Board of Directors in Common - Part 1

Tuesday 11 August 2026, 09:30 - 14:10

Board Room, DHC Headquarters, 2 Nuffield Road, Poole

Agenda

09:30 - 09:50
20 min

1. Patient Story

09:50 - 10:00
10 min

2. Formalities

- 01a Agenda BoD in Common - Part 1 - August 2026.pdf (3 pages)
- 02b BoDiC Minutes Part 1 17 06 2026.pdf (31 pages)
- 02c BoDiC Action Tracker - Part 1 Aug 2026.pdf (1 pages)
- 02e Workplan.pdf (2 pages)

10:00 - 10:05
5 min

3. Chairs Comments

10:05 - 10:15
10 min

4. CEO Report

- 04. CEO Report Aug 2026_FINAL.pdf (9 pages)

10:15 - 10:25
10 min

5. Board Assurance Framework

- 05.1 DHC DCH Board Assurance Framework Q1 August 26 Final.pdf (3 pages)
- 05.2 DHC BAF Q1.pdf (12 pages)
- 05.3 DCH BAF Q1.pdf (12 pages)

10:25 - 10:35
10 min

6. Corporate Risk Register

- 06.1 Board Risk narrative July 2026 - Dorset Healthcare - fv2.pdf (4 pages)
- 06.2 Corporate Risks DHC.pdf (2 pages)
- 06.3 DCH Board Risk narrative July 2026.pdf (5 pages)
- 06.4 DCH Corporate Risk Register.pdf (8 pages)

10:35 - 10:45
10 min

7. Quality Committee Assurance Report

- 07.1 Assurance Report QCIC July 2026.pdf (7 pages)

10:45 - 10:55
10 min

8. Maternity Report

- 07.2.1 Front Cover Maternity Neonatal Quality Safety Report.pdf (2 pages)
- 07.2.2 Maternity Neonatal Quality and Safety Report.pdf (21 pages)

10:55 - 11:15
20 min

9. Quality Annual Reports

Ellis Kara 06/08/2026 15:03:17

- 07.3.1 DHC IPC Front Sheet.pdf (2 pages)
- 07.3.4 DCH Infection Prevention Managment Front Sheet 2025-2026.pdf (2 pages)
- 07.3.6 DHC Annual Clinical Audit Assurance Report Front Sheet.pdf (2 pages)
- 07.3.8 DCH Annual Clinical Assurance Report Front Sheet.pdf (2 pages)

11:15 - 11:25
10 min

10. Mortuary Oversight Board Assurance Statement

- 07.4.1 front sheet mortuary oversight_2026.pdf (2 pages)
- 07.4.2 Annex 3 Board Assurance Statement DCHFT Jul 26 DD Signed.pdf (8 pages)

11:25 - 11:35
10 min

Break

11:35 - 11:45
10 min

11. Finance and Performance Committee Assurance Report

- 08.1 Assurance Report July 2026 FPCIC.pdf (7 pages)

11:45 - 12:05
20 min

12. DHC Integrated Performance Report & Finance Report

- 08.2.1 ICD Jun 26.pdf (29 pages)
- 08.2.2 ICS - Board Report Summary June 2026.pdf (1 pages)
- 08.2.3 CYP MHLD ICD PerformanceSummary_July26(Jun 26 data).pdf (2 pages)
- 08.2.4 DHC ~ Finance Report Month 3 June 2026 FPC.pdf (22 pages)

12:05 - 12:25
20 min

13. DCH Integrated Performance Report & Finance Report

- 08.3.1 DCH Integrated board performance - front sheet.pdf (3 pages)
- 08.3.2a Integrated Board performance report Aug Board Final.pdf (24 pages)
- 08.3.2b FPC performance Report and front sheet May and June 26 data.pdf (37 pages)
- 08.3.3 Front Sheet DCH Board M3.pdf (2 pages)
- 08.3.4 DCH Finance Report M3.pdf (12 pages)

12:25 - 12:30
5 min

14. Green Strategy Annual Report

- 08.4.1 Green Strategy Annual Report Front Sheet.pdf (2 pages)

12:30 - 12:35
5 min

15. Winter Planning

- 08.5.1 Front Sheet Joint Winter Planning.pdf (2 pages)
- 08.5.2 PRN02603 Winter planning 2026 27 expectations and assurance 17 July 2026.pdf (3 pages)

12:35 - 12:45
10 min

16. People and Culture Committee Assurance Report

- 09.1 PCCIC July 2026 Assurance Report.pdf (5 pages)

12:45 - 12:55
10 min

17. Medical Appraisal and Revalidation Annual Report (& Statement of Compliance)

- 09.2.1 DHC Medical Appraisal Statement of Compliance Front Sheet.pdf (2 pages)
- 09.2.2 Medical Staff Revalidation Update - Trust Board August 2026.pdf (6 pages)
- 09.2.3 DHC annual statement of compliance 2026.pdf (27 pages)
- 09.2.4 DCH Medical Revalidation RO report.pdf (4 pages)
- 09.2.5 DCH annual statement of compliance 2026.pdf (23 pages)

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12:55 - 13:30
35 min

Lunch

13:30 - 13:40
10 min

18. Strategy, Transformation and Partnership Committee Assurance Report

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

13:40 - 13:50
10 min

19. DCH and DHC Audit Committee Assurance Reports

- 11.1.1 Assurance Report July 2026 DHC Audit Committee.pdf (3 pages)
- 11.1.2 Assurance Report DCH Audit Committee 03 August 2026.pdf (2 pages)

13:50 - 14:00
10 min

20. Mental Health Legislation Committee Assurance Report

- 11.2 Assurance Report July 2026 MHLCIC.pdf (7 pages)

14:00 - 14:00
0 min

21. Charitable Funds Committee Assurance Report

- 12.2 Assurance Report - DCH Charitable Funds Committee (21.7.26).pdf (2 pages)

14:00 - 14:00
0 min

22. Charitable Funds Legacy Variation

- 12.3 Proposal to vary DHC charity legacies.pdf (3 pages)

14:00 - 14:00
0 min

23. Cost Collection Exercise

- 12.5 Finance and Performance Committee - NCC Post-Submission Report - 29th July 2026 - Final.pdf (5 pages)

14:00 - 14:10
10 min

24. Questions from the Public

14:10 - 14:10
0 min

25. AOB

Ellis Kara
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Dorset County Hospital
Dorset HealthCare

Meeting of the Boards of Directors (Part 1) of
Dorset County Hospital NHS Foundation Trust
and
Dorset HealthCare University NHS Foundation Trust
Tuesday 11 August 2026 at 9:30 to 14:10
Board Room, DHC Headquarters, 2 Nuffield Road, Poole and via MS Teams

AGENDA

Ref	Item	Trust	Format	Lead	Purpose	Timing
1.	**Patient Story**	DCH	Presentation	Jo Howarth	Information	9:30-9:50
2.	**FORMALITIES** to declare the meeting open.		Verbal	David Clayton-Smith Trust Chair	Information	9:50-10:00
	a) Apologies for Absence	Joint	Verbal	David Clayton-Smith	Information	
	b) Declarations of Interest	Joint	Enclosure	David Clayton-Smith	Information	
	c) Minutes of the Meeting dated 17 June 2026 Board in Common	Joint	Enclosure	David Clayton-Smith	Approve	
	d) Matters Arising: Action Log	Joint	Enclosure	David Clayton-Smith	Approve	
	e) Board workplan	Joint	Enclosure	David Clayton-Smith	Information	
3.	**Chair's Comments**	Joint	Verbal	David Clayton-Smith	Information	10:00-10:05
4.	**CEO Report**	Joint	Enclosure	Matthew Bryant	Information	10:05-10:15
5.	**Board Assurance Framework (BAF)** (July/August Audit Committees)	DHC DCH	Enclosure	Jenny Horrabin	Assurance	10:15-10:25
6.	**Corporate Risk Register** (July/August Audit Committees)	DHC DCH	Enclosure	Cara Southgate Jo Howarth	Assurance	10:25-10:35
7.	**Quality**					
7.1.	**Quality Committee Assurance Report**	Joint	Enclosure	Claire Lehman	Assurance	10:35-10:45
7.2.	**Maternity Report** (July QC)	DCH	Enclosure	Jo Howarth	Assurance	10:45-10:55
7.3.	**Quality Annual Reports:** • **Infection Prevention and Control Annual Report** (July QC) • **Annual Clinical Audit Assurance Report** (August AC)	DHC DCH	Enclosure	Cara Southgate Jo Howarth Lucy Knight Rachel Wharton	Assurance	10:55-11:15
7.4.	**Mortuary Oversight Board Assurance Statement**	DCH	Enclosure	Jo Howarth	Assurance	11:15-11:25
	Break 11:25-11:35					
8.	**Finance and Performance**					
8.1.	**Finance and Performance Committee Assurance Report**	Joint	Enclosure	Dave Underwood	Assurance	11:35-11:45
8.2.	**DHC**	DHC	Enclosure	Chris Hearn	Assurance	11:45-12:05

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	• **Integrated Performance Report** • **Finance Report**					
8.3.	**DCH** • **Integrated Performance Report** • **Finance Report**	DCH	Enclosure	Anita Thomas Chris Hearn	Assurance	12:05-12:25
8.4.	**Green Strategy Annual Report** (July FPC)	DHC DCH	Enclosure	Chris Hearn	Assurance	12:25-12:30
8.5.	**Winter Planning (delegating authority to FPC)**	DHC DCH	Enclosure	Anita Thomas	Approval	12:30-12:35
9.	**People and Culture**					
9.1.	**People and Culture Committee Assurance Report**	Joint	Enclosure	Eiri Jones	Assurance	12:35-12:45
9.2.	**Medical Appraisal and Revalidation Annual Report (and statement of compliance)** (July PCCIC)	DHC DCH	Enclosure	Lucy Knight Rachel Wharton	Approval	12:45-12:55
	Lunch Break 12:55-13:30					
10.	**Strategy, Transformation and Partnership**					
10.1.	**Strategy, Transformation and Partnership Committee Assurance Report**	Joint	Enclosure	David Clayton-Smith	Assurance	13:30-13:40
11.	**Audit and Governance**					
11.1.	**Audit Committee** • **DHC Assurance Report** • **DCH Assurance Report**	DHC DCH	Enclosure	Nikki Rowland Stuart Parsons	Assurance	13:40-13:50
11.2.	**Mental Health Legislation Committee in Common Assurance Report**	Joint	Enclosure	Andreas Haimbock-Tichy	Assurance	13:50-14:00
12.	**Consent Section**					
	The following items are to be taken without discussion unless any Board Member requests prior to the meeting that any be removed from the consent section for further discussion.					
12.1.	**Charitable Funds Committee Assurance Report**	DCH	Enclosure	Dave Underwood	Assurance	
12.2.	**Charitable Funds Legacy Variation**	DHC	Enclosure	Chris Hearn	Approval	
12.3.	**Cost Collection Exercise Report** (May/July FPC)	DHC DCH	Enclosure	Chris Hearn	Approval	
13.	**Questions from the Public**	All	Verbal	David Clayton-Smith		14:00-14:10
	In addition to being able to ask questions about discussion at the meeting, members of the public are also able to submit any other questions they may have about the trust in advance of the meeting to Abigail.baker@dchft.nhs.uk or jim.bailey2@nhs.net					
14.	**Any Other Business** Nil notified	All	Verbal	David Clayton-Smith	Information	14:10
15.	**Date and Time of Next Meeting**					

	The next part one (public) Boards of Directors' meeting of **Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University NHS Foundation Trust** will take place at **9.30am** on **Tuesday 13 October** in **Committee Room 2, Colliton Park, Dorchester and via MS Teams**.
	Resolution Regarding Press, Public and Others: To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.

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

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

Voting rights:
The Board of Directors is to comprise:

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

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

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

Part 2 Items

- Chair's Comments
- CEO Update
- Update on Performance Assurance Arrangements in DCH
- Cyber Security Update
- FutureCare Closedown Report
- Our Dorset Provider Collaborative Board Minutes
- DHC Joining the Dorset Estates Partnership

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Minutes of a public (Part 1) meeting of the Boards of Directors of Dorset County Hospital NHS Foundation Trust and Dorset HealthCare University Foundation Trust held at 9.30am on 17 June 2026 at Board Room, Dorset HealthCare HQ, Dorset HealthCare University Foundation Trust and via MS Teams videoconferencing.

Present:		
Joint Board Members		
Eiri Jones	EJ	Joint Non-Executive Director (Joint Deputy Chair) (Chair)
Beverley Bryant	BB	Joint Chief Digital Officer
Matthew Bryant	MBr	Joint Chief Executive
Dawn Dawson	DD	Joint Chief Nursing Officer
Chris Hearn	CH	Joint Chief Finance Officer
Jenny Horrabin	JeH	Joint Director of Corporate Affairs
Claire Lehman	CL	Joint Non-Executive Director
Nicola Plumb	NP	Joint Chief People Officer
David Underwood	DU	Joint Non-Executive Director
DCH Board Members		
Margaret Blankson	MBl	Non-Executive Director (DCH) (via videoconference)
Anita Thomas	AT	Chief Operating Officer (DCH)
Rachel Wharton	RW	Chief Medical Officer (DCH) (from BoDiC26/052)
DHC Board Members		
Suresh Ariaratnam	SA	Non-Executive Director (DHC) (via videoconference)
Andreas Haimboeck-Tichy	AHT	Non-Executive Director (DHC) (via videoconference)
Lucy Knight	LK	Chief Medical Officer (DHC)
Nikki Rowland	NR	Non-Executive Director (DHC)
Rachel Small	RS	Chief Operating Officer (DHC)
In Attendance:		
Abi Baker	AB	Corporate Governance Manager (DCH)
Mandy Ford	MF	Joint Deputy Director of Corporate Affairs
Jo Hartley	JHa	Head of Midwifery (DCH) (BoDiC26/056) (via videoconference)
Hannah Jenner	HJ	Occupational Therapist (DHC) (BoDiC26/044)
Rachel Pankhurst	RP	Patient Experience Facilitator (DHC) (BoDiC26/044)
Jenny Stickley	JS	Advanced Occupational Therapist (DHC) (BoDiC26/044)
Dave Walker	DW	Forensic & Offender Personality Disorder Services Manager (DHC) (BoDiC26/044)
Daniel Cunningham	DC	Corporate Performance Business Partner (DHC) (BoDiC26/059)
Julia Farmer	JF	Business Intelligence Development and Data Architecture Lead (DHC) (BoDiC26/059)
Members of the Public (observing via videoconference):		
Katherine Comey	KC	CQC
Kathryn Harrison	KH	DCH Lead Governor
Kamlesh Jannoo	KJ	CQC
Aimee Johnson	AJ	Xyla Services
Apologies:		
David Clayton-Smith	DCS	Joint Trust Chair (Chair)
Stuart Parsons	SP	Non-Executive Director (DCH)

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BoDiC26/044	Patient Story	
	HJ, RP, JS, and DW joined for this item. DD introduced the patient story from the STRIVE service (Support, Treatment, Risk Management, Identity, Values and Enabling) which was a community-based service for offenders with personality disorders, run jointly with His Majesty's Prison service (HMP). A video voiced by the patient was shared for the meeting. The patient described how trauma, substance misuse, and imprisonment shaped his life, and how engagement with STRIVE and Schema Therapy supported a significant transformation in his emotional wellbeing, self-understanding, and sense of purpose. He reflected on the importance of a safe, non-judgemental therapeutic environment and the development of practical psychological tools. The patient reported stability, resilience, and a sustained sense of hope and freedom. Board members commended the presentation and asked thanks to be extended to the patient for sharing a powerful story. In response to a question from CL, DW provided an outline of how the service worked and how it could be accessed, describing that patients accessed the service via a screening process whilst in prison. Patients accessing STRIVE were typically on long licence conditions as the service's interventions took time to work. There were two tiers to the service which offered differing levels of support to patients, depending on the needs identified by the screening process. SA asked about the conditions that would make a patients path more straightforward. JS explained that the service worked with people at high risk of harm to others, many of whom served long custodial sentences and limited social support outside of prison. For those individuals it was likely they would revert back to maladaptive behaviours and enter the damaging cycle of being released from and recalled to prison. STRIVE offered a psychologically informed model to support people to feel a sense of belonging to enable them to integrate in to the community. RS highlighted that JS had won the Allied Health Professional of the year award last year and congratulated her on her achievement. There was a discussion around the demand and capacity for the service. The service offered different levels of support to patients depending on their needs in order to provide the lightest touch necessary. The demand for the service was directed by the prison service and the screening process, but if there was more capacity then more service would be able to be offered. MBr asked about the links the service had with employment services. Colleagues described their work to support service users with finding employment, typically starting with volunteering before moving to paid employment, support with disclosing offences and working with employers to manage risks.	

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	MBr asked whether there was anything the board could support with, such as removing barriers or solving any issues. JS noted that it can be difficult for the service to access other services provided by the Trust whilst service users transition from prison to community, such as accessing prescriptions for ADHD medication. MBr asked what wellbeing support was available to staff in the service. HJ described feeling supported with regular supervisions in place and an open supportive environment where colleagues could share ideas, undertook peer reflective practice, and wellbeing walks. JS added that the various professional groups in the service were park of national networks where support was available. EJ thanked colleagues for their input, congratulated JS on her achievement as Allied Health Professional of the year, and thanked the whole team for their work. EJ further extended thanks to the patient for sharing his story in a public board meeting.	
	Resolved by the DHC Board: that the Patient Story be received for information. **Resolved by the DCH Board: that the Patient Story be received for information.**	
BoDiC26/045	**Formalities**	
	The Chair declared the meeting open and quorate. Apologies received from David Clayton-Smith and Stuart Parsons. Those observing the meeting were welcomed.	
BoDiC26/046	**Conflicts of Interest**	
	None declared. It was noted that SA had declared an additional item for the register; this had been added and would appear in the next set of Board papers.	
BoDiC26/047	**Minutes of the Meeting held on the 08 April 2026 (Board in Common)**	
	The minutes of the meeting held 08 April 2026 were approved as an accurate record of the meeting.	
	Resolved by the DHC Board: that the Minutes of the Meeting held on the 08 April 2026 be approved. **Resolved by the DCH Board: that the Minutes of the Meeting held on the 08 April 2026 be approved.**	
BoDiC26/048	**Matters Arising: Action Log**	
	The action log was considered, updates received in the meeting were recorded within the log, and approval was given for the removal of completed items.	
Ellis Kara 06/08/2026 15:53:11	**Resolved by the DHC Board: that updates to the action log be noted with approval given for the removal of completed items.** **Resolved by the DCH Board: that updates to the action log be noted with approval given for the removal of completed items.**	

BoDiC26/049	**Board Workplan**	
	The workplan was noted without any comments or questions.	
	Resolved by the DHC Board: that Board Workplan be received for information. **Resolved by the DCH Board: that Board Workplan be received for information.**	
BoDiC26/050	**Chair's Comments – DHC and DCH**	
	EJ highlighted a number of matters for the Boards' attention: • The new national regulatory environment, with the Integrated Performance Reports demonstrating the new way of working • The announcement of DHC receiving Advanced Foundation Trust status, with thanks extended to all involved in the work • System working continues to increase, particularly in relation to the Vista Health work, Our Dorset Provider Collaborative, and increasing partnerships with primary care • Four new Non-Executive Directors (NEDs) would be joining the two trusts in the coming months, pending final recruitment checks. The high number of new NEDs reflected the agreed succession planning work to bring a broader range of skills to the organisations, and forward planning as some NEDs would be ending their term this year. • DCS and EJ had recently met with the new regional chair who was keen to support NED workload and ensure the Dash report was embedded across the region • EJ had recently attended the DCH volunteers tea party where she was able to present some long service certificates. She would like to do something similar for DHC	
	Resolved by the DHC Board: that the Chair's comments be received for information. **Resolved by the DCH Board: that the Chair's comments be received for information.**	
BoDiC26/051	**CEO Report – DHC and DCH**	
	MBr highlighted a number of key issues from the report. Firstly, the Lord Mann report on antisemitism and racism in the NHS. This was an issue that the Boards had been working on for a considerable amount of time, including a Board Development Session, the signing of the anti-racism charter, and the recent launch of the 'We All Belong' campaign which had been the focus of this week's team brief. The CEO report highlighted a set of measures arising from the Lord Mann report which would be addressed and which linked closely to the ongoing work of the trusts. Secondly, MBr noted the appointment of Nick Broughton (NB) as the NHS England (NHSE) programme director for mental health, learning disabilities, and neurodevelopmental conditions. This was the first time the portfolio had been described in this way; MBr welcomed the breadth of the portfolio and noted the strong experience NB would bring to the role. The three priorities identified in the portfolio were out of area	

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	placements, 12-hour breaches for mental health patients in emergency departments, and long waiting times for children and young people mental health; the trust was working on these already and welcomed the renewed focus. MBr noted that the new regional chair had recently undertaken a visit of the DHC St Ann's site and the way in which the trust was development mental health facilities. It was hoped that she would visit DCH in the coming months as well. Closer to home the ICB cluster arrangements continue to develop with the first business meeting of the cluster board held yesterday. MBr attended this as well as the university Hospitals Dorset (UHD) CEO and representatives from both local authority councils. The CEO report summarised the strategic ambition of the ICB cluster which included a commitment to build systems around people, place, communities and prevention; this aligned with the trust own strategic ambitions to deliver the left shift. The ICB also aimed to adopt Integrated Health Organisation (IHO) contracts by the end of 2027/28. As an Advanced Foundation Trust DHC would be able to hold IHO contracts. MBr stressed that as those conversations progressed it was important to ensure that any decisions were made with a view to advancing health outcomes for the population. The report described the progress of Special Educational Needs and Disabilities (SEND) in the Bournemouth, Christchurch and Poole (BCP) local authority. Alongside this there was ongoing work to reform SEND services. The Trusts executive team was working to understand this, and this was discussed at the ICB business meeting; further detail would be presented to the Quality Committee in Common in due course. Within the Trusts the medium-term plan had been accepted by NHSE, and contracts were expected to be signed at the end of the week. Whilst this represented positive working with the ICB, there were a few areas of concern to highlight. For DCH, the Trust was exceeding the agreed levels of emergency activity and the impact of this, for patient experience and outcomes and money flows, needed to be understood. For DHC the national team were not accepting the ICB plan for talking therapies performance. Further conversations were ongoing in both regards. Additionally, the quarter four National Oversight Framework (NOF) segmentation had been released with both Trusts unchanged for the quarter. However, the NOF would be changing considerably for mental health and community trusts, and further work was required to understand this. Since the CEO Report was written the Advanced Foundation Trust policy framework had been published and this would be presented to July's Strategy, Transformation and Partnership Committee in Common to understand it's impact and how to make DHC's Advanced Foundation Trust status meaningful. Additionally, a memorandum of understanding had been developed with the GP Alliance as part of ongoing partnership working, and an Associate NED from the GP	

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	Alliance would be appointed to the Boards shortly. In tandem, a NED from the Trusts would be nominated as a representative to the Alliance. Finally, MBr highlighted a number of good-news stories, including the opening of New Hospital Programme (NHP) development for DHC, plans for a topping out ceremony for the DCH NHP build, and developments in stroke and stoma care. MBr further extended his congratulations to Pauline Kirtley who had won Practice Supervisor of the Year and the Student Nursing Times Awards. RS highlighted that local authority colleagues had expressed concerns about the changes being made by the ICB regarding SEND. She had been clear with local authority and education partners that this was a priority area for DHC and that the Trust was embedded in the governance structure for the SEND agenda. Further updates would be provided as the work progressed. With regards to the NHP RS added that the first service users had moved in to Chaddesley House yesterday and all had settled in to the new environment. It was hoped patients would be moved in to the Psychiatric Intensive Care Unit (PICU) in the coming weeks. NR sought further assurance about the processes the Trust has in place to successfully meet the ambitious timescales for IHO implementation. MBr confirmed that this was being worked through and highlighted three key elements. Firstly, working with system partners and recognising that it was not a solo effort for DHC. Secondly, to work with the purpose of improving population health, and thirdly to continue delivering business as usual without diverting focus from day-to-day business, including other transformation projects. These discussions would continue through Strategy, Transformation and Partnership Committee in Common and Board Development Session. AHT sought further detail about the national priorities for mental health and learning disabilities, feeling they were short term and tactical. MBr reflected that there was a parallel between these priorities and those for physical health in acute hospitals care, which aimed to build confidence in the sector and deliver national improvements in key metrics such as referral to treatment (RTT) and ambulance handover times. The priorities set for mental health were important to service users experiences and did not neglect long term priorities. The national direction was clear, linked to the 10-year plan, and it was important to deliver the left shift together as a Federation and for DHC as an Advanced Foundation Trust. MBl sought further detail about the freedoms offered to Advanced Foundation Trusts. MBr advised that this needed more time than was possible today and would be discussed in Strategy, Transformation and Partnership Committee in Common. The recently published Advanced Foundation Trust guidance would be circulated after the meeting. MBr welcomed views from all Board members about this guidance.	**JeH**
Ellis Kara 06/08/2026 15:53:11	**Resolved by the DHC Board: that the CEO Report be received for information.**	

	Resolved by the DCH Board: that the CEO Report be received for information.	
BoDiC26/052	**Board Assurance Framework and Strategic Review – DHC and DCH**	
	The report contained the quarter four Board Assurance Framework review and the proposed refreshed strategic risks for each organisation. These elements were discussed in turn. **DHC:** JeH provided the following key points: • Two risks scored over 15; SR3 (workforce capacity) and SR9 (digital infrastructure). • The risk score for SR6 (finance) had been reduced from 16 to 12 as a result of achieving the planned financial surplus • Three actions were overdue on three risks; updates and had been provided with new due dates set • There was an anomaly on SR2 (culture) where the unmitigated score was lower than the mitigated score. This would be reviewed in quarter one AHT questioned the achievability of wholetime equivalent (WTE) reductions. Whilst the Trust had achieved it's financial plan, WTE reductions had not been achieved this year and the targets for the coming year were substantial. MBr reflected that the strategic risk related to the ability to recruit and retain staff with the right skills, which in turn impacted what it was like to work for the Trust. With regards to the WTE reduction figures, NP considered on the ongoing work to reshape and resize the workforce whilst ensuring the risk skills were in place. Whilst the Trust did not meet the reductions required last year it had halted the year on year increase previously seen. Work continued to reduce headcount and inroads were being seen, with a particular focus on reducing temporary staffing and reshaping the workforce. CH added that workforce reductions continued to be monitored through Financial Recovery Board where they were triangulated with finances and productivity and considered through equality quality impact assessments. Asked about the scoring of SR5 (estates), CH described that there was inherent risk with the significant number of sites DHC operated. However, there had been key developments in recent months such as the completion of the six-facet survey which allowed infrastructure risks to be addressed in the capital plan. A joint green plan and joint infrastructure strategy had also been developed, both of which helped address SR5, and would be considered in part one and part two of today's meeting respectively. **DCH:** JeH provided the following key points: • Five strategic risks scoring over 15: SR1 (safety and quality), SR3 (workforce capacity), SR5 (estates), SR6 (finance) and SR9 (digital infrastructure).	

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	• The score for SR6 (finance) had been reduced from 20 to 16, reflecting the delivery of the 2025/26 financial plan • Three risks have at least one action overdue with updates provided and revised dates agreed CH confirmed that finance remained a key risk for the Trust and that the reason for the reduction was delivery the 2025/26 financial plan and the planned breakeven position for 2026/27. This would continue to be closely reviewed, and the quarter one financial position will inform the risk scoring in the Board Assurance Framework. Noting the comments made today and the compliance challenges, EJ suggested that executive colleagues reconsider the risk scoring of SR5 (estates) for both trusts. This should be triangulated and considered in light of service delivery, quality of care, finances, and NHP. MBr further noted the **Strategic risk review** JeH outlined that a review of strategic risks was undertaken on an annual basis. Appendix three of the paper set out the propose new wordings and mergers of some risks. Target scores had also been reviewed. All risks had been presented to and discussed in detail at committees. The quarter one Board Assurance Framework would include references to the approved risk appetite. The Boards approved the review of strategic risks.	
	Resolved by the DHC Board: that the Board Assurance Framework be received for assurance and the Strategic Risk Review be approved. **Resolved by the DCH Board: that the Board Assurance Framework be received for assurance and the Strategic Risk Review be approved.**	
BoDiC26/053	**Corporate Risk Register – DHC and DCH**	
Ellis Kara 06/08/2026 15:53:11	For both Trusts DD outlined the ongoing work to improve risk management. This included the publication of a new strategy, a new risk management system (Guardian) expected to launch in December, and the creation of new risk management groups in each organisation where all risks were reviewed to provide triangulation. All risks presented today had been reviewed by the relevant committee. **DHC:** DD outlined that there were two high level risks scoring 15+ at the point the report was produced. One related to consultant vacancy on Seastone CAMHS high intensity unit which may prevent the planned opening. Mitigations were in place and the risk was likely to reduce in due course. The second related to the new build, but mitigations were in place and Chine ward had now opened so the risk was expected to reduce in the next report. **DCH:**	

	DD outlined that the Trust had 43 risks scoring 15+, three of which scored 20. 63 risks had been closed or appropriately managed in the reporting period. There was one new risk relating to failure to meet timelines for ADHD medication titration. This had arisen as there had been investment in ADHD diagnosis, and this was impacting follow up at six months. AT advised that two new nurses had recently started in post which was starting to reduce the risk. EJ added that Quality Committee in Common had asked and been assured that there were no adverse impacts to patients. AT further highlighted the need for some risk reporting training, noting that the risk relating to access and endoscopy had closed but was still appearing on the risk register. The intersectionality of risks was noted with CL asking how the Trust was assured that the risks were reviewed with the appropriate focus. DD advised that at DCH each risk had a lead committee and a secondary committee, in recognition that risks often had various impacts. Furthermore, the new risk management group also considered all risks in the round, and the new risk management system would allow better oversight and triangulation. There was further work to do, but progress was being made in the management of risks. The meeting heard that the current risk system was limited in that it was not possible to automatically include updated, current mitigations in reports. Instead, the mitigations that automatically appeared in reports was that set at the time the risk was first recorded. It was therefore a manual process to include up to date mitigations in the report to provide the assurance required by Board. This would be address by the new system. MBr considered the difference between the acute trust and community and mental health trust. Given the number of risks at DCH it would be helpful to undertake a reflective exercise to understand if the trust's delivery plans and strategies were dealing with risk in a comprehensive and acceptable way over time.	**DD**
	Resolved by the DHC Board: that the Corporate Risk Register be received for assurance. **Resolved by the DCH Board: that the Corporate Risk Register be received for assurance.**	
BoDiC26/054	**Quality Committee Assurance Report - Joint**	
	CL provided the following summary: • Draft Quality Accounts for approval (to be presented to the 22nd June Board meeting, alongside the final Annual Report and Accounts) • Positive response to MenB vaccination requirements in Weymouth • Positive recruitment across both trusts of Chief Digital Information Officers, International Medical Graduates, and Consultants	

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	• System-level LeDeR reviews are currently paused due to ICB resourcing constraints, with no assurance yet on resumption. • Confirmation of MIS compliance, rebate >£250,000 which funds midwives • National publications anticipated in the coming months including Ockenden, Thirlwell, Baroness Amos, and MMBRACE reports in to maternity care. • The informal meeting in April received presentations on the CQC Well-Led Inspection and the use of escalation areas/corridor care at DCH. Following the meeting committee members undertook a site tour of the DCH escalation areas. Patients were spoken with and all were complimentary of the care they had received.	
	Resolved by the DHC Board: that the Quality Committee Assurance Report be received for assurance. **Resolved by the DCH Board: that the Quality Committee Assurance Report be received for assurance.**	
BoDiC26/055	**Learning From Deaths Report Q4 – DHC & DCH**	
Ellis Kara 06/08/2026 15:53:11	**<u>DHC:</u>** The papers contained both the quarter four and annual reports for DHC. LK spoke to the annual report, highlighting the following key points: • 137 unexpected deaths and 125 inquests in year, evenly spread throughout the year • One regulation 28 notice. This was a national regulation 28 notice which was sent to all national bodies. The inquest did not identify any learning particular to the Trust. • Across all inquests there was no new learning which had not already been identified by the Trust. This offered a high degree of assurance about the Trust's internal processes. • 27 deaths of people with learning disabilities, all of which were reviewed through the LeDeR process. As described by CL the system LeDeR process had been suspended for the last six months due to staff shortages. However, the Trust had a strong internal process to review deaths of people with learning disabilities including learning loops and rapid reviews, which identified good practice. Areas of improvement related to communication, documentation, discharge planning and risk assessment and escalation. • There were no identified systemic failings in relation to child deaths. The majority of child deaths were not people who were directly cared for by the Trust, but were reported by the Trust across the system • The Learning from Deaths approach was being reviewed with plans to introduce an avoidability rating by undertaking structured judgement reviews (SJRs). The incoming risk management system would also enable deaths to be reviewed by EDI metrics. Communication would also be focused on as a key theme moving forward. The introduction of an avoidability rating was welcomed.	

	The Board discussed the LeDeR position; whilst it was positive that the internal process was strong, it was a concern that there was no system-level process at present. RS asked whether the internal approach mitigated the lack of system learning, with particular reference to primary care colleagues who undertake physical health checks for patients with learning disabilities. LK confirmed that the Trust's internal process did review across the whole of the Dorset system, but that the whole LeDeR process was under review anyway. DD undertook to escalate the lack of system level LeDeR reviews to the ICB at the upcoming system quality group meeting. DD noted that she had recently had the privilege of opening the first federation end of life conference with over 120 individuals in attendance. DU asked if there was a benchmarking metric for community and mental health hospitals comparable to the Summary Hospital-level Mortality Indicator (SHMI) used in acute hospitals. LK confirmed there was no such metric and that some data was only available years after the event, such as suicide rates once cause of death had been confirmed. Other sources of information were used to triangulate with Learning from Deaths data, such as regulation 28, coroners reports and Patient Safety Oversight Panel reviews. LK added that an Associate Medical Director had been recruited who would review all Learning from Deaths approaches and consider how they could be improved. **DCH:** RW highlighted that the quarter four SHMI ranked DCH 27th nationally and that the SHMI was less than one which meant there were fewer deaths than expected in the reporting period. The report continued to highlight opportunities in orthogeriatrics. RW added that a new care of the elderly consultant had recently been recruited to whose role would include orthogeriatrics, given the surgery intake is older and frailer. RW noted that DCH would be working with LK and the new Associate Medical Director at DHC to improve the Learning from Deaths report. Furthermore, DCH had been completing SJRs for a long time so would share learning with DHC.	**DD**
	Resolved by the DHC Board: that the learning from deaths report be received for assurance. **Resolved by the DCH Board: that the learning from deaths report be received for assurance.**	
BoDiC26/056	**Maternity Report – DCH**	
	JHa joined the meeting, highlighting the below key points from the report: • No MOSS alerts in the reporting period • A risk relating to midwife staffing on labour ward had increased from 16 to 20 • Some non-compliance with mandatory training compliance linked to the Maternity Incentive Scheme (MIS) and the safety	

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	and quality of the service provided. A vigorous action plan was expected to ensure compliance in the coming months. • There were now two reporting periods for MIS and the Trust had agreed the mid- and endpoint for MIS. • The Trust continued to make good progress with Saving Babies Lives (SBL). There had been a slight reduction in compliance with smoking cessation but recruitment to a support role was expected to improve this position rapidly. DD expanded on the maternity staffing risk score, explaining that midwives from Yeovil District Hospital (YDH) had now returned to YDH following the reopening of the maternity service. The Trust was now actively reviewing staffing to address this gap. Some women had chosen to deliver with the Trust rather than return to YDH. JHa added that the service had recently been in OPEL 4 due to staff; this had been managed well with support from the deputy regional Chief Midwife in reviewing the staffing levels. JHa confirmed that the service was well supported by executives and the Director of Nursing. With regards to the financial impact of the YDH closure, CH advised that at year end the Trust had tracked £2.2m in associated costs which was fully reimbursed. Residual costs following the reopening continued to be tracked closely. AT thanked JHa and the team for their work. The transfer back to YDH had been well managed with patients support to make the right choice for them, and staff recognising how much they enjoyed working at DCH. This had set the trusts up for collaborative working and support in the future. MBr echoed these thanks, noting that the coming months would be pivotal for maternity services with a number of anticipated national reviews and within the south west region discussions about how to provide sustainable maternity services for a rural population. This will be an important strategic period and the Board needed to support the service and staffing, whilst looking outwards and consider the implications of the Amos report so the Trust could continue to provide high quality service to the population. As Board Maternity Safety Champion EJ commended the team on recognition as being a baby friendly service. Several national reports were expected in the coming months and this was a challenging time for the midwifery and obstetrics workforce, with the additional pressure on staffing and increased demand for elective c-sections. EJ had undertaken a walkabout last week focusing on staff morale and wellbeing and the midwives spoken to were upbeat and focused on the women they were caring for. EJ had also spoken to women and partners in the unit with feedback being overwhelmingly positive. The key escalation to the Board was around workforce, EJ was assured the DD was working with the service in this regard.	
Ellis Kara 06/08/2026 15:09:11	**Resolved by the DCH Board: that the DCH Maternity Report be received for assurance.**	
BoDiC26/057	**Inpatient Safe Staffing Report – Biannual Review – DHC and DCH**	
	DHC:	

	DD outlined the bi-annual community hospital report covering May to January. The report followed the safer nursing care tool and professional judgement in line with developing workforce standards. The report provided assurance that the Trust adhered to the standards. There was no additional requests made in the report but it was acknowledged that the additional healthcare support workers for Tarrant ward approved in the previous report, would be commencing in post in July. NR acknowledged the considerable amount of work to develop these reports. NR asked about the work ongoing to manage annual leave across the year. DD advised that the healthroster report was regularly presented to Quality Governance Group and identified any wards that exceeded the percentage monthly allowance. In these cases the wards were spoken to and reminded of the importance of balancing leave across the year. DD spoke to the previously circulated bi-annual mental health report, which covered May to January. Assurance was provided that the review was undertaken in the correct way using the mental health optimal staffing tool and professional judgement. DD highlighted that there were full rates for mental health support workers which exceeded the nighttime threshold. This could be due to the high acuity of patients requiring additional support, or if a registered mental health nurse was not available for a shift and a support worker backfilled the position. The Trust continued to be reliant on temporary staffing in mental health services and recruitment was ongoing to create a substantive peripatetic team who could be allocated wards on arrival depending on need. Both the community and mental health reports included a regional safer staffing review which showed one area where there was partial compliance regarding the availability of a quality dashboard; this was under development. NP noted the overall unavailability of workforce which was considerable. Work was underway with the regional head of workforce planning to understand this further, and the Trust was working with UHD to consider how they could jointly approach the healthcare support worker vacancies. Sickness was also a contributing factor to workforce unavailability, but long-term sickness had reduced for the past six months. This would continue to be focused on, and updates provided to the Board in due course. EJ asked if there were any red flags the Board needed to be sighted on; DD confirmed that these were contained within the report. Asked about safeguarding training rates, which were low in some teams, DD advised that this had since been addressed by the Safeguarding Group and that latest data showed compliance rate of 95.34%. **DCH:**	

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	DD outlined that the report excluded some areas such as maternity which was not yet due for review and had remained under close scrutiny following the changes with YDH. Additionally, a neonatal staffing audit continued with investment in recruiting new staff. This was excluded from the report, as was the Critical Care Unit which was being assessed through the New Hospital Programme. The report for the acute hospital covered January to February 2026 with all wards assessed using the safer nursing tool and professional judgement. Uplifts had been agreed prior to today's meeting, and this was helping to correct temporary staffing use. The regional team had undertaken an assessment, and this had been positive with a few areas of partial compliance, which were expected to be compliant soon. NP reflected on the increased activity in the Trust but noted that safe staffing had been maintained during this time. NP commended the progress that had been made whilst maintaining business as usual and improvements in staff survey metrics. This was a testament to the way leaders and managers had worked in the reporting period. CH recognised the investment in headroom alongside the requirement to address workforce spend so the proposals would be taken through Financial Recovery Board to make adjustments as required to reduce agency spend. MBr noted the assurance the reports provided. He was struck by the number of staff over the age of 55 and the need for workforce planning around this. For DCH the report detailed care hours per patient day over the last three years and in comparison to other trusts. It was important to understand how this linked to productivity and to map this to other quality outcomes to show how the Trust had invested in people and quality. This would be referred to Quality Committee in Common.	**QCIC**
	Resolved by the DHC Board: that the Inpatient Safe Staffing Report – Biannual Review be received for assurance. **Resolved by the DCH Board: Inpatient Safe Staffing Report – Biannual Review be received for assurance.**	
BoDiC26/058	**Finance and Performance Committee Assurance Report – Joint**	
Ellis Kara 06/08/2026 15:53:11	DU outlined the following key points from the assurance report: • Receipt of a report in to length of stay over 60 days which continued to be a challenge for DHC. The rate of patients clinically ready for discharge stood at 19% compared to a target of 7.5%. • At DHC children and young people access exceeded plan at 104% and urgent community response consistently exceeding activity and timeliness standards • For DCH, there was a continued focus on improving patient flow and timely patient movement from ED. Ambulance handovers were performing well regionally and RTT waiting list had reduced. • NHSE feedback had been received for both trusts in relation to the medium-term plan	

	• Significant unidentified cost improvement plan (CIP) savings at both Trusts, with a requirement from NHSE to have no unidentified CIP by the end of Q1. • A need for focus on improving talking therapies performance at DHC • At DCH there was additional focus on productivity with regional support for further analysis • The April informal meeting received a presentation on productivity overview and metrics, and Discussion on the challenges of measuring the implied productivity in mental health & community trusts which is required for the first time in the NOF • The committee approved the Joint Green Plan, DCH SubCo Ltd terms of reference and national cost collection submission approach. CH confirmed that NHSE had accepted the medium-term plans for both Trusts and the requirement to identify all CIP by the end of Q1 was national, not specific to the Trusts. The contracts were expected to be signed this week and there were no concerns re the timing of this. DCH had been working with the regional team regarding productivity, and it was anticipated the next informal meeting would provide an update on this. Talking therapies remained a key outstanding issue and DHC would continue to work closely with the ICB and NHSE to address this. These ongoing discussions were not expected to impact the signing of the medium-term plan contract. The Board noted the ongoing development of responsibilities between ICBs and NHSE and that work was ongoing to ensure there was no duplication of responsibility in the new regulatory regime.	
	Resolved by the DHC Board: that the Finance and Performance Committee Assurance Report be received for assurance. **Resolved by the DCH Board: that the Finance and Performance Committee Assurance Report be received for assurance.**	
BoDiC26/059	**Integrated Performance Reports – DHC and DCH**	
	DC and JF joined the meeting. **DHC:** EJ welcomed DC and JF to the meeting who had been instrumental in development the business intelligence (BI) element of the new integrated corporate dashboard (ICD). CH outlined that the new ICD had been launched in April and aligned to the NHS England Insightful Provider Board guidance, the new NOF metrics as well as aligning to the Trusts' strategic objectives. It had been coproduced with operational teams and stakeholders and RS thanked DC and JF for their work on the report. RS continued that national guidance had been followed but that the dashboard was intended to provide assurance to the Board on the delivery of care to people in Dorset. The report contained statutory and mandatory metrics as well as the Trusts' own metrics. The key change is that the new ICD reports on an exception reporting basis compared to the previous	

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	version which contained the same metrics each time; allowing the Board to focus on the most important areas. RS added that the introduction of a power BI dashboard represented a significant digital transformation and allowed the Board to review the same metrics as those being used operationally by teams, supporting ward to Board reporting. Further metrics would be developed in time for inclusion in the dashboard. RS shared a slideshow which demonstrated how the dashboard work, including the use of filters to drill down in to a high degree of detail, ability to view trends, and levels of assurance over time. DD highlighted the following key points regarding quality metrics: • An incident of a missing patient safety alert. This was incredibly unusual as the email from the central system had not been received by the Trust. The alert was not relevant to the Trust, but steps had been put in place to prevent it recurring • A threshold for complaints had not yet been set in the dashboard. Until this had been done it would be included in each report. There was good performance in complaints and focus continued to be on learning and applying Patient Safety Incident Response Framework (PSIRF) methodology. • Assurance was provided that duty of candour reporting was happening appropriately, and that the poor metrics related to limitations of the reporting system. Additional questions had been added to the system for those reporting incidents to answer regarding duty of candour. Improvement in the metrics were expected in the coming months. RS highlighted the following performance exceptions: • The Trust was currently failing the metric for length of stay in adult PICU beds and older adult mental health beds but was on plan for the predicted trajectory for older adult length of stay. 10% of people in hospital beds accounted for the longest length of stay, and it was important to centre the experience of the patient when considering this metric. Work was on track to improve this, but significant improvements were not expected until February 2027 give the scale of the work. • No criteria to reside in community hospitals stood at 36% against a target of 27.5%. The metric moved quickly in month, but the overall trend showed the Trust above threshold. A fortnightly executive system panel had been instigated to review patients with delayed discharge. • A deep dive had been undertaken in to 111 call back times with a number of actions underway to improve the position. It was not expected that the Trust would reach the 95% target based on the modelled staffing, but the Trust continued to be one of the higher performing trusts albeit performing below target. • A deep dive in to audiology waits had been undertaken with a recovery plan in place to improve performance • The Trust had capacity for emergency referrals for children and young people with eating disorders. However, if a patient opted to wait longer this was reported as a breach for the Trust. The Trust balanced clinical risks with the best way to engage with	

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	patient but did have emergency capacity. There were challenges with routine waits but a recovery plan was in place, with clinical oversight and triaging to mitigate risks. • Negotiations with the regional team continued with regards to talking therapies, particularly relating to the ability to meet expansion requirements without additional funding growth. Clinical oversight was maintained and other services were offered to those on the waiting list. NR sought further assurance around additional learning from other providers regarding length of stay. RS confirmed shew had met with the Chief Operating Officer of Berkshire Healthcare NHS Foundation Trust as one of the top performance organisations for length of stay and had presented to the south west learning improvement network with learning from those being piloted at DHC. It was further noted that high performing areas had better housing provision and so Dorset Council had agreed that their supported accommodation strategy would have a specific mental health section which would be co-produced with the Trust. NR further asked how young people who did not engage with eating disorder services were safeguarded. RS advised that these patients were not discharged, but that they were worked with at their pace and that the service linked with their families and wider networks. It was important to balance clinical risk and engaging with patients at their pace, and that the mental health act could be used in extreme circumstances. RS confirmed that there was geographical variability in no criteria to reside rates with smaller wards and those in the east of the county being particuarlly challenged. Work continued with local authority partners regarding available support. AT added that there had been improvements in flow from acute to community. There was a discussion around diagnostic metrics where it was noted that the Trust performed small number of diagnostic services, with audiology being the majority of these. Examples of administration errors occurred due to a 'clunky' waiting list system; there were a small number of these errors, but the impact on the patient was recognised. AHT asked if there were any other areas of poor performance that required focus. RS explained that deep dives in to metrics such as length of stay were taken to Senior Leadership Group (SLG). RS outlined the internal improvement work undertaken for this metric and recognised that it was not possible to meet the performance target until transformation work had been completed with partners, particuarlly around housing. MBr added that the first approach to such areas of concern was to understand the risk and put in place mitigations. With regards to 111 call back performance, it was known that it was not possible to meet the 95% performance rate. The contract was due to expire, and discussions were needed with the commissioner about the performance metrics. MBr stressed the importance of working with partners and that for some metrics the solution was additional funding.	

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	CH highlighted the following key points regarding financial performance: • Cash balance was not a material risk but was currently £5m below plan due to timing of spend on the New Hospitals Programme (NHP) and a degree of NHS debt held between DCH and DHC. • Capital spend position, again due to the timing of NHP spend Further detail about financial performance would be discussed under the finance report agenda item. Work was ongoing to include environmental sustainability metrics within the ICD. With regards to people metrics, NP considered whether to much was being asked of staff, noting the high expectation with mandatory training compliance and the introduction of additional training, as well as operational staffing pressures and productivity requirements. A national review of mandatory training requirements was underway and that a cross-trust group was reviewing additional local training requirements. Within this context NP felt the mandatory training rate was positive and that there was no clear evidence of increased risks as a result of non-compliance. NP further highlighted that appraisal compliance at 10th June was 73%, noting that the previous poor performance figure related to the new recording on the appraisal system, rather than suggesting appraisals were not being completed. An internal audit in to appraisals had rated the design as substantial and effectiveness as moderate. The Trust was on trajectory to reach 85% by the end of August. DC and JF left the meeting. **DCH:** AT outlined that the report included a range of measures, and the current iteration of the integrated performance report had been agreed in October. AT would work with colleagues to consider how the report could be updated to the same approach as DHC, but this would be a considerable piece of work. At the time of writing the report quarter four NOF data had not yet been published; it since had been and the Trust remained in segment three. Whilst this was not a change in score for the Trust there had been a change in the standards of the NOF. Further detail would be reported to Finance and Performance Committee in Common in due course. AT highlighted the impact of winter pressures, with the Trust ending the year with more than 10% increase in urgent and emergency care presentations compared to the previous year; in February there had been a 20% increase in such presentations. Early April saw a four-day bank holiday weekend and six days of industrial action. In this time the Trust maintained 95% elective activity but saw increased bed pressures. Unplanned absences in key areas such as ENT, orthopaedics and endoscopy impacted elective and cancer referral to treatment (RTT) times.	

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	The Trust had ended March in a better position with regards to cancer waiting times and had been released from tiering by the region but had struggled in endoscopy and skin and breast teams which had a considerable number of patients. This was starting to recover with unplanned absences in endoscopy ending, but there were still absences in ENT and orthopaedics. Improvements in emergency flow had been made towards the end of the year but deteriorated the following month. The number of patients with no criteria to reside had reduced compared to last year, although was not as low as desired. The Trust was focus on pathway zero, supporting discharge of patients who could discharged without further interventions. AT outlined that for RTT cancer waiting times and diagnostics a 12-week programme was being undertaken, with six weeks of intensive support to teams including review of individual patient lists, and six weeks of audit to ensure this work was embedded. The Trust had taken up support from the region with regards to productivity which had been helpful. £1.7m of virtual activity had been identified which had not been appropriately accounted for so would be resubmitted. Further updates would be provided to Finance and Performance Committee in Common in due course. The Board discussed the neighbourhood work as a mechanism for promoting the prevention agenda and that this was an area of focus for the Trust but would not be delivered quickly. Work was also ongoing to consider how to prevent delays in discharges with a local audit indicating there were opportunities, particularly in the day when more resources were available. RW noted the positive work in perioperative medicine to keep people well while they were waiting for surgery and the plans to expand this to general surgery, colorectal and upper GI. Additionally Active Dorset had conversations with patients at South Walks House about how to stay healthy. MBr reflected that more people than ever were attending the emergency department (ED), but that there was not the same increase in people being admitted to the hospital. Due to the issues AT had described, the Joint Executive Management Team meeting (JEMT) now received a weekly report providing in depth review of performance in elective and non-elective pathways. Admissions remained flat, but further work was needed to understand why people were attending ED. There was a relationship between this and preventative care, but an urgent treatment centre model also needed to be developed to support ED attendances. DD highlighted the following key points regarding quality metrics: • Positive performance in some infection prevention and control (IPC) metrics, but gram-negative rates were above threshold, as the Trust had been set a very low threshold. • Significant positive increases in two inpatient experience scores, bring the Trust in line with sector scoring. Positive progress had been made in providing patients and carers information on	

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	discharge and communicating effectively while people were waiting for admission. With regards to people metrics NP highlighted that the dashboard was reviewed in People and Culture Committee in Common and that detail about the key people performance indicators within the NOF were awaited. Sickness absence was flagging in the dashboard; a deep dive in to this had been reviewed at People and Culture Committee in Common in September but would be reviewed again. Although the score was below average, it did warrant reviewing again. CH outlined that although the Trust achieved its financial plan for 2025/26, the deficit position negatively affected the NOF score. Progress was being made in relation to finance and productivity.	
	Resolved by the DHC Board: that the Integrated Performance Reports be received for assurance. **Resolved by the DCH Board: that the Integrated Performance Reports be received for assurance.**	
BoDiC26/060	**Finance Reports – DHC and DCH**	
	DHC: CH noted that DHC had submitted a medium-term plan with a planned surplus of £0.5m for each of the three years of the plan. The year one efficiency requirement was 6.5% which totalled £28.8m which was phased equally across the year. The month one efficiency requirement was £2m. In month one the Trust delivered a £366,000 surplus which was broadly in line with the plan. Drivers of the position included • Overspend on out of area placements by £293,00 due to operational pressures. 12 patients were in out of area beds, including the eight-bed block. Developments at St Ann's hospital were expected to help reduce these placements. • Delivery of £1.7m CIP against the plan of £2m. Financial Recovery Board processes would work to mitigate this shortfall. To date 88% of CIP schemes had been identified. • Overspend of temporary staffing by £336,000 primarily in relation to medical agency staff • Overspends had been offset by underspend in clinical supplied, mental health collaboratives and associated incomes The Trust had £41m cash. This was lower than planned by £5.1m due to the timing of NHP spend and NHS debt which was being addressed via a payment plan. Capital spend was also marginally behind plan. **DCH:** CH noted that DCH had submitted a medium-term plan with a planned breakeven for each of the three years of the plan. Year one included deficit support funding of £2.6m but this could be withdrawn at any point in the year which posed a risk for the Trust. In the current financial year there was an overall efficiency programme of 6.5%, totalling £23.3m.	

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	In month one the Trust delivered a £1.3m deficit. This was adverse to plan by £216,000, all of which was directly linked to industrial action which had not been included in the initial plan. NHS England regional and national teams had advised there would be no additional funding to offset these costs, but the Trust continued to work with the commissioners to determine how this could be offset by the end of quarter one. Temporary workforce continued to reduce, with spend of £500,000 in April compared to £700,000 in March. Bank spend continued to be a pressure with £1.35m spent in month; one of the highest in recent months. Some of this related to industrial action and the Meningitis B response which was expected to be refunded to the Trust. It was positive that the Trust was able to meet the demand of these pressures largely through bank, as opposed to high-cost agency workers. The trust delivered efficiencies in month of £571,000 against a plan of £598,000. 61% of this was delivered recurrently. 80% of CIP savings were currently identified, but a lot of these were high risk, due to the previously discussed operational pressures. These would be monitored through Financial Recovery Board and reported to committee and Board as required. The Trust's cash position was ahead of plan with a balance of £23.7m, due to early receipt of Health Education England (HEE) income and higher than expected VAT recovery. However, cash continued to be a key risk for the Trust and would continue to be monitored closely. Capital spend was in line with plan.	
	Resolved by the DHC Board: that the Finance Reports be received for assurance. **Resolved by the DCH Board: that the Finance Reports be received for assurance.**	
BoDiC26/061	**Health and Safety Annual Compliance Report – DHC and DCH**	
	The report was taken as read and Board members invited to ask questions. NR sought further assurance about the work to prevent ligature incidents. RS advised that spikes in incidents were sometimes seen with particular patients as an expression of their distress. There were specific care plans and support in place to prevent such incidents, and assurance was taken from the high number of incidents reports on alarmed doors, showing that mitigations were in place. DD confirmed this was always an area of concern and was regularly reviewed regularly through Quality Governance Group. EJ requested that next years' report contain information about outcomes, as opposed to just processes. CH noted the recent appointment at DCH of a health and safety advisor who would be reviewing the reports.	
	Resolved by the DHC Board: that the Health and Safety Annual Compliance Report be received for assurance.	

