15
	234,744	220,171	**234,610**	220,081
Salaries and wages	175,263	166,121	175,146	166,043
Social security costs	22,238	17,272	22,223	17,263
Apprenticeship levy	870	839	870	839
Employer contributions to NHS Pension scheme	20,648	19,731	20,648	19,731
Employer contributions paid by NHSE on provider's behalf (25/26 9.4%, 24/25 9.4%)	13,477	12,905	13,477	12,905
Pension cost - other	24	33	22	30
Agency and contract staff	5,749	6,459	5,749	6,459
Termination benefits	322	478	322	478
Less: Staff costs capitalised as part of assets	(3,847)	(3,667)	(3,847)	(3,667)
Employee benefits expense	**234,744**	220,171	**234,610**	220,081

Salaries and wages include the cost of amounts accrued in respect of holiday earned by employees due to their service, but not taken, as required under IAS 19.

The amount of Employer's pension contributions payable in the year ended 31 March 2026 was £34,149k (2024/25: £32,669k), £13,477k (2024/25: £12,905k) of this figure is paid by NHSE on behalf of the Trust. Of this total, an amount of £1,713k (2024/25: £1,611k) was unpaid at the reporting date.

7.2 Retirement benefits

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

8. Retirements due to ill-health

During 2025/26 there were 3 cases (2024/25: 3 cases) of early retirement from the Trust agreed on grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £148k (2024/25: £519k). The cost of ill-health retirements is borne by the NHS Business Services Authority – Pensions Division. This information has been supplied by NHS Pensions.

9. Salary and pension entitlement of directors and senior managers

9.1 Directors remuneration

	Group		Trust	
	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000	**Year ended 31 March 2026 £000**	Year ended 31 March 2025 £000
Directors remuneration - Salaries and wages	965	1,044	965	1,044
Employers pension contributions in respect of directors	130	127	130	127
Less: amounts in respect of Director Recharges Salary*	(105)	(167)	(105)	(167)
Less: amounts in respect of Director Recharges Pension*	(15)	(24)	(15)	(24)
	975	980	**975**	980
	Number	Number	**Number**	Number
The total number of directors to whom retirement benefits were accruing under:				
Defined benefit schemes	**8**	9	**8**	9

*The amounts in respect of Director Recharge Salary and Pensions relates to the share of Director costs of the Joint Board between Dorset County Hospital NHS FT and Dorset Healthcare University NHS FT which commenced during 2023.

Detailed disclosures of the remuneration and pension entitlements of each director are set out on pages 49 to 63 of the Remuneration Report.

10. Finance income

	Group		Trust	
	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000	**Year ended 31 March 2026 £000**	Year ended 31 March 2025 £000
Interest on bank accounts	1,419	874	1,400	856
Total	**1,419**	874	**1,400**	856

11. Finance expenses

	Group		Trust	
	Year ended 31 March 2026 £000	Year ended 31 March 2025 £000	**Year ended 31 March 2026 £000**	Year ended 31 March 2025 £000
Loans from the Department of Health	97	97	97	97
Interest on lease obligations	650	655	650	655
Interest on the late payment of commercial	1	1	1	1
Total interest expense	748	753	748	753
Unwinding of discount on provisions	2	2	2	2
Total finance expenses	**750**	755	**750**	755

The Trust incurred interest and compensation charges of £760 during 2025/26 (2024/25 £879) under the Late Payment of Commercial Debt (Interest) Act 1998.

12. Gains/(losses) on disposals

	Group		Trust	
	Year ended 31 March 2026	Year ended 31 March 2025	**Year ended 31 March 2026**	Year ended 31 March 2025
	£000	£000	**£000**	£000
Gains on disposal of other property, plant and equipment	7	6	7	6
Gains on disposal of right of use assets	-	16	-	16
Gains on disposal of assets held for sale	2,934	-	2,934	-
Losses on disposal of other property, plant and equipment	(22)	(2)	(22)	(2)
Total gains on disposal of assets	**2,919**	20	**2,919**	20

13. Impairment of non-current assets

	Group		Trust	
	Year ended 31 March 2026	Year ended 31 March 2025	**Year ended 31 March 2026**	Year ended 31 March 2025
Impairment	**£000**	£000	**£000**	£000
Other	-	-	-	-
Changes in market price*	10,736	1,886	10,736	1,886
Reversal of impairments*	(226)	(417)	(226)	(417)
Total impairments	**10,510**	1,469	**10,510**	1,469

* Resulting from the revaluation of land and buildings as at 31 March 2026.