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	Resolved by the DCH Board: that the Health and Safety Annual Compliance Report be received for assurance.	
BoDiC26/062	**People and Culture Committee Assurance Report - Joint**	
	EJ highlighted the following from the report: • The April informal meeting took place in part as a learning and development opportunity, and in part as a response to EDS2 and the need to increase Board visibility across the organisations. The committee heard from representatives from staff networks and other staff forums about their experience in the Trusts. The impact of being a carer for some of the workforce was highlighted. • The committee received a number of reports that are also presented to Board today, including the Equity, Diversity and Inclusion Annual Report, the Guardian of Safe Working Reports, and Freedom to Speak Up Reports • General reflections on the risks relating to changes in people services arising from the target operating model and potential gaps in capacity.	
	Resolved by the DHC Board: that the People and Culture Committee Assurance Report be received for assurance. **Resolved by the DCH Board: that the People and Culture Committee Assurance Report be received for assurance.**	
BoDiC26/063	**Freedom to Speak Up Annual Report – DHC and DCH**	
	AH and LP joined the meeting. JeH noted that executive leadership for Freedom to Speak Up (FTSU) had moved to herself from NP in the last quarter. **<u>DHC:</u>** AH highlighted the following points from the previously circulated report: • An 18% increase in contacts this year compared to the previous year, totalling 215 contacts • The closure of the National Guardians Office in the coming weeks with NHSE taking over the function; this was not expected to have a particular impact on the Trust • 53% of cases were able to be resolved locally and informally, indicating there was room for improvement in this regard. Of the 215 cases it had been identified that there were 337 missed opportunities for these to be resolved locally. • Eight cases had reported detriment in year; these cases were taken very seriously and required continued focus • The recommendations from the external FTSU review continued to be actioned. The Trust was on track to full completion by the deadline. • A web-based form had been launched for people to report racist behaviours. These were sent directly to FTSU. • Training compliance had increased to 92% As FTSU NED for DHC, NR met regularly with AH to look at cases in detail. She requested that she be able to attend People and Culture	

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	Committee in Common when FTSU is reported. DU echoed this as FTSU NED for DCH. JH undertook to implement this. NR further noted that she would like to understand more about the drivers behind the increase in reporting and whether this was a concern or an indicator of a positive speaking up culture. Secondly, she asked if the two patient safety incidents detailed in the report had been resolved. AH confirmed they had. Finally, NR offered to support AH in understanding what more the Board could do to support a just and learning culture. CL asked if there were any concerns about the cases regarding sexual safety, noting this was a high priority area. AH advised that there had been a few cases in year, one of which there was not sufficient evidence to progress, but staff continued to be encouraged to report such incidents. The meeting heard there had been an increase in the number of FTSU champions in year and this had increased the number of cases. Whilst work continued to raise awareness of the service, work continued to meet the demand that generated. A new associate guardian was being recruited to support this. AH confirmed that champions were spread across clinical and non-clinical services and were a varied and rich resource. **DCH:** LP confirmed that triangulation of data continued and continued to highlight areas in the trust where additional support or training might be needed. Intelligence was shared between education, recruitment, organisational development, EDIB, and patient safety to support this triangulation. LP further highlighted and commended the collaborative working between the two trusts around a joint newsletter, policy, champion network meetings and peer audit tool and the development of a joint strategy. MBr thanked AH and LP for the reports, noting the positive progress made with training compliance, the cultural change that the FTSU champions supported, and the continued focus on cases of detriment. He acknowledged that AH and LP's worked showed them the more negative sides of the organisations and thanked them for their work.	**JeH**
	Resolved by the DHC Board: that the Freedom to Speak Up Annual Report be received for assurance. **Resolved by the DCH Board: that the Freedom to Speak Up Annual Report be received for assurance.**	
BoDiC26/064	**Guardian of Safe Working Report – DHC and DCH**	
Ellis,Kara 06/08/2026 15:53:11	**DHC:** LK summarised that the ten point plan for improving resident doctors' working lives (10-point plan) have improved the focus on wellbeing and links had been strengthened by having a lead resident doctor. As a result, slightly fewer exception reports had been made. 11 exception reports had been raised in the reporting period, seven of which related	

	to breaches in working time overnight. The Guardian was content that the working conditions were safe for resident doctors. **DCH:** RW highlighted that in the acute hospital, 250 doctors were eligible to make an exception report. In the reporting year 904 reports had been made, with most of these from the most recently qualified doctors. The high number of reports was felt to be a reflection of a positive reporting culture and work to encourage people to report. Additionally, the new reporting system made reporting much easier. The Trust had an excellent 10-point plan peer lead and a chief registrar who worked with the Guardian to ensure practice was good. EJ reflected that both trusts had robust infrastructure and the Chief Medical Officers and Guardians of Safe Working were accessible, which was positive.	
	Resolved by the DHC Board: that the DHC Guardian of Safe Working Report be received for assurance. **Resolved by the DCH Board: that the DCH Guardian of Safe Working Report be received for assurance.**	
BoDiC26/065	**Equality, Diversity and Inclusion Annual Report (incl. Equality Plan Update) - Joint**	
	NP took the report as read, noting the following key points: • The work of the team to make the report accessible, clear, and to link back to the data previously presented to committee and Board in year. • The Trusts had a maturing approach to equality, diversity and inclusion (EDI), with culture and conditions to support EDI taking shape. The foundations and building blocks were well established and were now embedding. • The report also described the frameworks used by the Trusts and the training in place for staff. • Despite this there was evidence of some staff experiencing persistent inequity. • The Trusts were looking to improve accountability, and shift to prevention and being proactive. CL noted the inclusive recruitment practices in place at DHC and wondered if this could be replicated at DCH. NP confirmed work was underway to develop this at DCH. Whilst not completely aligned, the report demonstrated the ways in which the Trusts were working jointly. Board members commended the report and noted the further work to do in the EDI field, including the need for the Board to be engaged and offer support in the delivery of EDI. A suggestion was made for Board members to visit staff networks, in the same way they visit services. MBr highlighted the work undertaken with intent by senior leaders, and the work undertaken by staff who were empowered to help shape this field which enabled a greater reach in to the organisation. With regards to the networks MBr noted the creation of the Culture and Inclusion Group which staff network chairs were invited to attend, and which	

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	offered the space for developing programmes in partnership with colleagues. Staff networks had also been given a role in Trust-wide team briefings. EJ commended the report and the progress it detailed but noted the importance of not being complacent in this arena.	
	Resolved by the DHC Board: that the Equality, Diversity and Inclusion Annual Report (incl. Equality Plan Update) be received for assurance. **Resolved by the DCH Board: that Equality, Diversity and Inclusion Annual Report (incl. Equality Plan Update) be received for assurance.**	
BoDiC26/066	**Reducing Violence and Aggression Update - Joint**	
	AT outlined the various routes that various reports on violence and aggression were reported to, but that the reducing violence and aggression strategy was new and focused on providing a safe working environment for staff. It included all prevention standards in one comprehensive space to ensure better oversight and review of effectiveness. A reducing violence and aggression group had been formed, a strategy written and a workplan for the strategy was in development, utilising the skills and experiences across both Trusts. DCH was revisiting the training needs analysis to ensure it was in line with the more comprehensive approach at DHC. Work was also ongoing to engage staff groups to improve historic underreporting. Updates on this work would be provided to People and Culture Committee in Common on a bi-annual basis. Board members commended and approved the strategy.	
	Resolved by the DHC Board: that the Reducing Violence and Aggression Update be approved. **Resolved by the DCH Board: that Reducing Violence and Aggression Update be approved.**	
BoDiC26/067	**Strategy, Transformation and Partnership Committee Assurance Report – Joint**	
	DU highlighted the following key points from the formal meeting of the committee on 28 May 2026: • A presentation from the DCH Ocean Midwives service had been well received by the committee as an outstanding example of improving services and quality, and the impact for patients • Good discussion of clinical digital risks and agreed for regular updates to be provided to the committee on the prioritisation of digital projects and resources • Receipt of the improving together plan for 2026/27 and detailed discussion in regard to making the plan real for all staff in the organisations • Consideration of the One Transformation Approach report with refreshed metrics focusing on outcomes and impacts	

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	• One Dorset Provider Collaborative – agreement amongst committee members that a visual representation/infographic of the work streams and their interdependencies would be helpful at a future meeting. • The committee also approved a number of items as outlined in the report. The informal meeting in April considered strategy/transformation impact measures and milestones and discussion around CQC Well-Led Review preparation.	
	Resolved by the DHC Board: that the Strategy, Transformation and Partnership Committee Assurance Report be received for assurance. **Resolved by the DCH Board: that the Strategy, Transformation and Partnership Committee Assurance Report be received for assurance.**	
BoDiC26/068	**Strategy Delivery Review - Joint**	
	NP outlined that the report captured the metrics adopted at the outset of the strategy and an assessment of maturity and transformation capability and resources. The report offered a holistic view of shared plans and progress across the federation, whilst retaining statutory responsibilities and duties, maintaining patient care and working towards the national plan. NP considered the ways in which the strategy, set out in 2024, aligned to the national picture and the assurance that offered the Board, particularly in relation to place, community and neighbourhood. The report also outlined the Trusts' partnerships and ability to deliver in a complex system. Appendix two outlined impact measures and narrative was provided where impact was expected but not being seen. MBr reflected on the encouraging view the report offered and that I provided assurance by evidencing that the Trusts were taking steps to deliver the strategy. Further work could always be done and the report set out the digital ambition for the coming years and detailed the framework for implementing the left shift, and the increasing external focus the trusts were moving towards when considering how they could work differently. This set the scene for future IHO discussions and partnership working with UHD. For DHC it was important to understand how new contracts would work over time, and for DCH to consider how to keep a small district general hospital sustainable in the new funding environment. The next steps of this will continue to see delivery of service changes and changes envisaged by the Vista Health report, and to understand what it would mean for DHC to be an IHO. The Board would need to return to this topic as the current structure of foundation trusts and payment by results meant that DCH is likely not a viable organisation in the medium term.	

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	Board members commended the report, noting the progress made in the last two years.	
	Resolved by the DHC Board: that the Strategy Delivery Review be received for assurance. **Resolved by the DCH Board: that the Strategy Delivery Review be received for assurance.**	
BoDiC26/069	**Joint Green Plan – Joint**	
	CH provided context to the plan, noting that it aligned with the Trusts strategic objectives and intentions as a federation, and aligned with the national requirements to focus on net zero carbon. The plan was developed and led by the Trusts' two sustainability leads and was developed in close collaboration with key internal and external stakeholders with broad clinical and operational engagement. The foreword from the Chief Finance and Chief Medical Offers demonstrates that this is a joint clinical, operational, and corporate plan. The plan set out key areas of development over the next three years and the governance and reporting requirements. Net zero guidance issued last year established a clear trajectory to net zero, including an 80% reduction in direct emissions by 2030 and indirect emissions by 2036. The plan embeds sustainability in to core decision making, procurement processes, recruitment processes, and food and nutrition. Next steps included developing a green travel plan, which was expected by the end of 2026, development of a climate adaptation report, development of key performance indicators within the ICD, and communication. CH reflected that there were some final refinements needed to the plan, but these would be immaterial and the content would remain largely unchanged. NR commended the report, particuarlly the use of therapeutic spaces. NR asked if plans to install solar panels were stress tested with electricity suppliers to determine if the local grid could accommodate it. CH confirmed that stakeholder engagement awas crucial, that these discussions did take place with local suppliers and that standards were followed in the case of the NHP to make the buildings more energy efficient. He further noted that the Trusts had been successful in bidding for additional funding for LED lighting and solar panels. JH noted that the report referenced Strategy, Transformation and Partnership Committee in Common as the reporting committee, but this was actually Finance and Performance Committee in Common. LK welcomed the report noting the importance of the broad range of sustainable measures including solar panels, rewilding, and therapeutic interventions, the latter of which could be developed further, particuarlly at DHC. The plan received strong supper from Board members and was approved.	
Ellis,Kara 06/08/2026 15:55:11	**Resolved by the DHC Board: that the Joint Green Plan be approved.**	

	Resolved by the DCH Board: the that Joint Green Plan be approved.	
BoDiC26/070	**Senior Information Risk Owner Annual Report – DHC and DCH**	
	JH outlined that the reports provided assurance about how key information governance risks were identified and addressed, and that reporting would be standardised in the coming year. **DHC:** JH noted that DHC had an Information Governance Steering Group, she had met with the Data Protection Officer and reviewed the Data Security and Protection Toolkit (DSPT) where the Trust was reporting 'standards met'. Since the report was written training rates had hit 98%. RS confirmed that duty of candour was applied in the incident detailed in paragraph 2.1. EJ queried whether the report provided enough information to provide the necessary assurance. JH provided additional context that assurance reports from Information Governance Steering Group were presented to Strategy, Transformation and Partnership Committee in Common and that Internal Audit had undertaken a review of DSPT which had been reported to Audit Committee. Executive responsibility for data protection at both Trusts would transfer to BB in due course. **DCH:** JH outlined that DCH had an Information Governance Group. She had met with the Data Protection Officer to review the DSPT submission, and the Trust would be submitting a 'standards met' response. Since the report was written training had risen to 92%, above the threshold of 90%.	
	Resolved by the DCH Board: that the Senior Information Risk Owner Annual Report be received for assurance. **Resolved by the DCH Board: that the Senior Information Risk Owner Annual Report be received for assurance.**	
BoDiC26/071	**Audit Committee Assurance Reports – DHC and DCH**	
Ellis Kara 06/08/2026 15:53:11	**DHC:** NR highlighted the following key points from the report: • Significant progress in external audit, with a reduction of the expenditure recognition risk with assurance that all is on track for the extraordinary meeting on 22nd June • Thanks were extended to the finance team who were commended by KPMG for their responsiveness in this year's audit • Receipt of the head of internal audit opinion with a classification of 'generally satisfactory with improvements required in some areas' • Receipt of the draft Annual Report and Accounts	

	• Significant improvements in conflicts of interest compliance with recognition for the work undertaken to make that improvement • Four overdue actions on internal audits with particular concerns in responding the cyber security audit CH echoed thanks to the finance teams in both trusts for their year-end work this year. It was noted that there was no particular learning for the Trust in relation to those outstanding actions; CH had followed these up immediately after the Audit Committee meeting but recognised these should be addressed prior to committee meetings. **DCH:** DU presented the report in SP's absence, highlighting: • Thanks were extended to the finance team who were commended by KPMG for their responsiveness in this year's audit • Receipt of the draft Annual Report and Accounts and Annual Governance Statement which was felt to provide a fair and balanced view of the organisation • Confirmation of compliance with the NHS Code of Governance, NHS Provider Licence, and Fit and Proper Persons • A number of items were approved as detailed in the report	
	Resolved by the DHC Board: that the Audit Committee Assurance Report be received for assurance. **Resolved by the DCH Board: that the Audit Committee Assurance Report be received for assurance.**	
BoDiC26/072	**Mental Health Legislation Committee in Common Assurance Report – Joint**	
	AHT highlighted: • Patient stories are now being presented to the Committee which gives a practical insight in terms of how the Legislation is applied and how it is making a difference. • Memorandum of Understanding is in place and is making a difference in terms of cross-agency working. • In depth report on the deaths of detained patients and the learning gained from those sad events. • Positive progress on the Section 132 reporting. • Improved dashboard, Mental Health Legislation Team were acknowledged for their dedication and improved reporting. DD added that the UK Supreme Court had made a judgement on Deprivation of Liberty Safeguards (DOLS) which overruled the Cheshire West Ruling which had been worked to for a number of years. Guidance was published on 15th June about how to assess DOLS under the new standards and work was actively ongoing in both Trusts to reassess patients currently under DOLS to ensure this was applied in line with the new guidance. There was an outstanding action for a paper on mental health legislation updates to be shared with Board members	**JeH**

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	and it would be helpful to consider this at a future Board Development Session.	
	Resolved by the DHC Board: that the Mental Health Legislation Committee in Common Assurance Report be received for assurance. **Resolved by the DCH Board: that the Mental Health Legislation Committee in Common Assurance Report be received for assurance.**	
BoDiC26/073	**Board Effectiveness Reviews, incl. NHS Code of Governance, NHS Provider Licence and Fit and Proper Persons Compliance – Joint**	
	JH described that one report had been produced but that as two statutory organisations reviews of compliance were undertaken separately. This built on work in recent Board Development Session and the recent committee effectiveness reviews. A report to both DCH and DHC Audit Committees declared compliance with the NHS Code of Governance and NHS Provider Licence. A provider capability assessment had been completed in October for both organisations, which included a self-assessment followed by NHSE review. DHC had been rated as 'green' and DCH 'amber green'. Feedback from the Board effectiveness review related to the length of board papers and timeliness of some papers, but the Board Improvement Plan should affect changes in the coming months.	
	Resolved by the DHC Board: that the Board Effectiveness Reviews, incl. NHS Code of Governance, NHS Provider Licence and Fit and Proper Persons Compliance be received for assurance. **Resolved by the DCH Board: that the Board Effectiveness Reviews, incl. NHS Code of Governance, NHS Provider Licence and Fit and Proper Persons Compliance be received for assurance.**	
	CONSENT SECTION	
	The following items were taken without discussion:	
BoDiC26/074	**Charitable Funds Committee Assurance Report – DCH**	
	Resolved by the DCH Board: that the Charitable Funds Committee Assurance Report be received for assurance.	
BoDiC26/075	**Estates Compliance Report - Joint**	
	Resolved by the DHC Board: that the Estates Compliance Report be received for assurance. **Resolved by the DCH Board: that the Estates Compliance Report be received for assurance.**	
BoDiC26/077	**DCH SubCo Ltd Assurance Report & DCH SubCo Ltd Effectiveness Review and Terms of References**	

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	Resolved by the DCH Board: that DCH SubCo Ltd Assurance Report be received for assurance and the DCH SubCo Ltd Effectiveness Review and Terms of References be approved.	
BoDiC26/078	**Questions from the Public**	
	One question had been received in advance of the meeting from one of DCH's Governors. The Governor asked why x-rays took three weeks to be returned to GPs. RW confirmed that turnaround time was accurate, the department were aware of the length of time and it related to increasing demand and lack of availability of reporting radiographers due to long term sickness. The Trust's Associate Chief Medical Officer, Martin Longley, was liaising with GPs about this. No patient safety issues had been identified from the delays.	
BoDiC26/079	**Any Other Business**	
	Nil.	
BoDiC26/080	**Date and Time of Next Meeting**	
	The next part one (public) meeting of the Boards of Directors of Dorset HealthCare University NHS Foundation Trust and Dorset County Hospital NHS Foundation Trust will take place at **9.30am** on **Tuesday 11 August 2026 at** Committee Room 2, Colliton Park, Dorchester and via MS Teams.	
BoDiC26/081	**Resolution Regarding Press, Public and Others**	
	To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.	

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BoDiC Action Tracker, Part 1 - 2026/27

Topic	Minute Reference & Name	Date of Meeting	Action	Lead	Deadline	Response	Status
Approach to thematic anlysis - Learning from Deaths	BoDiC26/010/ Learning from Deaths Report (Q3)	08.04.2026	LK to incorporate a brief summary in the Q1 Learning from deaths report on the plans and progress on undertaking thematic analysis.	LK	13.10.2026	Not yet due - for Q1 reporting	Open - Not yet due
Advanced Foundation Trust policy framework	BoDiC26/051 / CEO Report – DHC and DCH	17.06.2026	Advanced Foundation Trust policy framework to e circulated to Board	JH	10.08.2026	Complete. Circulated 19/06/2026	Complete
Risk reflective exercise	BoDiC26/053 / Corporate Risk Register – DCH	17.06.2026	A reflective exercise to be undertaken at DCH to understand if the trust's delivery plans and strategies were dealing with risk in a comprehensive and acceptable way over time.	DD	13.10.2026	Not yet due	Open - Not yet due
LeDeR reviews	BoDiC26/055 / Learning From Deaths Report Q4 – DHC & DCH	17.06.2026	DD to escalate the lack of system level LeDeR reviews to the ICB at the upcoming system quality group meeting.	DD	10.08.2026	DD raised the lack of system level LeDeR reviews at the System Quality Group meeting on 22.06.2026. The ICB Chief Nursing Officer explained that within the ICB new structure there will be a LeDeR team, which will strengthen the model which had previously been in place. The team will triage any outstanding cases which require review. Recommend close	Complete
FTSU NEDs attending PCCIC	BoDiC26/063 / Freedom to Speak Up Annual Report – DHC and DCH	17.06.2026	FTSU NEDs (DU & NR) to be invited to People and Culture Committee in Common meetings when FTSU report is presented	JeH	10.08.2026	DU and NR have been invited to existing planned meetings when FTSU is due to be presented.	Complete
Mental health legislation update at Board Development Session	BoDiC26/072 / Mental Health Legislation Committee in Common Assurance Report – Joint	17.06.2026	A future Board Development Session to consider mental health legislation updates	JeH	10.08.2026	This has been added to the Board Development Plan for 2026 and will be scheduled to take place before December 2026 – recommend close	Complete

Actions to other Committees

Topic	Minute Reference & Name	Date of Meeting	Action	Lead	Deadline	Response	Status	Committee referred to
Maternity staffing strategic review	BoDiC25/085 / Maternity Safety Report (DCH)	09.12.2025	A strategic overview of staffing in maternity to be returned to Quality Committee in Common in March	AT/JoH	~~08/04/2026~~ 11/08/2026	**March**: To be taken through SLG in April and then FPCIC due to financial ask of the paper. **May**: Work continues on the paper to determine if further investment is required **July**: Paper to be taken to July Finance and Performance Committee in Common. Recommend close	Complete	Quality
Better Payment Practice	BoDiC25/143/ Finance Report	10.02.2026	CH to bring a breakdown of the constituent areas that form part of the Better Payment Practice performance and areas of non-compliance to the FPC Committee.	CH	~~31/05/2026~~ 31/07/2026	Postponed until July 2026 due to system wide changes in Trust Procurement Teams. Agreed by FPC committee 28/05/2026. **July update:** Detailed reports relating to Better Payment Practice Code performance for both DHC and DCH were presented to the FPC committee on 29th July 2026 for assurance. Controls continue to be strengthened across both organisations to reduce late payment charges and support compliance with the Better Payment Practice Code. Recommend close	Complete	FPC
Mental Health Inpatient Flow	BoDiC26/014/ DHC Integrated Performance Report	08.04.2026	Cross-refer quality concerns related to mental health inpatient flow to the Quality Committee **(informal)**.	RS	01.06.2026	Mental health flow discussed in June informal Quality Committee in Common. Recommend close	Complete	QCiC
Audiology Service Long Waits	BoDiC26/014 / DHC Integrated Performance Report	08.04.2026	Breakdown of long waits within audiology and how waiting time information is communicated to patients to be incorporated into the next performance report for the FPC committee in July.	RS	~~10/06/2026~~ 31/07/2026	Further details on Audiology waiting times and how waiting time information is communicated to patients was incorporated into the DHC Performance Report to FPC on 29th July 2026 (Ref Section 3.8). Recommend close	Complete	FPC
Care hours per bed day / producivity / quality indicators	BoDiC26/057 / Inpatient Safe Staffing Report – Biannual (DCH)	17/06/20206	Quality Committee in Common to understand how DCH's care hours per patient day (as reported in the safe staffing report) linked to producivity, and to map this to other quality outcomes to demonstarte how thte Trust had invested in people and quality.	DD	13.10.2026	Not yet due	Open - Not yet due	QCiC

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

Trust Board Meeting in Public

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

Ellis,Kara
06/08/2026 15:53:11

Dorset County Hospital
Dorset HealthCare

Report to	Board of Directors in Common – DHC and DCH	
Date of Meeting	11 August 2026	
Report Title	Chief Executive Officers Report	
Prepared By	Jonquil Williams, Corporate Business Manager	
Approved by Accountable Executive	Matthew Bryant, Chief Executive Officer	
Previously Considered By	N/A	
Action Required	**Approval**	N
	Assurance	N
	Information	Y

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

Executive Summary

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

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

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

National

- National maternity update
- NHSE letter – mortuary oversight
- NHSE letter – preventing unlawful access to patient records
- Newly appointed Secretary of State for Health and Social Care
- Newly appointed CQC CEO
- National Oversight Framework
- NHS Quality Strategy
- Leadership and Management Framework
- Provider Capability Assessment 2026

Federation

- 2025-26 Annual Report and Accounts
- Quarter 1 Medium Term Financial plan

Trust specific

Ellie Ward 06/08/2026 15:53:11

- Dorset County Performance
- Dorset County GIRFT – outpatients
- Dorset County CQC
- Dorset Healthcare CQC
- Dorset County Topping Out ceremony
- Dorset Healthcare Gold award – Defence Employer Recognition Scheme (ERS)

Recommendation
Members are requested to receive the report for information.

Ellis Kara
06/08/2026 15:53:11

Chief Executive Officer's Report – August 2026

1. National/regional

1.1 New Prime Minister, Secretary of State and CQC Chief Executive

On 20 July Andy Burnham was announced as the new Prime Minister. He has announced his new cabinet and Yvette Cooper as the new Secretary of State for Health and Social Care. She has been an MP for 29 years and served as Chief Secretary to Treasury and Secretary of State for Work and Pensions during Gordon Brown's government. She returned to government as Home Secretary in July 2024, before becoming Foreign Secretary in September last year.

Emily Miles a civil servant who has run the food safety regulator will be the new CEO of the Care Quality Commission. She is currently Director General for Food, Farming and Biosecurity at the Department of Environment, Food and Rural Affairs. She was previously Chief Executive of the Food Standards Agency, which oversees Food Safety.

1.2 National maternity updates – triage specification, Ockenden review and Amos review

On 24 June 2026 the independent review of Nottingham University Trust was published and reported that through various reviews and reports that Nottingham University Trust revealed a pattern of

- repeated warnings that were not acted upon in a sustained or effective manner
- failure to embed learning from incidents and reviews
- cultural and structural barriers to escalation and transparency
- chronic workforce pressures affecting safety and governance
- limitations in organisational and system-level oversight

Following the Ockenden independent review and the Amos review the government has put in place a 10-point plan for neonatal and maternity services. This is a set of urgent actions in response to the recommendations in both reports that trusts, and the wider system have been asked to prioritise.

These urgent actions will support, and report into, the National Maternity and Neonatal Taskforce as it develops the National Action Plan, which will be published in December.

As outlined in NHS England's 10-Point Plan for maternity and neonatal services, all trusts must commit to delivering safe and effective maternity triage. Within three months, each trust should complete a board-level audit to identify any gaps and ensure services are consistently safe, responsive and appropriately resourced.

This national maternity triage specification will support local services in achieving this urgent action. It sets out what good maternity triage services should look like, recognising maternity triage as a safety-critical clinical environment, as the emergency front door for urgent and unscheduled maternity care. It establishes consistent national principles to strengthen, protect and sustain this core part of maternity services, closing gaps in current provision and supporting seamless pathways from early pregnancy services into maternity triage, so that women and families receive safe, timely urgent care when they need it.

Public Item
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There is an expectation that organisations will have fully implemented the specification within 12 months of publication. Additionally, within 3 months of publication, organisations will have audited their current maternity triage services, completed a gap analysis against this specification, and developed an implementation plan, with progress reported through a public Trust Board meeting and shared with regional NHS England teams.

The team at DCH are working through the gap analysis associated with the 10-Point Plan and the triage specification and will report this back through Quality Committee and the Board.

1.3 NHSE letter - mortuary oversight

On 26 June all trusts received a letter from NHSE in relation to the findings of Donna Ockenden's report. In the letter it was noted that these findings should consider this Phase 2 report of the independent inquiry into the crimes of David Fuller, published in July 2025. The report made 75 recommendations to strengthen the protection, security and dignity of people after death, including 29 that are immediately relevant to the NHS.

In response to Donna Ockenden's review and the Human Tissue Authority's (HTA) recent report on Nottingham University Hospital the Government has announced that the HTA is taking immediate action with a new requirement for mortuaries to review HTA reportable incident (HTARI) internal records from 2015-2026. This audit will ensure that all reportable incidents during this period have been logged with the HTA, and that any missing incidents are reported retrospectively. A regulatory update will be issued by the HTA in July setting out the parameters, timeframe, process and deadlines for the evidential compliance audit. The HTA will report findings to the Secretary of State in October.

On 31 July DCH submitted an assurance report to NHSE and will be discussed later in the meeting.

1.4 NHSE letter - preventing unlawful access to patient records

On 8 July a letter was sent to trusts issuing new guidance to support trusts in preventing unlawful access to patient records.

Patients using NHS services rightly expect their information to be kept secure by the people who treat them. This is why recent reports in the media of staff accessing patient information in unauthorised circumstances are particularly worrying for us all.

The majority of NHS staff handle patient information responsibly and professionally every day. However, a small minority of individuals undermine the trust that patients place in them and cause unnecessary distress and harm by accessing records without legitimate reason. Aside from the harm caused, these staff members risk their own careers through disciplinary action, dismissal, referral to their professional regulator, and even criminal prosecution.

Every time a breach occurs there is also inevitable and lasting damage caused to public trust in the NHS overall and, specifically, our ability to safeguard people's data – something which is critical to the long-term future of the NHS as we design technology like the Single Patient Record.

Across both trusts if there is risk flagged that a patient's record is being accessed inappropriately then we have disciplinary procedures in place to address these situations which have been successful used in the past. EPIC will have the functionality to evaluate who has had access to a patient record which will be able to analyse regularly. As part of the national plan the trusts have sent communication to all staff regarding inappropriate access to patient records.

Ellie.Kay@nhs.net 09/08/2025 15:56:11

1.5 National Oversight Framework 2026-27

The NHS Oversight Framework for 2026/27 is an integral part of the operating model providing clarity around accountability and our approach to oversight and intervention. Its objective is to bring fairness, proportionality, consistency, transparency and predictability to our oversight of NHS trusts and foundation trusts and ICBs.

During 2025/26, NHSE focused on embedding new operating arrangements and progressing provider capability assessments. Feedback from the service emphasised the importance of keeping the oversight model simple while ensuring it remained robust, data-driven and aligned with the priorities in the NHS Medium Term Planning Framework. This framework is designed to drive medium-term system transformation while maintaining operational performance tracking.

NHSE are bringing together measures of access, quality, productivity, people and finance, and considering organisational capability as the basis for proportionate support and intervention. Publication of this information – including publicly available league tables – enables everyone to see how organisations compare and what follows next, with boards expected to use this insight to drive tangible improvement alongside wider metrics recommended in the Insightful board documents.

The main changes from last year's framework are:

- alignment of the approach to delivery segmentation for ICBs and providers
- clearer recognition of highly capable, high-performing providers, including those that are awarded advanced foundation trust status and benefit from lighter-touch oversight
- update oversight metrics aligned to the NHS Medium Term Planning Framework, including new metrics for mental health, community and ambulance trusts
- refinement of the delivery segmentation methodology, moving from a quartile-based approach to statistical thresholds, to make tracking of improvement easier
- establishing a stronger link between the oversight response model and delivery segmentation, organisational capability, and other considerations around engagement intensity, support, potential incentives and consequences

Both the Chief Operating Officers have been reviewing the changes for each trust which was discussed at the Joint Board Development session in July, and we will start to evolve our board dashboards to include any new NOF metrics for 26-27.

1.6 New Leadership and Management Framework

The NHS Leadership and Management Framework responds to reviews of leadership in health and care, including the Messenger review (2022) and Kark review (2019), and supports the 10 Year Health Plan.

To deliver the ambitions set out in the plan, the NHS needs clinical and non-clinical leaders and managers at all levels, who are confident, capable, and future-focused to respond to the evolving needs of staff, patients, and communities.

Ellis Clarke
06/08/2026 15:53:11

The framework consists of 3 elements:

- A leadership and management code – this sets out the principles and behaviours expected of every manager and leader within our health and care system.
- A national, consistent set of standards – the essential competencies for all clinical and non-clinical NHS leaders and managers at every level.
- The national curriculum (this will be published in Winter 2026) – this sets out the development expectations at each level of leaders and managers.

All leaders and managers will have access to professional development and support to meet the expected standards and competencies in the NHS Leadership and Management Framework.

The framework will provide a consistent foundation for leadership and management development across the NHS. It has been published as part of the establishment of the new NHS College of Leadership and Management as the national home for NHS leadership, management and talent excellence.

In partnership with the service and building on the foundations established through existing leadership communities, the college will help strengthen professional identity, support career development, improve talent management and learning, and provide a recognised quality mark for leadership and management**.**

We held a Joint Leadership Forum in July to discuss the new framework with our leaders across both DCH and DHC.

1.7 New Quality Strategy

On 14 July the NHS published a new quality strategy.

The strategy provides a new structured approach to making quality the organising principle for all NHS activity in England over the next decade.

Its purpose is to ensure people receive high-quality care consistently across all NHS-funded services. By doing so, it aims to:

- improve health outcomes
- improve patient satisfaction with NHS services
- reduce health inequalities

It applies system-wide, guiding national bodies, NHS leaders, the wider healthcare workforce and partners whose actions influence the quality of care in local communities.

While social care is outside the strategy's scope, it recognises the need for strong partnerships between health and social care to improve quality where services meet.

Both Nursing and Quality teams are reviewing the strategy and will bring a report through to committee and board on how each trust will align to the strategy.

1.8 Provider Capability Assessment 2026

Eija Kara 06/08/2026 12:53:11

NHS trusts have been requested to undertake the 2026 Provider capability self-assessment against a set of capability statements across the domains derived from [The insightful provider board](). The

statements have been slightly altered this year, to include the following Cyber security and digital maturity at board-level, and board-level overview of staff wellbeing.

The purpose of this self-assessment is to strengthen NHS trust boards' assurance, focusing attention on key areas of governance and encouraging an open culture of 'no surprises' between providers and regional oversight teams. It will also supports the NHSE regional team to establish the level of oversight for the organisation over the year. The process remains similar to last year:

Trust boards conduct a self-assessment, using the attached Provider capability self-assessment form to set out their view of their capability in each of the six domains. For 2026 provider self-assessment will use the same language as the final capability rating, Green / Amber-Green / Amber-Red / Red. Following regional and national NHSE review an overall view of capability using the same rating system will be published.

As a Wave 1 Advanced Foundation Trusts Dorset HealthCare do not have to submit a return in 2026; their current rating will remain unchanged but may be reviewed if in-year matters arise, but they will carry out a self-assessment next year 2027.

A self-assessment will be completed for Dorset County Hospital. We will adopt the same review and sign off process that was used in 2025. This included Committee confirm and challenge in September 2026 followed by Board approval in advance of the submission deadline of Friday 2 October 2026.

2. Federation

2.1 2025-26 Annual report Dorset County and Dorset Healthcare

The annual reports for both Dorset County Hospital and Dorset Healthcare were laid before parliament in July and are now available publicly through our website.

Dorset County Link

Dorset Healthcare Link

2.2 NHSE letter Dorset County Hospital performance

On 26 June we received a letter from Sir Jim Mackey and Penny Dash in relation to the performance at Dorset County Hospital in the first quarter of the year.

In Dorset County Hospital, we have seen very high numbers of attendances in the Emergency Department and our emergency waiting times have not met the expected performance levels. This is also true of our waiting times for planned care (referral to treatment times and some of our cancer performance measures), where we have seen a rise in our waiting lists and longer waits than planned.

As a result of receiving this letter the executive team, Board and ICB worked collaboratively to submit a response to NHSE to provide assurance on our governance and oversight and the Recovery Plans in place.

2.3 Dorset County Hospital Getting It Right First Time (GIRFT) Outpatients

On 17 June Dorset County Hospital received a letter from Professor Tim Briggs regarding outpatient improvement.

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06/08/2026 15:03:11

To support improvements in outpatient care, GIRFT has led a series of targeted workstreams, most recently *Further Faster: Follow-Up*. Working with clinicians across 20 trusts, this programme has co-developed 85 pathway-specific follow-up protocols across 11 specialties, including 16 digital pathways. Developed in collaboration with relevant professional societies, these standardised protocols have shown significant potential to improve care. Audits by early adopter sites found that, on average, around 30% of follow-up appointments across these pathways could have been avoided or delivered differently, for example through written correspondence or Patient Initiated Follow Up (PIFU). Combined with efforts to optimise clinic templates in line with the national median for each specialty, standardisation alone has increased capacity by 15-30%.

Outpatient transformation is complex, and the GIRFT Further Faster guidance is accompanied by a number of key priorities set out in the appendices to this letter. Together, these align with the three strategic shifts in the NHS 10 Year Health Plan: from analogue to digital, from sickness to prevention, and from hospital to community.

On 17 July Dorset County submitted the following to the GIRFT team:

- acknowledgement of the national call to action;
- our planned approach to implementation;
- any challenges to adoption where GIRFT support would be helpful;
- details of the SRO leading this work within the trust.

Details of the letter have been shared with the joint executive team and will be overseen by the Finance and Performance Committee.

2.4 Dorset County Hospital CQC

The Care Quality Commission (CQC) has rated urgent and emergency care, and medical care, at Dorset County Hospital (DCH) as ‘good’ following an inspection.

An inspection was carried out at the Dorchester hospital in January 2026 as part of the CQC’s continual checks on the safety and quality of services.

Quality and medical leads at DCH are pleased that the hard work of staff to maintain high standards and to make improvements at a time when their services have been under significant ongoing pressure has been recognised by inspectors.

The overall rating for Dorset County Hospital also remains ‘good’.

2.5 Dorset HealthCare CQC

On 22 - 25 June we welcomed the CQC inspection team and NHSE finance colleagues to Dorset HealthCare to complete the onsite elements of the CQC well led inspection. The CQC spoke with over 200 staff across 16 focus groups and interviewed 33 staff over those 3 days. Following the CQC well led onsite inspection we received positive informal feedback from the CQC team which demonstrated the passion of Dorset Healthcare staff, our commitment to quality of care, clear commitment to quality improvement and impressive work by the Research and Development team.

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Data requests are still ongoing and the CQC aim to send the report within 85 days.

I want to thank all staff that contributed to the inspection.

2.6 Dorset County New Hospital Programme 'Topping Out' ceremony

It was a great privilege to join colleagues, partners and supporters at Dorset County Hospital on 16 July to celebrate the 'topping out' of the new Emergency Department (ED) and Critical Care Unit (CrCU), marking the completion of the building's highest point.

It gave us the opportunity to say thank you to our construction partners, Tilbury Douglas, and also to reflect on all the other partnerships that underpin the successful delivery of this new building.

This includes the support of the HELP Appeal charity who have generously funded the new rooftop helipad which will help to ensure patients receive timely access to life-saving emergency care. We were delighted to welcome HELP Appeal Chief Executive Robert Bertram, alongside representatives from the New Hospital Programme, which is funding the overall £100million development. We're also getting fantastic support through the Dorset County Hospital Charity's Emergency and Critical Care Appeal which is raising money to enhance the facilities.

2.7 Dorset Healthcare gold veterans award

I'm really pleased to share that Dorset HealthCare has achieved the prestigious Defence Employer Recognition Scheme (ERS) Gold Award this week. This is the Ministry of Defence's highest recognition for organisations that demonstrate exceptional support for the Armed Forces community.

Dorset HealthCare was one of just 162 organisations across the UK to receive the award this year, recognising our long-term commitment to supporting veterans, reservists, military families and Cadet Force adult volunteers. Achieving gold status reflects the work of colleagues across the Trust to create a forces-friendly workplace, with policies and support that go beyond our Armed Forces Covenant commitments. It shows that we actively champion the Armed Forces community and offer sustained, proactive support.

This is a significant achievement for the Trust and builds on the wider commitment across Dorset to supporting our Armed Forces community. Dorset County Hospital currently holds silver ERS status and I hope we can work towards the gold accreditation there too. Congratulations and thanks to everyone involved in helping Dorset HealthCare reach this important milestone.

Ellis Kara
06/08/2026 15:53:11

Report to	Board of Directors DHC and DCH	
Date of Meeting	11 August 2026	
Report Title	Board Assurance Framework – Quarter 1 2026/27	
Prepared By	Jenny Horrabin, Joint Director of Corporate Affairs	
Approved by Accountable Executive	Jenny Horrabin, Joint Director of Corporate Affairs	
Previously Considered By	Assigned risks considered by Committees w/c 27 July 2026 Full Board Assurance Framework considered by Audit Committee 31 July 2026 (DHC) and 3 August 2026 (DCH)	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

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

Executive Summary

1. Overview

The Joint Strategy 'Working together, improving lives' was approved at the DCH and DHC Boards on 31 July 2024 and 7 August 2024 respectively. The Boards held a workshop on 02 September 2025 to review the Risk Appetite statements of each organisation to see if they could be aligned, recognising that each organisation's tolerance may be different. This was approved by the Boards in December 2025. In accordance with good practice the strategic risks have been subject to annual review, and the revised risks were reviewed by the Committee in May 2026 and subsequently approved by the Board in Common on 17 June 2026. Each Trust has a joint set of strategic risks, and the template and review process are the same, as described below. However, the Board Assurance Framework is separate for each organisation as the controls and assurances, and risk scores are different between DCH and DHC.

As the risks have been reviewed and revised for 2026/27 the unmitigated, mitigated and target scores have been reviewed and reset.

Appendix One to this report is the DHC BAF for Quarter 1 2026/27

Appendix Two to this report is the DCH BAF for Quarter 1 2026/27

2. Board Assurance Framework: Review Process

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

Ellie Kay 07/08/2026 15:53:11

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

Controls and assurances are identified in terms of:

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

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

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

Each action is marked as:

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

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

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

Assigned risks were considered by Committees w/c 27 July 2026 and the full Board Assurance Framework considered by Audit Committee 31 July 2026 (DHC) and 3 August 2026 (DCH).

Dorset HealthCare - Quarter One Board Assurance Framework

Risk Scores

The highest scoring risk identified within the assurance framework (based on the mitigated risk score) are SR3: Workforce Capacity and SR8: Digital (each with a score of 15 or more).

Actions

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

All open actions have been carried forward from the previous related risks and these are marked as 'CFWD' to ensure that open actions continue to be addressed. 18 actions have been carried forward. Two out of nine risks have one action that is behind schedule (SR1 and SR6). In total there are two overdue actions The overdue actions have been considered by Committees.

There were no amendments arising from the Committee reviews.

Dorset County Hospital - Quarter Four Board Assurance Framework

Ellis, Sara
06/08/2026 10:53:11

Risk Scores

The highest scoring risk identified within the assurance framework (based on the mitigated risk score) are SR1 Safety and Quality; SR3 Workforce Capacity; SR4 Capacity and Demand; SR5 Estates; SR6 Finance; SR8 Digital (each with a score of 15 or more).

Actions

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

All open actions have been carried forward from the previous related risks and these are marked as 'CFWD' to ensure that open actions continue to be addressed. 16 actions have been carried forward. One out of nine risks have one action that is behind schedule (SR6). In total there is one overdue action. The overdue action has been considered by Committees.

There were two amendments arising from the Committee review:

Sr1 Safety and Quality – the overall assessment for the 'Priority Strategy and Plans' section was changed from green to amber to reflect the need for further assurance in respect of maternity services in response to recent national reviews.

Recommendation

Members are requested to:

- Receive **assurance** on the process in place to review the Board Assurance Framework
- Review and scrutinise the risks and identify any areas where further assurance is required and provide any further commentary on the controls, assurance and actions.

Ellis Kara
06/08/2026 15:53:11

Dorset HealthCare University
NHS Foundation Trust

Dorset HealthCare University NHS Foundation Trust
Board Assurance Framework
Quarter 1 July 2026

Ellis Kara
06/08/2026 15:53:11

Dorset HealthCare University NHS Foundation Trust

Board Assurance Framework Overview - Quarter 1 July 2026	Strategic Objectives				Responsibility		Score						Alignment to Risk Appetite
Strategic Risks	Care	Communities	Colleagues	Sustainability	Committee	Executive	Unmitigated Score	Mitigated Q1 26-27 Score	Mitigated Q2 26-27 Score	Mitigated Q3 26-27 Score	Mitigated Q4 26-27 Score	Target Score	
SR1: Safety and Quality If we are not able to deliver the fundamental standards of care and if we do not consistently create a positive safety culture, we will not be able to provide safe, effective and compassionate care across all settings that places peoples experience of care at the heart	X				**Quality**	Chief Nursing Officer	16	12				6	**Patient Safety and Quality - Cautious**
SR2: Empowerment If we do not create the culture and conditions where people thrive and feel empowered in their role, our ability to deliver improved patient outcomes and experience of care and high-quality compassionate and safe care will be compromised.	X		X		**People and Culture**	Chief People Officer	15	12				12	**Workforce - Seek**
SR3: Workforce Capacity If we do not reshape and modernise the workforce, underpinned by effective purposeful recruitment and retention, to ensure we have the required skills and capability, we will not be able to deliver the 3 shifts in accordance with the 10-year plan.	X		X		**People and Culture**	Chief People Officer	20	16				12	**Workforce - Seek**
SR4: Capacity and Demand If we do not meet current and expected demand, and achieve local and national metrics within available resources, patient outcomes and experience will be adversely affected, and we may face reduced autonomy and regulatory action.	X	X		X	**Finance and Performance**	Chief Operating Officer	16	12				9	**Operational Performance - Open**
SR5: Estates If we do not have access to an estate that is fit for purpose and economically and environmentally sustainable, we will be unable to provide the right environments for our staff to deliver high quality services to the communities that we serve.	X		X	X	**Finance and Performance**	Chief Finance Officer	20	12				9	**Finance and Value for Money - Open**
SR6: Finance If we do not deliver on our financial plans, including the required level of savings, it will adversely impact our ability to provide safe, sustainable services within the context of the developing NHS funding model and the 10-year plan.				X	**Finance and Performance**	Chief Finance Officer	16	12				9	**Finance and Value for Money - Open**
SR7: Partnerships and Transformation If we do not have effective and positive partnerships, with clear governance and accountability frameworks and a commitment to work in collaboration to transform services, then we will not be able to shape decisions and deliver the transformation required to deliver the ambitions of the 10-year plan and address the health inequalities within our population	X	X		X	**Strategy, Transformation & Partnerships**	Chief Executive Officer	16	12				12	**Innovation, Partnerships and Commercial – Seek**
SR8: Digital Infrastructure If we do not address and improve our digital and technological capabilities, including implementing our new EHR system, and utilising new digital technologies, we will not deliver safe and sustainable services.		X		X	**Strategy, Transformation & Partnerships**	Chief Finance Officer	20	16				12	**Digital - Seek**
SR9 Cyber security If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents	X			X	**Strategy, Transformation & Partnerships**	Chief Finance Officer	15	12				6	**N/A**

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Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care	**SR1: Safety and Quality** **If we are not able to deliver the fundamental standards of care and if we do not consistently create a positive safety culture, we will not be able to provide safe, effective and compassionate care across all settings that places peoples experience of care at the heart**	Quality

Executive Lead: Chief Nursing Officer

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

Rationale for Score: Good progress made in respect of PSIRP and reporting arrangements in place. Enhanced surveillance framework and early warning dashboard being developed

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Quality Priorities	Quality Account 25/26 approved and published by deadline - Quality Committee May 26 Board June 26. Approved quality priorities for 26/27 - Quality Committee May 26.	**Positive**	**Green**
PSIRF Response Plan	PSIRP updated for 26/27 - approved by Patient Oversight Panel and reported to QC July 26. CQC observed as part of CQC Well led Inspection June 26	**Positive**	
Risk Controls and Plans			
Quality Priority Improvement Plan (inc agreed standards and measurement)	Quality Priority Improvement Plan (inc agreed standards and measurement) and regular reporting to Quality Committee in year on progress	**Positive**	**Amber**
PSIRF implemented to improve patient safety	PSIRF Oversight Panel, reports to Quality Governance Group and Quality Committee bi-monthly. Used to inform Quality Priorities and informed PSIRF Response Plan (Quality Committee July 26)	**Positive**	
Patient Experience Metrics and Improvement Plans	Patient Experience Annual Report and Annual Complainst Report Quality Committee Nov 25 (inc local surveys and metrics), Friends and Family Test National Surveys, Patient Story to Board bi-monthly. Positive progress with collaboration of patient participation and patient experience.National Experience of Care framework to be adopted - in progress	**Positive**	
Quality Committee Framework and reporting	Implementation of enhanced surveillance framework - implement Q2 and test Q3; Individual CQC Inspection reports - reported to QGC and to QC; EQIA SOP in place and IA review provided substantial assurance (reported to Audit Committee May 26). and reported to Quality Committee bi-monthly; Risk and incident management system procured and in implementation phase which will further enhance reporting and triangulation; KPI monitoring and Quality Dashboard and Quality Reports - reported to Quality Committee bi-monthly.	**Neutral**	
Health Inequalities Plan	Joint Health Inequalities Steering Group commenced, health Inequalities Improvement Plan in place. PCREF reported to Board Oct 25 March 26. Work required to become more outcomes focussed in reporting	**Neutral**	
Oversight Arrangements for Governance & Engagement			
Quality Committee	Assurance Reports to Board	**Positive**	**Green**
Quality Governance Framework - reporting into Quality Committee	Quality Governance Framework in place, with Quality Governance Group reporting to Quality Committee bi-monthly and Committee approved workplan in place	**Positive**	

Lewis Kara 06/08/2026 15:51:41

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Review metrics and reporting - for 26/27 further work on reporting capability and refining of quality report to ensure compliance with contractual reporting obligations and national requirements (MTP) - Previous action re NQB expanded and later date proposed - reviewed all metrics and reporting and now waiting for BI for implementation - June 26 (end of Q1) **(CFWD)** - Completed for end of Q1	CS	~~Dec 25~~ ~~Mar 26~~ July 26	Complete
Review of reporting of health inequalities metrics with clearer focus on outcomes **(CFWD)** - In progress	HP	~~July 26~~ Sept 26	Behind Schedule
Implement enhanced surveliiance framework	CS	Aug-26	On Plan
Develop early warning dashboard - March 26	CS	Mar-27	On Plan

Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR2: Empowerment** **If we do not create the culture and conditions where people thrive and feel empowered in their role, our ability to deliver improved patient outcomes and experience of care and high-quality compassionate and safe care will be compromised.**	People and Culture

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief People Officer	Unmitigated	5	x	3	=	15
	Mitigated	4	x	3	=	12
	Target	4	x	3	=	12

Rationale for Score

Joint Inclusion and Belonging Group, anti-racism framework, managers guidance on unacceptable behaviours - continue to embed & measure impact. Service pressures coupled with high degree of uncertainty due to local/national changes. Launch of national leadership and management framework provides opportunity to review our approach to support people through change. Joint Inc and Belonging Strategy to be broadened to include inclusion as whole (wider than workforce)

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Enabling People Plan DCH/DHC in place and delivery mechanisms	Joint Strategy and Enabling Plans PCC April 26, Workforce KPI Dashboard to PCC and Board bi-monthly, People Enabling Plan - Objectives and Delivery Plan 26/27 to PCC May 26	Positive	Green
Joint Inclusion & Belonging Strategy	Board approved Joint Inclusion and Belonging Strategy and Plan, review in progress and to be reported to PCC Nov 26, Annual EDI Report to PCC May 26, Staff Survey Report and Action Plan reported in 25/26	Positive	
Leadership and Management Development Strategy	Approved strategy in place. New national leadership and mgs framework published July 26 and to review for end Q2 with a focus on equipping our staff to deal with major transformation programmes and change. Digital workforce risks to PCC May 26	Neutral	
Joint Workforce Wellbeing Plan	Plan approved Dec 24, Delivery Action Plan report to PCC Nov 25. Health and Wellbeing Plan update PCC May 26	Positive	
Risk Controls and Plans			
Staff Engagement Programme (including Staff Networks)	Staff Survey / Pulse Survey, Joint Leadership Forum met July 26, Staff Networks (informal PCC focus March 26), Staff Voice Report - approach to PCC May 26 report scheduled Nov 26 and bi-annual thereafter to follow Staff Survey	Positive	Green
EDI Framework and We All Belong - Anti-Racism Charter and Action Plan	EDI Annual Report PCC & Board May/June 26 (WRES, WDES, Pay Gap Reports during year in accordance with national timescales). Board Development Session on Anti-Racism and Inclusion Nov 25 and Anti-Racism Framework PCC Nov 25 and Charter Jan 26 - Board approved Feb 26 and launched June 26. Lord Mann review PCC July 26	Neutral	
Freedom to Speak Up arrangements	Freedom to Speak Up bi-annual Reports to Board and Committees May/June 26	Positive	
Reducing Violence and Aggression Strategy and Plan	Reducing Violence and Aggression update PCC May 26	Positive	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee in Common (DCH & DHC)	Assurance Report to Board	Positive	Green
EDI Delivery Groups and Workforce Wellbeing Steering Group	Assurance reports to People and Culture Committee	Positive	
Joint Culture and Belonging Group	Assurance reports to People and Culture Committee	Positive	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Launch of Mangers Guidance on Unacceptable Behaviour - review impact in line with EDI review and reporting cycle **(CFWD)** - Complete, guidance launched	NP	Jul-26	Complete
Review of format and function of Joint Inclusion and Belonging Group **(CFWD)** - Complete and operating	EH	Jul-26	Complete
Review of EDI and Health Inequalities governance across DCH and DHC **(CFWD)** - Superseded - EDI Groups reviewed, Joint Inclusion and Belonging Strategy to be reviewed to include health inequalities	JH	Jul 26 Sep 26	Complete
Leadership framework review, to encompass equipping our staff to move through period of uncertainty and change	NP	Sep-26	On Plan
Review Joint Inclusion and Belonging Strategy with a focus on inclusion (broader than workforce)	EH	Nov-26	On Plan

Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR3: Workforce Capacity** **If we do not reshape and modernise the workforce, underpinned by effective purposeful recruitment and retention, to ensure we have the required skills and capability, we will not be able to deliver the 3 shifts in accordance with the 10-year plan.**	People and Culture