Total impairments have been charged/(credited) to the following lines in the Statement of Comprehensive Income.

	Group		Trust	
	Year ended 31 March 2026	Year ended 31 March 2025	**Year ended 31 March 2026**	Year ended 31 March 2025
	£000	£000	**£000**	£000
Operating expenses	4,467	22	4,467	22
Revaluation reserve	6,043	1,447	6,043	1,447
	10,510	1,469	**10,510**	1,469

14. Intangible assets

14.1 Intangible assets - 2025/26

Group and Trust	Software licences £000	Asset under construction £000	Total £000
Cost or valuation at 1 April 2025	**14,357**	**10,740**	**25,097**
Additions - purchased	3,649	7,622	11,271
Reclassifications	4,741	(4,741)	-
Disposals	(13)	-	(13)
Cost or valuation at 31 March 2026	**22,734**	**13,621**	**36,355**
Amortisation at 1 April 2025	**7,939**	**-**	**7,939**
Provided in the year	3,046	-	3,046
Impairments charged to operating expenses	-	-	-
Disposals	(13)	-	(13)
Amortisation at 31 March 2026	**10,972**	**0**	**10,972**
Net book value 31 March 2026	**11,762**	**13,621**	**25,383**
Net book value total at 1 April 2025	**6,418**	**10,740**	**17,158**

14.2 Intangible assets - 2024/25

Group and Trust	Software licences £000	Asset under construction £000	Total £000
Cost or valuation at 1 April 2024	**13,685**	**9,806**	**23,491**
Additions - purchased	833	1,648	2,481
Reclassifications	714	(714)	-
Disposals	(875)	-	(875)
Cost or valuation at 31 March 2025	**14,357**	**10,740**	**25,097**
Amortisation at 1 April 2024	**7,691**	**-**	**7,691**
Provided in the year	1,123	-	1,123
Impairments charged to operating expenses	-	-	-
Disposals	(875)	-	(875)
Amortisation at 31 March 2025	**7,939**	**0**	**7,939**
Net book value 31 March 2025	**6,418**	**10,740**	**17,158**
Net book value total at 1 April 2024	**5,994**	**9,806**	**15,800**

Software licences have been assigned asset lives of between 3 and 15 years

15. Property, plant and equipment

The Trust's land and buildings were valued by external valuers as at 31 March 2026 on the basis of fair value, as set out in the accounting policy note 1.6.2. The valuation was undertaken by Avison Young.

15.1 Property, plant and equipment, current year 2025/26

Group	Total £000	Land £000	Buildings exc. dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000
Cost or valuation at 1 April 2025	**203,196**	6,663	114,610	5,179	24,114	38,672	13,300	658
Additions - purchased	**42,842**	-	3,027	-	30,536	6,479	2,800	-
Additions - assets purchased from cash donations/grants	**511**	-	478	-	-	33	-	-
Impairments charged to operating expenses	**(261)**	-	(261)	-	-	-	-	-
Impairments charged to revaluation reserve	**(9,663)**	(8)	(9,655)	-	-	-	-	-
Reversal of Impairments credited to operating expenses	**48**	-	48	-	-	-	-	-
Revaluations	**-**	-	-	-	-	-	-	-
Reclassification	**-**	-	2,875	-	(3,018)	-	143	-
Transfers to/from assets held for sale	**(7,478)**	(2,299)	-	(5,179)	-	-	-	-
Disposals/derecognition	**(3,095)**	-	(114)	-	(12)	(2,627)	(58)	(284)
Cost or valuation at 31 March 2026	**226,100**	**4,356**	**111,008**	**-**	**51,620**	**42,557**	**16,185**	**374**
Depreciation at 1 April 2025	**34,609**	-	762	-	12	24,179	9,338	318
Provided in the year	**9,577**	-	4,714	73	-	3,363	1,416	11
Impairments charged to operating expenses	**(134)**	-	(134)	-	-	-	-	-
Impairments charged to revaluation reserve	**(3,643)**	-	(3,643)	-	-	-	-	-
Reversal of Impairments credited to operating expenses	**(31)**	-	(31)	-	-	-	-	-
Revaluations	**-**	-	-	-	-	-	-	-
Transfers to/from assets held for sale	**(73)**	-	-	(73)	-	-	-	-
Disposals/derecognition	**(3,073)**	-	(114)	-	(12)	(2,605)	(58)	(284)
Depreciation at 31 March 2026	**37,232**	**-**	**1,554**	**-**	**-**	**24,937**	**10,696**	**45**