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief People Officer	Unmitigated	5	x	4	=	20
	Mitigated	4	x	4	=	16
	Target	4	x	3	=	12

Rationale for Score

Continued focus on reduction of temp staffing - ward headroom reduction programme established for 26/27 (phase 1 and 2) and phase 2 + 4 27/28. As at end of Month 3 - 1WTE behind plan for substantive, 29 WTE behind plan for bank 21 behind plan for agency, with net position of 52 WTE behind plan

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Medium Term Plan (MTP) 3 years with Workforce Plan 26/27	Reviewed by FPC and Approved by Board draft submission Dec 25 and final submission Feb 26 (including risks to achievement of plan). MTP Feedback letter FPC May 26 with actions arising to be reported to July FPC	**Positive**	**Green**
Enabling People Plan DCH/DHC in place and delivery mechanisms	Joint Strategy and Enabling Plans PCC April 26, Workforce KPI Dashboard to PCC and Board bi-monthly, People Enabling Plan - Objectives and Delivery Plan 26/27 to PCC May 26	**Positive**	
Learning Needs Analysis	Annual Education Quality Self-Assessment - PCC Nov 25 / Learning Needs Analysis & affordability - 26/27 reporting in PCC workplan	**Positive**	
Risk Controls and Plans			
MTP Workforce Plan 26/27	KPI dashboard to PCC bi-monthly and forms part of board reporting bi-monthly. WTE reductions reviewed by Financial Recovery Board (FRB) and forms part of CIP reporting to Finance and Performance Committee	**Neutral**	**Amber**
Joint People Plan delivery framework 26/27 (delivery framework from enabling plan)	Workforce dashboard to People and Culture Committee bi-monthly and in integrated performance reporting to Board Bi-monthly.	**Positive**	
Ten Point Resident Doctors Plan	Staff Turnover metrics in Workforce Dashboard to PCC. Ten Point Resident Doctors Plan to PCC Jan 26, and May 26	**Positive**	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee in Common (DCH & DHC)	Assurance Report to Board	**Positive**	**Green**
Divisional Performance Group	Reporting to PCC via KPI Dashboard	**Positive**	
Safer Staffing Group	Staff Staffing Report to Board June 26, Developing Workforce Safeguards Report March 26	**Positive**	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Look for opportunity to work more closely in Provider Collaborative to address common workforce issues (CWFD)Close action superseded by People Target Operating Model issued by NHSE	NP	May-26	Complete
Develop plan to ensure workforce in place to support transformation	NP	Dec-26	On Plan

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Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR4: Capacity and Demand** **If we do not meet current and expected demand, and achieve local and national metrics within available resources, patient outcomes and experience will be adversely affected, and we may face reduced autonomy and regulatory action.**	Finance and Performance

Executive Lead: Chief Operating Officer

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

Rationale for Score: Whilst performing well against some national standards, below thresholds in some areas - remained NOF 2 for Q4. Where below thresholds clear understanding of underlying issues and improvement plans and/or recovery trajectories in place. Dedicated programme launched to address ALOS. Two key transformation programmes moved to mobilisation (MH inpatient flow and CYP MH)

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Medium term Plan 3 years with Operational Plan 26/27	Reviewed by FPC and Approved by Board draft submission Dec 25 and final submission Feb 26 (including risks to achievement of plan). MTP Feedback letter FPC May 26 with actions arising to be reported to July FPC	**Positive**	**Green**
MH Inpatient programme mobilisation	Mental health inpatient flow transformation programme - Oversight at Joint Transformation and improvement Board (JTIB) and via programme report to STP Committee bi-monthly. Update to on quality implications Quality Committee (informal June 26). Associated performance measures re ALOS and OOA reported to FPC and Board via performance reporting bi-monthly	**Positive**	
Children, Young Person and Adolescent Mental Health (CYP MH) Programme Mobilisation	System programme approach and governance structure in place with clear outcomes and milestones - ICB approved business case wand full funding via MTP. Mobilising 26/27 and key metrics included in performance reports to FPC and Board bi-monthly.	**Positive**	
Integrated Neighbourhood Teams (INT) Transformation Programme (aligned to UEC transformation)	Oversight at Joint Transformation and improvement Board (JTIB) and via programme report to STP Committee bi-monthly. FPC Deep Dive June 26. Future Care Update FPC March 26. Future Care reported to Board detailed in 25/26 BAF. Closedown Report to Board scheduled August 26. From June 26 Future Care moving to BAU - next stage. INT Board Development Session July 26. Core design workshops Sept - Dec 26	**Positive**	
Risk Controls and Plans			
Performance Management Framework (and resulting deep dive reviews) including reporting against operational plans and National Oversight Framework (NOF) metrics. Key metrics against MH Inpatient programme and CYP MH in Integrated Corporate Dashboard	Performance Report to FPC and Board bi-monthly via Integrated Corporate Dashboard & Deep Dives. April 26 FPC Productivity; June 26 FPC NOF review. New NoF produced June 26 will be retrospectively applied to Q1. Full technical specification still awaited in July 2026. Elements reviewed at Board Development in July 26. Developing dashboard and reporting for MH inpatient metrics	**Neutral**	**Amber**
Seasonal surge plan	Surge plan reported to FPC with monitoring via Performance Report, Seasonal Surge Plan Plan approved and scheduled for FPC Sept 26 in accordance with national timeframes	**Positive**	
Productivity Plans	Reported to FPC informal April 26. Launching productivity programme 26/27	**Neutral**	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Assurance Report from FPC to Board bi-monthly	**Positive**	**Green**
Divisional Management Performance Meetings	Reporting to FPC via Integrated Corporate Dashboard	**Positive**	
Joint Transformation and Improvement Board (JTIB) - reports to STP	Programme Reports to STP and Assurance Report from JTIB to STP	**Positive**	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Review metrics and performance plans in response to NOF and segmentation **(CFWD)** - new reporting framework presented to Finance and Performance Committee Sept 25 - changes to reporting from Q1 26/27 - Complete new ICD from Q1 in place	RS	~~01/08/25~~ June 26	Complete
Peri-hospital mental health flow programme to launch from April 2026 - to review impact at end of Q1 **(CFWD)** - Complete reporting in place	RS	Jul-26	Complete
Productivity plans - design programme in Q3 and establish governance and commence reporting Q4 26/27	RS	Mar-27	On Plan
System MTP Oversight Group to be established	MBr	Aug-26	On Plan

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Dorset HealthCare University NHS Foundation Trust

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

Executive Lead

Chief Finance Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	5	=	20
Mitigated	4	x	3	=	12
Target	3	x	3	=	9

Rationale for Score

Size of backlog & funding required to eradicate not identified, as articulated in Estates Strategy. Net zero - climate adaption across our aeging estate will impact patient care. Significant investment required to achieve net zero funding yet to be identified

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Estates Strategy	Board approved June 2026	Positive	Green
New Hospital Programme	NHP Business Case, programme approved and build progressing. NHP benefits realisation reports to STP May 26	Positive	
Joint Green Annual Plan	Green Plan approved Board June 2026, Net Zero Progress Report FPC May 26. Significant investment required to achieve net zero funding yet to be identified	Neutral	
Operating model for estates and facilities across the Federation	Operating model reviewed and transitioning to federated structure that increases joint working - imlementing in phases to deliver efficiencies through joint working and building sustainable workforce model. Updated provided via Infrastructure Strategy June 26	Positive	
Risk Controls and Plans			
Estates compliance functions	Estates compliance report FPC June May 26.	Positive	Amber
Backlog maintenance plan	Reported to Capital Investment Meeting - Informed Infrastructure Strategy May 26 STP Committee and Board June 26. Part funding via capital plan 26/27 with further bid outcomes awaited	Negative	
Capital Programme	Approved annual via priority as part of Medium Term Plan Feb 26	Positive	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee for estates planning and compliance and Strategy Transformation and Partnerships Committee for transformation	Assurance Reports to Board	Positive	Green
Estates related compliance groups in place (water, fire, health and safety)	Compliance reports on estates and health and safety to FPC	Positive	
New Hospital Programme Board	Programme approved, NHP Programme Board report to STP & NHSE	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Backlog maintenance - funding required to maintain safe site **(CFWD)** - funding in plan for 26/27 as part of Capital Plan, with further bids submitted for additional funding and then ongoing - April 26 - prioritising highest risk - ongoing monitoring - leave ongoing action to maintain oversight	DM	Ongoing	On Plan
Programme of work to look at cooling strategy at each site - phased approach to be included in annual for 27/28	DM	Mar-27	On Plan

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Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Sustainability	**SR6: Finance** **If we do not deliver on our financial plans, including the required level of savings, it will adversely impact our ability to provide safe, sustainable services within the context of the developing NHS funding model and the 10-year plan.**	Finance and Performance

Executive Lead: Chief Finance Officer

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

Rationale for Score: Financial plan on plan end of Q1. Identified 100% CIP (target of 100%) at end Q1 with 19% high risk (20% target). Improved position at end Q1 compared to prior years, recognising scope to reduce high risks & improve recurrent position. Actions reported to Board session June 26 and MTP close down letter.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Medium Term Plan with £0.5m suplus position per annum	Medium Term Financial Plan. Draft organisational plan submitted on 17 Dec 25 showing a planned surplus of £500k. Medium Term Plan (MTP) and Board Assurance Statements for 3 year period from 26/27 approved Feb 26. Focus in 26/27 on temp staffing reductions planned. Scrutinsed through AFT Process (approved May 2026). NHSE Closedown letter on MTP reported to FPC May 26 - 'Compliant with conditions' actions	Positive	Green
Risk Controls and Plans			
Cost Improvement Plans	Financial Recovery Board and Financial Delivery Director operating / in post. FRB ToR reviewed July 2026 (FPC) and effectiveness review to be completed. Substantive Associate Director of Financial Delivery recruited - commence Oct 26. Finance Reports to FPC and Board. Board Development Session July 26 on CIP submission at end of Q1. IA review of financial recovery and assurance processes draft report received and no significant concerns	Neutral	Amber
Regular budget meetings, regular attendance at DMGs, budget manager training	Finance Reporting to Directorate Performance Meetings, Finance and Performance Committee & Trust Board	Positive	
Temporary Workforce Plan (biggest risk area in CIP Plan)	Temporary Workforce Reduction Plan (reported to FPC via FRB Assurance Reporting bi-monthly) - monitored weekly at Temporary Staffing Programme Board and fortnighly at FRB	Neutral	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Assurance Reports to Board, Finance Report to Committee and Board	Positive	Green
Financial Recovery Board	Finance Reports to Finance and Performance Committee	Positive	
Value Delivery Group	Assurance Report and Finance Reports to Finance and Performance Committee	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Substantive recruitment to financial delivery leadership post **(CFWD)**- on track recruitment process complete and in post Oct 26	CH	Dec-26	On Plan
Address actions in NHS MTP Closedown letter by required deadlines **(CFWD)** - end of Q1 CIP submission - Closed	CH	Dec-26	Complete
Establishment review to remove vacanct post and achive recurrent CIP **(CFWD)**- Incorporated into Temorary Workforce Reduction Plan - Sept 2026 to develop plan and enact by March 2027	CH	~~June 26~~ Dec 26	Behind Schedule
Financial Recovery Board efffectiveness review	JH	Sep-26	On Plan

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Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR7: Partnerships and Transformation** **If we do not have effective and positive partnerships, with clear governance and accountability frameworks and a commitment to work in collaboration to transform services, then we will not be able to shape decisions and deliver the transformation required to deliver the ambitions of the 10-year plan and address the health inequalities within our population**	Strategy, Transformation & Partnerships

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

Rationale for Score

Clinical services strategy review complete and action plans being developed with partners. MOU agreed with DGPA Alliance (DHC) to strengthen relationships. Developing strong relationships within new ICB cluster

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Strategy across DCH and DHC	Joint DCH/DHC Strategy approved July 24. Review of alignment to national 10 Year Plan STP July 25 and further analysis of alignment and 3 shifts STP Jan 26	Positive	Green
One Transformation Approach (Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow)	Transformation programmes, reporting and governance approved STP Nov 25. Annual review planned Nov 26.	Positive	
Our Dorset Provider Collaborative (ODPC) (including Vista Health Clinical Services review)	Member of ODPC. Independent Chair from May 26. B2B2B meetings in 25/26 and scheduled Sept 26. Vista Health Clinical Services Review completed - all partners signed up to actions and presented to Board April 26. Implementation programme being overseen by ODPC - reports to STP Committee May 26. Review of governance (including report to board and NED oversight) in progress to be concluded Sept 26.	Neutral	
Memorandum of Understanding with Dorset GP Alliance	MoU approved by DCH and DHC Board and DGPA June 26. MoU with DGPA approved at Board June 26. Workshop to be held to agree priorities and key principles to be implemented (NED)	Positive	
Risk Controls and Plans			
Strategy Delivery Reporting	Two year Strategy Delivery Report to STP May 26 and Board June 26. Review of metrics for 26-29 under review and scheduled to be reported to STP Sept 26	Neutral	Amber
Strategy enabling plans in place	Approved plans in place - assurance via bi-annual delivery reports, Quality and People April 25; Digital Strategy Dec 25, Finance Plan is Medium Term Plan Board Feb 26, Infrastructure Strategy May 26	Positive	
Joint Improvement Framework and Transformation Programmes reporting via Joint Improvement and Transformation Board	Approved Joint Improvement Framework approach implemented. Improvement Plan approved STP May 26. Transformation Reports bi-monthly to STP Committee; Neighbourhood review STP June 26 and Board Development July 26. Cyclical focus on each programme	Positive	
Clinical Services Review Implementation Plans	Plans for implementation are in development with governance framework for each programme established. Update at Board Development July 26	Neutral	
Oversight Arrangements for Governance & Engagement			
Strategy Transformation and Partnership (STP) Committee	Reports to board via bi-monthly assurance report	Positive	Green
Joint Transformation and Improvement Board	Portfolio Boards -Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow - Report to JTIB and Reports to STP Committee via Assurance Report and bi-monthly Transformation Report	Positive	
Our Dorset Provider Collaborative	Minutes to Board and NED Oversight Group quarterly. ODPC Report to STP 3 x per annum	Neutral	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
ODPC Governance Review Q1/2 2026/27 (CFWD)	JH	Sep-26	On Plan
Memorandum of Understanding with Dorset GP Alliance to be established (CFWD) - Complete approved by Board June 26	JH	Jul-26	Complete
Clinical services strategy review - development of agreed action plan and timeline for implementation (CFWD)	MBr	Sep-26	On Plan
Develop longer term strategic metrics 2026 - 2029	NP	Sep-26	On Plan
Develop our approach to becoming and IHO	MBr	Oct-26	On Plan
Clarify future hosting arrangements for Dorset Innovation Hub	DD	Sep-26	On Plan

Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Communities Sustainability	**SR8: Digital Infrastructure** **If we do not address and improve our digital and technological capabilities, including implementing our new EHR system, and utilising new digital technologies, we will not deliver safe and sustainable services.**	Strategy, Transformation & Partnerships

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Finance Officer	Unmitigated	5	x	4	=	20
	Mitigated	4	x	4	=	16
	Target	4	x	3	=	12

Rationale for Score

Strategy approved Dec 25. Roadmap will seek to mitigate risks with legacy infrastructure. Appointments made to senior team and new layer of management to be in place by 1 July 26. New EHR system procured and implementation plans, with required capacity being developed.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint digital strategy for DCH/DHC	Dorset Wide Digital Strategy (DCH/DHC/UHD) approved Committee Nov 25 STP Committee and Dec 25 Board. Monitoring arrangements in place via Strategy Delivery Roadmap to be reported to STP July 26	**Positive**	**Green**
EHR Programme (HealthSet)	Contract signed with Epic March 26. Mobilisation and recruitment to teams underway - approved new governance - June 26. Healthset Partnership Board effective Sept 26	**Positive**	
Risk Controls and Plans			
Target Operating Model (TOM)	In progress- Stage 1 was establishment of leadership team from Jan 26. Tier 4 leadership model developed and to be launched Sept 26. Digital workforce update to PCC May 26. Plan for remainder of team to be implemented 26/27. Update provided to STP bi-monthly	**Neutral**	**Amber**
Digital Strategy Delivery Roadmap	STP CiC Informal - June 26, STP CiC July 26	**Neutral**	
EHR Implementation phase 2026 - 2028	Healthset Governance - Board approved June 26. Bi-monthly progress reporting Board from Oct 26	**Neutral**	
Oversight Arrangements for Governance & Engagement			
Strategy, Transformation and Partnership Committee	Assurance Report from STP to Board bi-monthly	**Positive**	**Green**
Joint Digital Services Leadership Group DCH & DHC	Governance and reporting reviewed and strengthened - reviewed across all 3 Dorset providers within the context of the development of a Dorset wide Target Operating Model	**Positive**	
EHR Programme Board and EHR Partnership Board (from Sept 26)	EHR Report into Board from October 26	**Neutral**	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
TOM - new Tier 4 structures to be launched Sept 26 (CFWD)	BB	Sep-26	On Plan
Development of Infrastructure roadmap to support joint digital strategy (CFWD) - Complete reported to STP July 26	RK	~~Mar 25~~ ~~Dec 25~~ ~~Mar 26~~ July 26	Complete
EHR Partnership Board to commence Sept 26 with bi-monthly reporting to Board thereafter	RK	Oct-26	On Plan

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Dorset HealthCare University NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Sustainability	**SR9 Cyber security** **If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents**	Strategy, Transformation & Partnerships

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Finance Officer	Unmitigated	3	x	5	=	15
	Mitigated	3	x	4	=	12
	Target	2	x	3	=	6

Rationale for Score

Continue to understand and mitigate threat landscape. Regular reporting to STP Committee and Board. Fully implemented TOM by end 26/27.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint DCH/DHC Digital Strategy (inc cybersecurity)	Dorset Wide Digital Strategy (DCH/DHC/UHD) approved Committee Nov 25 STP Committee and Dec 25 Board. Monitoring arrangements in place via Strategy Delivery Roadmap (to be reported to STP July 26)	**Positive**	**Green**
Secure email accreditation	ISO 27001 compliance linked to secure email accreditation (DCB1596)	**Positive**	
Risk Controls and Plans			
Data Security & Protection Toolkit	Submission is via Audit Committee, and audited by BDO IA reports on DSPT 25/26 to Audit Committee May 26. SIRO Report to STP May 26 Board June 26. DSPT final submission to STP July 26 'Standards Met'	**Positive**	**Amber**
Regular phishing campaigns conducted, monitoring of alerts, patching and maintenance, password controls	Cyber Reports to STP Committee and Board - March/April 26	**Neutral**	
Cyber Security monitoring arrangements and system controls	Cyber Reports to STP Committee and Board - March/April 26	**Neutral**	
Target Operating Model (TOM)	In progress- Stage 1 was establishment of leadership team from Jan 26. Tier 4 leadership model developed and to be launched Sept 26. Digital workforce update to PCC May 26. Plan for remainder of team to be implemented 26/27. Update provided to STP bi-monthly	**Neutral**	
Oversight Arrangements for Governance & Engagement			
Strategy Transformation and Partnerships Committee	Bi-monthly Assurance Reports to Board	**Positive**	**Green**
Digital Transformation & Assurance Group	Quarterly assurance reports to STP Committee, reporting includes risks, cyber, projects	**Positive**	
Information Governance Group (also covers cyber)	Bi-monthly report to STP Committee	**Positive**	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
To implemented refreshed national cyber security training **(CFWD)**	RK	Sep-26	On Plan
TOM - new Tier 4 structures to be launched Sept 26	BB	Sep-26	On Plan

ASSURANCE ASSESSMENT

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

RISK SCORING MATRIX

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

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

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

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Dorset County Hospital
NHS Foundation Trust

Dorset County Hospital NHS Foundation Trust
Board Assurance Framework
Quarter 1 July 2026

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Dorset County Hospital NHS Foundation Trust

Board Assurance Framework Overview - Quarter 1 July 2026	Strategic Objectives				Responsibility		Score						Alignment to Risk Appetite
Strategic Risks	Care	Communities	Colleagues	Sustainability	Committee	Executive	Unmitigated Score	Mitigated Q1 26-27 Score	Mitigated Q2 26-27 Score	Mitigated Q3 26-27 Score	Mitigated Q4 26-27 Score	Target Score	
SR1: Safety and Quality If we are not able to deliver the fundamental standards of care and if we do not consistently create a positive safety culture, we will not be able to provide safe, effective and compassionate care across all settings that places peoples experience of care at the heart	X				**Quality**	Chief Nursing Officer	16	16				6	**Patient Safety and Quality - Cautious**
SR2: Empowerment If we do not create the culture and conditions where people thrive and feel empowered in their role, our ability to deliver improved patient outcomes and experience of care and high-quality compassionate and safe care will be compromised.	X		X		**People and Culture**	Chief People Officer	15	12				12	**Workforce - Seek**
SR3: Workforce Capacity If we do not reshape and modernise the workforce, underpinned by effective purposeful recruitment and retention, to ensure we have the required skills and capability, we will not be able to deliver the 3 shifts in accordance with the 10-year plan.	X		X		**People and Culture**	Chief People Officer	20	16				12	**Workforce - Seek**
SR4: Capacity and Demand If we do not meet current and expected demand, and achieve local and national metrics within available resources, patient outcomes and experience will be adversely affected, and we may face reduced autonomy and regulatory action.	X	X		X	**Finance and Performance**	Chief Operating Officer	20	20				9	**Operational Performance - Open**
SR5: Estates If we do not have access to an estate that is fit for purpose and economically and environmentally sustainable, we will be unable to provide the right environments for our staff to deliver high quality services to the communities that we serve.	X		X	X	**Finance and Performance**	Chief Finance Officer	20	16				9	**Finance and Value for Money - Open**
SR6: Finance If we do not deliver on our financial plans, including the required level of savings, it will adversely impact our ability to provide safe, sustainable services within the context of the developing NHS funding model and the 10-year plan.				X	**Finance and Performance**	Chief Finance Officer	20	20				9	**Finance and Value for Money - Open**
SR7: Partnerships and Transformation If we do not have effective and positive partnerships, with clear governance and accountability frameworks and a commitment to work in collaboration to transform services, then we will not be able to shape decisions and deliver the transformation required to deliver the ambitions of the 10-year plan and address the health inequalities within our population	X	X		X	**Strategy, Transformation & Partnerships**	Chief Executive Officer	16	12				12	**Innovation, Partnerships and Commercial – Seek**
SR8: Digital Infrastructure If we do not address and improve our digital and technological capabilities, including implementing our new EHR system, and utilising new digital technologies, we will not deliver safe and sustainable services.		X		X	**Strategy, Transformation & Partnerships**	Chief Finance Officer	20	16				12	**Digital - Seek**
SR9 Cyber security If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents	X			X	**Strategy, Transformation & Partnerships**	Chief Finance Officer	15	12				6	**N/A**

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Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care	**SR1: Safety and Quality** **If we are not able to deliver the fundamental standards of care and if we do not consistently create a positive safety culture, we will not be able to provide safe, effective and compassionate care across all settings that places peoples experience of care at the heart**	Quality

Executive Lead: Chief Nursing Officer

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

Rationale for Score: Good progress made in respect of PSIRP and reporting arrangements in place. Ongoing checks and balances in place to manage safe levels of staffing according to operational pressures, acuity and dependency. Heatwave in Q1 had implications for demand and estate. Risk and incident management system procured and implementation plans in place. Ockenden and Amos reviews for maternity to be considered

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Quality Priorities	Quality Account 25/26 approved and published by deadline - Quality Committee May 26 Board June 26. Approved quality priorities for 26/27 - Quality Committee May 26.	Positive	Amber
Maternity Oversight	Maternity Report, Quality Committee and Board bi-monthly , LMNS oversight and reporting, MIS End Point Review Outcome - Compliance. Internal Audit Report provided positive assurnance & in Internal Audit Plan 26/27. Maternity CQC Inspection Report 2025 'Good'. Maternity and Neo Nates Obstetric Workforce considered at June informal Quality Committee. Implications of Ockenden Review and Amos Review to be considered and maternity staffing under review	Neutral	
PSIRF Response Plan	PSIRP updated for 26/27 - approved by Patient Safety Committee and reported to QC July 26	Positive	
Risk Controls and Plans			
Quality Priority Improvement Plan (inc agreed standards and measurement)	Quality Priority Improvement Plan (inc agreed standards and measurement) and regular reporting to Quality Committee in year on progress	Positive	Amber
PSIRF implemented to improve patient safety	PSIRF Huddles, Patient Safety Committee oversight of Patient Incident response Plan and Quality priorities. Process of oversight of CQC self-assessents to CQC Compliance Group commenced (with reporting through to Quality Committee via QGC)	Positive	
Patient Experience Metrics and Improvement Plans	Patient Experience monthly, quarterly and Annual Complaints Report (inc local surveys and metrics), Friends and Family Test National Surveys, Patient Story to Board, 15 Steps Challenge; Complaints Policy in line with PHSO standards.	Positive	
Quality Committee Framework and reporting	Improved reporting in Q1 in line with national and contractual requirements, enhanced surveillance framework in place, Individual CQC Inspection reports - reported to QGC and to QC, EQIA SOP in place and IA review provided substantial assurance (reported to Audit Committee May 26). Risk and incident management system procured and in implementation phase which will further enhance reporting and triangulation. KPI monitoring and Quality Dashboard and Quality Reports - reported to Quality Committee bi-monthly. Quality impact of heatwave and ED crowding and corridor care to be considered (CQC Report on ED)	Neutral	
Health Inequalities Plan	Joint Health Inequalities Steering Group scoped and to commence, with a Joint Health Inequalities Improvement Plan developed and reported to QC Nov 25, Jan 26 and Board April 26 and Health Inequalities Steering Group in place (reporting to QC)	Neutral	
Oversight Arrangements for Governance & Engagement			
Quality Committee	Assurance Reports to Board	Positive	Green
Quality Governance Framework - reporting into Quality Committee	Quality Governance Framework in place, with Quality Governance Group reporting to Quality Committee bi-monthly and Committee approved workplan in plan	Positive	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Review metrics and reporting - for 26/27 further work on reporting capability and refining of quality report to ensure compliance with contractual reporting obligations and national requiremements (MTP) - Previous action re NQB expanded and later date proposed - reviewed all metrics and reporting and now waiting for BI for implementation - June 26 (end of Q1) **(CFWD)** - Completed for end of Q1	Jhow	~~Dec 25~~ ~~Mar 26~~ July 26	Complete
Review of maternity staffing levels	Jhow	Sep-26	On Plan
Review and respond to Ockenden and Amos maternity reviews	Jhow	Sep-26	On Plan
Consider quality impact of operational demand (including heatwave and winter surge) and review of heat related deaths	Jhow	Dec-26	On Plan
Consider quality impact of crowding in ED and corridor care (link to CQC ED report) Phase 1 Sept 26 and Phase 2 when NHP ED in place (Q4)	Jhow	Mar-27	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR2: Empowerment** **If we do not create the culture and conditions where people thrive and feel empowered in their role, our ability to deliver improved patient outcomes and experience of care and high-quality compassionate and safe care will be compromised.**	People and Culture

Executive Lead: Chief People Officer

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

Rationale for Score

Joint Inclusion and Belonging Group, anti-racism framework, managers guidance on unacceptable behaviours - continue to embed & measure impact. Service pressures coupled with high degree of uncertainty due to local/national changes. Launch of national leadership and management framework provides opportunity to review our approach to support people through change. Joint Inc and Belonging Strategy to be broadened to include inclusion as whole (wider than workforce)

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Enabling People Plan DCH/DHC in place and delivery mechanisms	Joint Strategy and Enabling Plans PCC April 26, Workforce KPI Dashboard to PCC and Board bi-monthly, People Enabling Plan - Objectives and Delivery Plan 26/27 to PCC May 26	Positive	Green
Joint Inclusion & Belonging Strategy	Board approved Joint Inclusion and Belonging Strategy and Plan, review in progress and to be reported to PCC Nov 26, Annual EDI Report to PCC May 26, Staff Survey Report and Action Plan reported in 25/26	Positive	
Leadership and Management Development Strategy	Approved strategy in place. New national leadership and mgs framework published July 26 and to review for end Q2 with a focus on equipping our staff to deal with major transformation programmes and change. Digital workforce risks to PCC May 26	Neutral	
Joint Workforce Wellbeing Plan	Plan approved Dec 24, Delivery Action Plan report to PCC Nov 25. Health and Wellbeing Plan update PCC May 26	Positive	
Risk Controls and Plans			
Staff Engagement Programme (including Staff Networks)	Staff Survey / Pulse Survey, Joint Leadership Forum met July 26, Staff Networks (informal PCC focus March 26), Staff Voice Report - approach to PCC May 26 report scheduled Nov 26 and bi-annual thereafter to follow Staff Survey	Positive	Green
EDI Framework and We All Belong - Anti-Racism Charter and Action Plan	EDI Annual Report PCC & Board May/June 26 (WRES, WDES, Pay Gap Reports during year in accordance with national timescales). Board Development Session on Anti-Racism and Inclusion Nov 25 and Anti-Racism Framework PCC Nov 25 and Charter Jan 26 - Board approved Feb 26 and launched June 26. Lord Mann review PCC July 26	Neutral	
Freedom to Speak Up arrangements	Freedom to Speak Up bi-annual Reports to Board and Committees May/June 26	Positive	
Reducing Violence and Aggression Strategy and Plan	Reducing Violence and Aggression update PCC May 26	Positive	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee in Common (DCH & DHC)	Assurance Report to Board	Positive	Green
EDI Delivery Groups and Workforce Wellbeing Steering Group	Assurance reports to People and Culture Committee	Positive	
Joint Culture and Belonging Group	Assurance reports to People and Culture Committee	Positive	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Launch of Mangers Guidance on Unacceptable Behaviour - review impact in line with EDI review and reporting cycle **(CFWD)** - Complete, guidance launched	NP	Jul-26	Complete
Review of format and function of Joint Inclusion and Belonging Group **(CFWD)** - Complete and operating	EH	Jul-26	Complete
Review of EDI and Health Inequalities governance across DCH and DHC **(CFWD)** - Superseded - EDI Groups reviewed, Joint Inclusion and Belonging Strategy to be reviewed to include health inequalities	JH	Jul 26 Sep 26	Complete
Leadership framework review, to encompass equipping our staff to move through period of uncertainty and change	NP	Sep-26	On Plan
Review Joint Inclusion and Belonging Strategy with a focus on inclusion (broader than workforce)	EH	Nov-26	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Colleagues	**SR3: Workforce Capacity** **If we do not reshape and modernise the workforce, underpinned by effective purposeful recruitment and retention, to ensure we have the required skills and capability, we will not be able to deliver the 3 shifts in accordance with the 10-year plan.**	People and Culture

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief People Officer	Unmitigated	5	x	4	=	20
	Mitigated	4	x	4	=	16
	Target	4	x	3	=	12

Rationale for Score

Continued focus on reduction of temp staffing - ward headroom reduction programme established for 26/27 (phase 1 and 2) and phase 2 + 4 27/28. As at end of Month 3 above plan on substantive WTE and behind plan for bank and agency, with net position of 15 WTE behind plan

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Medium Term Plan (MTP) 3 years with Workforce Plan 26/27	Reviewed by FPC and Approved by Board draft submission Dec 25 and final submission Feb 26 (including risks to achievement of plan). MTP Feedback letter FPC May 26 with actions arising to be reported to July FPC	Positive	Green
Enabling People Plan DCH/DHC in place and delivery mechanisms	Joint Strategy and Enabling Plans PCC April 26, Workforce KPI Dashboard to PCC and Board bi-monthly, People Enabling Plan - Objectives and Delivery Plan 26/27 to PCC May 26	Positive	
Learning Needs Analysis	Annual Education Quality Self-Assessment - PCC Nov 25 / Learning Needs Analysis & affordability - 26/27 reporting in PCC workplan	Positive	
Risk Controls and Plans			
MTP Workforce Plan 26/27	KPI dashboard to PCC bi-monthly and forms part of board reporting bi-monthly. WTE reductions reviewed by Financial Recovery Board (FRB) and forms part of CIP reporting to Finance and Performance Committee	Neutral	Amber
Joint People Plan delivery framework 26/27 (delivery framework from enabling plan)	Workforce dashboard to People and Culture Committee bi-monthly and in integrated performance reporting to Board Bi-monthly.	Positive	
Ten Point Resident Doctors Plan	Staff Turnover metrics in Workforce Dashboard to PCC. Ten Point Resident Doctors Plan to PCC Jan 26, and May 26	Positive	
DCH UEC and Planned Care Recovery Plans and workforce implications	To consider workforce implications of delivering the recovery plans - to be considered via weekly performance recovery group	Neutral	
Oversight Arrangements for Governance & Engagement			
People & Culture Committee in Common (DCH & DHC)	Assurance Report to Board	Positive	Green
Divisional Performance Group	Reporting to PCC via KPI Dashboard	Positive	
Safer Staffing Group	Staff Staffing Report to Board June 26, Developing Workforce Safeguards Report March 26	Positive	

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Actions to improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Look for opportunity to work more closely in Provider Collaborative to address common workforce issues (CWFD)Close action superseded by People Target Operating Model issued by NHSE	NP	May-26	Complete
Develop plan to ensure workforce in place to support transformation	NP	Dec-26	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR4: Capacity and Demand** **If we do not meet current and expected demand, and achieve local and national metrics within available resources, patient outcomes and experience will be adversely affected, and we may face reduced autonomy and regulatory action.**	Finance and Performance

Executive Lead

Chief Operating Officer

Risk Score	Consequence		Likelihood		Score
Unmitigated	4	x	5	=	20
Mitigated	4	x	5	=	20
Target	3	x	3	=	9

Rationale for Score

Q1 did not achieve key operating standards for UEC, planned care & cancer. Recognise in Q2 will not have recovered position. Recovery Plan in place to recover position by Q4 for UEC. Recovery plans developed for planned care & cancer, view to achieve by end Q4 subject to further discussions with ICB & NHSE region.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Your Future Hospital' programme	Aligned to strategy estates programme - Infrastructure Strategy approved by Board June 2026. Patient flow impacts reported to Board bi-monthly via Balanced Scorecard	Neutral	Amber
UEC Review (Newton - Future Care) with System partners	Future Care reported to Board detailed in 25/26 BAF. Closedown Report to Board scheduled August 26. From June 26 Future Care moving to BAU - next stage	Neutral	
Single Services Review	Single services gateway process with UHD- ODPC approved gateway process and to Committee March 26. South Coast Pathology Network - FPC Jan 26 (Full Business Case) - Agreed by Board. Next gateway Autumn and will discuss proposed models	Positive	
Medium term Plan 3 years with Operational Plan 26/27	Reviewed by FPC and Approved by Board draft submission Dec 25 and final submission Feb 26 (including risks to achievement of plan). MTP Feedback letter FPC May 26 with actions arising to be rpeorted to July FPC	Neutral	
Risk Controls and Plans			
Rapid Review and Self-Assesment and UEC and Planned Care Recovery Plans	Response to NHSE and recover plans approved by Board July 26. Agreed governance in place to oversee recovery plans and reporting to Board	Negative	Amber
Performance Management Framework (and resulting deep dive reviews) including reporting agaisnt operational plans and National Oversight Framework (NOF) metrics	Performance Report to FPC and Board bi-monthly via Balanced Scorecard & Deep Dives. April 26 FPC Productivity; June 26 FPC NOF review New NoF produced June 26 will be retrospectively applied to Q1. Full technical specification still awaited in July 2026. Elements reviewed at Board Development in July 26. Draft approach to Balanced Scorecard Board dependent on technical spec completion and BI capacity	Neutral	
Seasonal surge plan	Surge plan reported to F&P with monitoring via Performance Report, Sesaonal Surge Plan Plan approved and scheduled for FPC Sept 26 in accordance with national timeframes	Positive	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Assurance Report from FPC to Board bi-monthly	Positive	Green
Divisional Performance Group	Reporting to FPC via Integrated Corporate Dashboard and to the Weekly Operational Performance Recovery Group	Positive	
Operational Performance Recovery Group (new from July 26)	Reporting to FPC and weekly to NEDS	Neutral	
South Coast Pathology Owners Board	Reporting to FPC - next report scheduled Autum 26	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Future Care - devlopment of KPIs and reporting framework	AT	Dec-26	On Plan
Three speciality business case to board in Q3 26/27 (cfwd from 25/26 BAF)	AT	Dec-26	On Plan
System MTP Oversight Group to be established	MBr	Aug-26	On Plan
Reporting of Recovery Plans and trajectories to FPC, Board and NEDS	JH	Jul-26	On Plan
Development of Balanced Scoreecard to reflect new NOF metrics (dependent on release of technical spec)	AT	Aug-26	On Plan

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Dorset County Hospital NHS Foundation Trust

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

Executive Lead

Chief Finance Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	5	=	20
Mitigated	4	x	4	=	16
Target	3	x	3	=	9

Rationale for Score

Size of backlog & funding required to eradicate not identified, as articulated in Estates Strategy. Transferring to new compliance recording system (hosted by DHC) will have improved assurance on estates compliance -Expect to complete Mar 27. Net zero - climate adaption across ageing estate will impact patient care. Significant investment required to achieve net zero funding yet to be identified

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Estates Strategy	Board approved June 2026	Positive	Green
New Hospital Programme	NHP Business Case, programme approved and build progressing. NHP benefits realisation reports to STP May 26	Positive	
Joint Green Annual Plan	Green Plan approved Board June 2026, Net Zero Progress Report FPC May 26. Significant investment required to achieve net zero funding yet to be identified	Neutral	
Operating model for estates and facilities across the Federation	Operating model reviewed and transitioning to federated structure that increases joint working - imlementing in phases to deliver efficiencies through joint working and building sustainable workforce model. Updated provided via Infrastructure Strategy June 26	Positive	
Risk Controls and Plans			
Estates compliance functions	Estates compliance report FPC June May 26. Transferring to DHC system to improve compliance recording and reporting	Neutral	Amber
Fire safety compliance	Five Year plan in place and reported in 25/26 to FPC. Ongoing compliance reported via Estates Compliance Report to FPC May 26	Neutral	
Backlog maintenance plan	Reported to Capital Investment Meeting - Informed Infrastructure Strategy May 26 STP Committee and Board June 26. Part funding via capital plan 26/27 with further bid outcomes awaited	Negative	
Capital Programme	Approved annual via priority as part of Medium Plan Feb 26	Positive	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee for estates planning and compliance and Strategy Transformation and Partnerships Committee for transformation	Assurance Reports to Board	Positive	Green
Estates related compliance groups in place (water, fire, health and safety)	Compliance reports on estates and health and safety to FPC	Positive	
New Hospital Programme Board	Programme approved, NHP Programme Board report to STP & NHSE	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Backlog maintenance - funding required to maintain safe site **(CFWD)** - funding in plan for 26/27 as part of Capital Plan, with further bids submitted for additional funding and then ongoing - April 26 - prioritising highest risk - ongoing monitoring - leave ongoing action to maintain oversight	DM	Ongoing	On Plan
Programme of work to look at cooling strategy at each site - phased approach to be included in annual for 27/28	DM	Mar-27	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Sustainability	**SR6: Finance** **If we do not deliver on our financial plans, including the required level of savings, it will adversely impact our ability to provide safe, sustainable services within the context of the developing NHS funding model and the 10-year plan.**	Finance and Performance

Executive Lead: Chief Finance Officer

Risk Score	Consequence	x	Likelihood	=	Score
Unmitigated	4	x	5	=	20
Mitigated	4	x	5	=	20
Target	3	x	3	=	9

Rationale for Score: Q1 off plan (£193k) driven by IA & pay impact of operational pressures. Identified 85% CIP (target 100%) end Q1 - 17% high risk (20% target) 63% recurrent (target of 60%). Improved position end Q1 compared to prior years, recognising scope to reduce high risks and improve recurrent position. Actions reported to Board session June 26 and MTP closed on letter to recover position

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Medium Term Plan 3 years with Operational Plan 26/27	Medium Term Plan (MTP) and Board Assurance Statements for 3 year period from 26/27 approved Feb 26. Submitted break even plan as part of Medium Term Plan (MTP). For 26/27 Deficit Support Funding received Q1 confirmed Q2 . Risk associated with CIP Plan. NHSE Closedown letter on MTP reported to FPC May 26 - 'Compliant with conditions' actions	Positive	Amber
Controls associated with cash position	Daily cash monitoring; KPI review and action; efficiency delivery and cost controls. £20m June 26 but need to maintain focus with daily cash monitoring. Deficit Support Funding received Q1 confirmed Q2	Neutral	
Risk Controls and Plans			
Cost Improvement Plans	Financial Recovery Board and Financial Delivery Director operating / in post. FRB ToR reviewed July 2026 (FPC) and effectiveness review to be completed. Substantive Associate Director of Financial Delivery recruited - commence Oct 26. Finance Reports to FPC and Board. Board development Session July 26 on CIP submission at end of Q1. Identified 85% (against target of 100%) CIP at end of Q1 with 17% high risk (against 20% target) and 63% recurrent (against a target of 60%). IA review of financial recovery and assurance processes draft report received and no sigficant concerns	Negative	Amber
DCH UEC and Planned Care Recovery Plans and financial implications	To consider financial implications of delivering the recovery plans - to be considered via weekly performance recovery group	Neutral	
Regular budget meetings, regular attendance at DMGs, budget manager training	Finance Reporting to Divisional Performance Meetings, Finance and Performance Committee & Trust Board	Positive	
Oversight Arrangements for Governance & Engagement			
Finance and Performance Committee	Assurance Reports to Board, Finance Report to Committee and Board	Positive	Green
Financial Recovery Board	Finance Reports to Finance and Performance Committee	Positive	
Value Delivery Board	Assurance Report and Finance Reports to Finance and Performance Committee	Positive	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
Substantive recruitment to financial delivery leadership post - Advertise May 26 aim to have in post Oct 26 (current post holder leave end July) **(CFWD)-** on track recruitment process complete and in post Sept 26	CH	Dec-26	On Plan
Address actions in NHS MTP Closedown letter by required deadlines **(CFWD)** - end of Q1 CIP submission, with open ended actions remaining - Closed	CH	Dec-26	Complete
Focus on reducing temporary staffing spend - work focussing on bank and agency spend in progress - Op pressures in Q1 significant and inc in bank and agency increased. Temporary staffing expenditure is routinely monitored and reported through FRB **(CFWD)**	NP	July 26 Sept 26	Behind Schedule
Financial Recovery Board effectiveness review	JH	Sep-26	On Plan

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Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Communities Sustainability	**SR7: Partnerships and Transformation** **If we do not have effective and positive partnerships, with clear governance and accountability frameworks and a commitment to work in collaboration to transform services, then we will not be able to shape decisions and deliver the transformation required to deliver the ambitions of the 10-year plan and address the health inequalities within our population**	Strategy, Transformation & Partnerships

Executive Lead

Chief Executive Officer

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

Rationale for Score

Clinical services strategy review complete and action plans being developed with partners. MOU agreed with DGPA Alliance (DHC) to strengthen relationships. Developing strong relationships within new ICB cluster

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint Strategy across DCH and DHC	Joint DCH/DHC Strategy approved July 24. Review of alignment to national 10 Year Plan STP July 25 and further analysis of alignment and 3 shifts STP Jan 26	**Positive**	**Green**
One Transformation Approach (Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow)	Transformation programmes, reporting and governance approved STP Nov 25. Annual review planned Nov 26.	**Positive**	
Our Dorset Provider Collaborative (ODPC) (including Vista Health Clinical Services review)	Member of ODPC. Independent Chair from May 26. B2B2B meetings in 25/26 and scheduled Sept 26. Vista Health Clinical Services Review completed - all partners signed up to actions and presented to Board April 26. Implementation programme being overseen by ODPC - reports to STP Committee May 26. Review of governance (including report to board and NED oversight) in progress to be concluded Sept 26.	**Neutral**	
Memorandum of Understanding with Dorset GP Alliance	MoU approved by DCH and DHC Board and DGPA June 26. MoU with DGPA approved at Board June 26. Workshop to be held to agree priorities and key principles to be implemented (NED)	**Positive**	
Risk Controls and Plans			
Strategy Delivery Reporting	Two year Strategy Delivery Report to STP May 26 and Board June 26. Review of metrics for 26-29 under review and scheduled to be reported to STP Sept 26	**Neutral**	**Amber**
Strategy enabling plans in place	Approved plans in place - assurance via bi-annual delivery reports, Quality and People April 25; Digital Strategy Dec 25, Finance Plan is Medium Term Plan Board Feb 26, Infrastructure Strategy May 26	**Positive**	
Joint Improvement Framework and Transformation Programmes reporting via Joint Improvement and Transformation Board	Approved Joint Improvement Framework approach implemented. Improvement Plan approved STP May 26. Transformation Reports bi-monthly to STP Committee; Neighbourhood review STP June 26 and Board Development July 26. Cyclical focus on each programme	**Positive**	
Clinical Services Review Implementation Plans	Plans for implementation are in development with governance framework for each programme established. Update at Board Development July 26	**Neutral**	
Oversight Arrangements for Governance & Engagement			
Strategy Transformation and Partnership (STP) Committee	Reports to board via bi-monthly assurance report	**Positive**	**Green**
Joint Transformation and Improvement Board	Portfolio Boards -Integrated Neighbourhood Teams, Joint Improvement Programme, Mental Health Inpatient Flow and DCH unplanned care flow - Report to JTIB and Reports to STP Committee via Assurance Report and bi-monthly Transformation Report	**Positive**	
Our Dorset Provider Collaborative	Minutes to Board and NED Oversight Group quarterly. ODPC Report to STP 3 x per annum	**Neutral**	

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Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
ODPC Governance Review Q1/2 2026/27 **(CFWD)**	JH	Sep-26	On Plan
Memorandum of Understanding with Dorset GP Alliance to be established **(CFWD)** - Complete approved by Board June 26	JH	Jul-26	Complete
Clinical services strategy review - development of agreed action plan and timeline for implementation **(CFWD)**	MBr	Sep-26	On Plan
Develop longer term strategic metrics 2026 - 2029	NP	Sep-26	On Plan
Develop our approach to becoming and IHO	MBr	Oct-26	On Plan
Clarify future hosting arrangements for Dorset Innovation Hub	DD	Sep-26	On Plan

Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Communities Sustainability	**SR8: Digital Infrastructure** **If we do not address and improve our digital and technological capabilities, including implementing our new EHR system, and utilising new digital technologies, we will not deliver safe and sustainable services.**	Strategy, Transformation & Partnerships

Executive Lead	Risk Score	Consequence	x	Likelihood	=	Score
Chief Finance Officer	Unmitigated	5	x	4	=	20
	Mitigated	4	x	4	=	16
	Target	4	x	3	=	12

Rationale for Score

Strategy approved Dec 25. Roadmap will seek to mitigate risks with legacy infrastructure. Appointments made to senior team and new layer of management to be in place by 1 July 26. New EHR system procured and implementation plans, with required capacity being developed.

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint digital strategy for DCH/DHC	Dorset Wide Digital Strategy (DCH/DHC/UHD) approved Committee Nov 25 STP Committee and Dec 25 Board. Monitoring arrangements in place via Strategy Delivery Roadmap to be reported to STP July 26	**Positive**	**Green**
EHR Programme (HealthSet)	Contract signed with Epic March 26. Mobilisation and recruitment to teams underway - approved new governance - June 26. Healthset Partnership Board effective Sept 26	**Positive**	
Risk Controls and Plans			
Target Operating Model (TOM)	In progress- Stage 1 was establishment of leadership team from Jan 26. Tier 4 leadership model developed and to be launched Sept 26. Digital workforce update to PCC May 26. Plan for remainder of team to be implemented 26/27. Update provided to STP bi-monthly	**Neutral**	**Amber**
Digital Strategy Delivery Roadmap	STP CiC Informal - June 26, STP CiC July 26	**Neutral**	
EHR Implementation phase 2026 - 2028	Healthset Governance - Board approved June 26. Bi-monthly progress reporting Board from Oct 26	**Neutral**	
Oversight Arrangements for Governance & Engagement			
Strategy, Transformation and Partnership Committee	Assurance Report from STP to Board bi-monthly	**Positive**	**Green**
Joint Digital Services Leadership Group DCH & DHC	Governance and reporting reviewed and strengthened - reviewed across all 3 Dorset providers within the context of the development of a Dorset wide Target Operating Model	**Positive**	
EHR Programme Board and EHR Partnership Board (from Sept 26)	EHR Report into Board from October 26	**Neutral**	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
TOM - new Tier 4 structures to be launched Sept 26 (CFWD)	BB	Sep-26	On Plan
Development of Infrastructure roadmap to support joint digital strategy (CFWD) - Complete reported to STP July 26	RK	~~Mar 25~~ ~~Dec 25~~ ~~Mar 26~~ July 26	Complete
EHR Partnership Board to commence Sept 26 with bi-monthly reporting to Board thereafter	RK	Oct-26	On Plan

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Dorset County Hospital NHS Foundation Trust

Strategic Objective	Strategic Risk	Overseeing Committee
Care Sustainability	**SR9 Cyber security** **If we do not take sufficient steps to ensure our cyber security arrangements are maintained and up to date then we are at increased risk of a cyber security incidents**	Strategy, Transformation & Partnerships

Executive Lead

Chief Finance Officer

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

Rationale for Score

Continue to understand and mitigate threat landscape. Regular reporting to STP Committee and Board. Fully implemented TOM by end 26/27. Transition to nhs.net July 26 and risks separately captured

Controls *What we have in place to support delivery of the objective*	Assurance *Source of assurance - including internal (e.g. audits, policy monitoring, etc.) and external (e.g. regulators, internal audit, etc.)*	*Outcome of assurance*	Assessment *(See assessment guidance)*
Priority Programmes and Strategies			
Joint DCH/DHC Digital Strategy (inc cybersecurity)	Dorset Wide Digital Strategy (DCH/DHC/UHD) approved Committee Nov 25 STP Committee and Dec 25 Board. Monitoring arrangements in place via Strategy Delivery Roadmap (to be reported to STP July 26)	**Positive**	**Green**
Secure email accreditation	ISO 27001 compliance linked to secure email accreditation (DCB1596). Transition to nhs.net July 26	**Positive**	
Risk Controls and Plans			
Data Security & Protection Toolkit	Submission is via Audit Committee, and audited by BDO IA reports on DSPT 25/26 to Audit Committee May 26. SIRO Report to STP May 26 Board June 26. DSPT final submission to STP July 26 'Standards Met'	**Positive**	**Amber**
Regular phishing campaigns conducted, monitoring of alerts, patching and maintenance, password controls	Cyber Reports to STP Committee and Board - March/April 26	**Neutral**	
Cyber Security monitoring arrangements and system controls	Cyber Reports to STP Committee and Board - March/April 26	**Neutral**	
Target Operating Model (TOM)	In progress- Stage 1 was establishment of leadership team from Jan 26. Tier 4 leadership model developed and to be launched Sept 26. Digital workforce update to PCC May 26. Plan for remainder of team to be implemented 26/27. Update provided to STP bi-monthly	**Neutral**	
Oversight Arrangements for Governance & Engagement			
Strategy Transformation and Partnerships Committee	Bi-monthly Assurance Reports to Board	**Positive**	**Green**
Digital Transformation & Assurance Group	Quarterly assurance reports to STP Committee, reporting includes risks, cyber, projects	**Positive**	
Information Governance Group (also covers cyber)	Bi-monthly report to STP Committee	**Positive**	

Actions to Improve Controls and Assurance *(Required for any areas assessed Amber or Red)*	Lead	Target Date	Progress Summary
To implemented refreshed national cyber security training **(CFWD)**	RK	Sep-26	On Plan
TOM - new Tier 4 structures to be launched Sept 26	BB	Sep-26	On Plan

Ellis Kaye
06/03/2026 15:39:11

ASSURANCE ASSESSMENT

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

RISK SCORING MATRIX

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

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

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

Ellis Kara
06/08/2026 15:53:11

Dorset HealthCare University
NHS Foundation Trust

Report to	Board in Common	
Date of Meeting	11th August 2026	
Report Title	Corporate Risk Report (DHC)	
Prepared By	Karen Fulford, Joint Head of Risk and Clinical Legal Services	
Approved by Accountable Executive	Dawn Dawson, Joint Chief Nursing Officer	
Previously Considered By	Risks scoring 15+ have been previously considered by the relevant committees at their meetings in July 2026. • Quality Committee • Strategy, Transformation Partnerships Committee • People & Culture Committee • Finance & Performance Committee • Audit Committee	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	This report details several risks which are linked to the organisation's strategic risks, as well as emerging risks which may be reported within the Board Assurance Framework • SR1 Quality and Safety • SR3: Workforce Capacity • SR4 Capacity and Demand • SR5: Estates • SR6: Finance • SR8: Digital Infrastructure	
Financial	The report includes clinical risks where financial spends are cited as expected/needed to treat the risk, or the risk may impact on funding provided for service delivery.	
Statutory & Regulatory	The report includes risks which have been: • identified through statutory and regulatory requirements • may affect the organisation's ability to meet such requirements • Failure to treat the risk may lead to regulatory actions (improvement notices etc).	
Equality, Diversity & Inclusion	The report includes risks which may adversely impact on certain groups of patients and/or create health inequalities until the risk is treated.	
Co-production & Partnership	Risks scoring 15+ contained in this report are shared with Dorset Integrated Care Board (ICB) to support the triangulation of system risks.	

Ellis Kara
06/08/2026 15:53:11

Executive Summary

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

This report is a snapshot of relevant risks on the risk register on 28 July 2026. Subsequent updates to risks may be made before the Board convenes.

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

- Five risks currently score 15+.
- There have been three new risks scoring 15+ added to the register since the last Board report.
- One risk was also re-opened and added back to the live risk register.
- Two risks have been added to the report following increases in risk score.
- There have been three reductions in risk score since the last report, all risks fall below the Board's review threshold.
- In the period, one of the risks which saw a risk score reduction, was also closed.
- Two risks are overdue for review.
- Full details of all risks are contained in Appendix 1.

Risk management continues to strengthen across the Trust, evidenced by a lower than usual number of high-scoring risks, ongoing improvements in risk review compliance, enhanced training and awareness initiatives, and the establishment of a dedicated Risk Management Group to provide greater operational oversight and support continuous improvement in risk quality, action planning and risk reduction.

Recommendation

Members are requested to:

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

Ellis Kara
06/08/2026 15:53:11

Risk Report

1 Introduction

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

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

1.3 This report was compiled 28 July 2026 and is a snapshot of the risk register on that date; therefore, subsequent updates may be made before the Board convenes.

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

- Quality Committee
- Strategy, Transformation Partnerships Committee
- People & Culture Committee
- Finance & Performance Committee
- Audit Committee

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

2. Summary of current risks

2.1 <u>New Risks</u>

Three new risks scoring 16 have been added to the risk register since the last report to the Board. Table 1 below sets out basic details of the new risks.

Risk Reference	Risk Title	Risk score
2075	Significant wait for adult ADHD diagnosis (CAAS)	16
2090	Reduced service capacity and delayed patient care (CAMHS Bournemouth & Christchurch)	16
2100	Reduced service capacity and delayed patient care (CAMHS Poole)	16

2.1.1 Since the last report risk 1983 relating to the risk of identity fraud in temporary workforce was also reopened following the identification of a fraudulent worker attending to work on a ward.

2.2 <u>Changes in Risk Score</u>

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

Ellis Kara
26/08/2026 15:53:11

Risk Reference	Risk Title	Rationale for score increase	New risk score
1970	Nursing staff shortages – Waterston Ward	Risk score increased from 9 following increase in workforce shortages as a result of sickness, maternity leave and new vacancies. Four RMNs are due to commence employment in September 2026 once HR and induction processes have concluded. There are additional vacancies within the support worker roles.	16
2019	Reconnect low staffing levels	Risk score increased from 6 to 15. The team has gone back into business continuity due to staffing levels. This is a small team so any vacancies and other absences can easily result in the need to work in business continuity plan. New staff and maternity leave returners will improve the situation in September 2026 and adverts for STR workers have been completed. Aim to return to business as usual by November 2026.	15

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

2.3 Risk Reviews

At the time of writing, two risks have recently become overdue for review. The risk owners have been contacted to update their risks. This relates to risks 2090 and 2100 relating to reduced service capacity and delayed patient care for CAMHS Bournemouth and Christchurch and CAMHS Poole teams.

2.4 Closed Risks

Risk 2016 relating to the poor subcontractor performance for the new build project was closed on 9 July 2026 once both new builds went live. Both builds are now in a 12 month after care process, so the risk is now considered mitigated and business as usual.

2.5 Risk Register – Appendix 1 (Excel Sheet)

There are five risks currently scoring 15 or above which meet the Board's threshold for notification.

4 Recommendations

Members are requested to:

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

Karen Fulford
Joint Head of Risk and Clinical Legal Services.
28 July 2026

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5 Appendices

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

Risk Movement Since Last Report	Date added to register	Risk Ref	Directorate	Service	Risk Lead	Description of risk Cause, effect, impact	Initial risk score	Current score	Key Controls	Progress	Target risk score	Date of next review	Assurance Strucure Groups, Primary and Secondary Committees	Strategic Objective	Strategic Risks
↑ Risk score increased from 9 to 16	31/12/2024	1970	MH - AMH/ OPMH Inpatient	Waterston AAU	Tom Conroy	**Nursing Staff Shortages - Waterston Ward** Risk of being unable to provide safe staffing with substantive staff on the ward due to extensive vacancies leading to a high reliance on bank and agency workers including the use of block booked agency. Currently we have 7.9 B5 WTE vacancies Impact: The inability to provide safe staffing levels for the ward may lead to an increase in patient safety incidents, increase in patient complaints, reduction in patient flow (admission and discharges). This may have an impact on staff morale and staff sickness absence, cause increased stress to remaining staff and may result in further staff leaving their post, compounding the issues we are experiencing.	16	16	1) We have recruited our RNDAs (3 x WTE) who will graduate in May / June 2025.: These are 4 of our 7 RMNs. We are currently using 3 block booked agency nurses. 2) Incident reports are completed when staffing drops below BCP 3) Information has been shared with line management	23/07/2026 Safe staffing initiative has been agreed and implemented by trust due to staffing levels. VCP approved for blocked booked RMN x 2 and SW x 2 . 2 weekly review for agency escalation has also been agreed for shift reviews. 1 RMN applicant due to be employed has withdrawn. 1 band 6 CTL has put in retirement forms, due to retire on October 2nd 2026. 1 band 6 informed manager of plan to resign but yet to formally hand notice in. Due to ongoing absence from ward due to significant burnout and mental health distress manager to seek approval to have band 6 staff have shorter notice period. This will support them in wellbeing and ward to action job advert sooner. 2 new MHSW remain on orientation as delay in PMVA training so remain unable to support PMVA requirements on acute ward. 1 new MHSW and 1 RMN due to begin 2 week induction 3rd August. 2 new RMN's awaiting qualification confirmation from university but agreed to begin when this is confirmed as band 4 then once NMC PIN obtained to be back dated to band 5, HR and David Porter in agreement. This will likely be mid September. 1 RMN has returned from long term sickness on phased return and will be continued supervised by ward manager to ensure successful return to work. 3.5 vacancies remain for MHSW which are being pursued for adverts.	6	22/08/2026	MH/LD/CYPF DMG Quality Goveranance Group Quality Governance Committee Senior Leadership Group Audit Committee People and Culture CIC	Care	SR1: Safety and Quality SR6: Estates
★	08/04/2026	2075	MH - AMH/OPMH Community	CAAS	Melissa Mitchell	**Significant wait for Adult ADHD diagnosis.** There is a significant wait for diagnosis of ADHD in the adult population in Dorset. This service is not commissioned by NHS Dorset and there is an evident variation of service offer currently in Dorset. Diagnosis in the adult population is being undertaken by staff on fixed term contracts and a small group of staff members from the Community Mental Health Teams. The existing staffing does not meet the demand for the service and there is an ongoing process to mobilise a pan Dorset ADHD Service in the absence of additional investment. Impact: Educational failure, long-term unemployment, crime, substance misuse, suicide, mental and physical illness, significant economic and social costs, health inequalities and inequitable access to care.	16	16	1) Adult ADHD waitlists are discussed as part of the Neurodevelopmental Operational Group which is attended by representatives from NHS Dorset, University Hospital Trust, Dorset County Hospital and Dorset HealthCare. 2) Waitlist validation work is ongoing by clinicians to ensure that the ADHD waitlist is accurate. 3) Focus on 18-25 population awaiting ADHD assessment. This is a critical, high risk and priority age group where major life transitions occur and its imperative there is a focus on this age group. 4) Ongoing work to streamline a Dorset wide process and a single point of access for ADHD referrals and assessment. Establishing consistent clinical practice by bringing together clinicians working as part of the service.	15/07/2026 DHC internal ND Group that meet on a monthly basis. DHC, UHD and DCH continue to meet to discuss transitions and those ageing out of the paediatric waitlists. Ongoing work to pilot new ways of working across identified CMHTs where resource is able to be accessed and released. Temporary staff for ADHD service now in post and starting to work through longest waits.	8	14/08/2026	MH/LD/CYPF DMG Quality Goveranance Group Quality Governance Committee Senior Leadership Group Audit Committee	Care Communities Sustainability	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand
★	22/05/2026	2090	MH - CAMHS	CAMHS - Bmth + Christchurch	Lisa White	**Reduced service capacity and delayed patient care.** The team is currently operating below safe staffing establishment due to a combination of prolonged sickness absence across clinical staff, team lead and admin, aswell as clinical post vacancies with a further vacancy, planned sickness absence and maternity leave approaching in June. We are also expecting a team leader vacancy in September. This has created a shortfall in capacity and creates a risk to meet current demand and we are unable to maintain expectations regarding assessment, review appointment compliance and waiting times for intervention are increasing. Impact: Young people waiting may be at risk of mental health symptom escalation while they wait for assessment, review or treatment commencement. This may impact on all aspects of their lives including education attendance and achievement aswell as family relationships. This may increase strain on families, parents ability to work, partner agencies such as education and social care aswell and other parts of camhs services such as enhanced support and liasion. Staff are at risk of higher caseload sizes, increased time on duty resulting in moral injury, burnout, compassion fatigue, which could result in stress related sickness absence further compounding the issue. Staff retention risk may also increase if staff become demoralised or seek employment elsewhere.	16	16	1) All vacancies currently in recruitment process VCP agreement given for use of agency Outsourcing to xyla in process which will help with throughput of existing caseload/treatment lists 2) Agreement from Head of Camhs to implement current Business Continuity Plan with the aim of restricting attendance at all multi agency meetings other than high risk strategy, F camhs and Child protection level meetings and internal team meetings. Camhs Senior Leadership to consider staffing support available to support the team.	22/06/2026 Waiting time for reviews after transition from Gateway Camhs is now at 17 weeks. Psychological interventions waiting lists continue to lengthen beyond 12 months. Staff have begun to decline attendance at non urgent multiagency meeting meetings. Duty can be contacted and any specific concerns will be escalated and attendance discussed within team processes. Recruitment continues Camhs senior Leadership considering a general core camhs recovery plan. Meeting with Xyla organised to commence outsourcing low level intervention. Consideration to be given to learning regarding this from Camhs Gateway.	6	22/07/2026	MHLDCYPF DMG Quality Governance Group Quality Committee in Common Audit Committee Senior Leadership Group	Care Communities Sustainability	SR1: Safety and Quality SR3: Worforce Capacity
★ Risk added 18/06/2026	18/06/2026	2100	MH-CAMHS	CAMHS-Poole	Jennifer Thomas	**Reduced service capacity and delayed patient care** Poole C-CAMHS is operating significantly below safe staffing levels. From July 2026, clinical staffing capacity will reduce to 67% of establishment (12.09 WTE against 17.91 WTE), substantially below the 90% threshold identified within the BCP as necessary to maintain business as usual. Reduced clinical management and NMP capacity has resulted in limited ability to allocate clinicians to new and complex cases, increasing waiting times for intervention, and growing reliance on managers to hold clinical risk. There are currently 262 young people held on management caseloads without an allocated clinician, and therapy waiting times continue to increase. These pressures are impacting the team's ability to provide timely intervention, maintain a responsive duty service, and safely manage demand. There are increasing concerns regarding the sustainability of the current position and the associated risks to service delivery and patient care. Impact: Young people may experience deterioration or escalation in their mental health whilst waiting for assessment, intervention or allocation to a clinician. Delays in accessing treatment may increase risk, prolong distress, and negatively impact education, family relationships, social functioning and overall wellbeing. Increased demand may also place additional pressure on families, schools, social care and other CAMHS pathways.	16	16	1) All vacancies currently in recruitment process Head of Service agreement to offer fixed term maternity cover for Psychology post Head of Service agreement given for use of bank staff Outsourcing to Xyla is planned (not yet in place), which will help with throughput of existing caseload/treatment lists. Ongoing discussions regarding medic capacity and budget to meet demand of medic caseload. 2) Agreement from Head of CAMHS to prioritise attendance at urgent and high-risk meetings (e.g. MOUs, Strategy Meetings and Child Protection Meetings). Where staffing capacity does not allow attendance at other meetings, apologies will be sent with an explanation of the current service pressures. We will continue to attend final ESL meetings, but clinicians may send apologies to initial and midpoint reviews.	First review due 17/07/2026	6	17/07/2026	MH/LD/CYPF DMG PC Sub DMG Quality Goveranance Group Quality Governance Committee Senior Leadership Group Audit Committee	Care Colleagues	SR1: Safety and Quality SR4: Capacity and Demand
↑ Risk increased from 6 to 15 29/06/2026	21/08/2025	2019	MH - AMH/OPMH Community	Custody Liaison Service	Anna Fitzsimmons	**Reconnect Low staffing levels** Reconnect are not fully recruited for both qualified practitioners and support workers. They are at risk of not being able to carry out assessments/interventions in the time frames specified in our contract Not receiving the necessary support normally provided by Reconnect, on leaving prison.	15	15	1) Recruitment to posts is ongoing. Bank staff specific to our service (Prison and Police vetted) are being sought to cover vacancies. Permanent staff will be requested to cover gaps in assessments if no other solution can be found	03/07/2026 Reconnect has gone back into BCP due to staffing levels. We have a practitioner coming back from maternity leave in mid September and a new member of staff starting in late September 2026. An advert for an STR has just gone out today At the moment we are only taking referrals for clients coming out of prison into Dorset. We hope to back to BAU by November 2026	6	02/08/2026	MH/LD/CYPF DMG Quality Goveranance Group Quality Governance Committee Senior Leadership Group Audit Committee	Care Colleagues Sutainability	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand

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 Risk re-opened 09/06/2026 at score 15 **Risk score reduced from 15 to 12**	09/06/2026	1983	Trust Central Services	Trust Bank - Admin Team	Ellie Lindop	**Risk of identity fraud in temporary workforce and potential impact on patient safety, patient experience, the workforce, financial implications and reputation of the Trust.** There is a risk that if we do not have robust identity checks with at least two points of photo ID confirmation in place then we may have temporary workers in the Trust who have not undertaken the required identity checks, training relevant to role and DBS checks. Despite ID checks in place daily audits indicate these are not being completed. Impact: In general, agency staff who are not confirmed as able to work in the healthcare environment have impact at all levels. Patients: Not receiving the level of care, delivered by agency staff who are trained in line with the role being delivered. Our patients are vulnerable and so we need to safeguard them and ensure their experience of our services is to the standards we expect. Staff: If agency staff have not been cleared or trained to work within scope of the roles, there is a risk to our wider workforce as all agency staff should have been through a robust recruitment process and trained with relevant skills for roles and completed statutory/ mandatory training. The wider Trust: Impact financially and reputationally due to concerns that we could have agency staff working fraudulently within the Trust and subsequent potential impact on our patients in our care, visitors, families and staff. This could result in regulatory action.	16	12	1) All staff have been reminded of the two point photo identity checks before an agency worker commences a shift, links and processes shared, and the process if there s concern that the person presenting is not consistent with the booking information. The processes have been highlighted on DORIS under staffing but on the front page (length of time to be reviewed) 2) Agencies are unable to book direct shifts to ensure that the team can confirm correct profiles uploaded and authentication from the agency. 3) Incidents and complaints to be monitored regarding agency staff 4) If any areas of concern are identified regarding agency staff, a patient safety review will be coordinated, including safeguarding. 5) If any areas of concern are identified regarding agency staff, a patient safety review will be coordinated, including safeguarding. 6) Checking ID process of temporary medical workforce reviewed and validated as robust.	Risk reopened 09/06/2026 at risk score of 15. Risk reopened following incident on the 8 March 2026 of a fraudulent worker attending a ward. Checks carried out on this occasion but had worked 9 other shifts and checks not undertaken on 7 of these duties.	4	09/07/2026	**NQT DMG** **Quality Governance Group** **Quality Committee in Common** **Audit Committee** **Senior Leadership Group** **Board**	**Care Colleagues**	**SR1: Safety and Quality** **SR3: Capacity and Demand**
 Risk reduced from 15 to 8 25/06/2026	19/03/2026	2063	MH - CAMHS	Seastone	Rebecca Matoug	**Consultant vacancy on Seastone CAMHS High Intensity may prevent the unit opening as planned and commissioned.** Consultant vacancy on Seastone will mean we are unable to deliver care to young people, as in order to be admitted to a secure inpatient ward you would need an RC under the MHA. Seastone are commissioned to have 1.0 WTE consultant psychiatrist and there is a risk that the unit may not be able to open as planned after significant investment. Impact: Financial risk if this needs to be backfilled by a Locum and if we are unable to open as planned after funding the new build and recruiting staff. Regulatory risk if we are inspected without RC cover. Reputational risk due to poor quality care and risk of complaints through poor patient experience.	15	8	1) Recruitment attempts have taken place	Risk reduced from 15 to 8 25/06/2026 The medical staffing team across Seastone and Pebble wards will work flexibly across the two wards with overall Responsible Clinician support from the current Substantive Consultant for Pebble Ward, to allow the safe opening of Seastone Ward. This arrangement will continue pending recruitment of a Substantive Consultant to Pebble Ward, allowing the current incumbent to move over to Seastone Ward in September. Risk is largely mitigated.	5	24/12/2026	**MHLDCYPF DMG** **PC Sub-DMG** **Quality Governance Group** **Quality Governance Committee** **Senior Leadership Group** **Audit Committee**	**Care Colleagues**	**SR1: Safety and Quality**
 Risk reduced from 20 to 9 and then to 6. **Risk closed 09/07/2026**	31/07/2025	2016	MH - CAMHS	Estates CAMHS HIE	Christopher Hearn	**New Build project, poor subcontractor performance on delivery of Mechanical, Electrical and Plumbing - Risk G18 on project risk register** There is a risk that the delivery date for the new build for CAMHS HIE will be exceeded as one of sub-contractors on build is not delivering to programme Impact: There is a risk of delayed opening of the new CAMHS HIE - this would result in an inability to admit young people into local services. This would result in children and young people continuing to be treated out of area. This could impact the young person's health and wellbeing being so far from home. It would also affect family and friends who would be unable to support the young person as they could if they were in a local bed. There may also be an impact on the staff recruited to the new services and delayed commencements to posts.	15	6	1) Main Contractor is working with sub-contractor in open and transparent way to identify further mitigations, additional resources where this would support and options on additional working days	**Risk closed as mitigated and now business as usual 09/07/2026** Both builds are now live and in 12 month After Care process	9		**MH/LD/CYPF DMG** **Quality Goveranance Group** **Quality Governance Committee** **Senior Leadership Group** **Audit Committee** **People and Culture CIC**	**Care Colleagues**	**SR1: Safety and Quality** **SR3: Workforce Capacity** **SR4: Capacity and Demand** **SR6: Estates**

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Dorset County Hospital
NHS Foundation Trust

Report to	Board in Common	
Date of Meeting	11 August 2026	
Report Title	Corporate Risk Register	
Prepared By	Karen Fulford, Joint Head of Risk and Clinical Legal Services	
Approved by Accountable Executive	Jo Howarth, Interim Chief Nursing Officer	
Previously Considered By	Risks scoring 15+ have been previously considered by the relevant committees at their meetings in July 2026. • Quality Committee • Strategy, Transformation Partnerships Committee • People & Culture Committee • Finance & Performance Committee • Audit Committee	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	This report details several risks which are linked to the organisation's strategic risks, as well as emerging risks which may be reported within the Board Assurance Framework • SR1 Quality and Safety • SR3: Workforce Capacity • SR4 Capacity and Demand • SR5: Estates • SR6: Finance • SR8: Digital Infrastructure	
Financial	The report includes clinical risks where financial spends are cited as expected/needed to treat the risk, or the risk may impact on funding provided for service delivery.	
Statutory & Regulatory	The report includes risks which have been: • identified through statutory and regulatory requirements • may affect the organisation's ability to meet such requirements • Failure to treat the risk may lead to regulatory actions (improvement notices etc).	
Equality, Diversity & Inclusion	The report includes risks which may adversely impact on certain groups of patients and/or create health inequalities until the risk is treated.	
Co-production & Partnership	Risks scoring 15+ contained in this report are shared with the Cluster Integrated Care Board (ICB) as requested to support the triangulation of system risks.	

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

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

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

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

Recommendation

Members are requested to:

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

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Corporate Risk Report

1. Executive Summary

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

- Joint Quality Committee
- Strategy, Transformation Partnerships Committee
- People & Culture Committee
- Finance & Performance Committee
- Audit Committee

1.2 This data for the report was compiled 28 July 2026 and is a snapshot of the risk register on that date; therefore, subsequent updates may be made before the Board convenes.

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

2 Introduction

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

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

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

2.4 This report and appendix are accurate at the time of data extraction on 28 July 2026

3. Summary of current risks

3.1 <u>New Risks</u>

There are five new risks scoring 15+ which have been reported since the last Board report. Table 1 below sets out basic details of the new risks.

Risk Reference	Risk Title	Risk score
2357	Endoscopy – Air compressors need to be replaced and upgraded to prevent service failure	16
2359	Failure to achieve the standards for the maternity incentive scheme.	16
2349	SDEC capacity and bedding	16
2327	Backup solution replacement – Digital Technology	15
2351	Insufficient orthopaedic capacity to eliminate 52 week waits	15

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3.2 <u>Risk score increases</u>

There have been six increases in risk score since the last report which have have added five risks to the report. The risk relating to maternity staffing was included in the last report to the Board.

Risk Ref	Risk Title	Previous Risk Score	New Risk Score
1556	Theatre staffing sustainability	12	15
2199	No Dedicated Clean Space for Administration of IV Biologics/Chemotherapy on Kingfisher	12	15
1852	Neurophysiology Workforce levels not meeting Demand	12	15
2317	Demand Outweighs Capacity for Paediatrics IBD Infusions	12	15
2339	Low nursing skillset for Stroke patients due to large recruitment plan for Somerset expansion which may impact September go live	9	16
2309	Maternity Staffing	15	20

3.3 Risk Reviews

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

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

Table 1

Service of responsibility	Total number of overdue risks	Risk Reference
Ophthalmology	2	1781, 1780
Dietetics and Nutrition	2	2144, 2145
Digital Technology and Infrastructure (DTI)	1	2327
Paediatrics Service	1	1607
Total	**6**	

Risks are being regularly reviewed with services via the Risk Management Group.

3.4 Closed Risks

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

3.5 Risk Register – Appendix 1 (Excel Sheet)

There are 39 risks currently scoring 15 or above and they are detailed in full within Appendix 1.

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4 Conclusion

4.1 Organisational expectation for risks scoring 15+ would be a review to be performed on each risk at a minimum of once per month. There are currently six risks showing as overdue for review, all have become overdue within the last two weeks. All risks were

recently discussed at the Risk Management Group to receive assurance of current risk scoring.

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

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

5 Recommendations

Members are requested to:

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

Karen Fulford
Joint Head of Risk and Clinical Legal Services
28 July 2026

6 Appendices

6.1 Appendix 1 – Corporate Risk Register

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Risks scoring 15 and above

ID	Title	Risk Statement	Review date	Opened	Care Groups	Service of responsibility	Risk level (initial)	Previous current risk level	Risk level (current)	Risk level (Target)	Mitigations/Controls	Type of Risk
1914	ED crowding	ED crowding and use of escalation occurs when the department has reduced flow and continuing attendances. over the last 12-18 months there has been increasing waits for beds often in excess of 24 hrs which has caused the ED to become bedded and the ED escalation areas to be in constant use. the implementation of THP has impacted the use of the queue in corridor and now ED holds a greater number of patients under its clinical care. Bedding SDEC consistently has blocked emergency flow and resulted in slower patient moves for ambulatory patients.	24/08/2026	08/07/2024	Unscheduled Care (A3)	Emergency (ED) Services	20	⇔	20	9	There are a number of plans in place: - Implementation of extra staff for pressured times, including extra RNs to mitigate extra patients in the department. Additional B7s in recruitment to strengthen co-ordination Internal Professional Standards in consultation with clinical leads, due to be released June 2026 - Corridor Care SOP reviewed and updated - ACPs on the night to reduce unnecessary admissions and improve rapid decision making. - UEC recovery plan/ ICS recovery plan - Joint SOP with SWAST - AAU project (extended acute assessment unit) to be in place by end of 2026, in preparation for winter 2026 - UTC implementation. Plan for discussion with DHC in Q3/4 2026/27 - agreement to expand nursing coordinator shift to 3 from 2 recruitment underway agreement to expand consultant numbers to 12 with locum and agency filling immediate gaps and increasing senior decision makers at the front door during times of pressure plan to bolster ED front door in the summer of 2026 to remove patients who are lower acuity into the future UTC model	Finance and Performance Committee
2309	Failure to meet statutory and clinical timelines for ADHD medication titration and follow ups	The Core Diagnostics services (within Community Paediatrics) is unable to provide timely medication initiation for newly diagnosed ADHD patients and mandated 6/12 monthly follow reviews for existing patients. This is driven by a significant imbalance between the volume of referrals / diagnoses and available capacity of prescribing staff (medical and non medical prescribers)	30/07/2026	12/03/2026	Family Services (B4)	Paediatrics Service	20	⇔	20	2	Triage system - weekly triage meeting held for individual patient discussions with the MDT More work needed on mitigations	Quality Committee
876	Maternity Staffing	Very few shifts are fully staffed in all areas of the maternity service. This a combination of vacancies, long term sickness (poor mental health prevalent) STS and covid-related absence. This is patient safety issue and has been highlighted in the recent Ockenden Report.	07/08/2026	21/09/2021	Family Services (B4)	Maternity Service	20	⇑ Risk esclated to 20 from 15 on 8/6/26	20	4	Staffing is reviewed very regularly, several times a day. Staff are asked to work different shifts, to stay longer and to work extra. However, they are also supported to know they can decline these requests. Community midwives re-allocated to LW as required - this is on a daily basis and of course impacts workload in community. Staff called in oncall - also impacts staffing the next day. Specialist midwives & matrons regularly work clinically. Escalation policy utilised as required with escalation to divert occurring regularly during July, Aug and Sept. Good system working across the ICS with women diverted to other services.	People and Culture Committee
472	Patient Safety Concerns and Increased Risk of Adverse Outcomes Due to Prolonged Wait Times in Community Paediatrics	The community paediatric service is experiencing increasing and significant demand. There is not only prolonged waiting times, but also a gap between demand / caseload / complexity and the capapcity to manage these. This is exacerbated by; •Increased referrals into community paediatric service •year on year increased in waiting for ASD / ADHD assessments •increased waiting time for follow up appointments •recruitment and retention challenges within this highly specialised workforce (inc Doctors, Clinical Psychologists, Nurses and Admin) •demand versus capacity Obligations to support the SEND agenda. Increase in comorbid substance misuse in paediatric patients, and clinical systems ability to manage that complexity. The COVID-19 pandemic has further exacerbated the problem. While efforts are being made to address the issue, there is a pressing need for more coordinated action, investment, and workforce capacity building to reduce waiting times and mitigate the associated risks for children and families.	24/07/2026	10/09/2018	Family Services (B4)	Paediatrics Service	15	⇔	20	10	18/12/2025 12:38:58 Waiting List Reduction in OWL - 2659 1852 waiting over 52 weeks Insourcing Work continues with Psicon 24 new CYP to be sent over for assessment Work to conclude by March 31st 2026 Workforce Out to advert for 1.6wte Nurse / AHP non-medical prescriber post Internal fixed term increase in Clinical Psychology hours pending advertisement for 0.5wte Clinical Psychologist Grading New process continues Weekly monitoring of outstanding referrals awaiting grading Grading needs to be factored within job planning (outstanding) Risk Scoring Now completed for every new referral and expedite request For review in February 2026 Nov 25 Internal Governance at DCH completed - RCP approved in principle pending discussions regarding funding. AE to meet with SC (Divisional Director of Operations).	Finance and Performance Committee
1752	2003 Servers Out of Support Since 2010	Servers are not patched and are therefore a cyber risk. Hardware is out of date and no longer available. If anything on these servers breaks down parts are not available. There are five remaining 2003 servers at risk: JCAPO BUSOBJECT WBRSQL01 ALADDIN WEBAPPS	05/09/2026	01/11/2023	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	⇔	16	4	Systems will be migrated to supported platforms when commitment from projects and other digital staff become available.	Strategy Transformation and Partnerships Committee in Common

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1735	2008 Servers Out of Support Since January 2020	This risk is related to legacy operating systems within the Trust, for unsupported 2008 servers. Where an operating system (typically Microsoft) reaches end of life (EOL) security patches are no longer developed for the system. in order to mitigate the risks of legacy systems, it is recommended that plans are made to migrate to a newer operating system and decommission legacy servers that are replaced. Systems at risk: ICE LabTrac Sharepoint ClickView SmartStream	05/09/2026	01/01/2020	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	⇔	16	4	Plans are ongoing to reduce the no of legacy systems within the Trust, these are evidences in the Trusts quarterly cyber report, which is discussed at both DTAG and IGG (summary is as below) Reducing the presence of systems that no longer receive vendor patches or support considerably improves the Trusts cyber posture. Legacy systems contain known vulnerabilities and backdoors which are frequently abused by online crooks in large scale malicious campaigns. In retaining these known susceptible systems inevitably opens the Trust to unacceptable levels of risk. Through the snapshots below it is clear to see the departments commitment to reducing legacy systems wherever possible. 07/01/22 EoL Endpoint estate – 30.30% 27/03/23 EoL Endpoint estate – 10.62% 21/06/23 EoL Endpoint estate – 7.5% Note: A portion of the remaining 7.5% requires additional hardware to replace the EoL kit that does not support software upgrades to the latest iterations of Windows OS. The department continued to make progress with the server estate following a similar trend as the endpoints above. This typically takes longer due to the associated resources required (financial, operational & staffing) to successfully plan and implement system level upgrades. This process is also frequently held up due to contractual reasons – with suppliers not being liable for replacing/upgrading systems. As of the close of Q1, DCH has reduced the percentage of legacy servers down from 18.2% to 6.8% at the start of January. In addition, the department has been proactively upgrading the Server 2012 estate which is due go EoL in October, halving the number of these devices from 86 to 50.	Strategy Transformation and Partnerships Committee in Common
1745	2012 Servers Out of Support Since October 2023	Server 2012 is end of life from October 2023, this means that any Trust servers running this operating system will no longer receive critical security patches, or virus updates. this increases the cyber threat to the Trust. Systems at risk: Spacelabs	05/09/2026	16/10/2023	Chief Information Officer	Digital Technology and Infrastructure (DTI)	16	⇔	16	3	list of servers is regularly reviewed with Technical support teams and cyber, risks are shared at IGG and through quarterly cyber reporting	Strategy Transformation and Partnerships Committee in Common
2030	Administration Risk (Derm, ENT, Ophthalmology & OMF)	Delays within all admin processes due to vacancies and current establishment	06/08/2026	19/12/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Across all specialties	12	⇔	16	4	Hot desk space within departments are available Use of bank where possible Support from Operational team and team leaders acting as secretarial staff Review of all processes across the care group secretarial teams underway	Quality Committee
1903	Age of Washers in EDU	Washers in Endoscopy Decontamination Unit are over 12 years old: EDU Washer 13H100255Purchased Jan-14 EDU Washer 23H100256Purchased Jan-14 EDU Washer 33H100257Purchased Jan-14 AER Drying Cabinet 1M122304 Purchased May 2012 AER Drying Cabinet 2M092383 Purchased April 2014 AER Drying Cabinet 3M112465 Purchased April 2014 AER Drying Cabinet 3M112468 Purchased April 2014 EDU Washer 2 (3H100255) Chamber 2a & 2b Machine reached maximum cycles 06/06/2024. 32.767 cycles Chambers renamed to 2aa & 2bb to reset the cycle counter EDU Washer 1 (3H100255) Chamber 1aa & 1bb Maximum cycles reached in September 2024: 1B 32767 1A 31852 Chambers renamed to 1aa & 1bb to reset the cycle counter	24/08/2026	06/06/2024	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Decontamination Service	16	⇔	16	2	EDU Washer 13H100255 EDU Washer 23H100256 EDU Washer 33H100257 All washers renamed Summer 2024 as all reached maximum counts on TDOC. IHSS Southampton are our contingency site. ALL breakdowns are recorded as an incident on Datix - details of frequency can be seen in linked records and progress notes.	Finance and Performance Committee
1550	ambulance delays and hospital flow	Ambulance delays are increasing nationally and regionally with DCH still performing in the top 2 in the region. Unfortunately, in recent months ambulance delays have increased at DCH due to reduced hospital flow. The department is frequently over capacity leading to nowhere for ambulances to offload. The implementation of hospital THP has reduced ambulance delays but we are still over the target on handover times and the pressure now sits with ED to offload the ambulances within 45 minutes	24/08/2026	17/11/2022	Unscheduled Care (A3)	Emergency (ED) Services	16	⇔	16	6	the splitting of the blue light and walk in entrances has allowed the department to manage ambulance offloads better SWAST is currently implementing work to reduce conveyances THP has been implemented and this risk remains open while policy is embedded with plans to close once your next patient is embedded THP has further reduced ambulance delays but bed flow has declined meaning more patients are cared for in the THP corridor. ambulance delays are still higher than target therefore the risk remains open Monitoring via 3 times daily bed meetings with executive oversight. Additional staff to ensure safety in expanded ED footprint and escalation areas utilised within the hospital. Performance remains high particularly in respect of ambulance handover times. SWAST have implemented changes to their SOP to support trusts with reap 1-4 actions continued pathways meetings with SWAST to reduce patients being conveyed to ED	Finance and Performance Committee

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1152	Current Digital Staffing levels present risk to both operational and strategic activities	Risk Statement There is a risk that the hospital does not have sufficient digital workforce capacity and capability to maintain effective and safe service delivery, progress critical upgrades and projects in a timely manner, support hospital-wide governance and improvement initiatives, or deliver a large-scale Electronic Health Record (EHR) transformation programme. Risk Description The hospital's reliance on digital systems for clinical and operational processes requires a skilled and adequately resourced digital workforce. Insufficient staffing levels, lack of specialized expertise, or delays in recruitment and retention could lead to: Service Delivery Impact: Increased likelihood of system failures, delayed issue resolution, and compromised patient safety due to inadequate support for critical digital infrastructure. Programme and Project Delays: Failure to meet timelines for essential upgrades, transformation projects, and EHR implementation, resulting in operational inefficiencies and potential financial penalties. Governance and Compliance Risks: Inability to provide timely data, reporting, and assurance for regulatory compliance and hospital-wide improvement programmes. Strategic Impact: Reduced ability to achieve digital transformation objectives, negatively affecting organizational reputation, staff morale, and patient experience. Consequences if Risk Materializes: Disruption to clinical workflows and patient care. Increased cybersecurity vulnerabilities and data integrity risks.	02/09/2026	14/09/2021	Chief Information Officer	Clinical IT Systems	16	⇔	16	9	Development of Dorset Digital Strategy and Digital Target Operating Model (2026). Ongoing dialogue with Trust leadership and finance colleagues, to protect as much of the existing resource capacity as possible. Large scale review of digital demand and implementation of new digital demand management processes.	People and Culture Committee, Digital Systems Risk
1782	Diabetic Follow Up Long Waiters	Due to capacity within service we are unable to see patients for their follow ups in the appropriate timeframe.	19/07/2026	04/01/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	20	⇔	16	6	Plan to support clinical team to increase experience and knowledge over the next 3 months (as of May). To provide further stability within the sub speciality Awaiting D&C at sub specialty level for the service to ensure future workforce/ capacity can be planned, this will be a sub group of the One Dorset work that is underway Monitoring the waiting list monthly, however due to the current backlog, risk needs to remain high Returning Consultant on an as & when basis undertaking virtual FOWL review and undertaking additional clinics. In house Diabetic Consultant undertaking additional clinics as and when capacity allows. All patients overdue that were clinically appropriate were called back in July 2024 to DESP for community review. Reviewing further patients to be called back to DESP once capacity allows	Finance and Performance Committee, Patient Safety Group
2357 NEW	endoscopy	Air compressors need to be replaced and upgraded to cope with increased load and demand. Failure will result in Endoscopy having to shutdown.	07/09/2026	06/07/2026	Chief Finance Officer	Estates Department	16	NEW	16	4	We currently have a oversized temporary compressor in place, awaiting quotations to replace installation with duo compressors and duty swap over controls	Finance and Performance Committee
2359 NEW	failure to achieve the standards for the maternity incentive scheme	staffing concerns are directly impacting on the likelihood of achieving the maternity incentive scheme. Namely, 2 standards - 1. mandatory training having to be cancelled due to staffing gaps impacts compliance. This needs to be reported twice in the year (a change from only once for previous years). This was cancelled Monday 6th July. 2. Failure to convert fixed term midwives to substantive will result in failure to comply with BP Plus recommendations confirmed in 2025	07/08/2026	09/07/2026	Family Services (B4)	Maternity Service	16	NEW	16	4	reliance on agency staff, bank staff and incentives. Also specialist midwives and managers repeatedly being reallocated to clinical work	Quality Committee
1886	financial sustainability	Failure to remain in budgets and to make the cost improvements required.	30/01/2027	09/05/2024	Chief Finance Officer	Finance	16	⇔	16	6	Budget meetings, monitored at FPC and the introduction of the financial recovery board and interim inprovemnet director the focus on cost improvement delivery.	Finance and Performance Committee
1781	Glaucoma FOWL Long Waiters	Due to capacity within service we are unable to see patients for their follow ups in the appropriate timeframe. Lack of nursing staff has had impact on being able to run initial assessment clinics.	19/07/2026	04/01/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	20	⇔	16	6	Awaiting D&C at sub specialty level for the service to ensure future workforce/ capacity can be planned, this will be a sub group of the One Dorset work that is underway Monitoring the waiting list monthly, however due to the current backlog, risk needs to remain high Additional (in-house) activity is being put on as and when staffing allows. B4 technicians running assessment clinics to release clinicians time needed for F2F appointments Additional virtual reviews being put on as and when staffing allows. Insourcing additional activity with Medinet at the weekend Additional sessions from Consultant due to change in job plan	Finance and Performance Committee, Patient Safety Group, Clinical Effectiveness Group

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2144	Home Enteral Nutrition (HEN) Service Risk - Growing demand, insufficient staff & supply chain for enteral and SIP feed supplies	The Home Enteral Nutrition Service (HEN) was established c2008/9 and is funded via a block funding agreement in commissioner contracts. Since inception, workload and patient numbers have increased without additional funding following the service. The service at initiation was set up with a Paediatric and Adult pathways, with the expectation of patients remaining with the service for a long period of time. Complexity of case mix has increased, service users have a long life expectancy, therefore remain with the service long term. Service includes paediatric provision which has transition to additional adult workload. Oral and enteral feeds are provided by Fresenius Kabi. Ongoing issues with supply and therefore having to source alternatives or use inappropriate feeds have now largely resolved from a lens of supply chain. Long term, paediatric patients have become adult patients and remained in the service, Impact on patients as a result of the increased workload is insufficient capacity to follow up patients in the expected timeframe. This is reported on a monthly basis as an incident and linked to the risk register entry. Delays for routine reviews can be routinely 3-4 months for approx. 12-15 patients per month approximately. NICE guidance (CG32) states patients should be followed up every 3 to 6 months.	24/07/2026	15/04/2025	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	16	⇔	16	6	Internal skill mix review undertaken to increase staffing allocation to HEN service with Band 5 rotational support. Dietetic assistant role in place, with planned progression to registered dietitian through apprenticeship for staff member (LH) commencing Sep-25 Service provision has been reviewed to maximise opportunities for remote reviews. Monthly Datix reporting of missed reviews in place to ensure that risk remains sighted. Future opportunity to explore mitigation of risk through vertical integration / system working with Dorset Healthcare. Future mitigation plan in advanced stages of discussion now with reprioritisation of funding allocation within department budget to create an additional post to support the service. This will remain a financial risk to the organisation, but will mitigate the clinical risk to patients and also support succession planning for the highly specialised team.	Finance and Performance Committee
2138	Inadequate Supply of Stock, Implants and Equipment in Theatres	This risk applies to all Theatre and DSU consumable items. The inventory system introduced by Procurement has resulted in incorrect products and quantity of products arriving. Essential and routine items have also not been ordered meaning DCH has had to borrow essential items from neighbouring hospitals at very short notice. With the increase in Orthopaedic activity including running LLP lists at weekends, Orthopaedic implants are sometimes out of stock.	31/08/2026	07/04/2025	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	16	⇔	16	6	Implant levels are checked prior to or on the day of surgery. Out of stock implants are often sourced from other healthcare providers prior to or on the day of surgery. A new Inventory Management System (IMS) is in the process of being rolled out for Orthopaedics in Main Theatres. This system will automatically reorder items (except loan kit), thereby minimising the risk of human error and speeding up the ordering process. More benefits are expected once the system is fully up and running. The system has generated a list of our stock and this is currently in the process of Theatre and then Orthopaedic clinical review and validation, to ensure the held stock levels are appropriate for the level of activity undertaken at DCH.	Quality Committee
2007	Lack of Adequate Support for Digital Systems in a 24/7 Acute Trust	Lack of adequate support for clinical systems (covered by the Clinical Systems Support Team – CSST) and first line support (covered by Digital Technology & Infrastructure team – DTI) to cover mission critical systems that operate 24 hours a day 7 days per week. One analyst supports the whole site out of hours. That person cannot be an expert in all areas and utilisation of a voluntary Whatsapp group for support, advice and fixes is increasing as reliance on digital solutions increases. Clinical areas depend on uninterrupted digital systems. Without round-the-clock support there is a risk of; Delayed access to patient records, allergy alerts, and medication histories. For some departments, the inability to record or view observations in real time (NEWS2 scoring delays). Risk of avoidable harm when clinicians revert to paper under pressure. If the Agyle ED system is down, this impacts triage, tracking and clinical decision-making. This iscreases the likelihood of 4-hour breaches, RTT delays, and escalation to OPEL levels. Without immediate response to system failures the Trust may need to invoke BCP mode more frequently and increase manual workarounds. There is also potential for data loss if systems are unstable and not recovered promptly.	01/10/2026	19/11/2024	Chief Information Officer	Clinical IT Systems	12	⇔	16	8	Clinical systems support provided for out of hours. Greater number of on-call analysts to cover all areas of DTI.	Strategy Transformation and Partnerships Committee in Common
2339	Low nursing skillset for Stroke patients due to large recruitment plan for Somerset expansion which may impact September go live	Lack of stroke skilled nurses within an increased recruitment phase of the current nursing team to look after stroke patients as a result of an increased bed base on a refurbished ward. Beds increasing from 23 to 30 from 2nd September 2026 inline with Somerset Foundation Trust across Yeovil and Taunton. This risk does create a risk that the ward will not be ready for go live for the Somerset expansion of Beds.	03/08/2026	03/06/2026	Integrated and Holistic Care (A2)	Stroke Service	16	⇑ Risk esclated to 16 from 9 on 6/7/26	16	6	- Robust training programme devised by ward manage to upskill ward nurses - Divisional agreement that staff are not to be moved to cover other ward gaps unless in extremists - Beds to be slowly increased month on month by 2 taking the ward up to 30 by 2nd September 2026 inline with Yeovil closure and Taunton go live - Ward roster numbers to reflect staffing model at 30 beds (8 RNs and 6 HCSWs daytime, 7 RNs and 4 HCSWs night time). ACP and outreach team to be held of separate roster with working hours extended to 23:00 7 day service inline with consultation approval starting August 23rd 2026. - Protection of supernumerary staff to allow upskilling or nursing team by 2nd September - Staffing skill mix under constant review from Matron	Quality Committee
1780	Macular FOWL Long Waiters	Due to capacity within service we are unable to see patients for their follow ups in the appropriate timeframe.	19/07/2026	04/01/2024	Head & Neck, Specialist Medicine and Outpatients (B2)	Ophthalmology Service	20	⇔	16	6	Awaiting D&C at sub specialty level for the service to ensure future workforce/ capacity can be planned, this will be a sub group of the One Dorset work that is underway Monitoring the waiting list monthly, however due to the current backlog, risk needs to remain high Plans to implement Treat and Extend pathway within service. Identifying trial period for the service to allow PDSA cycle of the pathway Additional (in week) activity is being created when staffing allows. Failsafe Officer monitoring waiting list and escalating any clinical concerns to Macular Lead Consultant. Insourcing at weekends with Medinet, using the agreement funds from the LTFU and ERF work Utilising nurse led clinics for Risk 2 patients following macular meeting 19/11/25.	Finance and Performance Committee, Patient Safety Group, Clinical Effectiveness Group

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2253	Mental Health bed delays	Mental health bed waits have increased over the past 2 years with an increase in attendance and acuity. NHSE have introduced a reporting template for mental health patients in ED with a target of zero tolerance over 24 hours.	24/08/2026	18/11/2025	Unscheduled Care (A3)	Emergency (ED) Services	16	⟷	16	1	Process between DCH and DHC ongoing with meetings and development of pathways. The focus being on the patient receiving the correct treatment plan and having everything commenced in ED or where the patient is within DCH. Mental Health Steering group has as an agenda item which has executive oversight. Some improvements recently to help see & treat patients in the community with MH cars. Escalation to execs process is established for MH patients who remain in ED or the in patient wards. process for all 12 hour waits to be worked up through steering group incidents jointly reviewed with DHC and monthly meetings in place between service leads discussions individually about the best place for the patient and plans that are tailored to their needs pathways still in design with meetings in place for system discussion	Quality Committee
2265	Patients presenting with acute oncological need may not receive care from the DCH AOS resulting in sub-optimal care & interventi	The Acute oncology service is supported both via medical staffing (under Service Level Agreement from University Hospital Dorset(UHD) and nursing and Physician Associate team members from Dorset County Hospital (DCH). UKONS guidance (United Kingdom Acute Oncology Society) suggests Acute oncology service should be available 7 days per week, however DCH is currently only funded for and able to run a 5 day a week service. Medical staffing (Oncologist) is provided by University Hospitals Dorset, but due to local and national shortages, they are unable to provide a 52 week service - it's more aligned to a 39 - 42 weeks service provision and 3 weeks missing for On Call Service provision out of UHD. At weekends and overnight any AOS patient is taken under the care of the acute medical team. Further Info / Risk Revision:Feb-26 The outputs of the Clinical Service review undertaken and agreed c2018 means the consolidation of emergency and acute care and non elective bed capacity at the Royal Bournemouth Hospital site with effect from 23/02/2026. This potentially creates a risk for DCH patients as there is a planned reduction in Specialist oncology inpatient bed base as a result of the service changes. There is a patient experience challenge for this due to the geographical location of the Royal Bournemouth site, particularly for patients in the the far west of the county, particularly for those without access to transport and reliant on Public Transport. There are further challenges with Oncologist capacity & numbers at UHD, with a planned reduction in outpatient and Acute oncology support for DCH. The Acute oncology service at DCH is further challenged with increasing workload and a more junior workforce with a longer lead in time. Business planning outcomes are not yet known in relation to request for additional acute oncology nursing support to enable more service resilience and a 7/7 day service. The service also needs to better consider succession planning as there will likely be retirements in the medium term that could impact service provision.	31/07/2026	15/12/2025	Integrated and Holistic Care (A2)	Acute Oncology	12	⟷	16	6	Over time, the trust has created opportunities for increased cover for the Acute oncology service with externally funded posts such as Macmillan posts, which has improved staffing levels to current levels, but falls short of actual requirements. A proposal has been submitted for the 26/27 business planning round, but this has not been concluded yet, so no outcome known. Given the financial position of the trust and wider system, it will be a challenge for the trust to increase staffing provision. The service has been bolstered with more time allocated from a shared Physician Assistant post and the creation of a new Lead Acute Oncology Nurse post in addition to the core staffing numbers for Acute Oncology established in budget. UHD has attempted to mitigate the risk with additional support from registrars and agency locums, but this has had limited success and impact. Service is supported with access to UHD oncology on call team - first line response from a registrar grade and backup of an oncologist, but neither nursing or medical teams are staffed for a 7 day service and require longer term investment and growth to meet the growing demands on the service. Difficulties in accessing support from UHD occurs regularly and is being monitored via the incident reporting system. As part of the planned move to Royal Bournemouth Site all contact numbers / details will remain the same. Jun-26 Update: There is due to be some turnover within the Cancer Support worker Acute Oncology role and currently reviewing feasbility of uplifting this to Band 6 from Band 4 and backfilling admin duties in a different way. Working with Lead Cancer nurse and Acute oncology nursing team to look at this currently, which would give a future partial mitigation to risk and risk reduction.	Quality Committee
2012	Revalidation Officer	The Trust has one standalone Medical Appraisal and Revalidation Officer at B5 0.6 WTE since 2017. In that time the medical workforce has increased, along with that the complexity of appraisals and revalidation including the introduction of a process solely for LEDs. Despite this, the resource attached has not increased from 0.6. This role is a single point of failure in addition to the function not being deemed deliverable within the current 0.6WTE. The HWB of the current post holder is also a concern due to the workload vs capacity. The current post holder is likely to retire in the next 24 months (when is not known). There is no resilience attached to this role and no natural cover should the post holder be absent or leave. There are direct implications on Drs appraisals and ability to revalidate should this post not have additional WTE invested and should the post become vacant.	30/10/2026	25/11/2024	Workforce and Human Resources	Human Resorces	16	⟷	16	16	Banding has been reviewed as we are an outlier in comparison to many other Trusts. It is now a B5, as of October 2024, although other comparable roles are a B6 and have administrative support. Approved 6hrs a week overtime; but added to end of existing working days. Post holder does not want permanent additional hours. Significant work re centralisation of the management of Drs At DHC before we can explore collaborative options. 30/07 update - Additional 0.4WTE now in place so 1 WTE in total. Improved resilience however significantly low total WTE in place for size of medical workforce and dedicated LED appraisal process. 22/04 - The 0.4WTE is attached to a graduate visa; this role does not qualify for sponsorship so the postholder will be leaving the trust. Unless we are able to replace like for like, the risk level will revert to the same level as when this risk was first logged. 15/07 - Resignation received therefore resource will reduce to 0.6 by end of July.	People and Culture Committee
2145	Risk of eating disordered patients not receiving expert specialist care both in hospital and community.	Inpatients: Risk of lack of specialist trained staff to manage this cohort of patients within an inpatient setting. Community Patients: Inadequately commissioned or delivered resource to care for patients in the community. Avoidance Restrictive Food Intake Disorder (ARFID) patients not being given adequate support - both adult and paediatric from a multidisciplinary service / tertiary support.	17/07/2026	15/04/2025	Integrated and Holistic Care (A2)	Dietetics and Nutrition Service	12	⟷	16	6	Inpatients: Protocols in place for management of these patients. Easting disorder MDT's in place. Ability to convene system MDT for patients with Psych Liaison support / Gastro. ACP support (BS). Adequate MDT support and policies in place. Community Patients: This is area of greatest risk. Ultimate mitigation of inpatient admission.	Quality Committee
2349 NEW	SDEC capacity and bedding	SDEC has become consistently bedded over the last 6 weeks due to reduction in hospital flow. This has impeded emergency flow and removed opportunity to prevent crowding in ED further contributing to a decline in the 4 hour safety standard. This is a reputational risk to the trust as it is national guidance not to bed SDEC services. Where other services don't have clinical capacity patients who need urgent not emergency clinic appointments are being moved into SDEC further reducing emergency flow. The quality of patient care has declined with more datix logged during bedded periods and patients who could be turned around in SDEC are waiting longer in ED to access the correct care.	28/07/2026	23/06/2026	Unscheduled Care (A3)	Acute Medicine Service	16	NEW	16	1	SDEC capacity to be reviewed at bed meetings. SDEC to be deescalated at the earliest opportunity when bedded with exploration of suitable patients for other escalation areas. Divisional leads to review patient who could be seen elsewhere and remove non SDEC activity from SDEC. SDEC remains bedded overnight due to attendance numbers and only 13 admissions since midnight at 3pm yesterday. SDEC picked their own patients to ensure they were short stay/ SDECable. reviews taking place currently SDEC has not been bedded for the last few days but until a escalation plan is firmly in place the risk of bedding sdec is not reduced or fully mitigated	Quality Committee

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1221	Tackling the backlog of elective care	The 2026/27 operating plan sets out a requirement to reduce the time people wait for elective care, improving the percentage of patients waiting no longer than 18 weeks for elective treatment. Every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national performance target of 70%. For DCH, this translates to 70.89% by March 2027. For cancer metrics, every trust must deliver 94% performance for 31-day and 80% performance for 62-day standards by March 2027 and maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%. There is a risk that DCH won't deliver against these key elective and cancer performance metrics. Failure to do so and to deliver positively against the trajectory set out in the operating plan, will result in entering a performance management approach and to move into a higher segmentation in the NHS Oversight Framework 2026/27. There is a further reputational risk, with national league tables being published quarterly, throughout the period.	13/08/2026	09/03/2022	Operational Support	Central Appointments	20	⇔	16	8	The trust has had a challenging Q1, with all elective and cancer metrics off plan (apart from 31d). A full analysis of this has been presented to Board and includes staff sickness and key equipment failure, leading to the loss of activity. Other factors include heat waves and IA action (where activity was lost due to the short notice of cancellation of the IA action). A 4-week recovery period has been set, to allow for detailed modelling, at a speciality level to be completed and presented back to the Board. During this time, the following actions continue: 1) Comprehensive insourcing plan, with all activity insourced below the tariff rate 2) 12-week validation programme, which means all patients on the waiting list are contacted every 12 weeks to ensure they still want to be on the waiting list, and their condition has not changed 3) PTL management process, which includes clinical oversight to ensure patients clinical priority is regularly reviewed	Finance and Performance Committee, Clinical Effectiveness Group
2327 NEW	Backup solution replacement	The backup storage solution used at DCH since 2021 is end of life (EOL) in 2026. replacement was highlighted and put forward as part of business planning 2026/27 financial year, unfortunately it was not approved. This poses an operational and Cyber resiliency risk due to ageing hardware, lack of support and updates impacting the security and stability of the solution which is key to underpinning the organisations ability to recover from technical failure or cyber security incidents.	07/07/2026	06/05/2026	Chief Information Officer	Digital Technology and Infrastructure (DTI)	20	NEW	15	6	Control, DTI will continue to use the platform at risk but are unable to provide assurance on stability if components fail and are increasingly unavailable in the market.	Finance and Performance Committee
2291	Day Surgery being used as an Escalation Space for Inpatients	Inappropriately triaged inpatients. Complex discharges. Patients identified for discharge that are not optimised. DSU over capacity - effecting DSU + Main Theatres theatre flow. No showering facilities for inpatients. Transient agency staff caring for inpatients require significant support from DSU staff. Visiting for the escalation patients is facilitated if possible, but the space is limited and cannot allows be convenient if the areas is busy with post surgery patients.	24/08/2026	03/02/2026	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	15	⇔	15	2	Awaiting publication of SOP. Currently using agency nurses 24/7 (not established for this) to provide nursing care. These nurses work with the escalation bed patients, who are mixed cohort in two bays and two side rooms. The day surgery elective activity is run by the substantive team in the same area. There are situations when the work of both teams overlap, the DCH team support the agency nurses when required with drug checks and tasks. The agency nurses do not assist with the management of the day case patients, unless they fail to hit their recovery goals and turn into overnight patients, as there is no ward space for them to be transferred into. The escalation patients are provided with meals, delivered by hot locks. They are able to use the toilets or commodes on the ward, but leave the ward to shower on another ward. Privacy is provided with the use of curtains, the bed spaces are too small to allow for patient lockers or chairs. The basic patients needs are met, in the limited space, however it is far less than would be provided on a ward.	Quality Committee
2317	Demand Outweighs Capacity for Paediatrics IBD Infusions	Historically Specialist Infusions for Inflammatory Bowel Disease and Juvinile Arthritis were coordinated and managed with a Band 5 Day Case Nurse, this role was then absorbed into a different role when the team member left, the Day Case patients were then coordinate and cared for by the Paediatric Assessment Unit, which is a busy assessment unit for CYP who are referred into hospital via their GP, SWAST and Emergency Department. Due to the number of complaints and incidents in relation to this cohort of patients, the CCN Team took the patient caseload on to improve patient experiences and outcomes and alleviate the pressures on PAU. The CCN team took this cohort of patients with no additional workforce. At this time the caseload of patients in 2022 was around 8-10 patients. The patient caseload is now 20, this is due to infliximab being 1st line treatment option for IBD.	17/08/2026	27/03/2026	Family Services (B4)	Paediatrics Service	12	↑ risk esclated to 15 from 12 on 15/6/26	15	1	There is also a Risk on the register currently in regards to Outpatient Workforce, where this cohort of patients could be managed more effectively reducing pressures within the CCN Team.	Quality Committee
1912	ICE - unsent EDS (Electronic Discharge Summary) issues	Ongoing issue of EDSs not being sent in a timely way. Investigations shows that there are 3 reasons for the delays: •Due to a bug in VitalPAC, emergency admissions are currently dependent on the discharge information, •Not all wards use VitalPAC, •EDS's not being completed in a timely way by the Clinicians. Until these 3 reasons are addressed either with system upgrade or system user compliance GP surgeries will not receive patient EDS (Electronic Discharge Summaries) in a timely manner, which poses a clinical safety risk.	21/08/2026	03/07/2024	Chief Information Officer	Clinical IT Systems	20	⇔	15	12	Reports currently being generated by ICE. These notify each ward of incomplete EDS's that need to be actioned and are displayed in date order with alerts as the EDS's get older. We understand there are escalation routes to Divisions for outstanding summaries. Some EDS's aren't sent timely as they may have been created in a outpatient spell instead of an inpatient spell on ICE. CSST receive a daily report and move any incorrect spells and to the correct spell.	Strategy Transformation and Partnerships Committee in Common
2290	ICU Consultant Medical Staffing currently doesn't meet minimum standards as set out in GPICS V3 released 28/1/2026	The recent visit / inspection by the ICU Regional Network (Dec 2025), along with the release of GPICS v3 (Jan 2026) has shone a spotlight on several different issues: - DCH are currently non-compliant with the NHSE D05 Critical care Provision document (section 2.4 of DO5) and the recently released GPICS v3. We urgently need to provide weekend cover for ICU ward rounds separate from the current weekend anaesthetic service. This will require a significant ICU consultant expansion (at least 4 WTE) by summer 2027. As we do not meet the minimum standards for GPICSv3 we would therefore fall into either the 'inadequate' or 'needs improvement' rating in the event of any CQC assessment of the current or new critical care unit.	20/08/2026	30/01/2026	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Critical Care Service (CRC)	15	⇔	15	2	6/5/26 Business case to be presented at next Divisional Business Quality Governance meeting. Met with Divisional Director and raised to Divisional Management for support to complete a gap analysis and business case to fulfil the shortfall. Added to risk register.	Finance and Performance Committee, Quality Committee
2351 NEW	Insufficient Orthopaedic Capacity to Eliminate 52-Week Waits	The Orthopaedic waiting list is the largest proportion of patients in the 52 week cohort to be seen by March 2027 (2305 patients as of 26/06/26). Demand and Capacity modelling has shown we need to increase our capacity by 9 day surgery lists, 7 main theatre lists and 6 outpatient clinics per week. This level of additional capacity is not deliverable within the current model, creating a significant and ongoing gap between demand and capacity.	31/07/2026	26/06/2026	Trauma, Orthopaedics, Urology & Junior Doctors (B1a)	Orthopaedics Service	15	NEW	15	6	Additional capacity being set up through the LLP funded by ERF and reviewing options for insourcing to increase activity numbers.	Finance and Performance Committee
853	Lack of Administration Support for Critical Care & Outreach Impacting Ability to Deliver Call for Concern	No Administration support for Critical Care and Critical Outreach services including Call for Concern (Martha's Rule).	17/08/2026	15/12/2019	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Critical Care Service (CRC)	8	⇔	15	4	Band 7 leads managing all own administrative tasks which impacts on their capacity for completion of daily service management and clinical duties. Critical Care Outreach lead having to process all audit data, quality reporting, minutes of meetings alongside whole team having to input data into audit system which is extremely time consuming.	