15.2 Property, plant and equipment, current year 2024/25

Group	Total £000	Land £000	Buildings exc. dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000
Cost or valuation at 1 April 2024	**192,213**	6,668	112,730	5,179	15,281	38,028	13,667	660
Additions - purchased	**17,894**	-	4,736	4	11,397	1,446	311	-
Additions - assets purchased from cash donations/grants	**473**	-	-	-	396	77	-	-
Impairments charged to operating expenses	**(24)**	-	(24)	-	-	-	-	-
Impairments charged to revaluation reserve	**(5,118)**	(5)	(5,109)	(4)	-	-	-	-
Reversal of Impairments credited to operating expenses	**(51)**	-	(51)	-	-	-	-	-
Revaluations	**(15)**	-	(15)	-	-	-	-	-
Reclassification	**-**	-	2,344	-	(2,960)	593	23	-
Disposals/derecognition	**(2,176)**	-	(1)	-	-	(1,472)	(701)	(2)
Cost or valuation at 31 March 2025	**203,196**	**6,663**	**114,610**	**5,179**	**24,114**	**38,672**	**13,300**	**658**
Depreciation at 1 April 2024	**31,148**	-	55	-	12	22,377	8,441	263
Provided in the year	**9,594**	-	4,528	140	-	3,271	1,598	57
Impairments charged to operating expenses	**(10)**	-	(10)	-	-	-	-	-
Impairments charged to revaluation reserve	**(3,685)**	-	(3,600)	(85)	-	-	-	-
Reversal of Impairments credited to operating expenses	**(147)**	-	(147)	-	-	-	-	-
Revaluations	**(118)**	-	(63)	(55)	-	-	-	-
Disposals/derecognition	**(2,173)**	-	(1)	-	-	(1,469)	(701)	(2)
Depreciation at 31 March 2025	**34,609**	**-**	**762**	**-**	**12**	**24,179**	**9,338**	**318**

15.3 Property, plant and equipment DCH Subco Ltd

Note 15.1 contains £91k of Buildings, £5k of Information technology and £4k of Plant & machinery assets relating to DCH Subco Ltd (15.2 contains £nil) These are included in the Group position and should be removed to reflect the Trust position.

15.4 Property, plant and equipment financing

	Total	Land	Buildings exc. dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value as at 31 March 2026								
Owned assets	**183,725**	4,356	105,271	-	51,620	16,950	5,489	39
Donated assets	**5,143**	-	4,183	-	-	670	-	290
Total at 31 March 2026	**188,868**	**4,356**	**109,454**	**-**	**51,620**	**17,620**	**5,489**	**329**
Net book value as at 31 March 2025								
Owned assets	**162,650**	6,663	109,514	5,179	23,706	13,577	3,961	50
Donated assets	**5,937**	-	4,334	-	396	916	1	290
Total at 31 March 2025	**168,587**	**6,663**	**113,848**	**5,179**	**24,102**	**14,493**	**3,962**	**340**

16. Right of use assets

16.1 Right of use assets, current year 2025/26

Group and Trust	Total £000	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000
Cost or valuation at 1 April 2025	**21,100**	18,328	1,986	390	396
Additions - lease liability	**-**	-	-	-	-
Remeasurements of the lease liability	**922**	823	-	99	-
Impairments charged to operating expenses	**(848)**	(848)	-	-	-
Impairments charged to the revaluation reserve	**(77)**	(77)	-	-	-
Reversal of impairments credited to operating expenses	**(316)**	(316)	-	-	-
Revaluations	**(10)**	(10)	-	-	-
Disposals/derecognition - lease termination	**-**	-	-	-	-
Cost or valuation at 31 March 2026	**20,771**	**17,900**	**1,986**	**489**	**396**
Depreciation at 1 April 2025	**933**	-	682	181	70
Provided in the year - right of use asset	**1,586**	1,182	215	132	57
Impairments charged to operating expenses	**(652)**	(652)	-	-	-
Impairments charged to the revaluation reserve	**(54)**	(54)	-	-	-
Reversal of impairments credited to operating expenses	**(463)**	(463)	-	-	-
Revaluations	**(13)**	(13)	-	-	-
Disposals/derecognition - lease termination	**-**	-		-	-
Depreciation at 31 March 2026	**1,337**	**-**	**897**	**313**	**127**
Net book value at 31 March 2026	**19,434**	**17,900**	**1,089**	**176**	**269**

16.2 Right of use assets, prior year 2024/25

Group and Trust	Total £000	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Information technology £000
Cost or valuation at 1 April 2024	**21,029**	18,288	1,986	359	396
Additions - lease liability	**667**	546	-	121	-
Remeasurements of the lease liability	**951**	871	-	80	-
Impairments charged to operating expenses	**(708)**	(708)	-	-	-
Impairments charged to the revaluation reserve	**(104)**	(104)	-	-	-
Reversal of impairments credited to operating expenses	**(446)**	(446)	-	-	-
Revaluations	**(63)**	(63)			
Disposals/derecognition - lease termination	**(226)**	(56)	-	(170)	-
Cost or valuation at 31 March 2025	**21,100**	**18,328**	**1,986**	**390**	**396**
Depreciation at 1 April 2024	**645**	-	467	165	13
Provided in the year - right of use asset	**1,701**	1,243	215	186	57
Impairments charged to operating expenses	**(283)**	(283)	-	-	-
Impairments charged to the revaluation reserve	**(90)**	(90)	-	-	-
Reversal of impairments credited to operating expenses	**(767)**	(767)	-	-	-
Reversal of impairments credited to operating expenses	**(69)**	(69)	-	-	-
Revaluations	**(204)**	(34)	-	(170)	-
Depreciation at 31 March 2025	**933**	**-**	**682**	**181**	**70**
Net book value at 31 March 2025	**20,167**	**18,328**	**1,304**	**209**	**326**

17. Inventories

Current year 2025/26 Group	Drugs £000	Consumables £000	Other £000	Total £000
Balance at 1 April	1,731	3,222	137	**5,090**
Additions	29,477	12,112	918	**42,507**
Inventories recognised as an expense in the period	(29,048)	(11,150)	(843)	**(41,041)**
Write-down of inventories recognised as an expense	(74)	(166)	-	**(240)**
Balance at 31 March	**2,086**	**4,018**	**212**	**6,316**

Current year 2025/26 Trust	Drugs £000	Consumables £000	Other £000	Total £000
Balance at 1 April	1,451	3,222	137	**4,810**
Additions	23,441	12,112	918	**36,471**
Inventories recognised as an expense in the period	(23,222)	(11,150)	(843)	**(35,215)**
Write-down of inventories recognised as an expense	(70)	(166)	-	**(236)**
Balance at 31 March	**1,600**	**4,018**	**212**	**5,830**

18. Receivables

18.1 Receivables

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	**31 March 2026 £000**	31 March 2025 £000
Current				
Contract receivables (IFRS 15): invoiced	3,114	2,055	3,114	2,055
Contract receivables (IFRS 15): not yet invoiced/non-invoiced	11,925	13,269	11,925	13,269
Allowance for impaired contract receivables	(91)	(74)	(91)	(74)
Prepayments	3,262	4,576	3,259	4,573
Interest receivable	153	107	150	104
PDC dividend receivable	143	69	143	69
VAT receivables	1,057	552	928	454
Clinician pension tax provision	1	4	1	4
Other receivables	1,409	933	1,409	933
Total	**20,973**	21,491	**20,838**	21,387
Non-current				
Prepayments	597	310	597	310
Contract receivables (IFRS 15): not yet invoiced/non-invoiced	206	112	206	112
Clinician pension tax provision	128	169	128	169
Total	**931**	591	**931**	591
Grand Total	**21,904**	22,082	**21,769**	21,978

The great majority of trade is with Integrated Care Boards, as commissioners for NHS patient care services. As Integrated Care Boards are funded by central government to buy NHS patient care services, no credit scoring of them is considered necessary.