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1539	Medical and Nursing Agency Costs	Increase in both medical and nursing agency spend within the emergency department. High vacancy rate within the Nursing establishment is meaning more reliance on agency staff. There are vacancies within the medical roster particularly night shifts which are currently having to be covered by the ED consultant team. moved back to active due to implementation of THP, busy summer months and IA staffing pushing up costs of agency, bed flow reducing the moves to specialty beds increasing the need for coordination and nursing care.	24/08/2026	04/11/2022	Unscheduled Care (A3)	Emergency (ED) Services	15	⇔	15	6	Recruitment continues for both the medical and nursing vacancies. This includes domestic and internationally sourced staff. Recent proposal to increase the percentage of head room to recognise general absences due to study leave etc has been accepted and recruitment to address the establishment shortfall is underway. Budget and costs are monitored through governance meetings and performance meetings with executives and the Financial Recovery Board. increase in numbers of substantive MG, cons, ACP and nursing workforce to reduce locum costs and support workloads 24/7. plan to executive committee to increase the front door ED staffing model and reduce the escalation and nursing and agency rates as attendances have further increased the use of bank and agency has increased including using incentivised shifts due to staff fatigue.	People and Culture Committee
1852	Neurophysiology Workforce levels not meeting Demand	Neurophysiology is a small team of 3 WTE. Demand and complexity of activity is increasing and there is a pressure on the team. We are challenged by IP activity due to the size of the team and how referrals arrive (all or nothing) Risk- Clinical Demand exceeds capacity Risk -Skill mix - not all staff have same skill Risk - cover being available and the correct skill set being available Risk- Quality and health and safety work impacted by clinical demand Risk -Staff well-being	31/07/2026	27/03/2024	Radiology & Neurophysiology (B3b)	Neurophysiology Service	12	⇑ Risk esclated to 15 from 12 on 13/5/26	15	3	Business case approved - currently going out advert for posts. recent vacancy affect lists furtherJob planning will be reviewed to address the balance of work to support clinical and quality of service. We are going to review how urgent and IP are covered. There are times when we struggle to meet the IP demand We have created protected time for reporting ambulatories and will review if that is on track For a small team we also need to reflect on impact of this on health and well being for small team This situation is developing the DM01 is currently in a poor position and urgent and IP has doubled for escalation. Review KPI and TATs Stats to be weighted in respect to complexity to help monitor the system	People and Culture Committee
2199	No Dedicated Clean Space for Administration of IV Biologics/Chemotherapy on Kingfisher	Kingfisher Ward does not have a dedicated clean room or treatment space for the administration of chemotherapy and intravenous biologic infusions. Patients requiring these treatments are frequently cared for within a shared bay environment alongside acutely unwell children who are admitted via the assessment unit following referral from General Practitioners or the Emergency Department. Whilst chemotherapy is typically administered within a treatment room, this space is not exclusively allocated for this purpose and is often required for the assessment and management of acutely unwell children. Consequently, there is no guaranteed access to an appropriate clean environment for the delivery of treatment to immunocompromised patients. Children receiving chemotherapy and biologic therapies are at increased risk of immunosuppression and infection-related complications. The lack of a dedicated clean space increases the risk of exposure to infectious pathogens from other patients presenting with undifferentiated illnesses, including potentially contagious conditions. This creates challenges in maintaining optimal infection prevention and control standards and may impact patient safety, experience, privacy, and dignity. Best practice would be for all children who are immunosuppressed, or at risk of becoming immunosuppressed as a result of their treatment, to be assessed and treated within a designated clean clinical environment that is protected from exposure to acutely unwell patients and potential sources of infection. The absence of such a facility on Kingfisher Ward presents an ongoing clinical and operational risk and highlights the need for a dedicated treatment room for oncology and infusion patients.	24/08/2026	17/07/2025	Family Services (B4)	Paediatrics Service	12	⇑ risk esclated to 15 from 12 on 15/6/26	15	1	Chemotherapy Clinic is generally always held within the Paediatric Treatment Room on the ward, this is a separate space where no other patients are cared for during chemo clinic, however as this is the ward main treatment room it is often disruptive as staff are constantly coming in and out the room for things off trolleys or in stock cupboards. A separate Day Case Area would be more beneficial during this time. A review of the Day Case is taking place with the Team Lead CCNT currently to try and have a day clinic weekly to support these patients in a more protected space. However the challenge with this is the increasing demand for staff to be allocated to this clinic.	Quality Committee
1664	Skill Mix within Paediatric Outpatient Department - No Registered or Lead Nurse Allocated to Clinics or daily running of departm	There is a risk that the Paediatric Outpatient Department is unable to maintain safe and effective operational oversight due to the absence of a designated Registered Nurse or Lead Nurse responsible for the day-to-day management of the service. The department is located off-site from the main hospital and is primarily staffed by two Healthcare Support Workers (HCSWs), with no registered nursing leadership embedded within the team. Whilst nursing and medical staff are based within the building, they are not assigned responsibility for the operational management of the department. Line management and professional oversight are provided by the Matron; however, this role spans outpatient, community and specialist nursing services and does not provide a daily on-site presence. This lack of nursing leadership is further compounded by the absence of HCSWs trained to Safeguarding Children Level 3 and a lack of staff with Paediatric Immediate Life Support (PILS) competencies. This may result in delays in clinical decision-making, inadequate escalation of safeguarding concerns, insufficient response to deteriorating children, reduced assurance of safe service delivery, non-compliance with national standards and training requirements, and increased risk to patient safety, service quality, organisational reputation, and regulatory compliance.	17/08/2026	05/06/2023	Family Services (B4)	Paediatrics Service	12	⇔	15	6	Rely on Kingfisher staffing and available Bank staff to support the children's centre with staffing gaps for sickness and training. We have x3 substantive HCSW for the department and x3 bank HCSW to help when sickness, AL and additonal specialist clinics	People and Culture Committee
1556	Theatre Staffing Sustainability	A theatre establishment review has demonstrated that there are significant gaps in the funded establishment. These gaps currently equate to the loss of approximately 10 lists per week, therefore the risk score has been adjusted to high. High number of staff approaching retirement age within theatres over the next few years. Difficulty in recruiting to skill sets (ODP/Anaesthetic). Funding apprenticeships for ODPs will allow mitigation of staffing shortfalls in the future. Retention challenges due to lack of progression for Band 5 staffing and disparity with Pan Dorset for grades and staffing structure (too flat).	24/08/2026	20/03/2025	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	15	⇑ Risk esclated to 15 from 12 on 19/5/26	15	6	Workforce planning is still in progress as below to establish correct staffing levels. There have been some people leave recently and awaiting a number of new employees to the theatre complex. Current mitigation strategy is voluntary overtime and bank shifts being undertaken by Theatre staff in order to reduce the amount of lists stood down due to understaffing. However, this is not a sustainable solution as it is leading to burnout for staff taking on additional hours and is costing the Trust more than substantive staff would.	People and Culture Committee, Clinical Effectiveness Group

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1607	Tier 2 Paediatric Registrar - BAPM Compliance in SCBU	Our current Tier 1 staffing model is not BAPM compliant, as we do not provide a dedicated Resident Doctor on our SCBU unit 24/7. We commit an Resident Doctor from our Acute Paediatric Rota to SCBU from 08:30 – 17:00, Monday – Friday excluding Bank Holidays Our current Tier 2 staffing model is not BAPM compliant, as we do not currently provide dedicated staffing to achieve compliance with Tier 2. Three posts from a Business case were approved whereby 1 permanent registrar & 2 fixed term registrars were to be recruited to. The permanennt position was filled but the two fixed term positions were not. The Business case for these standards ceased to exist as of March 2026. In order to continue to meet the standards, the service requires financial approval to fill these positions at cost pressure. Registrars from the deanery do not meet minimum standard levels. Existing rota uses Consultants to act-down to cover gaps but also do planned resident cover. Moving forward, Consultants have come off the resident rota.	15/07/2026	08/02/2023	Family Services (B4)	Paediatrics Service	12	⟷	15	3	Rota reviewed to have consultant and tier 2 cover - needs funding and recruitment of additional tier 2 cover. Following ICB investment in response to Yeovil Maternity closure funding to cover 9 month fixed term 0.43 WTE tier 1, and 1.16 WTE tier 2. This will increase the fixed term establishment of tier 2 to 4.16 WTE and achieve BAPM standards for SCU low activity, recognising this is fixed term. This facilitates a dedicated Registrar in SCU. Long term substantive post will need to be part of business planning 2026/27. The ANNP posts will also be transferred into Registrar vacancies due to unsuccessful recruitment into training posts.	People and Culture Committee

Closed Risks

Approval status	ID	Title	Review date	Opened	Care Groups	Service of responsibility	Risk level (initial)	Risk level (current)	Risk level (Target)	Type of Risk	Mitigations/Controls
	1876	Alexandra House Fire Safety Compartmentation Defects	31/08/2026	29/04/2024	Chief Finance Officer	Accommodation Services	12	4	2	Finance and Performance Committee,	The supporting report provides information on the mitigations/controls required as an interim step towards compliance.
	1699	Fortuneswell pharmacy - Insufficient ambient storage space	21/04/2026	13/07/2023	DCH SubCo	Fortuneswell Pharmacy Service	9	9	6	Finance and Performance Committee	Overflow shelving installed summer 2020 Orders actively managed to maintain within storage limits. 21/1/26 - Fortuneswell Pharmacy moved to larger premises in summer 2025. Additional space is available for ambient medicines, however configuration of this is to be explored by AH to make best use of the storage available particularly in light of the increased stock holding associated with the transfer of out-patient activity from DCH pharmacy.
	1698	Fortuneswell pharmacy - insufficient refrigerator space	21/04/2026	13/04/2023	DCH SubCo	Fortuneswell Pharmacy Service	9	9	6	Finance and Performance Committee	Continous load temperature probe in situ - alarms to main pharmacy. 24 hour temperature graph monitored daily. Stock holding actively managed to maintain within capacity limits. 21/1/26 JK - AH investigating need to increase storage
	1629	Move of Hampshire Trust to a Sectra PACS	02/07/2026	21/04/2023	Chief Information Officer		16	9	9	Finance and Performance Committee	October 2023 - guidance to be provided to DCH clinicians in the specialities most effected (colorectal and liver cancers) they will have a change of process to request access to imaging if they believe it has been done by Hampshire hospitals. Rowe, Ian - PACS / RIS / IT Manager 22/10/2025 14:10:09 The risk remains. The additional risk around how the Trust will fund the solution beyond 2026 remains. The functionality proposed for the mitigation of the loss of the full DCH<>HHFT patient imaging record will not be achieved. Final functionality is still being developed and live product deployment anticipated in 2026, date to be confirmed. Testing and development of product functionality continues. Recent advice from SWASH is that only the HHFT imaging that has been stored on the SWASH Sectra PACS, following the HHFT PACS changeover , will be available via the XCAi solution being developed. Previous imaging of DCH patients that is on their systems from the HHFT Intelerad PACS will be unavailable to DCH PACS via this solution.
	2268	National Shortage of Levo/Fentanyl Epidural Bags	21/05/2026	22/12/2025	Family Services (B4)	Maternity Service	9	9	1	Quality Committee	pharmacy overview and arrangement in place.
	2237	Provision of Ultrasound Machines within Theatres	11/05/2026	13/10/2025	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	8	8	4	Quality Committee	Currently it may be possible to borrow a Mindray ultrasound machine from ICU. However, these machines are not of the same quality as the Theatre Sonosite machines. Clinicians have been encouraged to Datix when machines are not available or appropriate for use.
	1906	Total Intravenous Anaesthetic Pumps Required	08/06/2026	11/06/2024	Theatres, Anaesthetics, Critical Care & Decontamination (B3a)	Theatre Service	15	2	4	Quality Committee	We will continue to use the available pumps with a view to purchase additional TIVA pumps at the earliest opportunity. The department was told a Trust-wide procurement of pumps is due to take place and the TIVA pumps would be included in that. Theatres spoke to Nicholas Mason in Medical Engineering (Feb 2025), he has informed that there will be a tender process for infusion pumps starting in Oct 2025. The length of this process may have an impact on the risk.
	2292	YDH reopening	10/06/2026	03/02/2026	Family Services (B4)	Maternity Service	12	2	4	Quality Committee	unable to mitigate as it is not possible to identify how many YDH women will remain at DCH. Bank and agency staff can be utilised where available

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Dorset HealthCare

Quality Committee in Common Assurance Report for the meetings held on Tuesday 30 June 2026 (informal) Tuesday 28 July 2026 (formal)

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

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Discussion around the Board Assurance Framework and Corporate Risk Register, as described below. • Receipt of the Infection Prevention and Control Annual Reports for both Trusts, which would be presented to Board. • Potential challenges to MIS compliance this year, due to staffing and training
Key issues / matters discussed at the meeting	**The informal meeting of the committee held 30th June 2026 received:** • Part of the meeting was stood up to be a formal meeting for DCH, to consider the Maternity Neonatal and Obstetric Workforce Report, noting that compliance with key CNST safety standards had been maintained, although workforce pressures persisted, including a reported midwifery deficit identified through the Birthrate Plus review. Members provided challenge that a previously agreed 2024/25 staffing uplift had not yet been delivered and emphasised that, in the current national context, this represented a material safety risk. The Committee requested further discussion re the national reports in to maternity services at the upcoming Board Development Session (14th July 2026). • **Mental Health Patient Flow (DHC)** outlining the work of the mental health therapeutic admissions programme • A presentation on the **End of Life / NACEL Audit (DHC)** • A presentation and discussion around **tackling communication as a complaint theme (DHC)** **The formal meeting received of the committee held 28th July 2026, discussed and noted the following reports:** **Chief Nursing and Chief Medical Officer Update (DHC/DCH)**

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- Focus on maternity service with publication of national reports (Ockenden and Amos). Submissions submitted to ICB as required. A visit from NHS England in August to look at maternity staffing levels.
- Operational demand easing. Heatwaves since the last meeting have been an area of operational and quality focus. Humidity levels in first heatwave caused (approx. four heat-related deaths and (approx. 85) cancellations of planned operations. There were also four heat-related deaths. Work continues locally and regionally to ensure heatwave plans are robust appropriate.
- Redesign of the emergency department front door. to support increasing demand. Trialling command centres, and "call before convey" to support SWAST with identifying patients who don't need to be conveyed to hospital.

Dorset HealthCare

- CQC Well Led inspection continues with service level factual accuracy checks submitted. Information continues to be shared with CQC as it is requested.
- Work continues to plan for implementation of the new joint risk management system, Healthcare Guardian.
- Staffing issues on Radipole ward, Herm and St Brelade's, and Waterstone. All these wards were under safer staffing processes with greater oversight of staffing levels. A number of community nursing teams were in business continuity as well.
- Additionally, there were vacancies in senior medical leadership at Herm and St Brelade's. Retention of senior medical staff has been difficult for a number of years; conversations ongoing about how to make this a sustainable service.
- MenB vaccine support continues
- Visit to southwest neighbourhood team from Claire Fuller (national programme lead), who offered robust challenge, and positive feedback about the work, with a focus on delivery at pace.
- Positive recent meeting with clinical leads across the four trusts regarding EPIC implementation.

Board Assurance Framework (DHC/DCH) including refreshed risks from Q1. At DHC the score for SR1 is 12 with a target of six. At DCH the score for SR1 is 16 with a target of six. Both trusts have a risk appetite of 'cautious' for this risk. For DCH there was a discussion around the impact of national maternity reports on the level of assurance from the controls in place.

Corporate Risk Register (DHC/DCH)

Dorset HealthCare

- Second meeting of the new Risk Management Group, with particular focus on reviewing risks open for more than a year. Once reviewed

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these risks were either closed where appropriate or reviewed to understand residual risks.

- There were five risks scoring >15 and 16 new risks.
- Detailed discussion at Risk Management Group re risk 2075 (waits for ADHD service).
- There are multiple risks re capacity within CAMHS. These are being reviewed to understand if they can be consolidated and to understand the harm if they remain at their current level. There is also a focus on understanding national mental health priorities
- 12 risks re staffing (clinical) and 8 re waiting lists/demand and capacity
- Following yesterday's meeting, a referral was expected from People and Culture Committee in Common with regards to the quality impacts of workforce challenges.

Dorset County Hospital

- 14 high score risks for Quality Committee, with secondary committees listed in report where appropriate.
- Risk Management Group reviews risks and moderates their scores
- 4 new risks described for the committee (a national drug shortage; compliance with Maternity Incentive Scheme [MIS]; consistent bedding in SDEC; and all-age palliative care).
- It was not possible to provide the same reports between DCH & DHC given different risk systems. DCH report now includes additional narrative discussed at risk management group to provide contemporaneous information.
- Thorough discussions around the detail of the risks presented to committee and the level of assurance provided.

Quality Report (DHC/DCH) updating on core quality metrics for each Trust. Of note

Dorset HealthCare:

- Increase in reported medication incidents, due to the MenB response and errors reported in that period. This ranged from minor errors with no harm, to duplicated doses. There were a small number of cases, and all were reviewed and acted upon appropriately. Further detail would be taken through Medicines Safety Group and escalated to Quality Committee as necessary.
- Summary of learning from CDiff cases included in the paper.
- Increased workload in complaints recently. Work ongoing to understand the reasons behind this; an increase in lengthy AI generated complaints was thought to be a contributing factor.
- Positively, improvements in statutory duty of candour reporting.

Dorset County Hospital

- Strong performance in hospital acquired infections and pressure ulcers
- Similarly to DHC there had been increased complaint activity, with more complex and AI generated complaints being received.

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- Mixed sex accommodation breaches continue to occur due to pressure and reliance on escalation areas. Strong governance and oversight of these breaches continue. As bed reconfiguration work begins it is hoped that there will be a reduction in breaches.
- A Dorset wide network meeting for infection control and tissue viability helped to share learning with partners.

Quality Governance Groups Assurance Reports (DHC/DCH)

Dorset HealthCare:

- Many of the topics discussed at Group had already been covered or were to be discussed later on the agenda.
- A thorough discussion around the closure of incidents that had been open for a long period of time. This decision was made in agreement with Senior Leadership Group. There were over 3,000 such incidents. Learning for all rated moderate or higher had been acted upon, and all closed incidents would still be available in the archive (which would also be migrated to the new risk management system). Further detail to be provided to the committee in due course.

Dorset County Hospital

- Updates to Quality Governance Group from the groups that report in to it
- Dementia oversight to be incorporated in to the Mental Health and Learning Disability Steering Group to reduce duplication and strengthen oversight
- Discussion around the opportunities to strengthen joint working in a number of areas, whilst recognising the two Trusts remain separate

Infection Prevention and Control Annual Report

Dorset HealthCare:

- A thorough presentation summarising the IPC annual report
- Positive performance against key indicators, including achieving the C.Diff reduction target and significant reduction in bloodstream infections (BSI).
- Areas of partial compliance had been identified through the IPC assurance framework, with 17% of metrics being partially compliant. There were no areas of non-compliance.
- Discussions around the water surveillance process and antimicrobial stewardship

Dorset County Hospital

- Continued low rates of MRSA bacteraemia, a 4-year low in C.Diff infections and a reduction in outbreak activity, particularly norovirus outbreaks. While gram-negative BSI had increased marginally above trajectory, assurance was provided that performance remained strong overall and reflected the challenge of maintaining improvements against increasingly low baseline thresholds.

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- Continued embedding of PSIRF in IPC
- Discussion around IPC oversight for externally provided elective services.

Medicines Management/Optimisation Annual Report
Dorset HealthCare:
- Progress against Dorset wide medicines strategy, with continued delivery of national and local priorities across medicines safety, antimicrobial stewardship, digital transformation, workforce development and medicines optimisation.
- Significant progress in relation to sodium valproate safety arrangements.

Dorset County Hospital
- Assurance provided regarding the effectiveness of medicines governance arrangements, oversight from Medicines Committee, progress towards reopening the Aseptic Unit and ongoing implementation of medicines optimisation initiatives.
- Continued monitoring of controlled drugs through strengthened oversight arrangements
- Differences in the two trusts' reports were discussed with a view to aligning these more closely.

Equality Quality Impact Assessment Assurance Report
Dorset HealthCare:
- Assessments related to the One Dorset Procurement Service, temporary bed closures associated with capital works at Herm Ward and Alhumhurst Ward, and the relocation of a bed space at Colmers Ward
- Discussion around understanding the 'now what' of EQIAs, with further discussion and detail to be provided to a future informal meeting.

Dorset County Hospital
- Noting an equality quality impact assessment regarding headroom.

CQC Urgent and Emergency Care and Medicine Report (DCH)
- Rated 'good' overall with one 'requires improvement' in the matric regarding safety within urgent and emergency care.
- The context of the inspection (during winter pressures with escalation areas open) was noted and congratulations were extended to all involved for the results received.
- A single trust wide action plan to be developed and returned to committee in the coming months.

DHC Internal Assurance Report (incl. Quality Walkarounds Output)
- Monitoring of actions relating to Herm ward and closed actions

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	Maternity and Neonatal Quality and Safety Reports (DCH) noting: • Receipt of the Maternity and Neonatal Quality and Safety Report, Learning Reviews and Investigations Report, PMRT Report, Maternity Experience of Care Report and Maternity Training Report. • Focus on improving APGAR scores which were flagging as an increasing concern. • One period OPEL 3 and one OPEL 4 in period. The OPEL 4 period lasted most of a weekend • Home birth service suspended in the reporting period due to no staff to provide cover. Delays to elective c section, due to staffing capacity pressures. • Two new risks; one re failure to achieve MIS due to staffing and training. Second risk re clinical safety case for BadgerNet and management of associated actins • Maternity staffing was the highest rated risk, scoring 20. Recruitment progress continues but significant challenges remain. Extensive discussion around staffing noting the need to rebase establishment, the impact of reduced birth rate but increasing complexity, with work ongoing to consider how additional midwives could be funded, and with NHS England due to visit the service in August to look at staffing levels. • Positively, no Maternity Outcomes Signalling System (MOSS) triggers or concerns identified during the reporting period. **National Reports in to Maternity Care in England** • Receipt of a summary of the national maternity reports (Ockenden and Amos reviews), noting the significant alignment between them. • A local Task and Finish Group had been established to oversee delivery of the first phase of actions, with work already underway. • A regional maternity event would take place later in the year to consider the implications of the national reviews for maternity services across the Southwest, including the sustainability of smaller rural maternity units and the impact on equity of access and safety.
Decisions made at the meeting	• Deferral of safeguarding report and DCH Walkarounds report to the September meeting due to the meeting overrunning.
Issues / actions referred to other committees / groups	• Nil

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Quoracy and Attendance							
	26 May 2026	30 June 2026 (DCH)	28 July 2026	29 Sept 2026	24 Nov 2026	26 Jan 2027	23 Mar 2027
Quorate?	Y	Y	Y				
Claire Lehman	Y	Y	Y				
Suresh Ariaratnam	Y	n/a	Y				
Dawn Dawson	N	A	A				
Eiri Jones	Y	Y	Y				
Lucy Knight	Y	n/a	Y				
Stuart Parsons	Y	Y	Y				
Rachel Small	N	n/a	A				
Anita Thomas	Y	A	Y				
Rachel Wharton	Y	Y	A				
Cara Southgate	n/a	n/a	Y				
Jo Howarth	n/a	n/a	Y				

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Report to	Board in Common (DCH Board)	
Date of Meeting	11 August 2026	
Report Title	Maternity and Neonatal Quality and Safety Report May & June data	
Prepared By	Jo Hartley Director of the Midwifery and Neonatal Service	
Approved by Accountable Executive	Jo Howarth - Chief Nursing Officer	
Previously Considered By	Quality Committee in Common 28.07.26 Quality Governance Committee 15.07.26	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

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

Executive Summary

This report provides an overview of maternity and neonatal quality, safety and performance for May and June 2026, providing assurance of service quality, safety, effectiveness and governance. Key areas of focus include patient safety indicators, incident reporting, workforce compliance, patient experience and risk management.

Safe

- No Maternity Outcomes Signalling System (MOSS) triggers or concerns identified during the reporting period. A MOSS exercise is planned for September 2026 to support organisational preparedness and compliance with Maternity Incentive Scheme (MIS) Year 8 requirements.
- One neonatal death occurred at 13 days of age. The case is progressing through the appropriate review processes and a preliminary PMRT report has been received.
- Special cause variation has been identified for babies born with an Apgar score of less than 7 at five minutes, requiring continued monitoring and review.
- There was one OPEL 3 and one OPEL 4 escalation during the period, reflecting ongoing pressures associated with workforce capacity.

Caring

Five complaints, two early resolution concerns and one item of PALS feedback were received.

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Themes centred on communication, continuity of care, postnatal recovery, family support, documentation and the psychological impact of maternity and neonatal experiences. Positive feedback continued to highlight the compassion, professionalism and commitment of maternity and neonatal staff.

Effective

- Sustained improvement has been demonstrated in key Saving Babies' Lives indicators:
- Recording of Fetal Growth Restriction (FGR) status at booking.
- Carbon monoxide (CO) monitoring at booking.
- CO monitoring completed by 36 weeks gestation.
- Obstetric Anal Sphincter Injury (OASI) performance remains favourable and below national averages.
- PROMPT training compliance remains the principal area of concern for MIS Year 8, particularly amongst obstetric medical staff and obstetric anaesthetic staff.

Responsive

- Two in-utero transfers and one neonatal transfer to a tertiary centre occurred during the reporting period.
- Homebirth service suspension and delays to elective caesarean sections continue to reflect staffing and capacity pressures

Well led

- A Maternity Outcome Signalling System (MOSS) drill is planned for September to further strengthen compliance for MIS Year 8 and team engagement
- Two new risks have been added to the risk register:
- Risk 2359 – Failure to achieve the safety standards for the Maternity Incentive Scheme.
- Risk 2360 – Clinical Safety Case for BadgerNet and management of associated actions.
- Maternity staffing remains the highest-rated risk (score 20), with workforce pressures affecting service delivery, training compliance and quality improvement activity. Recruitment progress continues but significant challenges remain.
- 2260 - Progress has been made in reducing the risk associated with the SCBU evacuation plan through fire warden training and implementation of new evacuation equipment
- 2139 – Healthier Together App planned go live date end of July 2026.

Recommendation

Members are requested to:

- Review the contents of the report.
- Note the areas of improving performance and positive patient feedback.
- Note the ongoing risks relating to workforce capacity and MIS Year 8 compliance.
- Receive the report as assurance of maternity and neonatal quality and safety performance for May and June 2026.

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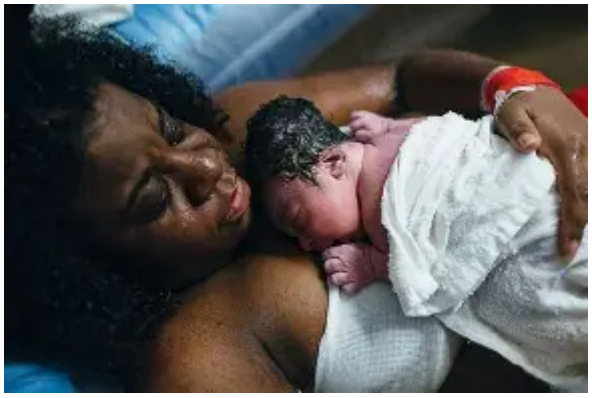
Maternity & Neonatal Quality and Safety Report

May and June (reporting in July) 2026

Submitted by Jo Hartley, Director of Midwifery & Neonatal Services

Executive sponsor: Dawn Dawson CNO



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Executive Summary

This report sets out the quality and safety activity covering the months of May and June and in some cases, quarter one. This is to provide assurance of maternity and neonatal quality, safety and effectiveness with evidence of quality improvements to the Executive and Non-Executive Team

- **No MOSS reporting**

Special cause variation of a concerning nature

- babies born with an Apgar score less than 7 at 5 minutes

Special cause variation of an improving nature:

- % of women with a FGR status recorded at booking
- % women with CO measurement recorded at booking
- % women who reach 36 weeks gestation with a CO measurement

- One episode of OPEL 3 and one of OPEL 4
- Neonatal death reported at 13 days of age. Preliminary PM report received.

New risks

- 2359 - Failure to achieve the safety standards for the maternity incentive scheme
- 2360 - Clinical Safety Case for BadgerNet – management of actions

Experience of care

- 5 complaints, 2 early resolutions, 1 PALS feedback
- Communication and Information Sharing
- Feeling Heard and Responded To
- Postnatal Care and Recovery
- Compassionate and Person-Centred Care
- Neonatal and Specialist Care Pathways
- Continuity and Coordination of Care
- Documentation and Information Governance
- Psychological Impact and Birth Trauma

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MOSS (Maternity Outcome Signalling System) reporting for DCH

MOSS shows changes in trends of term events (stillbirths and Neonatal deaths) to signal when trusts may have potential safety issues arising from care given during labour and birth.

- Planned MOSS drill in September as part of MIS year 8.

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Performance and Safety Dashboard

Metric: Multiple selections

Group: All

Variation (V)

Assurance (A)

Select an icon to view matching metrics.

Metric ID	Metric	Chart Type	Group	Latest Date	Value	Target	Variation	Assurance
1	No Of Bookings Made	XmR	Booking	30/06/26	144			
8	No Of Babies Born	XmR	Births	30/06/26	152			
23	% Of Babies Born By Elective Caesarean	XmR	Births	30/06/26	29%			
24	% Of Babies Born By Emergency Caesarean	XmR	Births	30/06/26	22.4%			
34	% Of Babies With 1st Feed Maternal	XmR	Births	30/06/26	78.7%			
57	No Of Hypoxic-Ischemic Encephalopathy (HIE) Incidents	XmR	Neonatal	30/06/26	0			
73	% Of Babies With FGR Born <3rd Centile Above 37+6 weeks	XmR	SBL - FGR	30/06/26	0%			
75	% Of Women With CO Measurement Recorded At Booking	XmR	SBL - Reducing smoking	30/06/26	97.2%	95%		
91	No Of Transfers From Neonatal Unit To Other Hospital	XmR	Neonatal	30/06/26	1			
102	Rate Per 1000 Of Still Births	XmR	Births	30/06/26	0	4		
103	Rate Per 1000 Of Neonatal Deaths < 28 Days	XmR	Births	30/06/26	0	2		
110	Rate Per 1000 Of Women With 3rd / 4th Degree Tears (MSDS - National Tear Definition)	XmR	Delivery	30/06/26	14.3	25		
134	% Of Women Smoking At Booking (MSDS - National Smoking At Booking)	XmR	SATOB	30/06/26	4.9%			
136	% Of Women Smoking At Delivery (MSDS - National Smoking At Delivery)	XmR	SATOB	30/06/26	4%	6%		
178	Rate Per 1000 Of Women With PPH 1500ml or More (MSDS - National PPH 1500ml or More - Previous 3 Months)	XmR	Delivery	30/06/26	33.1	30		
194	Rate Per 1000 Of Babies With APGAR Score < 7 At 5 Mins - Term Singletons (MSDS - National APGAR Definition - Current 3 Months)	XmR	Delivery	30/06/26	37			

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Special cause variation of a concerning nature

Metric ID	Metric	Chart Type	Group	Latest Date	Value	Target	Variation	Assurance
194	Rate Per 1000 Of Babies With APGAR Score < 7 At 5 Mins - Term Singletons (MSDS - National APGAR Definition - Current 3 Months)	XmR	Delivery	30/06/26	37			

Special cause variation of an improving nature

Metric ID	Metric	Chart Type	Group	Latest Date	Value	Target	Variation	Assurance
59	% Of Women With A FGR Status Recorded At Booking	XmR	SBL - FGR	30/06/26	95.1%	80%		
75	% Of Women With CO Measurement Recorded At Booking	XmR	SBL - Reducing smoking	30/06/26	97.2%	95%		
80	% Women Given Leaflet About Fetal Movements By 28 Weeks	XmR	SBL - RFM	30/06/26	100.7 %	95%		
169	% Of Women Who Reach 36 Weeks Gestation With A CO Measurement	XmR	Delivery	30/06/26	86.7%			

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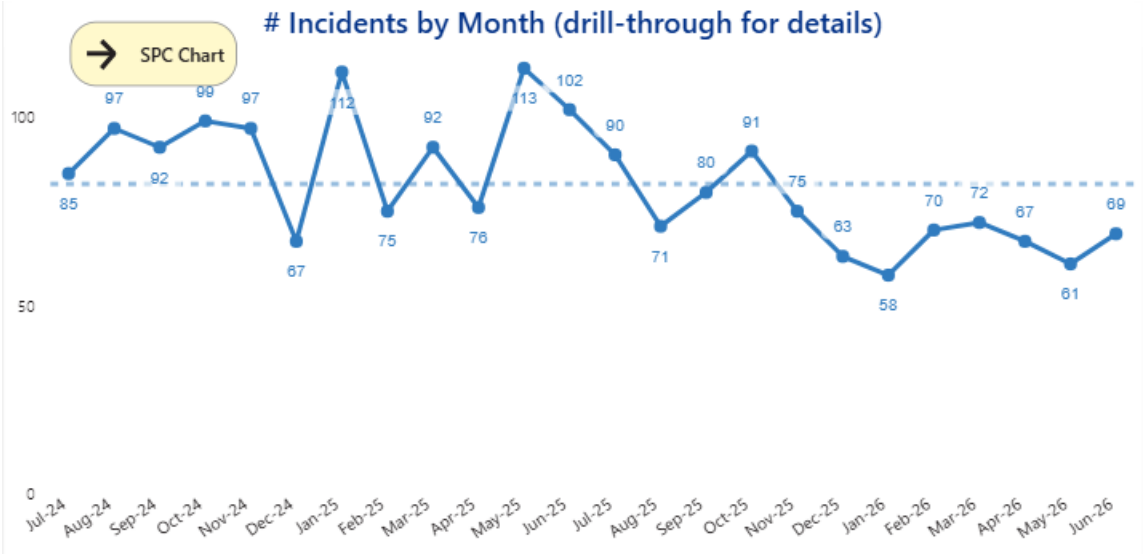
Total Number of Incidents submitted for May and June

Maternity, Obstetrics and SCBU – all incidents



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

Red flag	Descriptor	Incidents for May and June
RF1	Escalation to divert of maternity services & poor staffing numbers, including medical staffing and SCBU	1 x OPEL 3 1 x OPEL 4 2 x staffing concerns
RF2	Missed medication	0
RF3	Delay in providing or reviewing an epidural in labour	1
RF5	Full examination not carried out when presenting in labour	0
RF6	Delay of ≥2 hours between admission for induction of labour & starting process	3 x elective LSCS delayed until the next day
RF7	Delay in continuing the process of induction of labour	
RF8	Unable to provide 1 to 1 care in labour	0
RF9	Unable to facilitate homebirth	Multiple occasions when the service has been suspended
RF10	Delay of time critical activity	0

In-utero transfers – UHD is default level 2 NICU for DCH pregnancy <32 weeks	
25+2 twins, threatened premature labour - Portsmouth	31+0 maternal medicine and fetal concerns - S'hampton

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

IUD – intrauterine death/stillbirth - NND – nenonatal death

Date	Case ID	Datix	Initials	Incident	Investigator	Update	Actions and owner
May 12 2026	MAT 003-237 103738	DCH117547	EB	38+1 NND 13 days old	PMRT/CDRM	JAR12.5.26 provisional PMRT Sept 26	1) Postnatal clinic to be added to P/N Guidance: T P-P P/N Matron 2)further actions TBC
April 24 2026	MAT 003-002 058108	DCH116975	AC	39+2 Cooling HIE 2	MNSI	MNSI review in progress	1) Safety Pins shared 24/4/26- SBAR and Hourly Holistic Review: NC L/W Matron 2) further actions TBC
March 23 2026	MAT 002-456 T026/055967	DCH115968	LM	37+3 Maternal Death	MBRRACE/MNSI	Initial review held April 26, MNSI conducting staff interviews June 26	1) Action card for maternal collapse over telephone shared 1/4/26: NC L/W Matron 2) further actions TBC
February 9 2026	MAT 002-170	DCH114585	AG	41+1 HIE 2 (BT & bowel surgery)	MNSI/Internal	MNSI declined:MRI day 8, For internal review and Perinatal M&M.	1) Actions TBC
January 27 2026	T004	DCH113509	MM	22 days P/N Maternal Death at UHS (IUT DCH)	MBRRACE	Family declined MNSI, Joint MDT meeting with UHS to be arranged	1) Actions TBC
November 17 2025	MAT 000-668/49434	DCH112014	AL	37+2 Cooling	MNSI	MNSI Final report received, family declined tripartite	1) Develop additional MDT opportunities for newborn life support: CH Neo Cons
October 6 2025	MAT 000-120/100620	DCH110769	IW	31+6 IUD	PMRT	PMRT C/B: Not referred to CLC, no USS at PIH diagnosis, delay in recognition of abnormal ctg, p/n communication, Obstetric M&M June 26	1)Management plans added to 2026 digital update day Jan 2026: CB Digital Lead 2) Case added as CTG sessions, LOC poster shared Feb 2026 3) DV routine enquiry audit presented at RHCG April 2026 and QI project underway: KC Safeguarding Lead 4)further actions TBC
August 17 2025	99869/1, MI45424	DCH109284	HE	40+6 NND less than 6 hours of age	PMRT/CDRM/ MNSI	PMRT C/B/A: Recognition of delay in labour and transition to 2nd stage, FH not auscultated within a timely manner. No written info re SRM or ambulance t/f times. MNSI final report published and tripartite undertaken	1) Developing a home birth information leaflet with input of service users: LB HoM 2) New National Ambulance leaflet to be shared with families planning homebirth: NC L/W Matron 3) Home birth service provision reviewed April 2026: JH DoM 4) Recognition of 2nd stage raised at staff meeting May 2026 and included in FM training: NB FM Lead 5) IA frequency audit being undertaken: DW Audit Lead 6) Team update March 2026 included escalation via emergency services: JH DoM 7) SROM leaflet updated Feb 2026: JH DoM
May 22 2025	98704/1, MI42426	DCH106403	MM	41 weeks NND 2 days old	PMRT/CDRM/ MNSI	Final MNSI report published, awaiting PM, tripartite outstanding	No safety recommendations

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Saving Babies'Lives (version 3.2) Board Report. Q1 2026

NHS
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Executive summary

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

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

	Q2	Q3	Q4	Q1
Element 1 Smoking in pregnancy	90%	100%	75%	**92%**
Element 2 Fetal growth restriction	100%	95%	100%	**100%**
Element 3 Reduced fetal movements	100%	100%	100%	**100%**
Element 4 Fetal monitoring in labour	100%	100%	100%	**100%**
Element 5 Preterm birth	100%	88%	100%	**82%**
Element 6 Diabetes	83%	100%	100%	**100%**
Total implementation (all elements):	97%	94%	96%	96%

Element 1	• The band 4 is poised to start in the team. The inpatient NRT grab bag training is set to start imminently. This will increase exposure of the smoke stop service.
Element 2	• High levels of compliance across this element • Achieved 88% compliance for uterine artery scans which is the highest since the audit began. • Good MDT review of audit & learning, including the sonography team
Element 3	• Small decrease in the next working day USS. Exceptions monitored, no adverse outcomes. • 100% of CTG's were computerised.
Element 4	• Continued high level of compliance with training. • 1 cooling case referred to MNSI, possible contributory factor relates to intermittent auscultation, await full MNSI report • Thematic review for IA & low risk labour in progress, look at gap analysis training/outcomes.
Element 5	• Due to the small number of pre-term babies this makes interpreting the data of themes difficult. • 3 out 6 babies were not within the correct normothermia parameters on admission • Good MDT review of exceptions have successfully helped to identify areas for improvements. • To review progress of cervical length training
Element 6	• This element remains fully compliant.

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Healthier lives Empowered citizens Thriving communities

Risk Register

ID	Title	Risk Statement	Open	Risk	responsibility
2359	Failure to achieve the safety standards for the maternity incentive scheme	staffing concerns are directly impacting on the likelihood of achieving the maternity incentive scheme. Namely, 2 standards - 1. mandatory training having to be cancelled due to staffing gaps impacts compliance. This needs to be reported twice in the year (a change from only once for previous years). Cancelled Monday 6th July. 2. Failure to convert fixed term midwives to substantive will result in failure to comply with BP Plus recommendations confirmed in 2025	30/06/2026, Jo Hartley, DoMN, monthly review	Major 16	division
2360	Clinical Safety Case for BadgerNet – management of actions	having reviewed the clinical safety case for Badgernet it became clear that the number of actions required for compliance outstrips the capacity within the maternity digital team (currently one midwife band 7 and a band 6 midwife working adhoc hours to support)	09/07/2026, Jo Hartley, DoMN, quarterly review	Moderate 9	Care group
2356	Lack of Second Paediatric Team to cover use of a second theatre in Maternity	Maternity has access to one dedicated theatre located on the maternity unit. Occasionally if the maternity theatre is in use and an emergency procedure is required, a second theatre is made available as a priority. This means that on some occasions a second paediatric team is required to attend. There is no capacity within the service to provide two emergency teams. There are no mitigations in place. If two emergencies occur simultaneously out of office hours there is not enough staff. Only doing office hours that there are sufficient medical staff to accommodate two emergency situations	02/07/2026, Clare Hollingsworth, Paediatric Consultant, quarterly review	Moderate 8	Care group
2333	Shortage of dinoprostone for induction of labour	NatPSA/2026/003/DHSC Shortage of dinoprostone 3mg vaginal tablets and 1mg/2.5ml, 2mg/2.5ml vaginal gel. Used for induction of labour for maternity women. This will be an ongoing issue until the Autumn **Update:** alternative product sought and service maintained with no delays	21/05/2026 Nichola Coliandris, Matron, monthly review	Moderate 12	Service specific

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2334	Primary care to cease prescribing maternity recommended medications	primary care to cease prescribing for maternity woman for recommended medications. this will apply to asymptomatic infections, or medications recommended to support the wellbeing of the woman or pregnancy as per RCOG/NICE recommendation. GP funding does not support cost or time for this. GP will still prescribe for symptomatic cases **Update**: Inpatient matron sent communication to all maternity staff on 20/6/26 to notify of change to prescribing with reference to new pathways for PGD of aspirin, folic acid and ferrous sulphate as agreed with pharmacy, GP and LMNS. Pathway to be added to the antenatal care guideline. To support midwives with the supply of medications in the community, along with treatment for the asymptomatic test results, we have developed a BadgerNet referral for Prescription requests. The new pathway commenced from Monday 22 June 2026. No known incidents have arisen from this change to practice. This process will continue to be reviewed	26/05/2026, Nichola Coliandris, Matron, monthly review	Moderate 9	Service specific
2312	Neonatal CPAP devices reached end-of-life with no service contracts available	4 CPAP devices (SLE1000) have now reached End of Support status and will no longer have renewing service contracts or supplying service kits. Of the 4 devices, one is already unavailable needing repair. No other CPAP devices available to use with neonatal patients. If the remaining 3 working devices stop working we will have no means of providing CPAP therapy, meaning patients will need to be transferred to other units.	18/03/2026 Débora Pascoal-Horta, Neonatal Matron, quarterly review	Moderate 9	Service specific
2292	YDH Reopening	YDH due to reopen April 22. Currently the plan is that YDH staff return to YDH for the reopening leaving DCH without the extra staffing, on the assumption women will immediately return to YDH. This may not happen, exposing DCH to the risk of inadequate staffing. This poses a risk to safety and quality **Update** Staffing maternity to 7-8 midwives plus the coordinator (prior to reopening, staffed to 8-9 plus coordinator). Number of LSCSs and IOLs has not noticeably changed	03/02/2026, Jo Hartley, DoMN, Monthly review	Moderate 9	Division

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2306	Local, service specific induction process for obstetric trainees and new starters	Currently, the induction process for trainees and locally employed doctors in obstetrics and gynaecology fails to ensure all the required information is shared in a timely manner. Start dates and names are not confirmed and Outlook contact groups are not updated, invitations to essential meetings and training opportunities are not sent, required training is not completed, access to digital systems is not completed and doctors report being unprepared for their role. **Update** No identified progress with this risk. Dissatisfaction anticipated in GMC survey	09/03/2026, James Male, Service Manager, monthly review	Moderate 9	Care group
2224	Potential inadequate capacity and staffing for antenatal ultrasound	The new maternity unit at UHD opened in March 25 and this has resulted in some women from East Dorset transferring their care to DCH and an increase in new bookings. In addition to this YDH maternity unit closed with no notice in May and a significant number of women have transferred their care to DCH. This is putting the Ultrasound Department under considerable pressure for the following reasons: **Update** Update requested but unavailable	29/09/25, Julia Morris, Radiology Manager, monthly review	Moderate 12	Division
2260	Evacuation plan for SCBU	at the present time, there is no finalised evacuation policy for the neonatal unit, in the event of a fire **Update** Senior nurses already attended or booked to attend fire warden training. Waiting for simulation / scenario to be arranged by fire officer, to utilize new evacuation cots	04/12/25 Sarah True, Neonatal Risk Lead, quarterly review	Moderate 8	Division
2180	Lack of psychological support service for neonatal service	Lack of funding for specialist psychological professional, to support parents, in line with staffing recommendations for the Neonatal Units. Discrepancy in care across the region, as some units have psychological support in place (level 2 and 3 around us). When infants step down in care and move to DCH this support is nonexistent. **Update** Drop-in sessions happening every other week but no recurrent funding to maintain this offer	25/06/2025, Débora Pascoal-Horta, Neonatal Matron, quarterly review	Moderate 12	Service specific

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2159	Patient and governance confidentiality	Layout of neonatal unit results in daily breaches of confidentiality. Notes trolley in corridor. Phone conversations in the middle of the ward. Multidisciplinary conversations with external agencies in the middle of the ward. Inability of staff to leave the area for private conversations. Mitigation: Covers created for patient observations clipboards. Staff reminded about confidentiality and the need to move to a different area for private conversations, when possible. Staff asked to datix when they witness incidents related to confidentiality. Daily observation and reminder by Matron and Governance Lead to the Team about open folders and iPads and logging out PCs after use. **Update** no progress with office space project	09/05/2025, Débora Pascoal-Horta, Neonatal Matron, quarterly review	Moderate 8	Division
2139	Risk to the maternity advice line provided by UHD for all of Dorset	the maternity advice line provides a dedicated maternity triage service for all pregnant women in Dorset. A request has now been submitted by UHD that DCH pay a proportion of running costs - approx £80k per annum. UHD may serve notice on the service if an agreement is not made. Without UHD providing this dedicated service, DCH would have to provide a 24/7 service for DCH women **Update** Healthier Together app planned for go live end of July	07/04/2025, Jo Hartley, DoMN Services, monthly review	Moderate 12	Division
1980	EPAC restricted service	**Update** Currently EPAC remains open for most Mondays-Fridays. However, this comes at a cost pressure to maternity as a midwife has been reallocated to EPAC and vacant shifts are being covered by bank staff Business case has been submitted and awaiting amendments **Update** The service continues to be reduced with an increase in complaints received. The business case is not progressing due to funding. The risk rating has been raised as the rate of closure of the service is increasing	20/09/2024, Jo Hartley, DoMN Services, quarterly review	Moderate 12	Division

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1881	Neonatal Nursing	**Update** Business case approved and CoE actioned, increasing the establishment for the unit and allowing recruitment in the next few weeks. RNs with QIS also joined the bank and are now doing regular shifts on the unit, reducing drastically the use of agency. Risk still present but reduced. YDH neonatal nurse also working all her hours at DCH. Recruitment ongoing. Consultation with some staff to change band 3 to band 6 nurse on nights - allowing for 3 RNs and therefore a supernumerary lead nurse **Update** One new nurse in post but still supernumerary. 3 new starters still to commence	01/05/2024 Débora Pascoal-Horta, Neonatal Matron, monthly review	High 16	Division
1689	Opening a second theatre in an emergency &the elective pathway	**Update** A second theatre was required in an emergency 4 times in May and June. All cases reviewed. No progress towards an elective pathway. Elective caesareans regularly delayed for 5-6hrs. Increasing number of elective caesareans being delayed more than 24 hours.	29/06/2023 managed by Jo Hartley DoM, quarterly review	moderate 12	Division
876	Maternity Staffing	**Update** whilst incidents of escalation to OPEL 3 and 4 continue to occur regularly and IOLs and LSCSs are regularly delayed, there has been progress in relation to recruitment. 6.4wte NQM appointed for 12 months fixed term. 2 wte additional band 6 midwives recruited for fixed term 12 months. Agency now used regularly and ward staffing increased to 8 plus the coordinator. However, the manager oncall frequently called in to bolster numbers and incentives used regularly. There isn't enough coordinators to ensure a 24/7 oncall for homebirths and senior cover. Sickness in the senior team often has to be covered by matrons. Given the challenges with ensuring a coordinator is available for every shift, the significant reliance on agency and the frequency of rotas not being fully staffed, the risk remains high **Update: t**he majority of shifts are not fully staffed due to approx 10wte maternity leaves. Agency midwives relied on for night shifts. The manager oncall regularly working on the ward during their oncall - recently the MoC worked Saturday, during OPEL 4. During the week, the MoC is unable to attend to other work due to requirement to attend to staffing concerns. Community midwives reallocated on a daily basis, requiring bookings to be rescheduled and not completed within KPIs and visits cancelled. Specialist midwives regularly reallocated directly impacting important workstreams around case review, MNSI cases, MIS, SBL and other QI workstreams.	21/09/2021 Managed by Jo Hartley, Director of Midwifery, monthly reviews	High 20	Corporate

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		Mandatory training cancelled regularly reallocated directly impacting training figures and therefore MIS compliance. Complaint responses delayed, patient experience workstream delayed. Business case submitted to convert 6.4wte fixed term midwives to substantive		

Neonatal transfer out data for May and June

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

Experience of care

Metric	May 2026	June 2026
Complaints	1	4
ERC	0	3
Feedback via PALS	0	1

During May and June 2026, feedback from women and families highlighted both excellent examples of compassionate maternity and neonatal care and opportunities for improvement. Positive feedback consistently praised staff kindness, professionalism, reassurance and support during labour, birth, postnatal recovery and neonatal admissions.
Themes identified through complaints and feedback primarily related to communication, consistency of information, feeling listened to, continuity of care, discharge planning and the emotional impact of complex care journeys. Several families described the lasting psychological effects of their experiences, reinforcing the importance of trauma-informed, family-centred care.

Key Themes from Feedback and Complaints

Theme	What Women and Families Told Us	Actions/Response
Communication and Information Sharing	Women reported receiving inconsistent advice regarding postnatal recovery, wound care, thromboprophylaxis, breastfeeding support and care plans. Families also described delays in receiving investigation outcomes and diagnostic information.	Reinforce consistent communication standards, improve documentation and strengthen information sharing across maternity, neonatal and community services.
Feeling Heard and Responded To	Several women felt concerns regarding symptoms or complications were not escalated promptly, resulting in them feeling dismissed or unsupported.	Continue promoting active listening, escalation of concerns and personalised care through team learning and governance forums.