18.2 Allowance for credit losses (doubtful debts)

Contract receivables and contract assets	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
Balance at 1 April	74	80	74	80
New allowances arising	49	40	49	40
Reversals of allowances	(32)	(46)	(32)	(46)
Balance at 31 March	**91**	74	**91**	74

19. Cash and cash equivalents

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
Balance at 1 April	25,165	8,805	24,410	8,609
Net change in year	2,299	16,360	2,332	15,801
Balance at 31 March	**27,464**	25,165	**26,742**	24,410
Made up of				
Commercial banks and cash in hand	7	7	7	7
Cash with Government Banking Service	27,457	25,158	26,735	24,403
Cash and cash equivalents	**27,464**	25,165	**26,742**	24,410

20. Trade and other payables

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
Current	**£000**	£000	**£000**	£000
Trade payables	21,811	18,638	21,082	18,160
Capital payables	11,189	4,578	11,189	4,578
Accruals	5,730	3,872	5,730	3,872
Other taxes payable	5,191	4,438	5,170	4,403
PDC dividend payable	-	-	-	-
Pension contributions payable	2,880	2,683	2,880	2,683
Total	**46,801**	34,209	**46,051**	33,696

21. Borrowings

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
Current	**£000**	£000	**£000**	£000
Loans from Department of Health and Social Care	442	4,604	442	4,604
Lease liabilities	1,744	2,072	1,744	2,072
Total	**2,186**	6,676	**2,186**	6,676
Non-current	**£000**	£000	**£000**	£000
Loans from Department of Health and Social Care	3,943	-	3,943	-
Lease liabilities	24,675	25,496	24,675	25,496
Total	**28,618**	25,496	**28,618**	25,496
Total borrowings (current and non-current)	**30,804**	32,172	**30,804**	32,172

The Trust drew down a capital loan on the 1st August 2011 from the Department of Health at an annual interest rate of 2.11%. The loan repayment has been restructured and extended by the Department of Health and Social Care in a letter dated 11th December 2025 to six monthly repayments from 15th March 2026 until 14th March 2036.

21.1 Reconciliation of liabilities current year 2025/26

Group and Trust	**Total £000**	**DHSC loans £000**	**Lease liabilities £000**
Carrying value as at 1 April 2025	**32,172**	4,604	27,568
Cash movements:			
Financing cash flows - principle	**(2,169)**	(219)	(1,950)
Financing cash flows - interest	**(868)**	(97)	(771)
Non-cash movements:			
Additions	**-**	-	-
Lease liability remeasurements	**922**	-	922
Interest charge arising in year	**747**	97	650
Early termination	**-**	-	-
Carrying value as at 31 March 2026	**30,804**	4,385	26,419

21.2 Reconciliation of liabilities prior year 2024/25

Group and Trust	**Total £000**	**DHSC loans £000**	**Lease liabilities £000**
Carrying value as at 1 April 2024	**32,024**	4,604	27,420
Cash movements:			
Financing cash flows - principle	**(1,498)**	-	(1,498)
Financing cash flows - interest	**(686)**	(97)	(589)
Non-cash movements:			
Additions	**667**	-	667
Lease liability remeasurements	**951**	-	951
Interest charge arising in year	**752**	97	655
Early termination	**(38)**	-	(38)
Carrying value as at 31 March 2025	**32,172**	4,604	27,568

22. Provisions

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
Current		
Pensions early departure costs	9	9
Pensions injury benefits	15	15
Other legal claims	20	23
Clinician pension tax reimbursement	1	4
Total	**45**	51

	31 March 2026	31 March 2025
	£000	£000
Non-current		
Pensions early departure costs	9	16
Pensions injury benefits	49	64
Clinician pension tax reimbursement	128	169
Total	**186**	249

22.1 Provisions movement

Group and Trust	**Total £000**	**Pensions early departure £000**	**Pensions injury benefits £000**	**Legal and other claims £000**	**Clinician pension tax £000**
At 1 April 2025	**300**	25	79	23	173
Change in discount rate	**(12)**	-	(2)	-	(10)
Arising during the year	**54**	15	1	38	-
Utilised during the year - accruals	**(10)**	(6)	(4)	-	-
Utilised during the year - cash	**(55)**	(16)	(12)	(26)	(1)
Reversed unused	**(56)**	-	-	(15)	(41)
Unwinding of discount	**10**	-	2	-	8
At 31 March 2026	**231**	18	64	20	129
Expected timing of cash flows:					
Within one year	**45**	9	15	20	1
Between one and five years	**66**	9	26	-	31
After 5 years	**120**	-	23	-	97
Total	**231**	18	64	20	129

Provisions that are not expected to become due for several years are shown at a reduced value to take account of inflation.

Provisions shown under the heading 'Pensions early departure costs' have been calculated using figures provided by the NHS Pension Agency. They assume certain life expectancies. Provisions shown under the heading 'Legal claims' relate to public and employer liability claims. The liability claims amounts have been calculated using information provided by NHS Resolution and are based on the best information available at the balance sheet date.

22.2 Clinical negligence liabilities

Group and Trust	**31 March 2026 £000**	31 March 2025 £000
Amount included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust	89,705	81,166

23. Other liabilities

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
Deferred income - goods and services	2,238	1,669	2,238	1,669
Total	**2,238**	1,669	**2,238**	1,669

24. Lease Liabilities

24.1 Maturity analysis

Group and Trust	**31 March 2026**	31 March 2025
	£000	£000
Undiscounted future lease payments		
not later than one year	2,348	2,670
later than one year and not later than five	7,955	8,165
later than five years	24,349	25,285
Total gross future payments	34,652	36,120
Finance charges allocated to future periods	(8,233)	(8,552)
Net lease liabilities	**26,419**	27,568
of which :		
Currenly not yet invoiced/not relating to current year	1,744	2,072
Non-Current	24,675	25,496
	26,419	27,568

24.2 Movement in the carrying value current year 2025/26

Group and Trust	**Total £000**
Carrying value at 1 April 2025	**27,568**
Cash movements:	
Financing cash flows - principle	(1,950)
Financing cash flows - interest	(771)
Non-cash movements:	
Lease additions	-
Lease liability remeasurement	922
Interest charge arising in year	650
Termination of lease	-
Carrying value at 31 March 2026	**26,419**

24.3 Movement in the carrying value prior year 2024/25

Group and Trust	Total £000
Carrying value at 1 April 2024	**27,420**
Cash movements:	
Finance cash flows - principle	(1,498)
Finance cash flows - interest	(589)
Non-cash movements:	
Lease additions	667
Lease liability remeasurement	951
Interest charge arising in year	655
Termination of lease	(38)
Carrying value at 31 March 2025	**27,568**

24.4 Reconciliation of the carry value of lease liabilities current year 2025/26

Group and Trust	Total £000
Carrying value at 1 April 2025	**27,568**
Lease additions	-
Lease liability remeasurement	922
Interest charge arising in year	650
Termination of lease	-
Lease payments (cash outflows)	(2,721)
Carrying value at 31 March 2026	**26,419**

24.5 Reconciliation of the carry value of lease liabilities prior year 2024/25

Group and Trust	Total £000
Carrying value at 1 April 2024	**27,420**
Lease additions	667
Lease liability remeasurement	951
Interest charge arising in year	655
Termination of lease	(38)
Lease payments (cash outflows)	(2,087)
Carrying value at 31 March 2025	**27,568**

Lease liabilities are included within borrowings in the statements of financial position. A breakdown of borrowings is disclosed in note 21.

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.
These payments are disclosed in note 6. Cash outflows in respect of leases recognised on-SOFP are disclosed in the reconciliation above.

25. Contingencies

Contingent liabilities	31 March 2026	31 March 2025
Group and Trust	**£000**	£000
Pensions injury benefits	9	9
Pensions early departures	1	1
Risk pooling*	15	15
Total	**25**	25

*Risk pooling is in respect of employer and public liability incidents for which claims have been made against the Trust. The contingent liabilities have been calculated using information provided by NHS Resolution. Provisions relating to these cases are included in Note 22.

26. Financial instruments

26.1 Financial assets

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
Loans and receivables	**£000**	£000	**£000**	£000
Trade and other receivables with NHS and DH bodies	14,570	12,164	14,570	12,164
Trade and other receivables with other bodies	2,274	4,407	2,272	4,404
Cash and cash equivalents at bank and in hand	27,464	25,165	26,742	24,410
Total at 31 March	**44,308**	41,736	**43,584**	40,978

The financial assets consist of the financial element of trade and other receivables (note 18.1) and cash and cash equivalents at bank and in hand (note 19). Financial assets in the table above are valued at amortised cost.