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Postnatal Care and Recovery	Concerns included wound management, postnatal complications, pain management, discharge arrangements, aftercare coordination and support following caesarean birth.	Review postnatal pathways and discharge processes to improve continuity of care and follow-up arrangements.
Compassionate and Person-Centred Care	Women valued staff who were kind, reassuring, informative and emotionally supportive. Positive feedback frequently highlighted individual staff members who made women feel safe and cared for.	Positive feedback shared through recognition processes and team briefings.
Neonatal and Specialist Care Pathways	Families described the emotional burden of neonatal admissions, specialist transfers and uncertainty surrounding diagnosis and treatment.	Continue collaborative working with tertiary centres and strengthen family support throughout neonatal pathways.
Continuity and Coordination of Care	Concerns were raised regarding communication between hospital, specialist and community services, including follow-up arrangements and discharge communication.	Review handover processes and strengthen coordination between teams and organisations.
Documentation and Information Governance	Concerns included inaccuracies in electronic documentation and one reported breach involving discharge information being sent to the incorrect GP practice.	Learning reviewed through governance and information governance processes.
Psychological Impact and Birth Trauma	Several women and families described significant anxiety, distress and loss of confidence following complex birth experiences, postnatal complications or neonatal admissions.	Promote trauma-informed care, debrief opportunities and access to psychological support.

Positive Feedback Highlights
Women and families praised:

- Kind, compassionate and professional maternity and neonatal staff.
- Exceptional support from individual midwives during labour and postnatal recovery.
- Reassuring communication during emergency situations.
- High-quality care provided by neonatal, theatre and specialist teams.
- Staff who demonstrated empathy, kindness and commitment to family-centred care.

One woman specifically highlighted a midwife whose calm and reassuring support during a caesarean birth significantly improved her experience and confidence during recovery.

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Experience of Care Case Themes
During this reporting period, complaints highlighted:

- Delayed recognition and escalation of postnatal wound concerns.
- Perceived lack of compassion and support during community postnatal visits.
- Concerns regarding antenatal detection of congenital abnormalities and communication surrounding neonatal care pathways.
- Frustration regarding delays in investigation outcomes following neonatal care concerns.
- Conflicting information regarding treatment plans and postnatal interventions.
- Concerns relating to labour and birth experiences, including access to services, communication and recovery following emergency caesarean birth.
- Historical complaints relating to delayed escalation during labour and perceived lack of responsiveness to maternal and fetal deterioration.

A number of complaints demonstrated the significant emotional impact that maternity and neonatal care experiences can have on women, babies and their families, particularly where outcomes were unexpected or care journeys became complex.

Training Figures as of June 2026 –

Perinatal Training

Rolling 12-month period ending June 2026

Key	
≥90% compliance MIS	
<90% compliance MIS	
(%) = Previous month compliance %	
Compliance met, non-MIS reportable.	

Compliance

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MIS Year 8 Reportable Training	Staff Group	Compliance (%) May 2026	Compliance (%) June	Narrative
SBLv3 Element 1.8	Carbon Monoxide Monitoring Midwives and MSWs giving Antenatal Care	93%	91%	
SBLv3 Element 1.9	Very Brief Advice All staff	93%	93%	
SBLv3 Element 2.11	Practical SFH assessment	93%	93%	
Fetal Monitoring and Surveillance in the AN and Intrapartum period	Obstetric Consultants	90%	90%	
	Obstetric doctors (Registrars)	90%	90%	
	Midwives	93%	93%	
PROMPT	Obstetric consultants	30%	30%	Monthly review with care group manager and practice development midwife to manage rostering.
	Obstetric Registrars*	50%	50%	Monthly review with care group manager and practice development midwife to manage rostering.
	Drs on obs SHO rota*	75%	75%	Monthly review with care group manager and practice development midwife to manage rostering.
	Midwives	91%	92%	
	MSWs	91%	92%	
	Obstetric anaesthetic consultants	92%	77%	Staff denominator =13 3 non-compliant June. 2 due to expire in August.

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	and autonomously practising obstetric anaesthetic doctors			Escalation: Obstetric Anaesthetic Lead aware and managing. Pre-declared MIS Year 8 checkpoint= September.
	All other obstetric anaesthetic doctors contributing to the obstetric rota	91%	91%	Risk: staff due to expire in September as yet not booked to attend available sessions.
	8.12 Rotational Anaesthetic Staff	90%	90%	Risk: staff due to expire/expired as yet not booked to attend available sessions.
Neonatal Basic Life support (NBLS) Yearly	Paediatric consultants	80%	80%	2 staff expired, 1 booked to attend July. 1 not yet booked to attend individual update.
	Paediatric registrars	88%	100%	
	Neonatal nurses	83%	88%	Expected compliance July.
	MSWs and HCAs who require this training as per local policy	100%	100%	
	ANNP	100%	100%	
	Midwives	89%	89%	Monthly review with Practice Development/Governance Support PA to maternity management and practice development midwife to ensure correct staff rostering,

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				compliance expected September.
RCUK NLS Certification	Senior midwives and homebirth midwives	100%	100%	
	Paediatric Consultants	100%	100%	
	Paediatric Registrars	88%	100%	
	Neonatal Nurses	91%	87%	Expected compliance September.
Non-MIS Year 8 reportable training				
CCFv2 Training Saving Babies Lives Study Day – mandated within CCFv2, agreed by quadrumvirate in November 2023.	Midwives	92%	92%	
	Obstetric Consultants	50%	50%	Obstetric staff no longer routinely rostered for SBLv3.2 update day.
	Obstetric Registrars	60%	60%	
	Drs on SHO rota	25%	25%	
Safeguarding Level 3 Children Trust Mandated	Midwives	91%	91%	
	MSWs	83%	83%	
Basic Life Support – Adult Trust Mandated	Midwives	86%		ESR system issues identified – RAG report error, data unavailable. Escalation: Corporate and Mandatory Training manager
	MSWs	94%		ESR system issues identified – RAG report error, data unavailable. Escalation: Corporate and Mandatory Training manager
	Obstetric Consultants	50%		ESR system issues identified – RAG report error, data unavailable.

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				Escalation: Corporate and Mandatory Training manager
	Obstetric Registrars	60%		ESR system issues identified – RAG report error, data unavailable. Escalation: Corporate and Mandatory Training manager
	Drs on Obstetric SHO rota	75%		ESR system issues identified – RAG report error, data unavailable. Escalation: Corporate and Mandatory Training manager

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Dorset HealthCare University
NHS Foundation Trust

Report to	Board in Common	
Date of Meeting	11th August 2026	
Report Title	Infection Prevention and Control and Audit Annual Report 25/26	
Prepared By	Donna Kiss Infection Prevention and Control Lead	
Approved by Accountable Executive	Cara Southgate Interim Chief Nursing Officer/Director of Infection prevention and control (DIPC)	
Previously Considered By	Quality Governance Group 5th May 2026 Quality Committee in Common, 28th July 2026	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality	
Financial	No implication.	
Statutory & Regulatory	Regulated reporting of gram negative bacteraemias, MRSA, MSSA bacteraemias Clostridioides Difficile infections (CDI) are reported in this paper	
Equality, Diversity & Inclusion		
Co-production & Partnership	Reviews of infections are carried out with our acute partners.	

Executive Summary

This Annual Infection Prevention and Control (IPC) Report provides assurance that Dorset HealthCare University NHS Foundation Trust has maintained robust arrangements to prevent and control infection throughout 2025/26 and remains substantially compliant with the Health and Social Care Act 2008: Code of Practice and the NHS England Infection Prevention and Control Board Assurance Framework.

The IPC agenda continues to be led by the Director of Nursing, Therapies and Quality in the role of Director of Infection Prevention and Control (DIPC), Lead for Infection Prevention and Control supported by a multidisciplinary IPC Team and robust governance arrangements through the quarterly Infection Prevention and Control Group. Surveillance, audit, outbreak management and post-infection review processes remain well embedded across the organisation.

Performance against key infection indicators has been positive. The Trust achieved its Clostridioides difficile (CDI) objective, reporting 13 cases during 2025/26, meeting but not exceeding the agreed annual threshold of 13 cases. Bloodstream infections demonstrated a significant improvement, reducing from 19 cases in 2024/25 to 8 cases in 2025/26, representing a 42% reduction year on year and remaining well below the agreed threshold of 17 cases. Notably, E. coli bacteraemia cases reduced by 25% compared with the previous year.

The Trust managed a range of infectious disease outbreaks during the year, including sixteen COVID-19 outbreaks, two Influenza A outbreaks, four Norovirus outbreaks, three Respiratory Syncytial Virus (RSV) outbreaks and one scabies outbreak. Outbreaks were effectively managed with support from the IPC Team, and post-outbreak reviews identified learning and improvement opportunities, particularly around communication, visitor management and risk assessment processes.

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The annual review demonstrates good progress against the 2025/26 IPC Work Programme and confirms that the majority of Board Assurance Framework standards are assessed as compliant.

Areas of partial compliance remain in relation to implementation of the IPC Education Framework, water safety assurance, completion of waste management actions, antimicrobial stewardship capacity, patient information resources, and FFP3 fit-testing compliance. Improvement actions have been incorporated into the 2026/27 IPC Work Programme and are being actively monitored through established governance arrangements.

The IPC audit programme identified good compliance within inpatient services; however, inconsistent audit returns from some community and non-inpatient services reduced organisational assurance. A review of audit tools, reporting arrangements and engagement processes has therefore been prioritised for 2026/27 to strengthen oversight across all service areas.

Overall, the report provides assurance that effective infection prevention and control systems remain in place across Dorset HealthCare, that key infection targets have been achieved or improved upon, and that identified risks are recognised and supported by clear improvement plans for 2026/27.

The following reports are available in the Board in Common document folder on Admincontrol for the August 2026 meeting, titled:
'7.3.2 DHC IPC Annual Report
7.3.3 7.3.3 Appendix 6 Letter from UK Health Security Agency'

Recommendation

Members are requested to:

- Receive the report for **assurance**

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Report to	Board in Common (DCH)	
Date of Meeting	11th August 2026	
Report Title	Infection Prevention Management Annual Report 2025-2026	
Prepared By	Emma Karamadoukis, Infection Prevention Management lead specialist Nurse.	
Approved by Accountable Executive	Jo Howarth, Interim Chief Nursing Officer	
Previously Considered By	Quality Committee July 2026 Quality Governance Group Infection Prevention Management Committee	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	No implication	
Statutory & Regulatory	Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections and related guidance, which was a last updated in December 2022.	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary

As part of the assurance required for Trust Board an annual Infection Prevention Management report is required. This meets the national requirements set via Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections NICE, NHSE.

The purpose of the report is to provide assurance that the Trust remains compliant with the Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections and related guidance Department of Health, 2015. The code sets out 10 criterion which are listed in the contents and the report uses these criterions as a guide to provide evidence and assurance.

The annual report provides a summary of the Infection Prevention Management (IPM) activity over the last year and status of the healthcare associated infections (HCAIs) for Dorset County Hospital NHS Foundation Trust (DCHFT). Infection Prevention Management is the responsibility of everyone in healthcare, and this is successful with strong leadership and collaborative working.

For noting: 2025 - 2026 was another successful year, meeting key standards and regulatory requirements for IPM. Below documents a highlight for the IPM year: -

- **Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections** remained low, and **Methicillin-susceptible *Staphylococcus aureus* (MSSA) bloodstream infections** remained stable.

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- **Gram-negative bloodstream infections (GNBSIs)** for *E. coli* and *Klebsiella* rose slightly and were marginally above the NHS England trajectory; **Pseudomonas aeruginosa** rates were also just above trajectory but lower than the previous year.
- **Clostridioides difficile** rates remained below the NHS England threshold and are now at a four-year low.
- The **IPM Patient Safety Incident Response Framework (PSIRF)** has been fully embedded for two years, enabling expert case reviews, thematic learning, and evidence-based action plans.
- The Trust's **Winter Plan** was further strengthened, supported by point-of-care testing in Emergency Department and Paediatric's to reduce nosocomial transmission.
- **Hand hygiene compliance** remained consistently high at 97%.
- Mandatory **Surgical Site Infection (SSI) surveillance** for elective orthopaedic knee replacements continued to be fully met.
- The **Sterile Services Department** has maintained its Quality Management System and certification to BS EN ISO 13485:2016 and remains registered with the MHRA.
- The Trust successfully expanded **IPM Education Framework Tier 3** training, with strong uptake and positive feedback. DCHFT remains the first Trust in the ICS and most of the Southwest to implement this tiered approach.
- **Antimicrobial Stewardship (AMS)** remained a key priority, aligned with the UK AMR National Action Plan (2024–2029). We successfully appointed a Consultant Pharmacist in a joint post with University Hospitals Dorset.
- **Face-to-face IPM teaching** continued to increase alongside the updated e-learning program, maintaining strong mandatory training compliance.
- **Enhanced water safety monitoring** remained in place to mitigate pseudomonas and legionella risks.
- The Trust continues to be a **national benchmark** in the use of ICNET for infection prevention data management.
- **Healthcare-associated infection rates** have remained stable, despite increased hospital activity and admissions.
- Despite increasing monthly admissions and increased weekly occupied bed days our **healthcare associated infections have remained stable**.
- The **number of declared outbreaks has reduced**, particularly norovirus, despite rising incidence levels within the community.

Recommendation

Members are requested to:

- Receive the report for **assurance**

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Report to	Board in Common (DHC)	
Date of Meeting	11 August 2026	
Report Title	Clinical Effectiveness Annual Report	
Prepared By	Sandra Hayward - Joint Lead for Clinical Effectiveness	
Approved by Accountable Executive	Dawn Dawson, Joint Chief Nursing Officer	
Previously Considered By	Quality Governance Group, 2nd June 2026 DHC Audit Committee, 31st July 2026	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	

Implications	Describe the implications of this paper for the areas below.
Board Assurance Framework	SR1 Quality and Safety
Financial	No implication
Statutory & Regulatory	Direct implications of non-compliance with statutory and regulatory obligations, therefore requiring the Trust to monitor the compliance and act on any identified actions.
Equality, Diversity & Inclusion	As above
Co-production & Partnership	As above

Executive Summary

During 2025/26, Dorset HealthCare has made measurable progress in strengthening its clinical effectiveness arrangements, with a clear focus on improving consistency, governance, and system-wide collaboration.

A total of 65 clinical audits were undertaken across the organisation, including 18 national (Priority 1) audits, all of which were submitted within required deadlines. National audit outputs are increasingly delivered via real-time dashboards, enhancing transparency but requiring further development in data interpretation, ownership, and governance integration. Clinical leads now present national audit findings through the Clinical Effectiveness Group to improve assurance, shared learning, and escalation.

Significant progress has been made in developing digital audit tools, notably the My Wellbeing Plan audit, enabling real-time analysis and supporting quality improvement at ward level. Similarly, enhancements to the National Early Warning Score (NEWS) audit have strengthened data use and improvement capability, alongside the introduction of a new governance framework for audits undertaken outside the central team.

Work has commenced to establish a Community Hospital clinical audit programme, alongside improvements to data collation and reporting processes, supporting a transition towards more automated and accessible audit systems.

The draft Clinical Audit Programme for 2026/27 has been developed in line with best practice guidance and meets all current statutory and mandatory requirements. It reflects both national and local priorities

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and has been shaped through engagement with key stakeholders across operational and corporate services. The programme received approval from the Clinical Effectiveness Group in February 2026.

However, digital infrastructure remains a key limitation, particularly for clinical audit and NICE reporting, where current systems are resource-intensive and lack functionality. Investment in a bespoke solution is required to improve efficiency, oversight, and organisational assurance.

There are currently 30 NICE guidance items in progress, with implementation slowed in some areas due to cross-service complexity and clinical capacity pressures. A new Clinical Effectiveness Sub-Group has been established to strengthen accountability, streamline processes, and improve engagement.

Leadership of the Clinical Effectiveness Group has been strengthened, identifying key organisational priorities including improved accountability, consistency of approach, and greater use of digital solutions. These issues are being escalated to senior leadership for consideration.

Collaboration with our federated partners at Dorset County Hospital has advanced, with joint working now established across audit and NICE. This includes development of joint priorities early work towards a shared clinical effectiveness framework and database and joint representation at several events throughout 2026/27.

Overall, while challenges remain, particularly around system capability, variation in engagement, competing clinical pressures, and national changes, the Trust has established a stronger foundation for clinical effectiveness. The focus for 2026/27 will be on embedding consistency, strengthening governance, improving digital capability, and maximising the benefits of system-wide working.

The following reports and appendices are in the Board in Common Reading Room on Admincontrol under the August 2026 meeting folder. Titled:
'07.3.7 DHC Annual Clinical Audit Assurance Report'

Recommendation
Members are requested to: Receive this report for **assurance**

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Dorset County Hospital
NHS Foundation Trust

Report to	Board in Common	
Date of Meeting	11August 2026	
Report Title	Annual Clinical Audit Report 2025-26	
Prepared By	Sandra Hayward - Joint Lead for Clinical Effectiveness	
Approved by Accountable Executive	Dr Rachel Wharton - Chief Medical Officer	
Previously Considered By	Clinical Audit Committee & DCH Audit Committee	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No
Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	No implication	
Statutory & Regulatory	Direct implications of non-compliance with statutory and regulatory obligations, therefore requiring the Trust to monitor the compliance and act on any identified actions.	
Equality, Diversity & Inclusion	As above	
Co-production & Partnership	As above	

Executive Summary

Achievements

During 2025/26, the Trust maintained delivery of its Clinical Audit and NICE Guidance programmes despite significant workforce disruption, increasing regulatory requirements and ongoing operational pressures.

The appointment of a Joint Lead for Clinical Effectiveness strengthened leadership and supported greater alignment of clinical effectiveness activity across federated partners.

Several improvements to governance arrangements were delivered during the year, including the introduction of a Trust-wide Clinical Audit Programme, implementation of a Clinical Audit Prioritisation Framework, strengthened Clinical Effectiveness Committee oversight, and development of plans to replace the current Clinical Audit and NICE databases through implementation of dedicated modules within the new Risk Management System.

The Trust continues to participate in relevant national clinical audits and maintains a substantial programme of local clinical audit and NICE review activity. Assurance can be provided that clinical audits and NICE reviews are being undertaken and that governance arrangements are in place to oversee findings, recommendations and organisational learning.

Challenges

The report highlights several areas where assurance remains limited:

- 128 NICE publications require overdue Baseline Assessments and/or Compliance Statements to be reviewed.
- 140 NICE implementation actions remain overdue, including 92 identified as presenting a potential risk if not implemented.

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- Capacity constraints within both operational services and the Clinical Effectiveness Team continue to affect the timely implementation, monitoring and re-audit of agreed actions.
- Current Clinical Audit and NICE management systems rely heavily on manual processes, limiting organisational oversight, reporting and assurance.

In response, structured reviews of outstanding clinical audit and NICE actions have commenced with Care Groups and service leads to strengthen oversight, improve risk-based prioritisation and increase accountability for delivery.

Implementation of the Clinical Audit and NICE modules within the new Risk Management System represents a significant opportunity to improve governance, visibility, reporting and assurance across the organisation.

Key Priorities for 2026/27

- Strengthen accountability for the implementation of clinical audit and NICE actions.
- Increase focus on demonstrating measurable improvements and sustained outcomes.
- Further embed the Clinical Audit Prioritisation Framework.
- Improve visibility and oversight of outstanding actions and associated risks.
- Implement the Clinical Audit and NICE modules within the new Risk Management System.

Recommendation

- Note the progress made during 2025/26.
- Note the risks and assurance gaps relating to implementation of improvement actions, NICE compliance monitoring and current system limitations.
- Receive assurance that actions are underway to strengthen oversight, prioritisation and accountability.
- Support the identified priorities for 2026/27, including implementation of the Clinical Audit and NICE modules within the new Risk Management System.

The following reports and appendices are in the Board in Common Reading Room on Admincontrol: '07.3.9 DCH Annual Clinical Audit Assurance Report'

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Dorset County Hospital
NHS Foundation Trust

Report to	Board in Common (DCH)	
Date of Meeting	11 August 2026	
Report Title	NHS England System Letter on **mortuary oversight - Board Assurance Statement** for NHS Provider Trusts (Nottingham maternity review findings on post-death care and key actions required following the Fuller inquiry).	
Prepared By	Sonia Gamblen, Divisional Head of Nursing and Quality Judith Whitehead, Head of Bereavement and Mortuary Services	
Approved by Accountable Executive	Jo Howarth, Interim Chief Nursing Officer	
Previously Considered By	N/A	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 – Safety and quality	
Financial	N/A	
Statutory & Regulatory	Human Tissue Authority compliance	
Equality, Diversity & Inclusion	Not specifically	
Co-production & Partnership	Nil	

Executive Summary

On 26th June 2026, Dorset County Hospital received a letter from NHS England, sent to all NHS Trusts providing mortuary services, in response to the findings of the recently published Ockenden report into maternity and neonatal care in Nottingham. The letter sets out actions and assurances required as a consequence of the learning from Nottingham and also following the initial and subsequent Fuller inquiries into unacceptable care of the deceased

The Trust is asked to consider the findings of Donna Ockenden's report alongside the Phase 2 report of the independent inquiry into the heinous crimes of David Fuller, published in July 2025. The report made 75 recommendations to strengthen the protection, security and dignity of people after death, including 29 that are immediately relevant to the NHS. DCH Board have previously received assurance and actions plans on the Fuller recommendations in 2022 and 2024 with all actions complete.

In response to Donna Ockenden's review and the Human Tissue Authority's (HTA) recent report on NUH, the Government has announced that the HTA is taking immediate action with a new requirement for mortuaries to review HTA reportable incident (HTARI) internal records from 2015-2026. This audit will ensure that all reportable incidents during this period have been logged with the HTA, and that any missing incidents are reported retrospectively. A Regulatory update will be issued by the HTA in July setting out the parameters, timeframe, process and deadlines for the evidential compliance audit. The HTA will report findings to the Secretary of State in October.

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This work has commenced with a Task and Finish group reviewing data on incidents, laboratory non-conformities and HTARI submissions for audit of completeness.

The letter sets out that '*No system or process can totally mitigate malign or malicious intent. However, every Board member and senior leader involved in the care of the deceased should read these reports and ask themselves if this could be happening in their organisation. They should explore this by visiting services, listening to staff, encouraging concerns to be raised and acted on, and asking themselves whether the care provided would be good enough for their own loved ones. Boards are responsible for maintaining clear oversight of mortuaries, related storage areas and any other areas where people who have died are cared for, and for ensuring dignity, security and post-death care are central to local planning, governance and delivery*'.

Every Board should continue to review its local position and assure itself that all deceased people cared for in NHS settings are treated with the respect, dignity, security and compassion they deserve. This goes beyond compliance; it is fundamental to compassionate care.

On the basis that all NHS providers may be involved in caring for people after they die, we need assurance that each Board has robustly tested its position. All NHS Provider Trusts that have a mortuary, related storage area for the deceased, or routinely care for people after death, are asked to complete and return the Board Assurance Statement provided at Annex 3 by 31 July 2026.

Trust Response

The Board Assurance template has been completed and reviewed prior to submission for the deadline of 31st July.

- There is robust evidence of board level reporting on actions and compliance following the Fuller Inquiry recommendations.
- The Mortuary has been subject to two HTA compliance inspections since 2022, the latest taking place on 26th July 2026, with no immediate actions or concerns being highlighted. The 2026 inspection
- The HTA data analysis is underway
- Trust governance and oversight is via Divisional Governance Meetings to Performance Review and via the Trust Palliative and End of Life Committee to Quality Governance Group and through to Quality Committee

Recommendation

Members are requested to:

- **Discuss and note the publications and assurance report.**

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Annex 3 – Board Assurance Statement for NHS Provider Trusts. Please return this assurance statement to the NHS England Inquiry Team by 31 July 2026 to: england.nhsinquiryteam@nhs.net

Assurance statement – Dorset County Hospital	**Confirmed (yes/no)**	**Additional comments or qualifications (optional)**
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	The Trust is satisfied that mortuary services are subject to external oversight by the Human Tissue Authority (HTA), with regular inspections and audits undertaken. Previous HTA audits, the Fuller Inquiry, and subsequent action plans, confirm responsibilities are defined and compliance arrangements within mortuary services have been reviewed and tested through external assurance processes and this is sighted at board level. **Estates** – swipe card access is limited to departmental staff only. Porters have limited access – body store only. Entry points and internal surveillance of the body store is monitored daily. CCTV on all access doors to the mortuary and the body store. Additional weekly audits are carried out to further monitor access to the mortuary, including swipe card access, key log and visitor log. Fridge spaces have been reconfigured with appropriate size spaces for dignified storage of the deceased. There is a specific stand-alone fridge for babies/NVF/ POCs. There is an individual fridge unit which can be used for children and young adults. Servicing contracts are in place for fridge and equipment maintenance.

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		Safeguarding – the role of the Safeguarding Team is aligned with the recommendations of the Fuller Report. Whilst operational responsibility for mortuary services rests with the mortuary, pathology, estates and bereavement teams, the Safeguarding Team provides independent oversight and assurance, ensuring that risks are identified, escalated and reviewed through appropriate governance processes. The team also provides safeguarding oversight in relation to safer recruitment practices, including assurance regarding Disclosure and Barring Service (DBS) checks, and supports the management of concerns about staff and volunteers through the appropriate Local Authority Designated Officer (LADO) and People in Positions of Trust (PiPoT) processes where safeguarding concerns arise. Working collaboratively with relevant departments, including Workforce, Recruitment and clinical teams, the Safeguarding Team supports a culture of vigilance, transparency, professional curiosity, learning and continuous improvement, in line with the recommendations of the Fuller Inquiry and the NHS Safeguarding Accountability and Assurance Framework. **Pathology** – There are policies and procedures in accordance with national guidance and regulation that govern the handling and storage of human tissue. Histopathology is subject to UKAS audit and accreditation; the latest inspection occurred on the 29th July 2026. Published reports are subject to review and scrutiny at the One Dorset Pathology Governance Group and subsequently reported via assurance routes to the Trust Quality Governance Group and onwards to Quality Committee and Trust Board.

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		Mortuary – The Mortuary carries out a schedule of audits to maintain the standard required by the HTA for Security, Dignity, Storage and Care of deceased and tissue. These are in line with the HTA Codes of Practice, Standards and Legislation. Non-Conformities (NCs) and Datix reports are submitted to raise awareness of any issues within and outside of the department. These are investigated and acted appropriately. HTA reportable incidents are completed via the HTA Portal (HTARI). **Corporate** – Oversight of mortuary services, operational, performance and quality issues, including HTARI, are reported through the Mortuary Services Group via the Urgent and Integrated Divisional Governance Meetings and included in monthly Divisional Performance Reviews with Executive leads. In addition, Mortuary and Bereavement Services are standard agenda items on the Trust Palliative and End of Life Care Committee which is chaired by the Chief Nursing Officer. Formal reporting on the activities of the Committee are shared at the Joint Quality Committee in Common via the Trust Quality Governance Group.
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	Following a comprehensive review, several improvements to mortuary security and access controls were implemented in 2022/23. A formal report on the findings, recommendations and actions was subject to Board level review and support approved for immediate improvements. These enhancements have strengthened governance, monitoring and audit arrangements, with identified actions complete. No further areas for action were identified in the HTA inspection in 2024. Whilst there is a ‘swipe in’ access control system, there is no ‘swipe out’ function. A local risk assessment concluded that this is mitigated by existing controls including the

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		CCTV system with 24/7 motion-detection capability that records and monitors access in and out of the department, as well activity within, and regular weekly audits of access and activity. The Trust therefore considers the residual risk associated with the absence of a ‘swipe out’ function to be low and appropriately managed through existing controls, with the position kept under regular review as part of ongoing governance and security arrangements.
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	Whilst the Trust Chief Medical Officer takes executive leadership for oversight of care after death, including oversight of mortuary, pathology, coronial and learning from deaths provisions, the Chief Nursing Officer leads on arrangements and oversight of Trustwide safeguarding arrangements to ensure statutory compliance is met. The Trust is satisfied that appropriate safeguarding assurance mechanisms are in place and recommends submission of the assurance position. However, it is noted that there is currently no specific reference to deaths within the Safeguarding Commissioning Assurance Toolkit (SCAT) documentation, and consideration should be given to whether this would strengthen the overall governance framework and alignment with mortuary, bereavement and safeguarding processes. In addition, the Trust is aware of previous discussions regarding NHS England training requirements within SCAT. To date, national training arrangements have not been finalised or implemented. It is understood that this may be linked to ongoing organisational changes within

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		NHS England, which have impacted the progression and clarification of training expectations. Further review of the relevant national documentation and operating procedures (DOC) is recommended to ensure roles, responsibilities, escalation routes and governance requirements are clearly articulated and sufficiently robust. Strengthening the documentation would provide additional assurance that processes remain consistent, well understood and aligned to current national guidance. Whilst these matters do not currently represent significant risks at a local level, they provide opportunities to enhance assurance, strengthen governance arrangements and ensure continued compliance with evolving NHS England requirements and expectations.
The Board can assure itself the organisation has a plan in place to ensure an effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	The Trust has established robust governance, security and safeguarding arrangements to provide assurance regarding mortuary access, the management of foetal remains and bereavement services. Oversight of mortuary services, operational, performance and quality issues, including HTARI, are reported through the Mortuary Services Group to the Urgent and Integrated Divisional Governance Meetings and included in monthly Divisional Performance Reviews with Executive leads. In addition, Mortuary and Bereavement Services are standard agenda items on the Trust Palliative and End of Life Care Committee which is chaired by the Chief Nursing Officer. Formal reporting on the activities of the Committee are shared at the Joint Quality Committee in Common via the Trust Quality Governance Group. Feedback from families is captured and reviewed through established bereavement services processes, including parental feedback received via the Maternal Bereavement

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		Team. Complaints, incidents, Patient Mortality Review Tool (PMRT) findings, Datix reports and external reviews relating to community deaths are monitored and acted upon to identify learning and drive service improvement. Effective safeguarding arrangements are in place, including clear links between safeguarding teams and the Coroner's Service when concerns are identified following a patient's death. Safeguarding policies support consistent decision-making, information sharing and escalation processes where required. Assurance is provided through documented and trackable processes governing access to mortuary facilities and bereavement environments. Regular compliance and audit reports are presented through divisional governance structures and relevant committees, including the Safeguarding Committee, to provide oversight of performance, risks and any required actions. The Trust has processes in place to ensure that concerns raised by HM Coroners are reviewed, investigated and responded to in a timely manner, with learning incorporated into governance and quality improvement processes. High levels of physical and electronic security are maintained within maternity services, including restricted access arrangements for maternity units and secure storage facilities for foetal remains. Access controls and monitoring processes provide assurance that only authorised personnel can enter these areas.

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		Information governance requirements are supported through adherence to Caldicott principles. The transfer of babies to and from bereavement suites, including the use of cold cots, is managed through defined procedures and documented equipment logs, enabling audit, traceability and assurance regarding the appropriate use of equipment and handling of remains.
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.	Yes	During recent heatwave conditions, Estates staff identified that the external air-conditioning cooling plant serving the mortuary was operating with reduced efficiency due to its current location. This issue has been reviewed and actioned, with plans in place to relocate the external cooling equipment to a more suitable position to improve operational performance and resilience during periods of elevated temperatures. In relation to the NHS Premises Assurance Model (PAM), we can confirm that there is an agreed programme in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model within the current submission window. The assessment will be completed and the required data submitted before the deadline of 8 September 2026. Furthermore, the process will incorporate appropriate governance and assurance arrangements, including review and formal sign-off by the Trust Board prior to submission. This will ensure that the assessment accurately reflects the organisation's position, that any identified risks or improvement actions are captured, and that the submission meets NHS England's requirements within the prescribed timeframe.

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Trust Name	Trust CEO/AO name	Date	Trust Chair name	Date
Dorset County Hospital NHS Foundation Trust	Matthew Bryant CEO Signatory Dawn Dawson (Deputy CEO)	31st July 2026	David Clayton Smith	31st July 2026

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Dorset HealthCare

Finance and Performance Committee in Common Assurance Report for the meeting held on Wednesday 29 July 2026

Chair	Dave Underwood, NED
Executive Lead	Chris Hearn – Joint Chief Financial Officer Rachel Small – Chief Operating Officer, DHC Anita Thomas – Chief Operating Officer, DCH
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Martyn's Law - recommendation that Trust Board acts as the Responsible person for DCH & DHC, as per NHSE guidance. • The Committee was assured that recovery plans are in place to support urgent and emergency care delivery, with partial assurance provided for elective care recovery whilst plans are still in development.

Key issues / matters discussed at the meeting	A joint informal meeting with the Strategy, Transformation and Partnerships Committee took place 29th June 2026 covering the following topics for discussion: • Deep Dive into Neighbourhood Programme. • Digital Strategy Update. • Update on the New Hospital Programme followed by a walk-around of the Emergency Department. The formal committee received and considered the following reports: **Board Assurance Framework Assigned Risks** The Committee received the Quarter 1 Board Assurance Framework report for assurance. Members noted the annual review of strategic risks, including revised risk wording, refreshed controls and assurances, and alignment of target scores with the Trust's risk appetite framework. The Committee's assigned risks remain Capacity and Demand (SR4), Estates (SR5) and Finance (SR6). The Committee noted that Dorset County Hospital risk scores remain elevated across Capacity and Demand, Estates and Finance, reflecting current performance, estate and financial pressures. Members discussed the Capacity and Demand risk and noted that recent performance challenges had prompted a rapid review and strengthened recovery arrangements. Assurance was provided that enhanced oversight, reporting and recovery actions are now in place. The Committee also discussed estate-related risks and received assurance that capital investment continues to be prioritised against the highest-risk

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areas. A summary of the maintenance backlog and associated technical debt will be presented at a future meeting.

Corporate Risk Register Assigned Risks
DHC - report received for assurance noting changes to the risk profile reflecting ongoing mitigation activity and programme delivery. An emerging risk relating to infrastructure requirements to support delivery of the National Child Measurement Programme was noted, with further information being sought before a decision is made on inclusion within the risk register. Assurance was provided on the reduction of risk associated with the CAMHS High Intensity Unit. Members also noted the proposed closure of a longstanding bed availability risk, reflecting sustained mitigation and management over time.

DCH - Members noted new risks relating to endoscopy infrastructure and trauma and orthopaedic waiting times, together with the continued high-rated risk associated with urgent and emergency care performance. Assurance was provided that mitigating actions are in place to manage endoscopy infrastructure risks, with regional support being sought to secure funding for replacement of end-of-life equipment. Further assurance was provided on the trauma and orthopaedic waiting time recovery actions as part of the Trust's wider performance improvement programme. long waiting times within community paediatrics was discussed with assurance that additional capacity has been secured and system-wide work is progressing to support sustainable improvement.
The Committee also discussed opportunities to strengthen assurance through future deep dives on cross-cutting risks where there are interdependencies across Board committees

DHC Performance Report
The Committee received Report for assurance. Members noted that nine national performance metrics remain off trajectory, with the majority relating to Talking Therapies and Audiology. Assurance was provided that recovery actions are in place for Audiology, including investment to support backlog reduction and proposals submitted to the ICB to support sustainable service delivery. The Committee noted significant improvement in waiting times, with no patients waiting over 13 weeks. Members also noted that performance against Talking Therapies continues to be impacted by funding constraints and that discussions with the ICB remain ongoing. The Committee discussed ongoing pressures relating to mental health flow, length of stay and out-of-area placements and noted that recovery plans remain in place. Members asked executives to ensure that commissioners make required funding decisions so that DHC can make service delivery decisions as part of operational planning.

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DCH Performance Report

Members noted that Quarter 1 performance was significantly impacted by sustained demand, operational pressures, workforce shortages and infrastructure challenges, resulting in performance below plan across urgent and emergency care and elective recovery measures. Assurance was provided that recovery actions are underway, including strengthened operational oversight, delivery of the Your Future Hospital programme and targeted interventions to improve patient flow. Early signs of improvement during July were noted. The Committee discussed elective care performance and noted continuing pressures relating to waiting lists, workforce availability, equipment failures and capacity constraints. Partial assurance on recovery for elective care was provided, whilst plans are still being developed; with particular focus on orthopaedics, endoscopy and cancer pathways. Members also discussed the interdependencies between committee portfolios and agreed that cross-cutting issues may benefit from future joint committee consideration.

Operational Recovery Group Terms of Reference

The Committee received an update on the establishment of the Operational Performance Recovery Group, introduced in response to actions arising from the NHS England performance review. Assurance was provided that the Group has been established, terms of reference drafted, and weekly meetings commenced with executive oversight in place. Members noted that ICB representation has been incorporated within the arrangements and that weekly performance briefings are now being circulated to Non-Executive Directors. The Committee approved the Terms of Reference.

DHC Finance Report

The Committee received the Report for assurance. Members noted that the Trust remains on plan at Quarter 1, reporting a surplus in line with forecast. The Committee noted delivery of £4.6m of efficiency savings, although performance remains behind plan, primarily reflecting temporary staffing expenditure and continued out-of-area placement pressures. Assurance was provided that both areas remain a focus of the Financial Recovery Programme. Members received assurance that temporary staffing expenditure has reduced compared to the same period last year and that work is underway to improve recurrent savings delivery through establishment review and substantive recruitment.
The Committee also noted progress on VAT recovery arrangements and that capital expenditure is below plan, largely reflecting the reprofiling of New Hospital Programme expenditure.

DCH Finance Report

Members noted a small adverse variance against plan at Quarter 1, primarily reflecting industrial action costs and operational pressures.

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Efficiency delivery was reported ahead of plan; however, the Committee noted that a proportion of savings remains unidentified and that delivery of recurrent schemes continues to represent a key financial risk. Assurance was provided that targeted recovery arrangements are in place to support scheme identification and delivery. The Committee noted continued pressures relating to temporary staffing expenditure, whilst recognising the significant reduction in agency spend achieved over recent years. Assurance was provided that focused work is underway to reduce temporary staffing costs and improve recurrent savings delivery. Members also received assurance on the Trust's cash position and noted confirmation of Deficit Support Funding for Quarters 1 and 2. Capital expenditure remains behind plan, largely reflecting the reprofiling of planned schemes, including the New Hospital Programme.

Lead Provider Collaborative Finance and Other Commissioning Activities Contracting Report (DHC)

The Committee received the Adult Eating Disorders Provider Collaborative report for assurance noting that the arrangement remains subject to routine quality monitoring and that the single out-of-area placement is expected to be resolved imminently. A business case to continue as Lead Provider across Dorset, Hampshire and the Isle of Wight has been submitted to Regional colleagues. The Committee noted a forecast surplus within the Collaborative, reflecting lower than anticipated use of out-of-area placements and enhanced packages of care. Members received assurance that the surplus will be reinvested to support service development and improve patient access across the geography. The Committee also discussed quality governance arrangements and agreed that consideration should be given to the alignment of reporting through existing governance structures.

Cost Collection Exercise Report

The Committee received the National Cost Collection post-submission report for ratification. Members noted that the report had been presented in accordance with national guidance following the pre-submission review considered at the previous meeting. Assurance was provided that both Trusts successfully submitted their National Cost Collection returns within the required timescales and with no material issues identified. The Committee noted that the submissions had been subject to detailed review prior to submission and were compliant with national requirements.

Annual Procurement Compliance Report

The Committee received the Report for assurance. No procurement breaches had been identified during the reporting period, and all procurement activity had been undertaken in accordance with regulatory requirements and internal governance processes. Members noted the establishment of the One Dorset Procurement Service, hosted by

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University Hospitals Dorset, and the work underway to align procurement processes across Dorset organisations.

Better Payment Practice Performance (DHC and DCH)
The Committee received the DHC and DCH reports for assurance. Members noted that Dorset HealthCare continues to achieve the required standard across the majority of measures, with minor variances relating to NHS invoice processing. Assurance was provided that appropriate actions are in place to address delays and strengthen process compliance. DCH remains below target for a small number of measures, reflecting challenges in invoice processing and validation. Assurance was provided that a targeted action plan is in place to improve performance. Controls continue to be strengthened across both organisations to reduce late payment charges and support compliance with the Better Payment Practice Code.

Martyn's Law Bi-Annual Update
The Committee received the update report for assurance and noted that implementation activity across both Trusts is progressing in line with NHS guidance. All relevant sites have been assessed and categorised, with Dorset County Hospital identified as an Enhanced Duty premises and a number of sites across both organisations identified as Standard Duty premises. Work is now focused on ensuring compliance with the requirements of each tier ahead of the April 2027 implementation deadline. Members received assurance that policies, procedures, training and testing arrangements are being reviewed and strengthened, with work underway to address identified gaps in monitoring and physical security measures. The Committee also noted the recommendation that Trust Boards act as the Responsible Person under the legislation.

Green Strategy/Net Zero Annual Report (Joint)
The Committee received the Annual Report for assurance noting progress across both Trusts in delivering sustainability objectives, including estate decarbonisation, sustainable procurement, waste reduction and development of net-zero compliant facilities. Assurance was provided that governance arrangements and delivery workstreams are established across the Federation to support implementation of the Green Plan. The Committee also noted the increasing importance of climate adaptation and estate resilience in response to the impact of extreme weather on operational services and infrastructure. Members supported the continued rollout of the Green Plan communications programme and received assurance on ongoing monitoring through established sustainability performance measures.

FutureCare Programme Closedown Report
The Committee received the Closedown Report for assurance noting improvements in patient flow, discharge processes and system-wide

Ellis Kara
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	coordination across health and social care partners. Members noted the establishment of Transfer of Care Hubs, earlier discharge planning and reductions in lengths of stay for patients with no criteria to reside. Assurance was provided that these initiatives have helped mitigate increasing system demand. The Committee also noted that, whilst operational improvements have been achieved, the full benefits of the programme have not yet been realised, including anticipated reductions in bed capacity and associated financial benefits. Further system-wide transformation and community capacity development will be required to support delivery of these benefits. **Joint Financial Recovery Board Terms of Reference** Received for approval. Members noted that the Board continues to operate effectively and provide focused oversight of financial recovery delivery. Minor amendments were proposed, including updating the title from Financial Recovery Group to Financial Recovery Board, the addition of the Associate Director of Financial Recovery Delivery to the membership, and alignment of future reviews with the annual governance cycle. The Committee also supported the proposal to remove the time-limited status of the Board, recognising its ongoing role in supporting financial recovery. **The following escalation reports from subgroups were received for assurance by the committee members:** The following were received for assurance without discussion: • Joint: Financial Recovery Board DHC & DCH Sustainability Working Groups • DHC: Capital Investment Meeting Efficiency Delivery Group Emergency Planning & Resilience Group • DCH: Capital Planning and Space Utilisation Group Emergency Planning & Resilience Group Health & Safety Group Value Delivery Board
Decisions made at the meeting	Approvals and Ratifications by DCH and DHC committees: • Operational Recovery Group Terms of Reference - DCH • Cost Collection Exercise Post Submission Report • Joint Financial Recovery Board Terms of Reference
Issues / actions referred to other committees / groups	• Mental Health Bed Capacity and Patient Flow - Refer to STPCIC for an update on expected impact and benefits realisation.

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- Provider Collaborative Adult Eating Disorder - consider the quality aspect of this to report into QCIC.

Quoracy and Attendance						
	27/05/2025	29/07/26				
Quorate?	**Y**	**Y**				
Dave Underwood	Y	Y				
Claire Lehman	Y	Y				
Andreas Haimbock-Tichy	N	Y (first 2 hours)				
Chris Hearn	Y	Y				
Lucy Knight	Y	Y				
Rachel Wharton	Y	N				
Anita Thomas	Y	Y				
Rachel Small	N	N				

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NHS
Dorset HealthCare University
NHS Foundation Trust

Report to	Board in Common	
Date of Meeting	11 August 2026	
Report Title	Integrated Corporate Dashboard – June 2026	
Prepared By	Daniel Cunningham Corporate Performance Business Partner	
Approved by Accountable Executive	Chris Hearn Chief Finance Officer Rachel Small Chief Operating Officer	
Previously Considered By	N/A	
Action Required	**Approval**	
	Assurance	Y
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1: Safety and Quality SR3: Workforce Capacity SR4: Capacity and Demand SR6: Finance	
Financial	Finance metrics for assurance.	
Statutory & Regulatory	Many of the metrics within the report are statutory or regulatory and so these are provided for assurance.	
Equality, Diversity & Inclusion	Completeness of Patient Ethnicity Data for assurance.	
Co-production & Partnership	No implication	

Executive Summary

- **Clostridioides Difficile Infections** - The Trust reported three cases in Q1 2026/27, compared with two cases in the same period in 2025/26, representing a slight increase.

- **Other Significant Healthcare Associated Infections** - The Trust reported two bloodstream infections (BSIs) in Q1 2026/27, compared with three cases in the same period in 2025/26, representing a slight reduction.

- **Medication Incidents** - Medication incidents exceeded the upper process limit in May. This was largely attributable to increased reporting of transfer of care incidents and incidents linked to the Weymouth/Portland meningitis response.

- **Complaints** - Complaints increased to 74 in June (from 66 in May), with communication, patient care, appointments, clinical treatment and discharge planning being the dominant themes.

- **Length of Stay** - Average length of stay remained above the target of 76 days. Performance is being disproportionately affected by a small number of patients with very long stays, often linked

Elvis Kara
06/08/2026 14:33:41

to discharge complexity and lack of suitable accommodation. A new review process for patients exceeding 45 days is being introduced.

Older Adult Mental Health bed length of stay was 117 days against a threshold of 125.8 days, Work continues with local authority partners to further reduce discharge delays and improve patient flow

- **Intermediate Care Beds Occupied By People With No Criteria To Reside** - During June, 36.7% of occupied bed days were attributed to patients with no criteria to reside, with 68 patients remaining in community hospital beds at month end despite being fit for discharge. This continues to place pressure on patient flow and bed availability across the system.

- **Diagnostic Waiting Times (6-week standard**) - Performance remains below target. Increased demand following the introduction of Audiology self-referral, combined with workforce capacity pressures, has contributed to a growing backlog. A recovery plan has been approved, supported by £114k of non-recurrent funding.

- **Children and Young People (CYP) Access -** Performance remains above target, with both CYP mental health access and MHST access exceeding planned trajectories, reflecting the continued success of recovery actions implemented in 2025.

- **Children & Young People Eating Disorders** - Performance remains below the 95% target for both urgent and routine referrals, with only 75% of urgent referrals starting treatment within one week and the routine recovery plan having been off track since February 2026. Recovery actions have now been implemented, and interim July data indicates a significant improvement in performance.

- **Completeness of Patient Ethnicity Data** - Recording completeness improved but remains below the local target of 100%, creating a data quality risk and limiting full analysis of performance, access, experience and outcomes by ethnicity. Following restoration of a previously broken data link, the metric is now subject to daily monitoring by Business & Performance, with further work underway to address known reporting issues and support improvement.

- **Individual Placement Support** - Access remains below target, with 530 people accessing the service against a threshold of 699. A recovery plan has been submitted, and current in-month activity suggests year-end recovery remains achievable.

- **Talking Therapies -** Several Talking Therapies metrics are showing signs of deterioration and emerging performance risk. Reliable Recovery is now below target, while Reliable Improvement and Completed Courses of Treatment remain above target but have demonstrated sustained below-average performance over the last ten months. Waiting times continue to be a significant pressure, with workforce shortages, increasing demand and limited investment impacting both access and outcomes. Recovery actions are underway, supported by ongoing discussions regarding additional funding.

Ellis Kara
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- **Active Inappropriate Adult Acute Mental Health Out Of Area Placements** - Five out of area placements were reported in June. Increased demand, higher patient acuity and delays in discharge continue to impact inpatient flow and local bed availability.

- **Completed Appraisals last year** - Compliance improved to 77.7% but remains below the 85% target. The transition to a new appraisal system continues to affect performance.

Recommendation

Members are requested to:
- Receive the report for **assurance**
- Note the areas where recovery plans are being developed.

Ellis,Kara
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Dorset HealthCare University
NHS Foundation Trust

Integrated Corporate Dashboard

June 2026

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Introduction

Dorset HealthCare University
NHS Foundation Trust

Celebrating Progress across Dorset Healthcare

May and June brought significant achievements for the Trust, reflecting the dedication of our colleagues and continued investment in services for local communities.

National recognition

Dorset HealthCare became one of the first six trusts in England to achieve **Advanced Foundation Trust status**, recognising its strong record of quality, leadership and financial sustainability.

Transforming mental health care

The new **£23 million Chaddesley House** facility opened at St Ann's Hospital, followed by **Seastone**, a £17.9 million specialist inpatient unit enabling more young people to receive care closer to home.

Outstanding care recognised

Westminster Memorial Hospital achieved **Gold Standards Framework Platinum Status** and received a national award for its improvements to end-of-life and bereavement support.

Celebrating our colleagues

Debbie Sharman received the Royal College of Podiatry's **Diamond Lifetime Achievement Award**, recognising her contribution to improving care for people living with diabetes.

Ellie Clarke
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Understanding SPC Charts

Dorset HealthCare University
NHS Foundation Trust

Statistical Process Control (SPC) charts help distinguish between normal variation and meaningful change so the Board can focus on the issues that need attention.

What an SPC chart tells you

- The centre line shows the average level of performance
- The control limits show the range within which normal variation is expected
- A stable process will vary, but usually within those limits
- Special cause variation suggests something has changed and may need review, escalation or learning
- SPC is more useful than looking at one month in isolation because it shows the pattern over time

How to interpret the signals

Blue dots	Improvement or better-than-expected performance.
Orange dots	Potential concern or worse-than-expected performance.
Assurance icon	Whether the current process is capable of achieving the required standard consistently.

Assurance			Variation						
Consistently **Passes** target	Pass and fail target subject to random variation	Consistently **Fails** target	**Special Cause** Concerning variation either **Higher** or **Lower**		**Special Cause** Improving variation either **Higher** or **Lower**		**Special Cause** Neither improving nor concerning variation		**Common Cause**

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Why this matters for the Board: SPC supports better assurance by showing whether changes reflect expected fluctuation, a genuine deterioration, or sustained improvement.

Clostridioides Difficile Infections

Month	Number of Cases
April 2026	0
May 2026	2
June 2026	1

Description of metric

Number of Clostridioides difficile cases identified on a hospital ward in the month. This includes those which are found not to be due to a lapse in care.

In Month: 1 **Threshold:** 2026/27 TBC (2025/26 , <13)

The Trust reported three cases of Clostridioides difficile (C. difficile) in Q1 2026/27, representing a slight increase compared to the same period in 2025/26.

The key challenge is reducing the risk of C. difficile infection in a patient population that often transfers into Dorset HealthCare following multiple courses of antibiotics, increasing their susceptibility to infection.

The Infection Prevention and Control (IPC) Team reviews all C. difficile cases, visits affected patients to provide information and support, undertakes swarm huddles to identify learning and actions, and shares findings with the IPC Doctor. Cases are also reviewed through local and ICS post-infection review processes to identify themes and opportunities for improvement.

Antimicrobial exposure remains the principal risk factor for C. difficile infection. To mitigate this risk, IPC continues to work with Pharmacy to strengthen antimicrobial stewardship and improve C. difficile risk assessment within Electronic Prescribing and Medicines Administration (EPMA). Ongoing surveillance, case review, and system-wide learning support early identification and management of risks.

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Other Significant HCAI

Month	Number of Cases
April 2026	1
May 2026	1
June 2026	0

Description of metric

Number of patients affected by significant healthcare associated infections. This excludes MRSA, C difficile & E.coli, COVID and Flu.

In Month: 0 **Threshold:** None

The Trust reported two bloodstream infections (BSIs) in Q1 2026/27, representing a reduction compared to the three cases reported in the same period in 2025/26.

The key objective is to understand the factors contributing to bloodstream infections and ensure robust preventative measures are consistently applied, particularly in patients with invasive devices and complex clinical needs.

All BSI cases are reviewed by the Infection Prevention and Control (IPC) Team to identify potential contributing factors and learning opportunities using Patient Safety Incident Response Framework (PSIRF). Findings are shared with the IPC Doctor, with a focus on invasive device management, aseptic technique, and adherence to local IPC policies. Themes and lessons learned are also discussed through relevant governance and review processes.

Patients requiring indwelling devices, mainly urinary catheters devices and those with multiple co-morbidities remain at increased risk of bloodstream infection. This risk is managed through ongoing surveillance, education regarding catheter care and ensuring the need for urinary catheters is reviewed regularly, staff education, and promoting compliance with aseptic non-touch technique (ANTT). Continued monitoring and case review support early identification of trends and opportunities for improvement.

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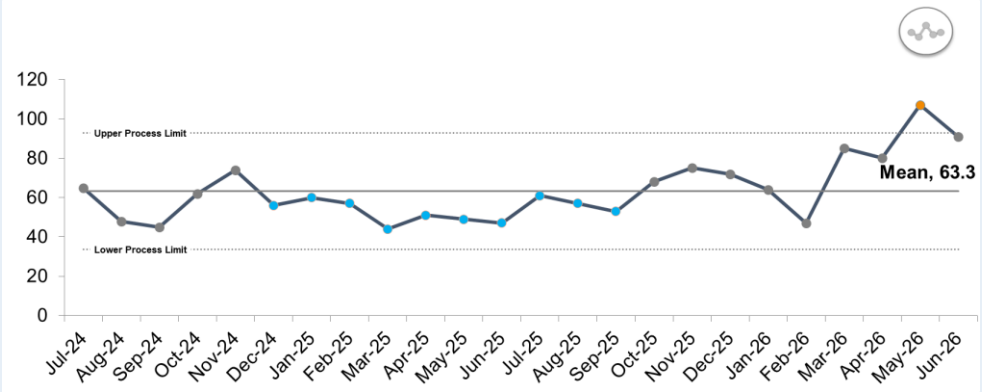
Medication Incidents



Description of metric

A count of medication errors reported on Ulysses in the reporting month with a unique incident number.

In Month: 91 **Threshold:** none

Medication incidents were above the upper process limit in May. There are two causes identified for this. Firstly, in March 2026 a request was made for pharmacy staff to document all incidents relating to transfer of care. This followed a request for data on this type of incident from the two acute Trusts in Dorset. This has led to an increase in reporting, which can be seen in March, April and June as well. Secondly, there were 25 incidents reported relating to the response to the meningitis outbreak in the Weymouth/Portland area. These were reported through April and May (the main response to the incident was in April but some reports were created later in May). With these reports removed, the number of incidents, though still higher than average, drops back below the upper process limit. As such, no action is currently needed but incidents numbers will be monitored closely and a further investigation into the increase since March will be completed shortly.

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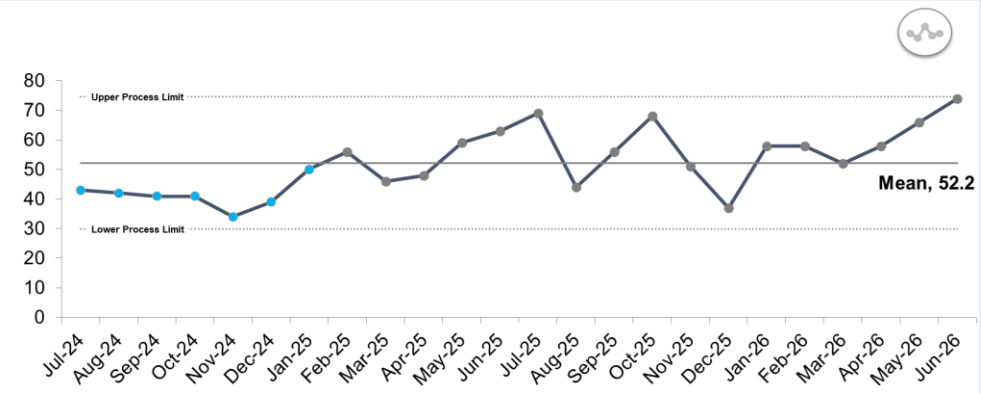
Complaints



Description of metric (in month figure)

Number of complaints received, both written and verbal, including any themes identified. (74)

The number of complaints that, the Parliamentary and Health Service Ombudsman has notified the Trust, have been referred to the Ombudsman. (0)

The number of complaints, both written and verbal, that have been reopened during the month. (5)

Thresholds: None

Complaints increased to 74 in June (from 66 in May), with demand remaining highest in Mental Health Community Services, CAMHS, ICS Specialist Services and Integrated Urgent Care. Performance remains strong, with the majority of complaints acknowledged and managed within agreed timescales.

The most common themes were communication, patient care, appointments, clinical treatment and discharge planning. Communication with patients, relatives and carers continues to account for the largest proportion of concerns, alongside issues relating to access and continuity of care.

Thirteen complaints were resolved through early resolution, while learning from complaints has focused on improving communication, strengthening follow-up processes, enhancing documentation, and reinforcing professional behaviours.

Five complaints were reopened during the month, highlighting the need to ensure all concerns are fully addressed and expectations managed effectively. Ongoing service improvements continue to focus on reducing repeat complaints and improving patient experience.

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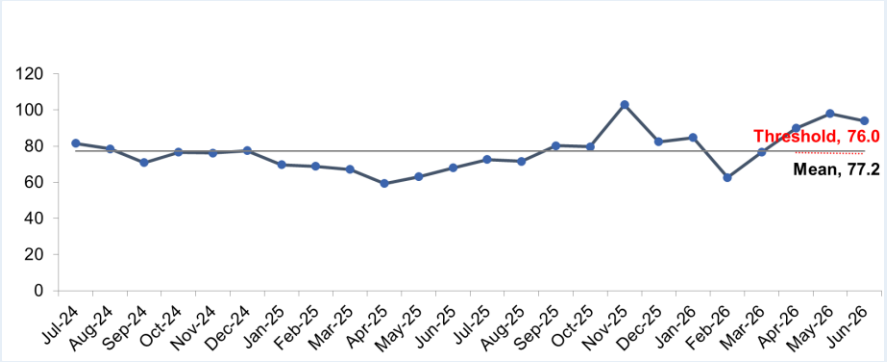
Length of Stay



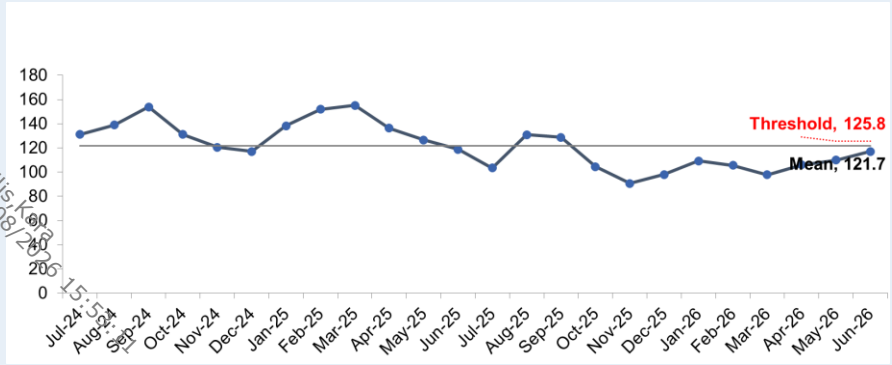
Average length of stay for patients in Adult Acute and Psychiatric Intensive Care Unit (PICU) Mental Health Beds

Medium Term Operational Planning & National Oversight Framework metric

Description of Metric

The mean length of stay for anyone discharged in the reporting period. Three month rolling period.

In Month: 94 **Threshold:** 76



Average Length of Stay for Patients in Older Adult Acute Mental Health Beds

Medium Term Operational Planning & National Oversight Framework metric

Description of Metric

The mean length of stay for anyone discharged in the reporting period. Three month rolling period.

In Month: 117 **Threshold:** 125.8

Length of Stay

Narrative

Length of stay across both adult Acute and PICU wards remains above target but has seen a reduction. Ongoing work through the Mental Health Therapeutic Admissions programme has identified that the length of stay metric is predominantly increased by a small number of individuals who have an extraordinarily long length of stay. DHC's median position for June (47 days) the national average for England is 48 days. In April and May several patients were discharged with a LoS >100 days. In May, five patients with the longest LoS made up 64% of the total LoS.

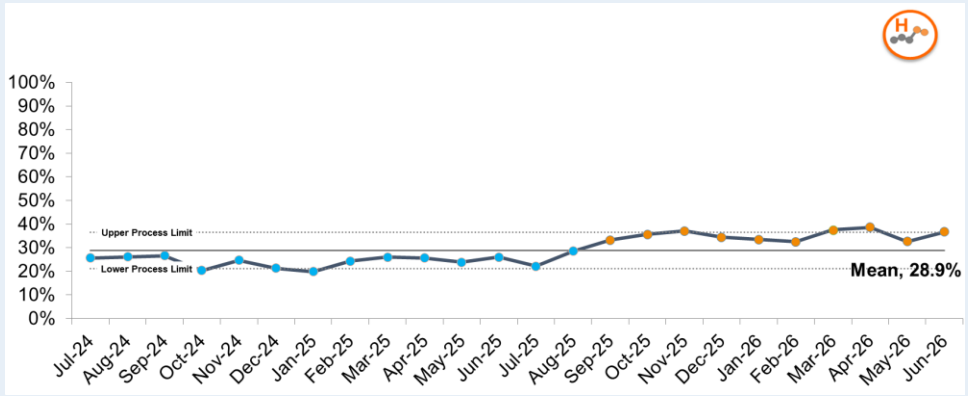
Extended length of stay is clinically appropriate for a small minority of this group, however, many of this group have an extended length of stay due to challenges around provision of an appropriate discharge either due to complexity/risk associated with the individual (for example those with a fire-setting history), or the lack of suitable accommodation. As a result, a panel is being stood up to review all patients with a length of stay of 45 days within Acute and PICU beds to ensure that any elements that may extend their length of stay are identified and mitigated appropriately, aiming for them to be discharged before 60 days. This is being undertaken as part of the Inpatient Processes workstream of Mental Health Therapeutic Admissions programme which is one of the trusts key transformation projects this year.

Length of stay across Older Persons Mental Health (Functional and Organic) beds remains below threshold but focus continues on the processes both on the wards and with local authority partners to reduce any unnecessary delays to expediting discharge with the ambition to further reduce length of stay and increase flow across these wards.

Ellis Kelly 06/08/2025 10:53:17

Length of stay remaining off target increases demand on inpatient capacity and means that people are at risk of having an increased wait for access to inpatient care or may be required to receive inpatient care out of area. All patients clinically ready for discharge are reviewed weekly at a system-wide Operational Flow group to address areas of delay that require escalation and patients awaiting admission are reviewed daily and least restrictive options are prioritised wherever possible with the support of community teams.

Intermediate Care Beds Occupied By People With No Criteria To Reside



Medium Term Operational Planning Metric

Description of metric (in month figure)

Percentage of Occupied Bed Days where patients in Community Hospitals are marked as fit for discharge during the month.

In Month: 36.7% **Threshold:** none

During June, the percentage of Occupied Bed Days where there was No Criteria to Reside (NCtR) was 36.7% with 68 inpatients having no right to reside at the end of the month.

DHC host the Place-based Transfer Of Care Hubs alongside Social Care partners and the voluntary sector to support and oversee the process for patients who need new or enhanced support to go home or into interim care after once they have no criteria to reside in an Acute or Community Hospital.

There is an established Place based System Improvement Group (WIG) monitoring and implementing actions. The chair of WIG has recently passed from the ICB UEC team to the Acute Trust Deputy COOs. Aligned to this DHC has implemented a refreshed escalation process that feeds through to the fortnightly COO led System reviews aimed at addressing inpatients with long extended stays once fit to leave.

There are programmes of work in both Place regions between DHC and the Local Authorities building on the FutureCare work and developed relationships aimed at improving access and equity of interim care provision and addressing NCtR.

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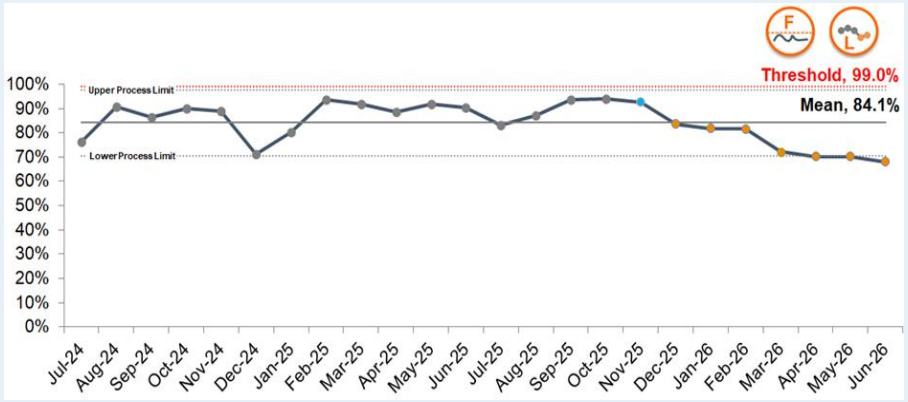
Maximum 6 week wait for diagnostic procedures



Medium Term Operational Planning Metric

Description of metric

Percentage waiting less than 6 weeks at the end of the month for specific diagnostic tests.

In Month: 68% **Threshold:** 99%

Performance has declined against the diagnostic standard due to staff resources and increased referrals as a result of implementing self referral in Audiology in Q3/4 2025/26 as required by NHSE and commissioners.

There has been improvement in the longest waiting position in month which has lowered to 16 weeks, however there is growth in the cohort of patients waiting over 13 weeks (26 patients).

A recovery action plan has been developed proposing a range of costed options along with productivity and recruitment gains to deliver recovery. This has been reviewed by SLG and an agreement for £114k non recurrently in year has been approved to provide short term capacity to address the current backlog, this will be overseen by a fortnightly performance recovery meeting. Concurrently a paper has been shared with commissioners through the contract review process that articulates the recurrent investment required to deliver a sustainable services, this will be pursued through operational planning and commissioning negotiations for 2027/28.

Clinical risk is minimised through a robust triage processes. Whilst there is a risk to delay in patient care there is no evidence of harm. Patient information from assessment to hearing aid fitting is made available at the time of assessment, and overall waiting list information is now being published on the Trust website.

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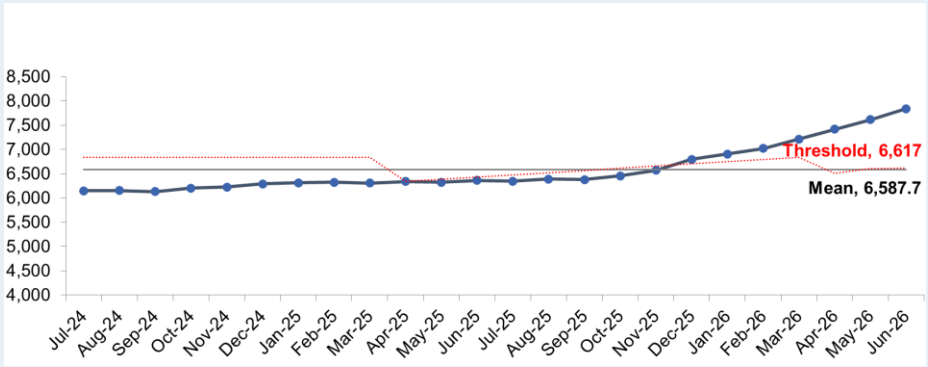
Children & Young People Access

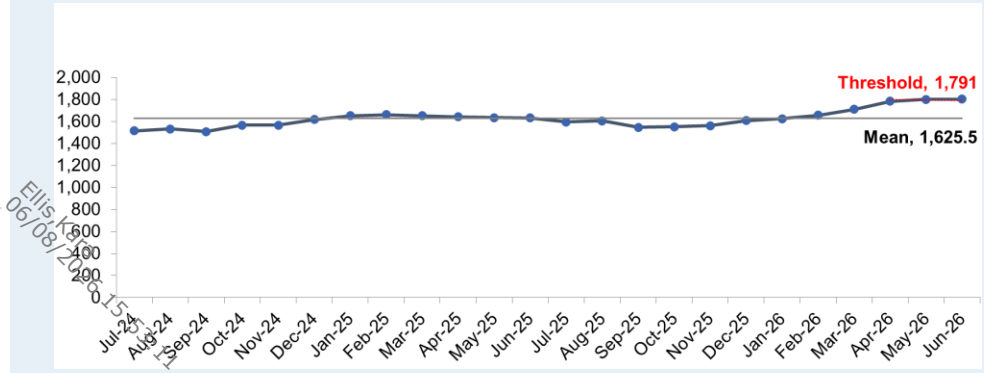


Children & Young People (CYP) Access 1+ Contact, DHC Under 18s rolling 12 months

Medium Term Operational Planning Metric

Description of Metric
Number of CYP aged under 18 supported through NHS funded mental health with at least one contact (either direct or indirect) in the previous 12 months. 12 month rolling period.

In Month: 7,842 **Threshold:** 6,617



Number Of CYP Aged 0-17 Supported Through NHS Funded Mental Health Services Receiving At Least One Contact With An MHST

Medium Term Operational Planning Metric

Description of Metric
Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact with an MHST. 12 month rolling period.

In Month: 1,803 **Threshold:** 1,791

Children & Young People Access

Narrative

Performance for CYP Access to mental health services and access via MHST Teams continues to remain above the overall threshold for 12 month rolling access and meets the national expectations for coverage.

The metric is performing above the agreed Medium Term Plan trajectories for month 3 and is included to note the positive performance outside of previous process controls.

This continues to evidence the success of the recovery plan initiated in October 2025, which is now monitored monthly via the MTP trajectories.

There is no associated risk with this metric.

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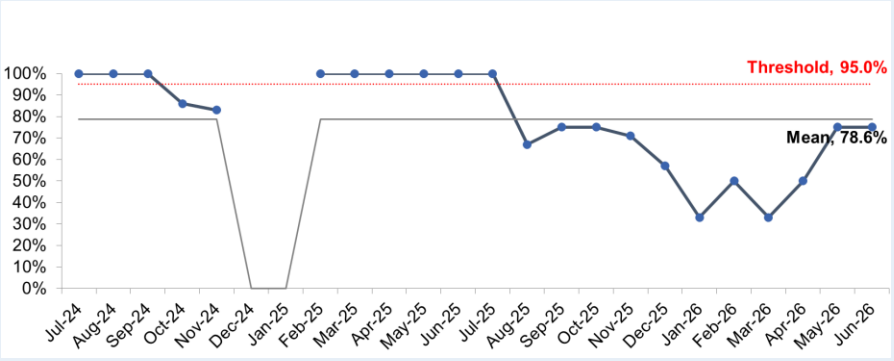
Children & Young People Eating Disorders (CYPED)



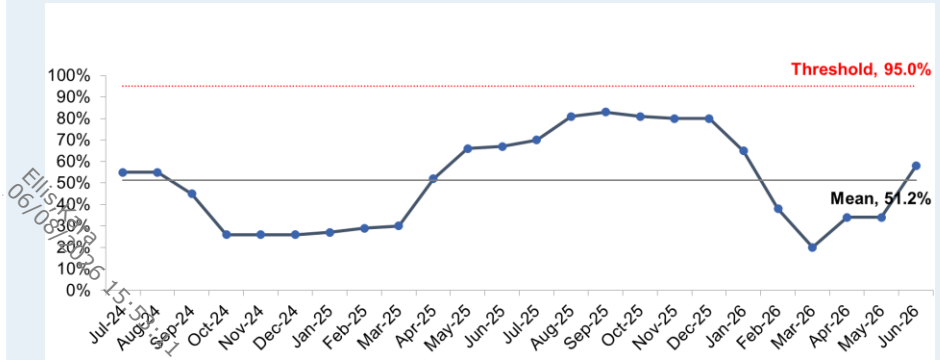
Urgent Referrals

Long & Medium Term Operational Planning Metric

Description of Metric

Proportion of referrals with eating disorders categorised as urgent cases entering treatment within one week in the reporting period, aged 0-18.

In Month: 75% **Threshold:** 95%



Routine Referrals

Long & Medium Term Operational Planning metric

Description of Metric

Proportion of referrals with eating disorders categorised as routine cases entering treatment within four weeks in the reporting period, aged 0-18.

In Month: 58% **Threshold:** 95%

Children & Young People Eating Disorders (CYPED)

Narrative

The CYP ED routine waits recovery plan has been off track since February 2026. Actions to improve patient flow, clinical decision-making and assessment capacity are now embedded, enabling appointments to be offered within required timescales. Recovery to 95% compliance is anticipated by July 2026. Ahead of formal July data reporting interim data indicates 100% compliance.

Service analysis, supported by Business & Performance, identified limited multi-family clinic availability as the main cause of delays. Patient or parent choice outside the 28 day target also affects performance, as NHSE does not recognise this as a valid clock stop. Clinic cancellations and a small number of DNAs were additional factors.

The service has embedded multidisciplinary assessment clinics and a Dorchester clinic base, introduced flexible assessment capacity to support recovery and demand, added consultant paediatrician input to duty screening twice weekly, with review planned for September, routed all 18 year olds directly into the adult assessment pathway, introduced Friday confirmation calls for Tuesday clinics to reduce non-attendance and raised the treatment of patient choice with NHSE, although this is not currently accepted as a valid clock stop.

Longer waits may adversely affect clinical outcomes and patient experience, as well as the Trust's performance assessment. Achievement of the 95% KPI remains affected where patients or parents decline appointments offered within target or request later dates.

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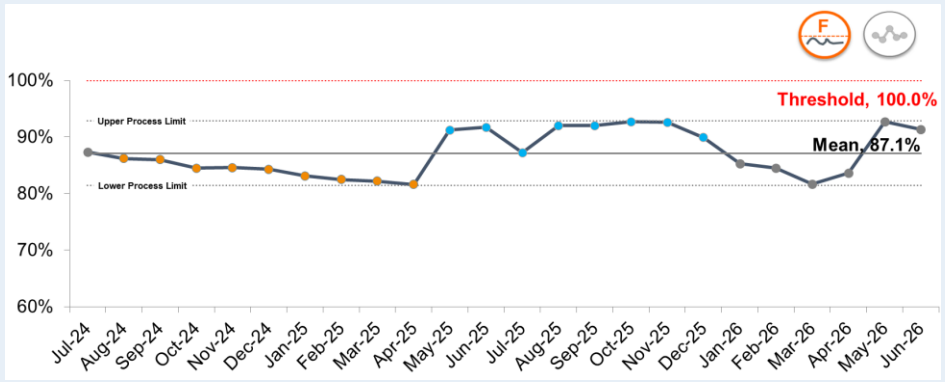
Completeness of Patient Ethnicity Data



Description of metric

The percentage of service users who have their ethnic category recorded on a source system and which can be used for reporting purposes.

In Month: 91.3% **Threshold:** 100%

Completeness of patient ethnicity data remains below the local target of 100%, creating a data quality risk and limiting full analysis of performance, access, experience and outcomes by ethnicity. The recent improvement in this metric relates to the re-establishment of a broken data link between DHC and DiiS. To mitigate future issues this has been added to daily monitoring within Business & Performance which will assess the potential for future failure and ensure that action is taken in a timely manner.

Work is underway to look at the potential exclusion of some cohorts from Ethnicity reporting data, specifically children under the age of six months. This will mitigate the known issue of delayed GP registration and therefore, a delay of up to six weeks in the data flow of ethnicity. Exclusion will be applied once the details have been documented in full.

This work supports future analysis by protected and other characteristics. In the interim, Trust priorities continue to be guided by national, regional and system intelligence, including the Patient and Carer Race Equality Framework and a focus on Gypsy, Roma and Traveller communities.

Ellis, Kara
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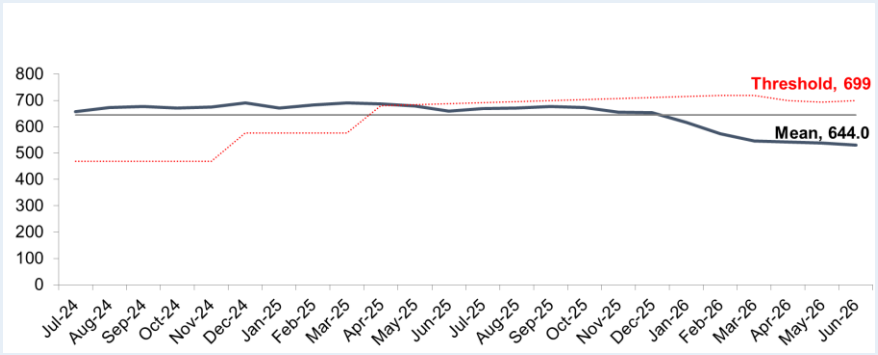
Individual Placement Support



Medium Term Operational Planning Metric

Description of Metric

Access definition A person is counted as having accessed an IPS service if they have had an attended face to face, via telephone, video conferencing or talk type. The contact should be 'clinical' (in the case of IPS this means it was not predominantly admin related), e.g. a vocational profile or action plan was started or worked on

In Month: 530 **Threshold:** 699

Dorset Work Matters (DWM) is the IPS service which supports people with a Serious Mental Illness (SMI) to retain, return and seek employment. The service over-achieved the agreed access target for 2024/25 set at 575, (achieving 633 which was used to set the 2025/26 expected outturn). The service experienced challenges meeting the increased access target for 2025/26 due to a pause on expansion funding and staffing configuration. The MTP trajectories have been set to achieve 719 by March 2027. The metric is reported on a 12 month rolling period therefore any previous period of reduced activity impacts the ability to catch up with performance (and requires a period of over delivery to achieve). Despite this, quality remains high with the service achieving a 90% fidelity score with the IPS Grow review in 2025/26.

A contributing factor to the decline in performance could be a year-on-year reduction in referrals and caseload to the Service (not yet fully scoped/tested). Caseload has a carryover function built into the access rate therefore a reduction in caseload will have an impact.

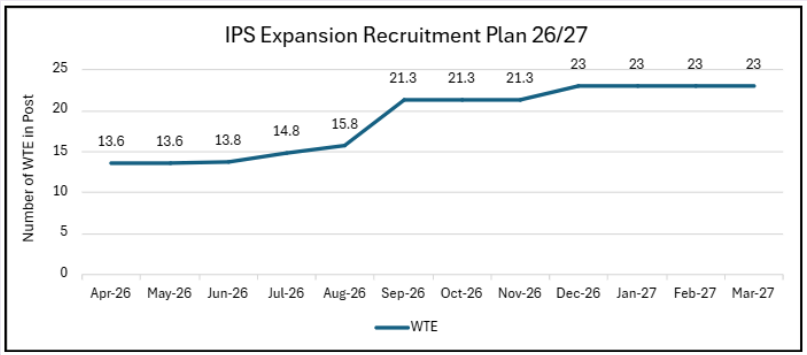
Ellis,Kara 06/08/2026 09:43:11

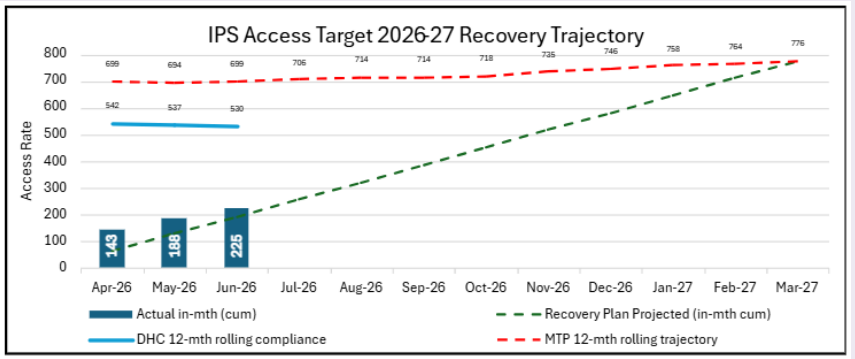
Individual Placement Support

The DWM team submitted a recovery plan to the Senior Leadership Group and NHSE Southwest Regional team on 10 June 2026 outlining the actions being taken to address performance.

Local M3 2026/27 data indicates a rolling 12 month period compliance of 530/699 (-169 below M3 MTP threshold). It is important to note that this is looking at the current month activity plus the previous 11 months compliance and is not projecting to March 2027.

The in-month recovery trajectory indicates the correct level of activity is on track to deliver the end of year threshold.





Ellis Kara
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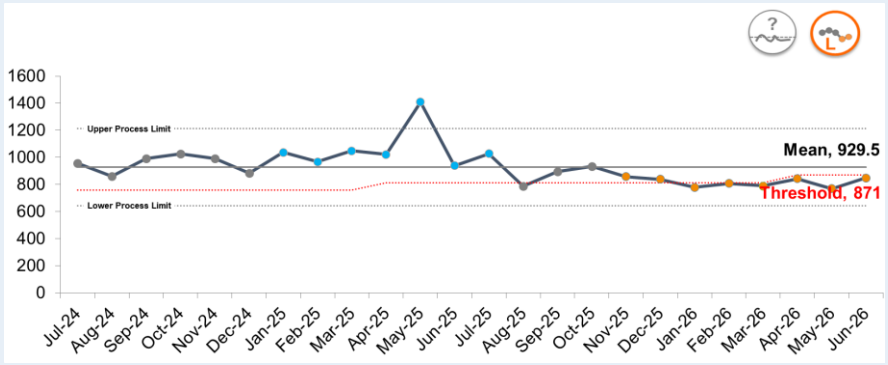
Talking Therapies



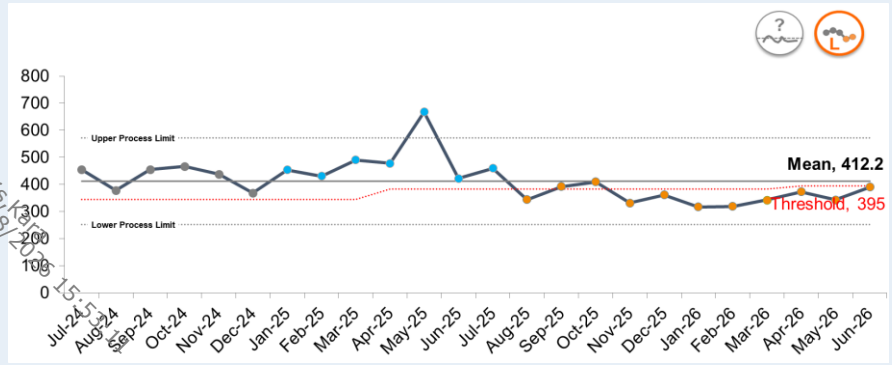
Courses of Completed Treatment

Long & Medium Term Operational Planning metric

Description of Metric

The number of people who have a course of treatment (2+ contacts).

In Month: 848 **Threshold:** 2026/27 871 TBC
(2025/26 812)



Reliable Recovery

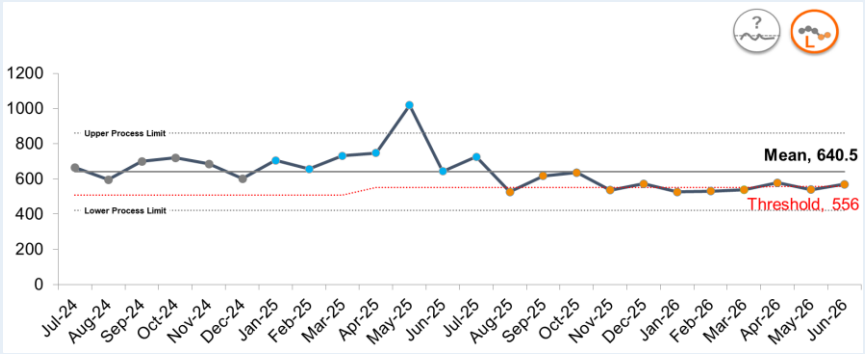
Long & Medium Term Operational Planning & National Oversight Framework metric

Description of Metric

Number of patients that achieved reliable recovery.

In Month: 390 **Threshold:** 2026/27 395 TBC
(2025/26 384)

Talking Therapies



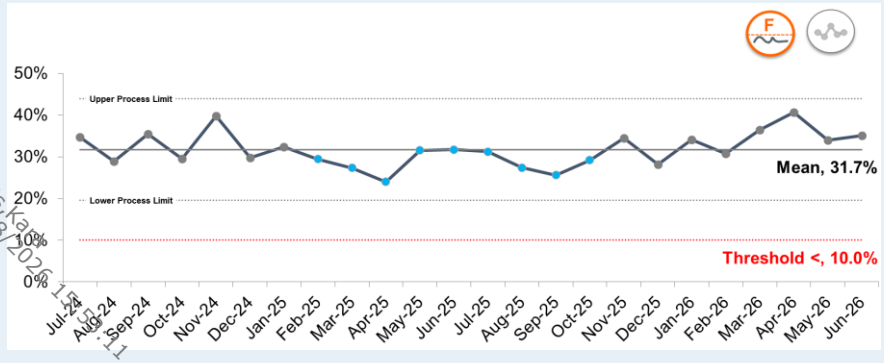
Reliable Improvement

Long & Medium Term Operational Planning & National Oversight Framework metric

Description of Metric

Number of patients that achieved reliable improvement.

In Month: 570 **Threshold:** 2026/27 556 TBC (2025/26 552)



Ellis Kane 06/08/2026

Talking Therapies 1st to 2nd Treatment

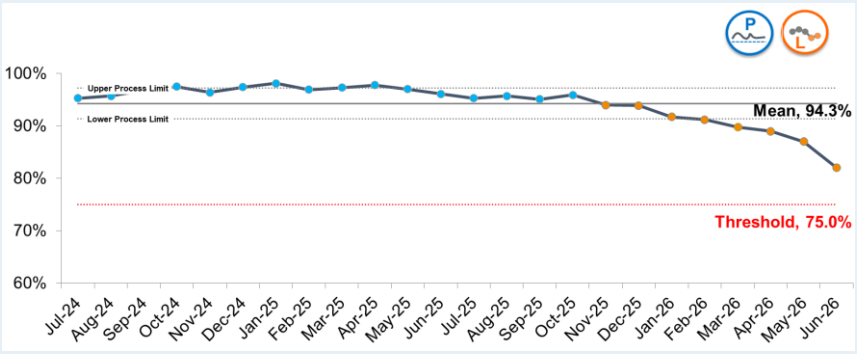
Long Term Operational Planning metric

Description of Metric

The proportion of people who waited over 90 days between first and second treatment appointment (where the second treatment appointment occurred within the month) in the reporting period.

In Month: 35.1% **Threshold:** 10%

Talking Therapies



Talking Therapies Waiting Times - 6 weeks

Long Term Operational Planning metric

Description of Metric

Proportion of referrals that finished a course of treatment in the reporting period that waited 42 days or less for first treatment.

In Month: 82.0% **Threshold:** 75%

Narrative

Courses Of Treatment

The courses of treatment threshold continues to be exceeded; however, the chart is showing special cause variation due to sustained below mean performance over the last ten months and therefore future compliance is at risk. The service is continuing discussions with NHS England to review whether the target should be brought into line with national fair share expectations for 2026/27 as it was increased substantially last year due to previous high performance on this metric in 2024, but expansion resources were not matched in line with this. The discussions to finalise the target for 2026/27 remain ongoing currently.

Ellis.Gale
06/08/2024 15:03:11

Talking Therapies

Narrative (cont.)

Reliable Recovery

Reliable Recovery remains a concern and is showing special cause variation, with sustained below mean performance over the last ten months. This indicates a deteriorating position. The impact of the lack of expansion for 2025/26 has previously been outlined through the Board report and quality impact assessment. A recovery plan was considered at the Senior Leadership Group in June 2026 and a request shared with the ICB for recovery funding.

The key issue is the interaction between current waiting lists, investment and the known relationship between longer waits and outcome measures. The service is reviewing improvement options within current resources. There remains a significant risk that the target will not be achieved if access targets remain the same without investment. The intention is to increase dosage and reduce wait times with relevant funding and modelling has been shared with commissioners on the required resources. In-year funding has been identified for 2026/27, which will be diverted to third party providers to improve waiting times and therefore outcomes. Without substantive investment, this will only be a temporary reprieve, and the waiting lists would be expected to creep back up in future years.

Reliable Improvement

Reliable Improvement is meeting target, but performance is showing special cause variation due to sustained below mean performance over the last ten months. This should be treated as an emerging risk, as waiting times are correlated with both Reliable Recovery and Reliable Improvement outcomes. Conversations with NHS England and the Dorset system are ongoing as outlined above.

Ellis, Kate
06/08/2026 11:53:11

Talking Therapies

Narrative (cont.)

1st to 2nd Treatment

This indicator remains above the 10% target. Performance has deteriorated over the last month and is now above the mean, indicating increased pressure on access. Waiting list improvement is variable, with some interventions and localities reducing waits over the last six months while others have increased. The main pressure remains within High Intensity (HI) individual interventions, where demand and workforce capacity continue to affect waiting times. The focus on offering least intrusive interventions is currently being revisited following a significant increase in the percentage of patients entering HI individual interventions (those with the longest waiting times). Service finances has meant that support from external providers have been reduced, impacting on wait times. Additional funding for this is currently being explored for 26-27.

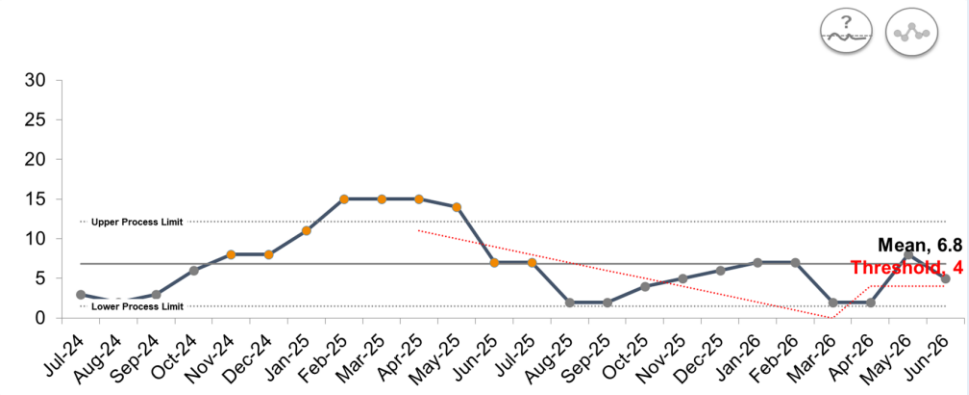
Other initiatives such as adherence to the new attendance policy and reviewing treatment in supervision is ongoing. NHS England funding for trainees was received in 2025/26; however, it will be Q3 and Q4 of 2026/27 before these staff are at full clinical capacity. With a 13.7 WTE vacancy for High Intensity and 6.3 WTE Low Intensity vacancy that cannot be recruited to due to the temporary nature of these vacancies (maternity, secondments, career breaks etc). A lack of HI CBT bank staff availability and agency controls mean that this is a risk to reducing the HI CBT waiting list. Recovery of this metric would need to follow the recovery modelling underway for the core operational planning metrics (completed treatments, reliable recovery and reliable improvement).

Ellis Kaye 06/08/2026 16:53:11

6 week wait

The 6 week wait target continues to be achieved; however with performance reducing, dipping below the lower process limit. This is not a target failure, but it indicates an emerging risk if demand, capacity and workforce pressures continue. The service has identified the localities where performance has dipped, this is related to staffing and capacity being below what is required to run the services. This is being discussed with NHS England and the ICB.

Active Inappropriate Adult Acute Mental Health Out Of Area Placements



Long & Medium Term Operational Planning & National Oversight Framework metric

Description of metric

The number of active placements at the end of the reporting month

In Month: 5 **Threshold:** 4

There was an increase in out of area use in May, stabilising in June 2026, which was driven by an increase in demand and high acuity. This is alongside a stable number of patients who are identified as a delay but clinically ready for discharge and therefore continuing to occupy an adult acute bed. OOA use should not be viewed in silo as all aspects of patient flow impact on the decision to send a person out of area. All patients within our inpatient adult acute and PICU beds have been reviewed to identify those people who may be able to be discharged and unblock some of the barriers in order to increase capacity. All patients who are in OOA beds remain closely monitored by the OOA Coordinator to ensure that they are having their plans reviewed as well as reviewing their need for repatriation or direct discharge to community option without delay. In addition, the Patient Flow Team are standing up a "45 day panel" to review those patients who have been in inpatient care, across our adult acute and PICU beds for longer than 45 days in order to identify any immediate areas of support required either clinically or to facilitate more rapid discharge. It is recognised that patients should receive care as close to home as possible, ensuring that they retain access to their support networks, and communities. To support this, whilst work is ongoing through the New Hospital Programme to increase local capacity, a block booking with Southampton Priority remains in place to support DHC's inpatient footprint and we remain diligent in sustaining further reduction in OOA bed use in line with our MTP trajectory.

Ellis Kyte
06/08/2026 15:55:14

Finance

Finance			
Metrics (£000s)	**In Month**	**YTD**	**YTD Threshold**
Cash Balance	-1,656 Decrease	50,996	46,496
Capital Expenditure	656	3,797	8,300
Financial efficiency : variance from efficiency plan	804 Adverse	750 Adverse	4041
Financial stability : variance from NHSE plan	-5 Favourable	-5 Favourable	-694 Surplus
Better payment practice code		96.3%	95.0%

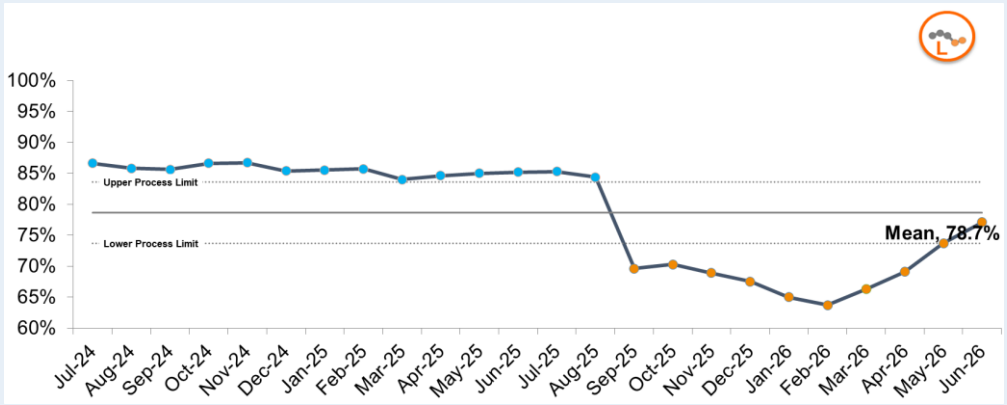
National Oversight Framework

The capital expenditure is below plan by £5.3m due to slippage of the New Hospital Programme new builds, but these are now complete. However, this has delayed the start on the St Ann's refurbishment. All risks are managed at programme level and the programme remains on financial target.

Efficiency savings are behind plan by £1.55m. The CIP programme has not yet delivered temporary workforce reductions. A programme of work has been set up with savings not expected to deliver until Month 4. Further work is underway to progress schemes to reduce the risk ratings. The full savings target of £28.8m has been identified with only 19% being high risk.

Ellis.Kay 06/08/2026 15:09:11

Completed Appraisals last year



Description of metric

Percentage of Staff having recorded an appraisal conversation within the past 13 months.

In Month: 77.7% **Threshold:** 85% by August 2026

Appraisal compliance has improved from 73.7% to 77.7% over the last month, demonstrating positive progress against our recovery plan to reach the 85% target by August.

The transition to the new appraisal system and associated reporting requirements continues to impact overall compliance levels.

However, adjustments to appraisal templates and the provision of updated guidance materials are helping to improve staff understanding and make the process easier to complete. Monthly reminders continue to be issued to staff, and throughout June, Directors received fortnightly reports highlighting outstanding appraisals to support targeted follow-up and further improvement.

Continued non-compliance with appraisal requirements may impact staff development, performance management, workforce engagement, and retention, while also limiting assurance that staff are receiving regular support and objective-setting discussions, for these reasons this remains a priority area.

Elliott Kiba
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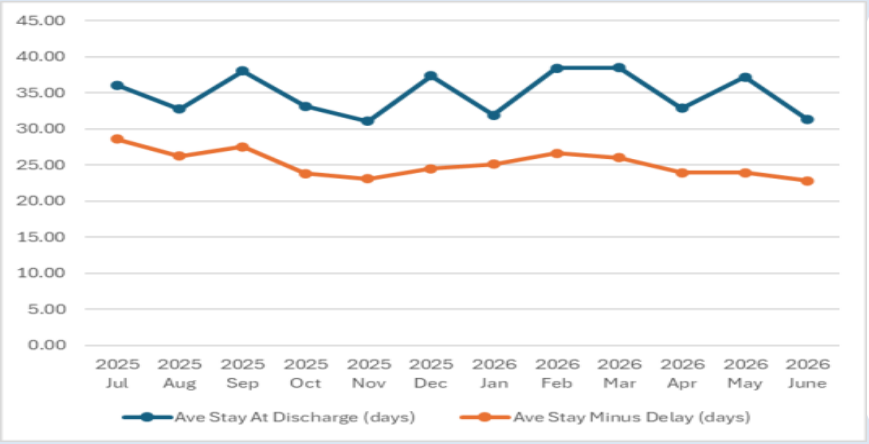
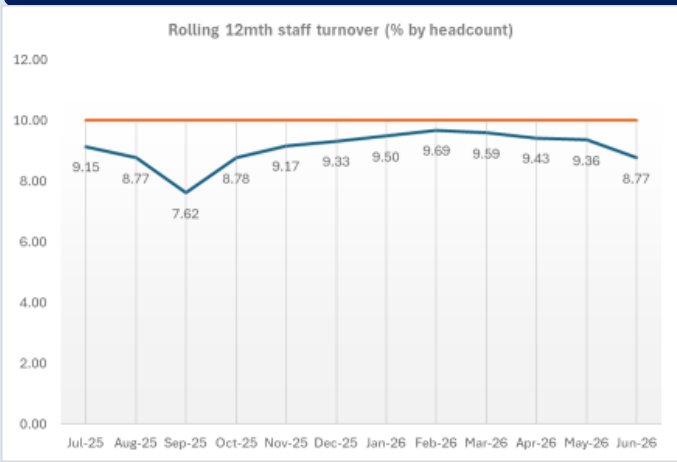
Integrated Community Services–Operational Performance Board Summary – June 2026 (3)

Community Hospitals Average Length of Stay



In June '26 average LoS at discharge was 31.26 days. If average delays of 8.46 days had not occurred, average LoS would have been 22.8 days.

Staff Turnover Rate



The 12 month turnover rate (headcount) for Community Services was 8.77% in June '26 against a Trust total of 8.6%. This is within the target of <10%.

Highlight on a Service

Acquired Brain Injury Rehabilitation Service (ABIRS): 2025/26

The Dorset Healthcare Acquired Brain Injury Rehabilitation Service (ABIRS) provides highly specialised, multidisciplinary rehabilitation for adults with complex acquired brain injuries, supporting patients and families to maximise independence, recovery and quality of life. During 2025/26, the service received 136 referrals, with 93 patients accepted for specialist rehabilitation and a further 80 referrals managed through the Adult Neuropsychology Service.

ABIRS demonstrates good practice through its holistic biopsychosocial approach, integrating neuropsychology, occupational therapy, physiotherapy, speech and language therapy, and specialist case management. Rehabilitation is goal-orientated and tailored to individual values, aspirations and functional outcomes.

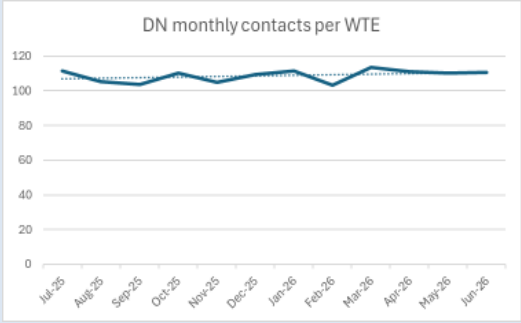
Outcome data demonstrates positive impact. Across patients completing SF-36 outcome measures, improvements were seen in all domains, particularly health perception, physical role limitation and emotional role limitation. The NHS Dorset Complex Brain Injury Rehabilitation Pathway supported 32 highly complex patients, with significant improvements in Functional Independence Measure and Functional Assessment Measure (FIM+FAM) scores. Of 18 patients discharged from specialist rehabilitation placements, 14 successfully returned to community living.

The service continues to innovate through a broad programme of group interventions, including Brain Injury Education, Cognitive Rehabilitation, Fatigue Management, Emotional Resilience and Exercise Groups. Education Group participants increased knowledge scores from an average of 4.78/10 to 8.12/10, while Fatigue Management participants achieved an average 20% improvement in fatigue impact scores.

Patient experience remains exceptionally positive, with 100% of 39 feedback responses rating the service as good or very good. ABIRS further enhances recovery through peer support volunteers, carers' support pathways, community-based rehabilitation groups and innovative therapies including music therapy, breath and movement sessions, and vocational rehabilitation support.

Finance Report 2026 v3 Feb

Contacts FTE in community nursing



In Jun 26 there was an average of 111 contacts per WTE for District Nursing Staff, compared to 105 in Jun 25. There has been an increase in contacts per wte over the last year. Many factors are contributing to the increase in contacts including the move towards more community-centred care, earlier discharges and patients requiring administration of medication at home with an increasing number of patients requiring insulin

Service Director Commentary

As previously reported DHC performance against the diagnostic standard has remained challenged. A deep dive has identified a data flow that was inaccurately providing assurance relating to referral growth. This is now fully understood, and an in-year recovery plan has been approved via SLG. Commissioners have been made aware that additional funds will be required to deliver a sustainable service through contracting meetings.

DHC has seen growth in the total number of patients waiting for a community appointment. Noting that none are wating beyond 52 weeks. Reporting community services against 18-week Referral to Treatment (RTT) standards from April 2026 has commenced at aggregate level the MTP target of >78% of patients waiting less than 18 weeks is being achieved.

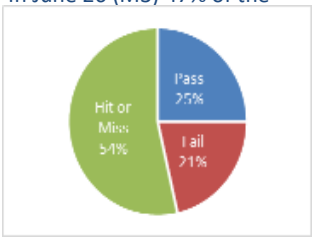
Our 111 and Urgent Care teams have continued to see high demand, both in terms of call numbers and required clinical intervention. A scheme to reduce demand on 20-minute call backs has been approved though SLG and is being implemented, analysis of impact will follow.

CYP, All Age Mental Health & Learning Disability Services – Operational Performance Summary June 2026 (M3)

Dorset HealthCare University NHS Foundation Trust

Overview of Operational Performance/KPI Metric Summary

There are 117 local & contractual metrics across All Age MH&LD, CYP and NHSTT Services plus 28 National metrics (MTP & NoF) of which 19 have reportable targets. In June 26 (M3) 47% of the national metrics were on track 9/19.

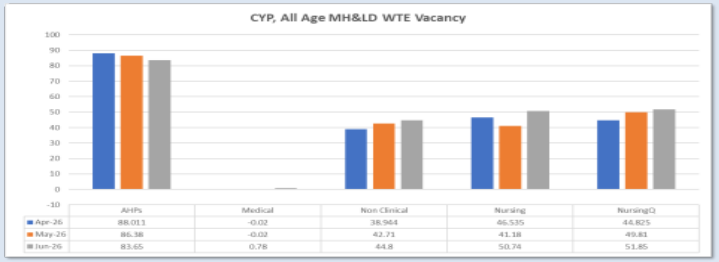


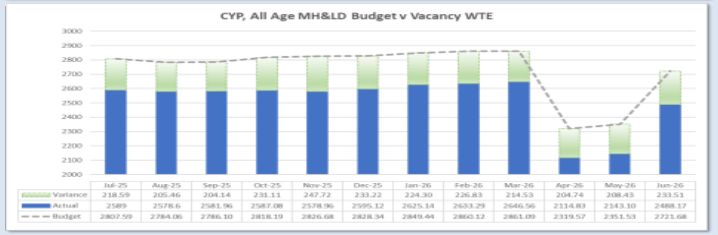
M3 Performance against MTP 26/27 Trajectories
CYP 1+ Access: on track continues to exceed target
IPS Access: off track: recovery plan in place
Adult Acute, PICU LOS off track MH Therapeutic Admission Prog.
NHSTT Reliable Recovery: off track recovery plan in place
Perinatal & MMHS Access Rate: on track
Out of Area Placements: off track (-1) new National MH Sector Priority metric for 26/27

The local & contractual metrics are monitored monthly as agreed Operational priorities by the DMG/ICB. These are a mixture of activity based and non-targeted metrics.

Exception summaries and action plans are in place for those off track some of which are part of longer-term transformation /development plans.

Workforce





As at M3 June 26: The vacancy rate is 8.58% based on a budgeted 2721.68 WTE.

CYP 0-19 PHS:	12.53 WTE
CYP SaLT:	-2.15 WTE
CiC:	0.03 WTE
NHSP:	0.37 WTE
CAMHS:	71.52 WTE
MH Other:	10.93 WTE
Prim & Psych:	49.78 WTE
LD & Pro Collab:	80.21 WTE
Secondary Comm:	52.98 WTE
High Acuity:	113.45 WTE

Caseload Summary

DIRECTORATE COMBINED CASELOAD	25/26 YTD	26/27 YTD	Growth	% Growth
	182,555	168,534	-14,020	-8%

There are on average 27,110 people (excluding school aged children) on caseload each month, this is approx. 3.3% of the Dorset Population (820,721 - DiiS).

Eligible Cohort & Open Caseload

CYP&F	25/26 YTD	26/27 YTD	Growth	% Growth
Health Visiting	30,805	27,110	-3,695	-12%
School Nursing	116,912	113,674	-3,238	-3%
Paed SaLT	5,671	5,748	77	1%
Children in Care Health Team	1,021	1,117	95	9%
Total Caseload	154,409	147,648	-6,760	-4.38%

Activity Summary

DIRECTORATE COMBINED REFERRALS	25/26 YTD	26/27 YTD	Growth	% Growth
	19,960	17,351	-2,609	-13%

DIRECTORATE COMBINED CONTACTS	25/26 YTD	26/27 YTD	Growth	% Growth
	157,105	123,273	-33,832	-22%

Activity is slightly off track compared to the same period last year. This is no cause for concern at M3 reporting.

Finance: (Brackets) = favourable variance

Financial Summary £m		
Annual Budget	YTD Actual	YTD Variance
134.5	22.3	(0.2)

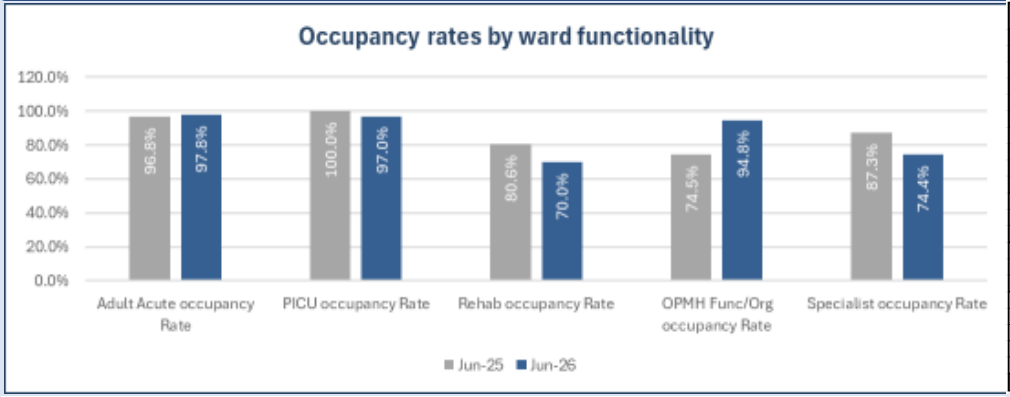
Kara 06/08/2026 13:53:01

The finance summary provides a combined overview of CYP, MH&LD. Forecasting commences from M3.
The YTD variance is attributable to
- 0.2 MH Services
- 0.0 CYP Services

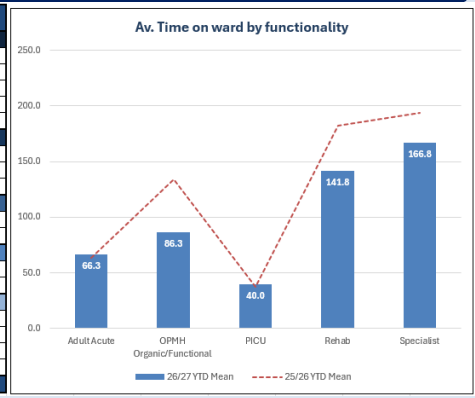
Service Director Commentary

- Overall Demand remains high (~43.5k caseload); activity slightly below last year at M3
- Performance 47% of national metrics on track (9/19), Strong delivery in CYP access, & Perinatal. Improvement needed in IPS, OOA, LOS and NHS TT – recovery plans in place.
- Inpatient Flow - High occupancy (94.5%; Adult Acute 98.6%) driving pressure. LOS above target in Adult Acute/PICU; discharge flow remains a constraint.
- Out of Area Placements - Appropriate use well managed; low inappropriate placements. Reduction trajectory slightly off track; block beds fully utilised.
- Workforce & Finance - Vacancy rate 8.58%; pressures in key areas remain. Financial position stable at M3.
- Key Priorities - Improve flow and reduce LOS. Continue to recover access standards (IPS, Perinatal). Sustain OAP reduction and continue to improve community offers through the peri-hospital programme. .