26.2 Financial liabilities

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	**£000**	£000
Borrowing excluding finance lease and PFI contract	4,385	4,604	4,385	4,604
Obligations under finance lease	26,419	27,568	26,419	27,568
Trade and other payables with NHS and DH bodies	14,163	12,300	14,163	12,300
Trade and other payables with other bodies	24,047	14,408	23,318	13,930
Provisions under contract	231	300	231	300
Total at 31 March	**69,245**	59,180	**68,516**	58,702

The financial liabilities consist of the financial element of trade and other payables (note 20), plus current and non-current borrowings (note 21) and provisions (note 22.1) excluding legal costs. Financial liabilities in the table above are valued at amortised cost.

Maturity of financial liabilities	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
Finance leases				
In one year or less	2,348	2,670	2,348	2,670
In more than one year but not more than five years	7,955	8,165	7,955	8,165
In more than five years	24,349	25,285	24,349	25,285
	34,652	36,120	**34,652**	36,120
DHSC loans				
In one year or less	528	4,697	528	4,697
In more than one year but not more than five years	2,021	-	2,021	-
In more than five years	2,318	-	2,318	-
	4,867	4,697	**4,867**	4,697
Trade & Payables: DHSC group bodies				
In one year or less	14,163	12,300	14,163	12,300
	14,163	12,300	**14,163**	12,300
Trade & Payables: other bodies				
In one year or less	24,047	14,408	23,318	13,930
	24,047	14,408	**23,318**	13,930
Provisions				
In one year or less	45	51	45	51
In more than one year but not more than five years	66	84	66	84
In more than five years	120	165	120	165
	231	300	**231**	300
Total				
In one year or less	41,131	34,126	40,402	33,648
In more than one year but not more than five years	10,042	8,249	10,042	8,249
In more than five years	26,787	25,450	26,787	25,450
	77,960	67,825	**77,231**	67,347

The figures above are based on undiscounted future contractual cash flow as per IFRS 7 Financial Instruments.

26.3 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the continuing service provider relationship that the Trust has with Integrated Care Boards and the way those Boards are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the Finance Department, within parameters defined formally within the Trust's Standing Financial Instructions and Policies agreed by the Board of Directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

26.3.1 Currency risk

The Trust is a UK based organisation with no overseas operations. The vast majority of its income, expenses, assets and liabilities are denominated in sterling, and therefore it has low exposure to currency risk.

26.3.2 Interest rate risk

The Trust's exposure to interest rate risk is limited to the rate of interest it earns on short-term cash deposits placed with the National Loans Fund and its cash balances with the Government Banking Service. All the borrowings of the Trust are at fixed rates of interest.

The Group earned interest of £1,419k (at an average rate of approximately 3.93%) during 2025/26. An increase in interest rates of 0.5% would increase interest earned by approximately £181k.

26.3.3 Credit risk

The majority of the Trust's trade and other receivables are due from other NHS bodies that are funded by central government. As a result, the Trust has a low credit risk profile. Exposures as at 31 March are disclosed in the Trade and other receivables note.

The Trust has a credit control policy and actively pursues unpaid debts, utilising the services of a debt collection agency for certain older debts. The Trust does not enter into derivative contracts.

26.3.4 Liquidity risk

The Trust's net operating costs are incurred under annual service agreements with local Integrated Care Boards, which are financed from resources voted annually by Parliament with revenue support also available under an agreed borrowing limit. The Trust also largely finances its capital expenditure from internally generated funds, or from facilities made available from Government under an agreed borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

The Trust has a deficit of £14.2m in the current financial year and has a cash balance of £27.5m. The Trust delivered its planned financial position for 2025/26 and has a breakeven plan for 2026/27. Accordingly, liquidity risk is considered low, with sufficient cash resources to meet liabilities as they fall due.

27. Events after the reporting period

There have been no significant post balance sheet events requiring disclosure.

28. Related party transactions

Dorset County Hospital NHS Foundation Trust is an independent public benefit corporation as authorised by NHS Improvement in their Terms of Authorisation. None of the Trust's Directors, senior managers, or parties deemed to be related to them, has undertaken any material transactions with Dorset County Hospital NHS Foundation Trust.

The Department of Health and Social Care is regarded as the ultimate parent of the Trust. During the year the Foundation Trust has had a significant number of transactions with entities for which the Department of Health is regarded as the ultimate parent. Central and Local Government and NHS entities, with which the Foundation Trust had transaction totals exceeding £500,000 for the year, are listed in the following table.

	Income in year to 31 March 2026 £000	Expenditure in year to 31 March 2026 £000	Receivables at 31 March 2026 £000	Payables at 31 March 2026 £000
Department of Health and Social Care	258	-	-	4,385
Dorset Healthcare University NHS Foundation Trust	3,557	6,660	952	11,981
HM Revenue and Customs - Tax & NI	-	23,124	-	5,191
NHS Blood and Transplant	14	1,059	-	41
NHS Bath, North East Somerset, Swindon & Wiltshire ICB	530	-	83	-
NHS Dorset ICB	253,385	396	6,297	45
NHS England - Central Specialised Commissioning Hub	2,601	-	786	-
NHS England - Core	8,768	21	-	244
South West Regional Office	14,242	-	-	-
NHS Hampshire and Isle of Wight ICB	4,308	-	279	-
NHS Somerset ICB	29,567	-	1,616	-
NHS Resolution	-	7,479	-	-
NHS Pension Scheme	-	34,125	-	2,880
Somerset NHS Foundation Trust	1,016	728	489	119
University Hospital Southampton NHS Foundation Trust	570	393	219	190
University Hospitals Dorset NHS Foundation Trust	4,299	4,238	3,445	1,668
Dorset Council	183	1,281	126	790
DCH Subco Ltd	91	6,132	-	178

The payables included above in respect of HM Revenue and Customs and NHS Pension Scheme include both employee and employer contributions. The expenditure figures for these organisations are only in respect of employer contributions.

The Trust receives revenue payments and contributions to the cost of non-current assets from the Dorset County Hospital NHS Foundation Trust Charitable Fund, of which the Foundation Trust is the corporate trustee.

Transactions with Dorset County Hospital NHS Foundation Trust Charitable Fund:	**31 March 2026 £000**	31 March 2025 £000
Contributions from the Charity to non-current assets	511	473
Contributions from the Charity to expenditure	84	71

29. Third Party Assets

The Trust did not hold cash and cash equivalents which relate to monies held on behalf of patients (2024/25 £nil).

30. Losses and special payments

Group and Trust	Number of cases		Total value of cases	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	Number	Number	**£'000**	£'000
Losses;				
Losses of cash due to:				
theft, fraud etc	**2**	-	**-**	-
Damage to buildings and property due to:				
stores losses	**2**	1	**240**	65
other	**4**	4	**1**	1
Special Payments;				
Compensation under court order or legally biniding arbitration award	**1**	-	**5**	-
Ex-gratia payments in respect of:				
loss of personal effects	**6**	8	**2**	1
other	**-**	-	**-**	-
	15	13	**248**	67

31. Limitation on auditor's liability

The limitation on the Trust's auditor's liability is £1.0m (2024/25: £1.0m).

32. Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
not later than 1 year	5,002	6,009	5,002	6,009
after 1 year and not later than 5 years	4,905	2,881	4,905	2,881
paid thereafter	87	203	87	203
Total	**9,994**	9,093	**9,994**	9,093

33. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements comprise

	Group		Trust	
	31 March 2026	31 March 2025	**31 March 2026**	31 March 2025
	£000	£000	**£000**	£000
Property, plant and equipment	40,929	64,206	40,929	64,206
Intangible assets	5,448	168	5,448	168
Total	**46,377**	64,374	**46,377**	64,374

34. Non-current assets held for sale

Group and Trust	Total £000	PPE: Land £000	PPE: Dwellings £000
NBV non-current assets held for sale at 1 April 2025	**-**	**-**	**-**
Assets classified as available for sale in year	7,405	2,299	5,106
Less assets sold in year	(3,035)	(941)	(2,094)
Less impairments of assets held for sale	(4,370)	(1,358)	(3,012)
NBV non-current assets held for sale at 31 March 2026	**-**	**-**	**-**
NBV non-current assets held for sale at 1 April 2024	**-**	**-**	**-**
Assets classified as available for sale in year	-	-	-
Less assets sold in year	-	-	-
Less impairments of assets held for sale	-	-	-
NBV non-current assets held for sale at 31 March 2025	**-**	**-**	**-**