Operational Performance Inpatient Flow



Av. Time On Ward (Days)	25/26 YTD Mean	26/27 YTD Mean	Growth (Days)	% Growth	26/27 YTD Median	26/27 YTD Mode
Adult Acute	**63.2**	**66.3**	**3.2**	**5%**	**-43.5**	**#N/A**
AAU Seaview	19.6	19.3	-0.3	-2%	-15.5	7.0
Chine Ward	57.4	109.2	51.8	90%	-77.0	20.0
Harbour Ward	39.4	83.3	43.9	111%	-48.0	9.0
Melstock House	113.2	65.3	-47.9	-42%	-39.0	19.0
Waterston Acute Assessment Unit	86.3	54.6	-31.7	-37%	-43.5	18.0
OPMH Organic/Functional	**133.7**	**86.3**	**-47.4**	**-35%**	**-90.5**	**#N/A**
Alumhurst Ward	133.7	86.3	-47.4	-35%	-74.5	43.0
Herm	96.2	93.0	-3.2	-3%	-90.5	0.0
St Brelades	71.8	103.8	32.1	45%	-112.0	0.0
PICU	**37.5**	**40.0**	**2.4**	**6%**	**-18.5**	**#N/A**
Psychiatric Intensive Care Unit – F	44.1	50.4	6.3	14%	-21.5	3.0
Psychiatric Intensive Care Unit - M	30.9	29.5	-1.4	-5%	-15.5	9.0
Rehab	**182.6**	**141.8**	**-40.9**	**-22%**	**-120.5**	**#N/A**
Glendinning Unit	147.0	90.0	-57.0	-39%	-50.5	30.0
Nightingale House	218.2	193.5	-24.7	-11%	-190.5	0.0
Specialist	**194.0**	**166.8**	**-27.2**	**-14%**	**-73.0**	**#N/A**
Kimmeridge Court	201.0	95.0	-106.0	-53%	-91.0	29.0
Pebble Lodge	69.1	263.0	193.9	280%	-55.0	19.0
Perinatal In-Patient Mother's Ward	64.8	32.4	-32.5	-50%	-12.0	2.0
Twynham Ward	441.0	277.0	-164.0	-37%	-277.0	277.0
Total	**114.6**	**102.8**	**-11.8**	**-10%**	**-52.8**	**0.0**



Occupancy Rates:

- There were 5,811 bed days available in June 26, (excl. Marchwood Priory)
- 5,257 were Occupied during the month for an overall Occupancy Rate of 89.4%
- Adult Acute Occ. Rates remain consistently high at 97.8%

Average Time Spent on a Ward:

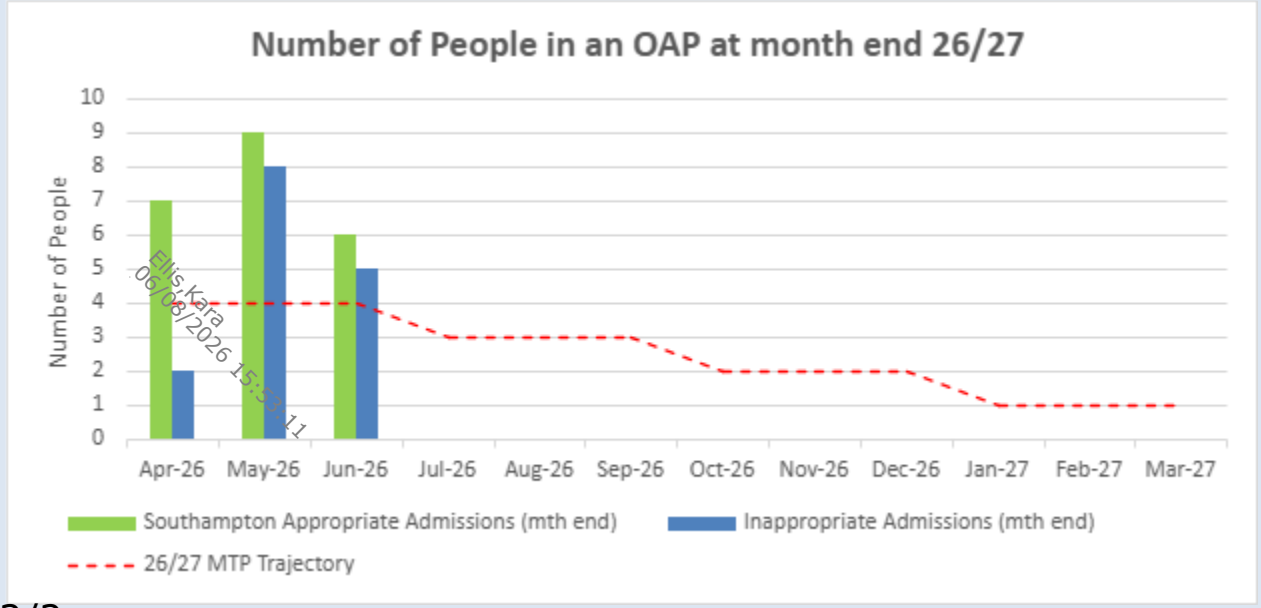
- This differs to Length of Stay which is based on Hospital Episode (total time from admission to discharge irrespective of internal movement/ transfers) compared to the same period in 25/26).

26/27 Operational Planning (MTP): Av. Length of Stay: M3

- Adult Acute & PICU Average LOS (3-mth rolling period) 94 days (target 76 days)
- OPMHS Average LOS (3-mth rolling period) 117 days (target 126)

61.8% of Adults had a LOS >60 days in June

Out of Area Placements (OAP) No. of Patients Admitted



Supporting Commentary

Out of Area Placements:

- **Appropriate Placements**: As of 30 June, there were nine patients admitted to the Priory. There were six admissions in month and five discharges. A total of 316 Occupied Bed Days were utilised.
- **Inappropriate Placements**: As of 30 June, there were five patients admitted to other OAP providers. There were eight admissions in month and eleven discharges for 220 OBDs. This is off track (-1) against the MTP 26/27 trajectories. A recovery plan is in place via the Mental Health Therapeutic Admissions Programme.
- The 8 block purchased beds at Southampton Priory are being appropriately and fully utilised.

Report to	Board in Common (DHC)	
Date of Meeting	11th August 2026	
Report Title	Trust Finance Report for Month 3, June 2026	
Report Author	Michele King – Head of Management Accounts	
Approved by Accountable Executive	Chris Hearn, Joint Chief Finance Officer	
Previously Considered By	Finance and Performance Committee in Common 29/07/2026	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR6: Finance If we do not deliver on our financial plans, including the required level of savings, then and this will adversely. impact our ability to provide safe sustainable services	
Financial	Value for money and financial sustainability addressed in the report	
Statutory & Regulatory	Underpins long term financial sustainability and delivery of operational plan	
Equality, Diversity & Inclusion	No implications arising from the report	
Co-production & Partnership	System financial plan delivery	

Executive Summary

Key messages for the three months ended June 2026 are as follows:

- The Trust delivered an adjusted year-to-date surplus of £773k at month 3 which equates to a surplus of £10k against the plan submitted to NHSE for 2026/27.
- With the exception of Medical Staffing, People and Culture, and Strategy, Transformation and Partnerships, all areas are underspent at month 3.
- As at month 3 savings of £4.59m have been delivered against a plan of £6.14m leading to a deficit against target of £1.55m. The Trust's full year efficiency target is £28.8m.

Actions:

- Collectively work together to agree the actions to resolve the financial position at month 3.
- Continue to identify recurrent savings.

Recommendation

The Board is requested to:

- Receive the report for assurance

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Trust Financial Performance Report

Month 3 2025/26 – June Summary

1. Summary

At the end of June half of the KPIs are rated green.

KPI	RAG
Current Month Break Even	
Year to Date Variance to Plan.	
Forecast Outturn (assuming no further savings)	
Year to Date Capital Spend against Plan	
Delivery of Savings Programme	
Better Payment Policy	

Key messages

- The Trust has three standard measures of financial performance: Income over expenditure, performance against NHSE Plan and, due to phasing of budgets different from NHSE plan, the budget plan.
- The Trust delivered an adjusted year-to-date surplus of £773k at month 3 which equates to a surplus of £10k (£5k surplus month 2) against the plan submitted to NHSE for 2026/27.
- With the exception of Medical Staffing, People and Culture, and Strategy, Transformation and Partnerships, all areas are underspent at month 3.
- As at month 3 savings of £4.59m have been delivered against a plan of £6.14m leading to a deficit against target of £1.55m (£0.75m month 2). The Trust's full year efficiency target is £28.8m.

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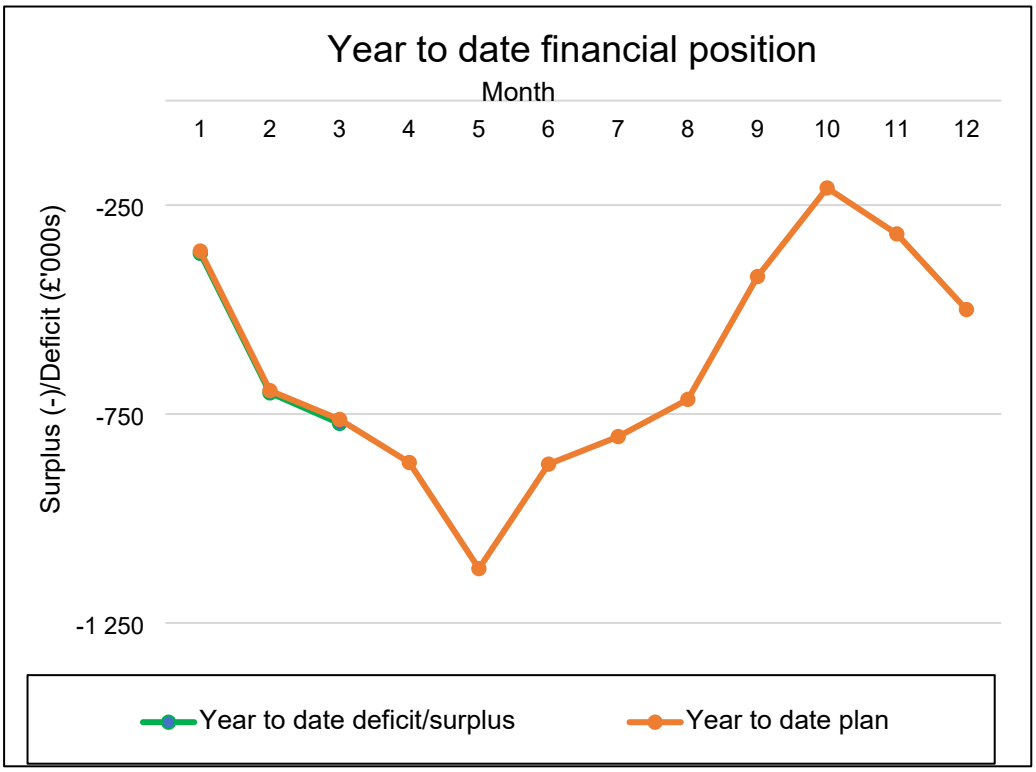
2. Year to date performance

2.1 Summary

- The graph below shows that the Trust delivered an adjusted year-to-date surplus of £773k at month 3. This equates to a surplus of £10k (£5k surplus at month 2) against the plan submitted to NHSE for 2026/27.
- Appendix 1 includes the full detail of the Trust's financial performance.



- The key drivers of the Trust's position are set out in the table below.

Drivers of Financial Performance	£'000s
Efficiency savings	1,553
Out of area placements	393
Pay slippage	(1,264)
Premises costs	(423)
Education and training	(269)
Surplus against NHSE plan	**(10)**

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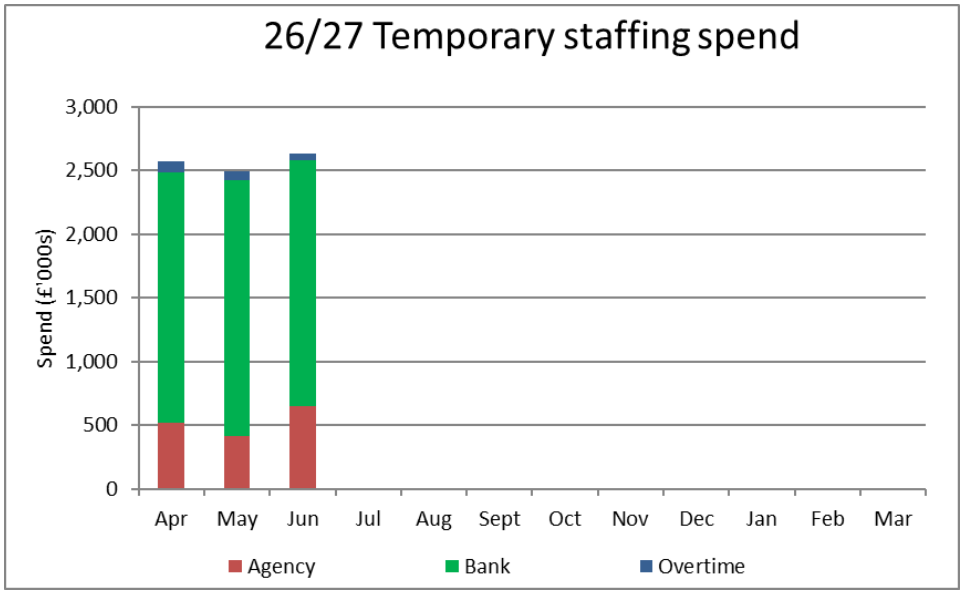
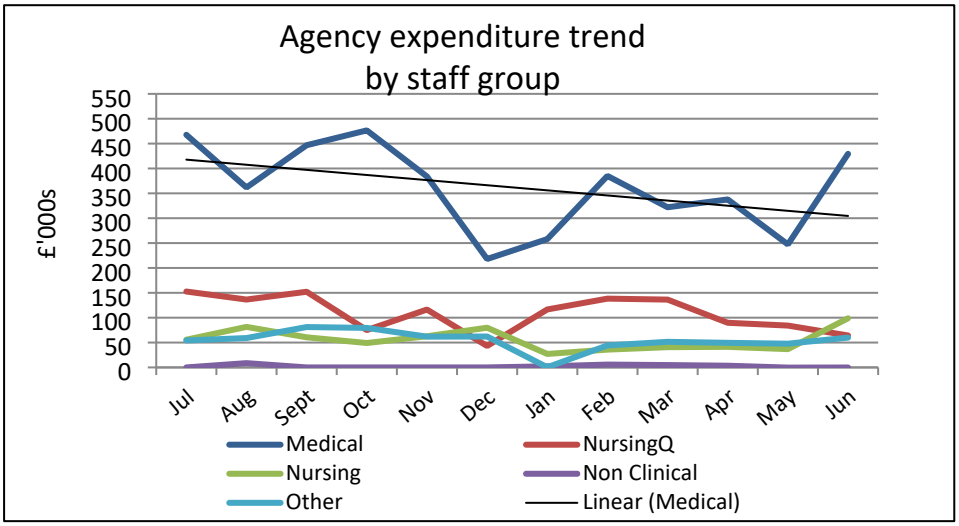
2.2 Temporary staffing

- Temporary staffing costs increased by £142k in month 3.
- Agency costs increased by £236k, from £416k to £652k, bank reduced by £80k and overtime reduced by £15k.
- Agency expenditure is £470k lower than the same period last year, bank £90k lower and overtime costs £74k lower.
- The largest area of agency spend is currently in the Medical directorate, which is £407k lower than the same period in 25/26.
- The month 3 increase in Medical agency costs is linked to VAT treatment rather than usage. A review of VAT treatment in the ledger is underway to ensure that the impact is mitigated going forward.
- Agency expenditure is above plan by £173k and 1.88% of total pay costs.
- Bank expenditure is above plan by £814k and is 6.99% of total pay costs.





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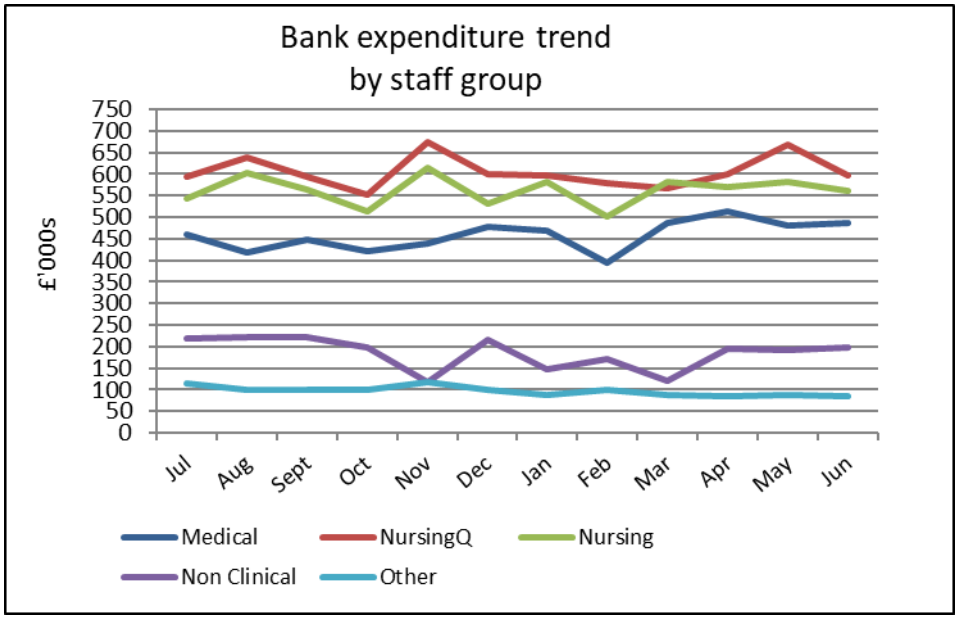

2.3 Efficiency Programme

- The total target for 2026/27 is £28.8m. This is made up of £22.2m assigned to operational efficiencies and a central stretch target £6.6m.
- The table below shows the position as at the end of June.
- As at month 3, savings of £4.59m have been delivered against a plan of £6.14m leading to a deficit against target of £1.55m (£0.75m at month2).

						Of identified:				
						Risk level			R/NR	
Division	Core Target Allocations £'000	Temporary Workforce Allocation £'000	Core Identified £'000	Core (Unidentified) / over £'000	Core % Identified	Low £'000	Medium £'000	High £'000	Recurrent	Non Recurrent
Core - 5%										
MH & CYP	3,549	4,102	4,434	885	125%	3,034	1,150	250	1%	99%
ICS	2,713	2,295	2,734	21	101%	2,027	451	256	45%	55%
Medical		2,360	-	-			-	-		100%
Estates	2,437	96	2,787	350	114%	1,138	149	1,500	46%	54%
Finance	254	19	254	0	100%	159	95	-	37%	63%
Digital	1,083	26	1,083	(0)	100%	244	553	287	70%	30%
Business & Performance	362	-	382	21	106%	382	-	-	52%	48%
Transformation & QI	14	-	14	0	100%	14	-	-	100%	0%
Nursing & Quality	503	34	506	2	100%	339	118	49	61%	39%
People & Culture	831	19	831	(0)	100%	280	227	324	97%	3%
Corporate	63	1	79	16	125%	79	-	-	100%	0%
Central	1392		1,392	(0)	100%	1,293	77	-	76%	24%
Temporary Workforce Reduction	8,953	(8,953)	7,090	(1,863)	79%	1,600	4,544	946	100%	0%
Subtotal	**22,154**	**-**	**21,586**	**(568)**	**97%**	**10,590**	**7,362**	**3,611**	**60%**	**40%**
Central Stretch - 1.5%	6,646		7,214	568	109%	3,906	1,331	2,000	49%	51%
Total	**28,800**		**28,800**	**0**	**100%**	**14,495**	**8,693**	**5,611**	**45%**	**55%**

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- 100% of efficiency schemes have been identified with 45% being recurrent.

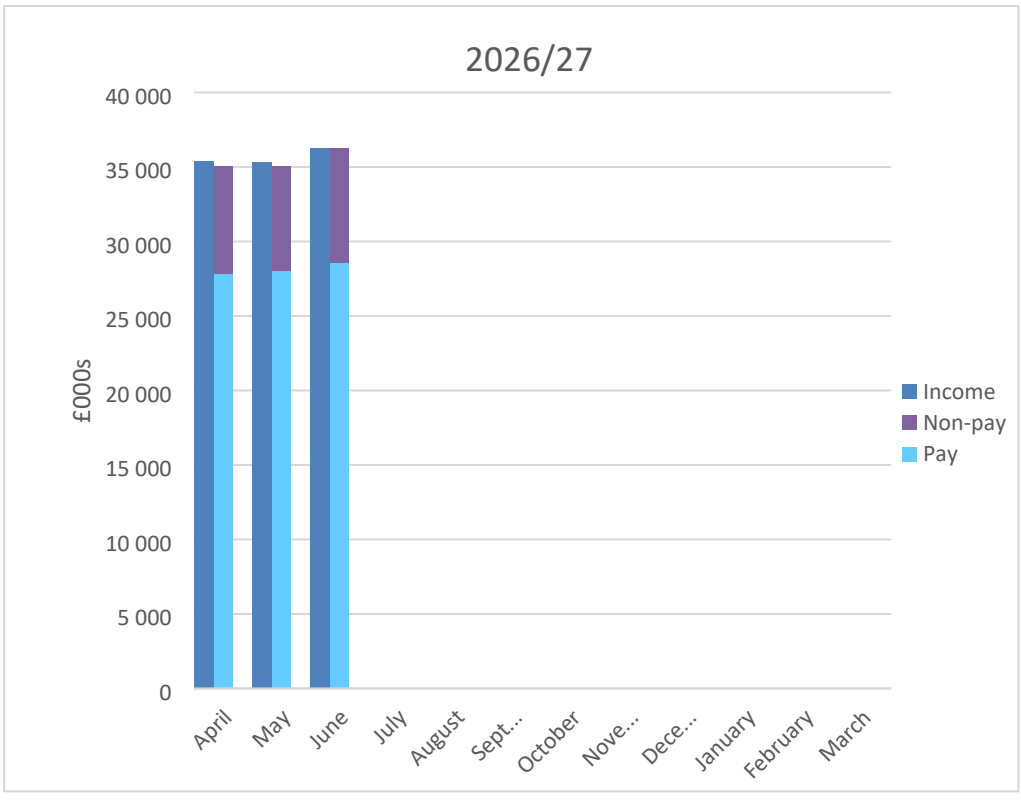
- Of these:
  - £14.5m (50%) is low risk.
  - £8.7m (30%) is medium risk
  - £5.6m (20%) is high risk.

2.4 Out of area placements

- The mental health bed capacity in Dorset is currently below the modelled requirements, meaning that out of area placements will continue to be necessary until the new St Ann's hospital fully opens.
- 8 beds have been block booked at the Priory in Southampton to compensate for the lack of capacity**.**
- The budget has been set based on the use of 10 beds until December, after which the beds increase to 12. Of these beds, 8 are block booked.
- With 4 patients remaining in a non-block booked bed at the end of June, the budget is overspent by £393k.

3. Performance in month

- During the month of June, the Trust's income exceeded expenditure by £39k. This is before technical adjustments and impairments. The run rate is shown in the graph below.



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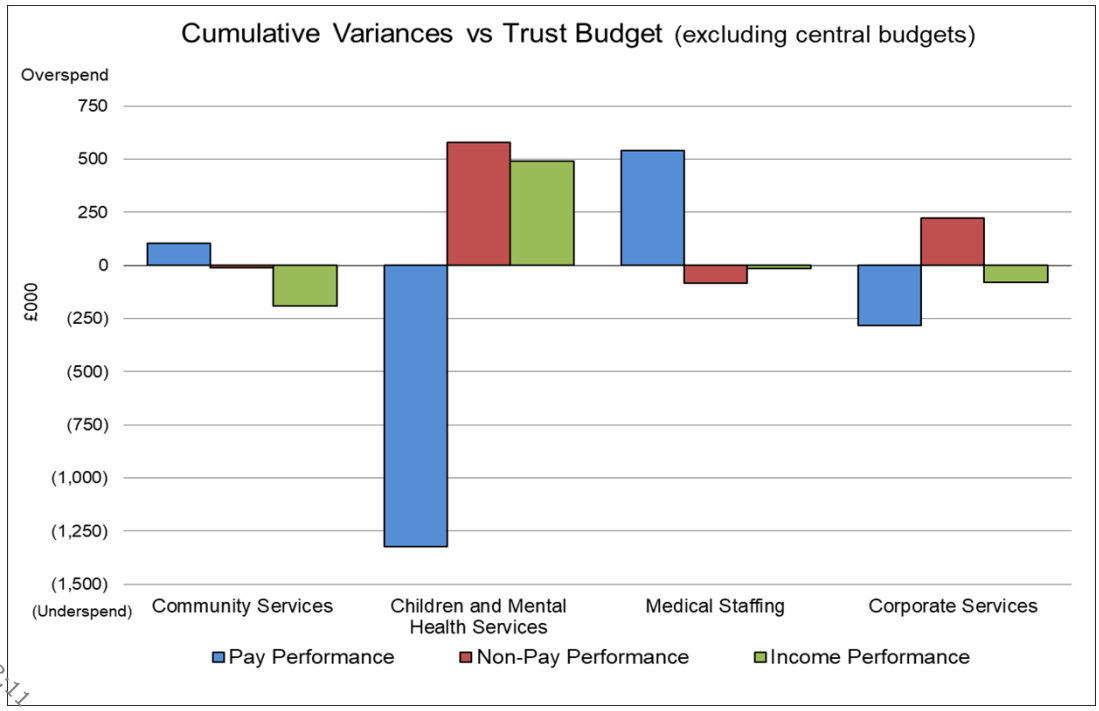
4. Directorate performance

- The table below sets out the financial performance by directorate, with only Medical Staffing, People and Culture, and Strategy, Transformation and Partnerships facing financial challenges.
- Note that the variance to budget is an internal control measure only and is a key indicator of individual directorate performance. It is not reported as the Trust's deficit externally as the budget phasing does not align with the plan submitted to NHSE. The phasing difference is primarily due to CIP scheme timelines.
- Both the central stretch savings and temporary workforce targets sit within central budgets.

	Full year budget	Month 3 spend	YTD spend	Variance to budget at Month 3
	£'000s	£'000s	£'000s	£'000s
Trust Wide Income	(353,141)	(29,546)	(88,421)	(0)
Central budgets	37,684	(100)	135	643
Integrated Community Services	114,669	9,623	28,397	(96)
Mental Health & Children's Service	134,153	11,015	33,225	(256)
Medical Staffing	29,175	2,807	7,932	442
Nurse Executive and Quality	9,659	752	2,284	(106)
Finance and Strategic Development	42,629	3,383	10,127	(207)
People & Culture	5,555	428	1,132	67
Strategy, Transformation & Partnerships	14,541	1,251	3,762	140
Corporate Services	4,114	349	1,049	(33)
Total	39,037	(39)	(378)	594
Capital donations/grants/peppercorn lease	(39,537)	34	(394)	
Adjusted total	(500)	(5)	(773)	

- The table above reflects the net position of each service.



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4.1 Integrated Community Services

	Full year budget	Month 3 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(19,308)	(1,685)	(5,148)	(19,819)	(511)
Pay	111,570	9,433	27,959	111,497	(73)
Non-pay	22,406	1,875	5,586	22,589	182
Total	114,669	9,623	28,397	114,267	(401)

Drivers of year-to-date performance

- Unachieved savings of £123k.
- Vacancies in the Pain, Podiatry, Musculoskeletal and Integrated Community Rehabilitation services, offset by vacancy factor and MIU costs due to service demand.
- High LVA and MIU income.

Key Factors in outturn forecast position

- Assumed unachieved efficiency savings of £1,183k – only savings that have already been banked are included in the forecast.
- Vacancies noted above, partly offset by vacancy factor, high MIU costs and district nursing cost pressure.

Performance against efficiency target

- The Integrated Community Services directorate's savings requirement is £2.71m.
- The table below indicates the level of savings schemes that have been identified and the confidence in delivery. It also indicates the percentage of identified savings that are recurrent and non-recurrent.

			Of identified:				
			Risk level			R/NR	
Core Target Allocations £'000	Core Identified £'000	Core % identified	Low £'000	Medium £'000	High £'000	Recurrent	Non Recurrent
2,713	2,734	101%	2,027	451	256	45%	55%

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Actions to improve financial sustainability

- Ongoing scrutiny of vacancies.
- Engagement events with clinical teams to see where changes can be made to improve quality and reduce wastage and costs.
- Working with corporate teams to understand service cost base and benchmarking information to identify opportunities to learn from other service models.
- Fortnightly meetings of the management team to review progress towards schemes that improve quality, productivity and cost.
- Monthly review of temporary workforce spend at cost centre level.
- Requirement for SLT approval for agency.
- Six monthly review of budgets with cost centre budget holders, Service Director and Finance Business Partner.

4.2 Mental Health and Children's Services

	Full year budget	Month 3 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(32,706)	(2,542)	(7,147)	(30,590)	2,117
Pay	149,737	11,945	35,616	144,092	(5,645)
Non-pay	17,123	1,611	4,757	19,126	2,003
Total	134,153	11,015	33,225	132,629	(1,525)

Drivers of year-to-date performance

- With 4 patients remaining in a non-block booked bed at the end of June, the OOA budget is overspent by £393k.
- Unachieved savings of £125k.
- Vacancies in learning disabilities services, community mental health and rehab teams, primary and psychological services and Child and Adolescent MH services, partly offset by a pay inflation pressure in public health services and high ward bank and agency expenditure.

Ket factors in outturn forecast position

- Assumed unachieved savings of £1,603k – only savings that have already been banked are included in the forecast..
- Vacancies across most areas.
- High out of area placement expenditure.

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Performance against efficiency target

- The Children's and Mental Health Services directorate's savings requirement is £3.55m.

- The table below indicates the level of savings schemes that have been identified and the confidence in delivery. It also indicates the percentage of identified savings that are recurrent and non-recurrent.

Core Target Allocations £'000	Core Identified £'000	Core % identified	Of identified: Risk level Low £'000	Medium £'000	High £'000	R/NR Recurrent	Non Recurrent
3,549	4,434	125%	3,034	1,150	250	1%	99%

Actions to improve financial sustainability

- Working with the system to investigate alternative options to the use of out of area beds. New unit to open in the coming months at St Anns with decants happening to improve current wards before the new 12 bed unit is expected to open in 2027.
- Reviewing income received and identifying opportunities to support service cost pressures.

4.3 Medical Staffing

	Full year budget	Month 3 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(3,064)	(283)	(789)	(3,152)	(88)
Pay	30,663	2,983	8,307	31,420	757
Non-pay	1,575	107	414	1,508	(67)
Total	29,175	2,807	7,932	29,776	601

Drivers of year-to-date performance

- The cost pressure in Medical Staffing is driven by agency costs, which are lower than the same period in 2025/26 by £407k.

Drivers of outturn forecast position

- High, but decreasing, agency expenditure.

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Performance against efficiency target.

- As any savings achieved are likely to be generated through a reduction in agency expenditure, which falls under the temporary staffing target, medical staffing does not have a core savings target.

Actions to improve financial sustainability

- IMG recruitment to reduce the need for agency locums. Twelve new associate specialists starting over the course of 2026.
- Working to reduce sickness rate through increased support when concerns are raised.

4.4 Nursing Executive and Quality

	Full year budget	Month 3 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(1,591)	(161)	(473)	(1,710)	(119)
Pay	9,887	802	2,436	9,679	(208)
Non-pay	1,362	111	320	1,360	(2)
Total	9,659	752	2,284	9,329	(330)

Drivers of year-to-date performance

- Unachieved CIP savings of £91k.
- Pharmacy, R&D and participation income ahead of target.
- Lower non-pay spend.

Drivers of forecast outturn position

- Assumed unachieved savings of £362k – only savings that have already been banked are included in the forecast.
- Vacancies partly offset by vacancy factor.
- High R&D and Pharmacy income.

.

Performance against efficiency target.

- The Nursing Executive and Quality directorate's savings requirement is £503k.
- The table below indicates the level of savings schemes that have been identified and the confidence in delivery. It also indicates the percentage of identified savings that are recurrent and non-recurrent.

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Core Target Allocations £'000	Core Identified £'000	Core % identified	Of identified: Risk level Low £'000	Medium £'000	High £'000	R/NR Recurrent	Non Recurrent
503	506	100%	339	118	49	61%	39%

4.5 Finance and Strategic Development

Finance and Strategic Development includes finance, estates and facilities, and counter fraud. The lead provider function for adult eating disorders is also within the directorate.

	Full year budget	Month 3 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(9,848)	(1,268)	(2,400)	(9,874)	(26)
Pay	17,998	1,412	4,218	16,725	(1,272)
Non-pay	34,479	3,239	8,310	35,128	649
Total	42,629	3,383	10,127	41,980	(649)

Drivers of year-to-date performance

- Unachieved CIP savings of £385k.
- Facilities and finance vacancies.
- Low facilities and estates non-pay expenditure.

Drivers of outturn forecast position

- Over achievement of savings target by £299k.
- Facilities vacancies.
- Low rent and electricity expenditure.
- Low estates contract costs.

Performance against efficiency target

- The Finance and Strategic Development directorate's savings requirement is £2.69m (Finance and Counter Fraud £254k and Estates £2.44m).
- The table below indicates the level of savings schemes that have been identified and the confidence in delivery. It also indicates the percentage of identified savings that

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are recurrent and non-recurrent.

	Core Target Allocations £'000	Core Identified £'000	Core % identified	Of identified: Risk level Low £'000	Risk level Medium £'000	Risk level High £'000	R/NR Recurrent	R/NR Non Recurrent
Estates	2,437	2,787	114%	1,138	149	1,500	46%	54%
Finance	254	254	100%	159	95	0	37%	63%

Actions to improve financial sustainability

- Ongoing review of leased estate to identify where it may not be required or could be used more efficiently.
- Review of non-value added work.

4.6 Strategy, Transformation and Partnerships

The Strategy, Transformation and Partnerships directorate includes Information Management and Technology.

	Full year budget £'000s	Month 3 spend £'000s	Year to date spend £'000s	Forecast Outturn £'000s	Forecast variance to budget £'000s
Income	(51)	(8)	(21)	(86)	(35)
Pay	10,327	898	2,696	10,606	279
Non-pay	4,265	362	1,088	4,653	388
Total	14,541	1,251	3,762	15,174	633

Drivers of year-to-date performance

- Unachieved CIP savings of £285k.
- Low IT related expenditure.

Drivers of outturn forecast position

- Assumed unachieved savings of £1,139k – only savings that have already been banked are included in the forecast.
- IM&T vacancies.
- Low IT non-pay expenditure.

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Performance against efficiency target

- The Strategy & Transformation directorate's savings requirement is £1.46m (Digital £1.08m, Business & Performance £362k and Transformation and QI £14k).
- The table below indicates the level of savings schemes that have been identified and the confidence in delivery. It also indicates the percentage of identified savings that are recurrent and non-recurrent.

				Of identified:				
				Risk level			R/NR	
	Core Target Allocations £'000	Core Identified £'000	Core % identified	Low £'000	Medium £'000	High £'000	Recurrent	Non Recurrent
Digital	1,083	1,083	100%	244	553	287	70%	30%
Business & Performance	362	382	106%	382	0	0	52%	48%
Transformation & QI	14	14	100%	14	0	0	100%	0%

Actions to improve financial sustainability

- Continued development of the One Transformation approach to support the Trust and DCH to deliver change.

4.7 People and Culture

	Full year budget	Month 3 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(6,371)	(515)	(1,753)	(6,288)	83
Pay	9,322	789	2,361	9,373	51
Non-pay	2,603	154	524	2,719	116
Total	5,555	428	1,132	5,805	250

Drivers of year-to-date performance

- Unachieved CIP savings of £139k.
- Payroll and Learning and Development vacancies.
- Low non-pay spend.

Drivers of outturn forecast position

- Assumed unachieved efficiency savings of £559k – only savings that have already been banked are included in the forecast.
- Vacancies.

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Performance against efficiency target

- The People and Culture directorate's savings requirement is £831k.
- The table below indicates the level of savings schemes that have been identified and the confidence in delivery. It also indicates the percentage of identified savings that are recurrent and non-recurrent.

			Of identified:				
			Risk level			R/NR	
Core Target Allocations £'000	Core Identified £'000	Core % identified	Low £'000	Medium £'000	High £'000	Recurrent	Non Recurrent
831	831	100%	280	227	324	97%	3%

4.8 Corporate Services

	Full year budget	Month 3 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(572)	(52)	(156)	(625)	(53)
Pay	3,418	282	844	3,322	(97)
Non-pay	1,268	119	361	1,247	(21)
Total	4,114	349	1,049	3,943	(170)

Drivers of year-to-date performance.

- Low non-pay expenditure.
- Achievement of the efficiency savings target.

Drivers of forecast outturn position

- Vacancies.

Performance against efficiency target

- The Corporate Services directorate's savings requirement is £63k.
- The table below indicates the level of savings schemes that have been identified and the confidence in delivery. It also indicates the percentage of identified savings that are recurrent and non-recurrent.

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Core Target Allocations £'000	Core Identified £'000	Core % identified	Of identified: Risk level Low £'000	Medium £'000	High £'000	R/NR Recurrent	Non Recurrent
63	79	125%	79	0	0	100%	0%

5. Year-end forecast outturn position

- The table below shows that the current year-end forecast is a potential deficit of £7.2m against the planned £0.5m surplus.
- Current projections assume no further efficiency savings, only the fully developed schemes where budget has been removed.
- The central budgets line includes the central stretched 1.5% efficiency target, the temporary workforce target, cost pressures, overheads, non-pay inflation, pay inflation, MHIS/SDF and capital charges budgets that remain unallocated.
- The forecast has been adjusted for known service changes and one-off costs and highlights that action is required to realise further savings.

Forecast Outturn	Variance to budget at Month 3	Straight line year-end forecast	Known adjustments to Forecast	Revised forecast variance	Value of actions needed to breakeven
	£'000s	£'000s	£'000s	£'000s	£'000s
Community Services	(96)	(384)	(17)	(401)	
Mental Health & Childrens Services	(256)	(1,025)	(499)	(1,525)	
Medical Staffing	442	1,769	(1,168)	601	(601)
Nurse Executive & Quality	(106)	(424)	94	(330)	
Finance & Strategic Development	(207)	(826)	177	(649)	
People & Culture	67	270	(20)	250	(250)
Strategy, Transformation & Partnerships	140	561	72	633	(633)
Corporate Services	(33)	(133)	(37)	(170)	
Trust Wide Income	(0)	(1)	2,443	2,442	(2,442)
Central budgets	643	2,571	2,875	5,446	(5,446)
Total	594	2,377	3,920	6,297	(9,372)
Capital donations/grants/peppercorn lease				916	
Adjusted forecast - Variance to Plan				7,212	

6. Provider Collaborative Financial Position

6.1 Dorset HealthCare as Provider

Dorset HealthCare provides a number of services through various provider collaboratives. The month 3 financial position is shown below.

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Service	Provider Collaborative	Lead	Risk share	Expenditure variance to budget at month 3 £000s	Forecast expenditure variance to budget £000s
Adult secure (low and medium) - For Me PC	Thames Valley and Wessex	Oxford Health	15.44%	(174)	(552)
Children & adolescent mental health services (CAMHS) Tier 4	South West	Devon Partnership	19%	(98)	(360)
Perinatal mental health	South West	Devon Partnership	14%	1	(5)
Adult eating disorders	Hampshire and Isle of Wight.	Dorset HealthCare	100%	51	177

Drivers of year-to-date performance

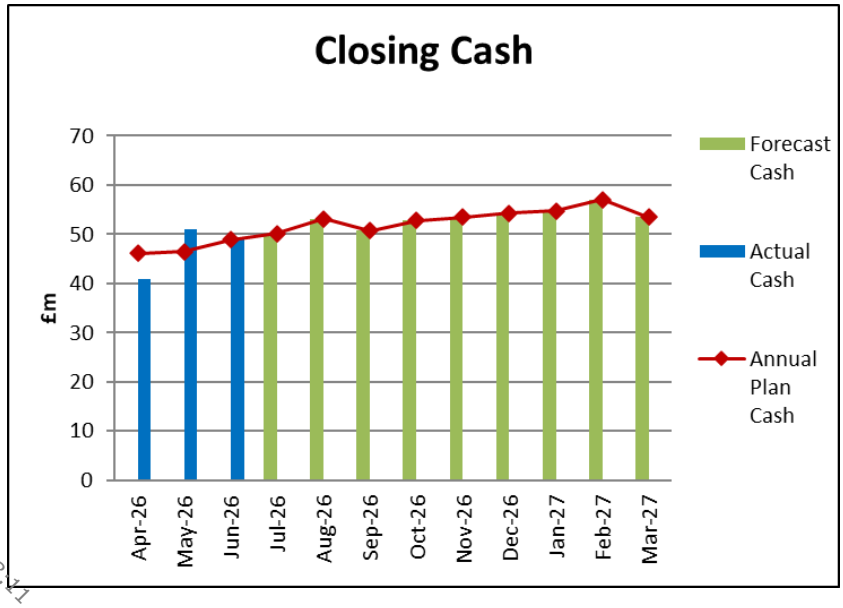
- Adult low and medium secure – vacancies.
- CAMHS Tier 4 – Vacancies.
- Adult eating disorders – reduced income due to low activity.

Drivers of outturn forecast position

- As above.

7. Cashflow and Payments

- The cash balance at M3 was £49.3m (£51.0m at month 2), a reduction of £1.7m which is due to the utilisation of previously deferred income in month.
- Cash levels are above plan by £0.4m.
- Overall debtors remain high with £11.40m of LA and NHS debt which is over 90 days old. DCH represents 99.7% of this balance.



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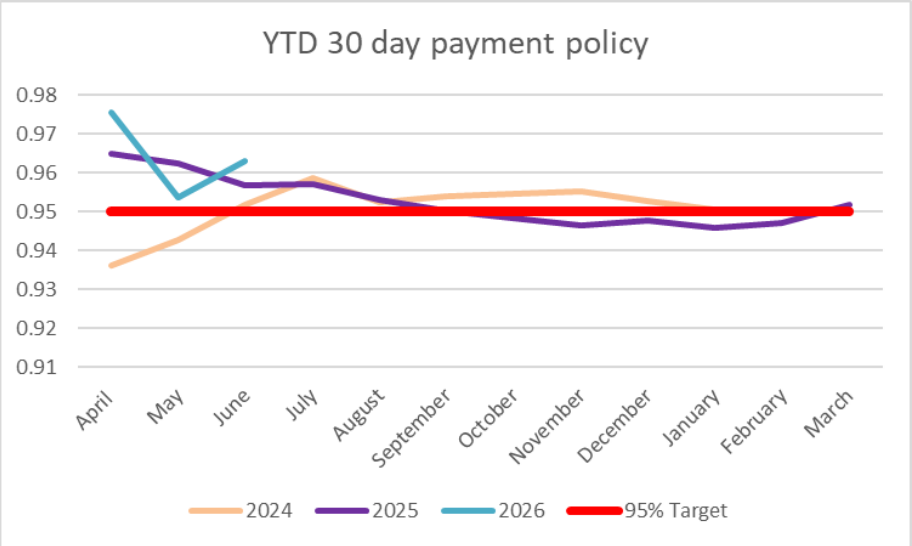
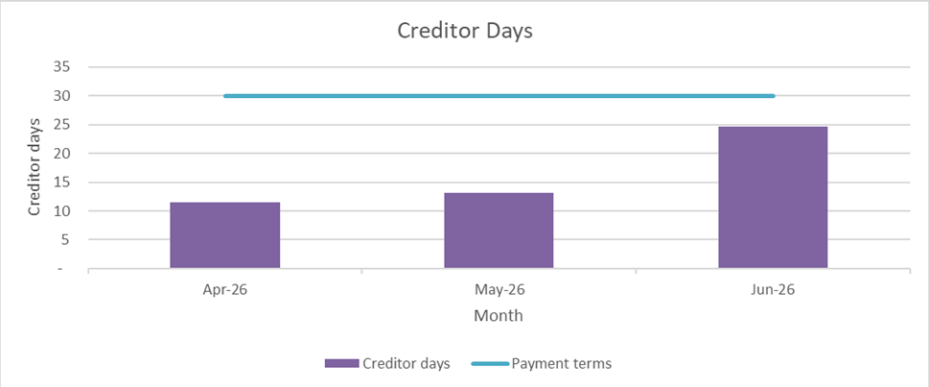
- The YTD Better Payment Practice Code performance is shown below. The target is 95% which has been achieved again this month.

YTD			
Month	1	2	3
BPPC performance	97.55%	95.35%	96.30%



- Favourable creditor days based on trade payables only. This is the time it takes the Trust to pay its outstanding liabilities.



A standard 30-day payment term has been used for comparison.

- The cash days graph below shows the number of days that the Trust could sustain its current level of expenditure without any further income, giving a snapshot of our current cash position.

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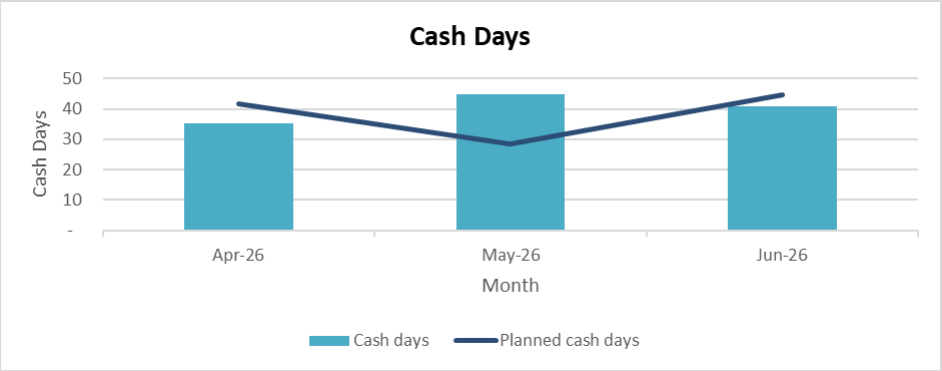
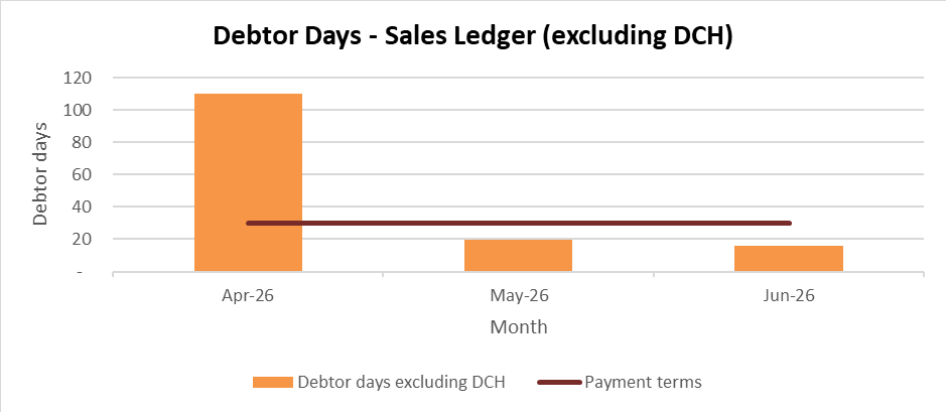


- The debtor days graph below shows how long it takes the Trust to collect payment from its customers. Debtor days excluding Dorset County Hospital is below 30 days and reflects the efforts of the team to collect any debt owing.
- Debtor days have increased as there has been minimal levels of invoicing at the start of the year.



8. Capital programme.

- The capital expenditure target for 2026/27 is £27.20m.
- Total year to date spend was £4.45m against a year to date plan of £9.80m. Internally funded capital CDEL spend was £2.21m and externally funded capital spend was £2.24m.
- Forecast 2026/27 New Hospital Programme spend is £16.23m. This is the result of some slippage on the new builds which have now been completed. However, this has delayed the further refurbishment works to be undertaken at St Ann's which also required additional design work. It is likely that NHP forecast spend in year will be revised down during M4.
- Work is being undertaken to see if the underspend from zero rated VAT can be used for additional opportunities in line with the business case objectives and St Ann's NHP is under review for scope enhancements.

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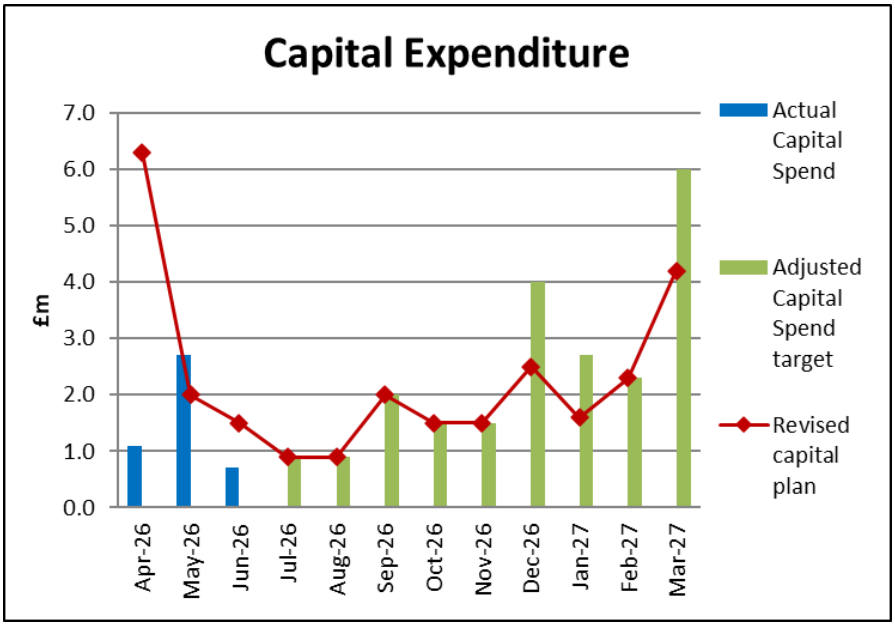
- Slippage on the NHP new builds has moved planned month 1, 2 and 3 spend into later in the year.
- The delivery of the capital programme will be achieved by:
  - Regular meetings between the capital finance team and key capital budget managers.
  - Line by line review of larger capital project lines, such as the NHP project, backlog maintenance and IT projects.
  - The investigation of variances between plan and actual spend.
  - The accurate accruing to completion at the quarter months.
  - The identifying of internally funded capital slippage, and the reallocation to additional spends in year brought forward from future years.
  - Regular monthly meetings of the Capital Investment Meetings (CIM), where progress is reported, and adjustments agreed to the in-year programme to compensate for slippage.
- Key projects within the 2026/27 capital programme include:
  - St Ann's, CAMHS PICU, and HIP 2 – £16.2m (externally funded)
  - Backlog maintenance - £2.7m (internally funded)
  - Herm ward extension - £1.8m (internally funded)
  - St Leonards repurpose - £1.5m (internally funded)
  - Healthset - £1.0m internally funded plus an additional £1.4m from intra Dorset brokerage.
- Depreciation totalled £3.59m (plan £3.47m) at month 3, £116k above plan. This is due to the Trust mitigating capital slippage towards the end of 2025/26 with equipment purchases plus the securing of £600k additional in that year which was largely used to purchase equipment which has a shorter life in use. This increases subsequent year depreciation.



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9. Conclusion.

- 2026/27 will be a challenging year for the NHS and Trust finances.
- Financial balance will only be achieved by individuals and directorates working hard to achieve a successful outcome.
- There are a number of risks to financial balance which are being monitored closely across all areas of the Trust.

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Appendix 1 – Trust financial performance

INCOME & EXPENDITURE SUMMARY								
Month 3 2026/27		YTD			IN MONTH			
June	**ANNUAL BUDGET**	**YTD Budget**	**YTD Actuals**	**YTD Variance**	**Budget**	**Actual**	**Variance**	
	£'000	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	
INCOME								
Baseline Income	(351,400)	(87,822)	(87,822)	(0)	(29,353)	(29,353)	(0)	G
Integrated Community Services	(19,308)	(4,959)	(5,148)	(189)	(1,645)	(1,685)	(40)	G
Children, Y.P. & Family Services, All Age Mental Health & L.D. Services	(32,706)	(7,637)	(7,147)	490	(2,750)	(2,542)	208	R
Medical Staffing	(3,064)	(773)	(789)	(16)	(263)	(283)	(20)	G
Nurse Executive & Quality	(1,591)	(403)	(473)	(69)	(134)	(161)	(27)	G
Finance & Strategic Development	(9,848)	(2,390)	(2,400)	(10)	(1,287)	(1,268)	19	G
People & Culture	(6,371)	(1,777)	(1,753)	24	(528)	(515)	13	R
Strategy, Transformation & Partnerships	(51)	(13)	(21)	(9)	(9)	(8)	1	G
Corporate	(572)	(143)	(156)	(13)	(48)	(52)	(4)	G
Interest Received	(1,741)	(599)	(599)	0	(194)	(194)	0	G
Central Budgets	(2,001)	(504)	(663)	(158)	(92)	(203)	(110)	G
Total Trust Income	**(428,653)**	**(107,020)**	**(106,971)**	**49**	**(36,302)**	**(36,263)**	**40**	R
EXPENDITURE								
Integrated Community Services	133,977	33,451	33,545	93	11,266	11,308	42	R
Children, Y.P. & Family Services, All Age Mental Health & L.D. Services	166,860	41,119	40,372	(746)	13,822	13,557	(266)	G
Medical Staffing	32,238	8,263	8,721	458	2,932	3,090	157	R
Nurse Executive & Quality	11,250	2,793	2,756	(37)	933	913	(20)	G
Finance & Strategic Development	52,477	12,724	12,527	(196)	4,720	4,650	(70)	G
People & Culture	11,925	2,842	2,885	43	930	943	12	R
Strategy, Transformation & Partnerships	14,592	3,635	3,784	149	1,216	1,259	43	R
Corporate	4,686	1,225	1,205	(20)	410	401	(9)	G
Central Budgets	(5,221)	(1,494)	(959)	535	(1,080)	(394)	686	R
Impairments	38,942	0	265	265	0	0	0	R
Total Trust Expenditure	**461,725**	**104,557**	**105,102**	**545**	**35,150**	**35,727**	**577**	R
NET INCOME & EXPENDITURE	**33,073**	**(2,464)**	**(1,869)**	**594**	**(1,152)**	**(536)**	**616**	
PDCD	5,964	1,491	1,491	0	497	497	0	G
RETAINED (SURPLUS)/DEFICIT	**39,037**	**(973)**	**(378)**	**594**	**(655)**	**(39)**	**616**	R
EBITDA			**4.8%**					

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Report to	Board in Common (DCH)	
Date of Meeting	11 August 2026	
Report Title	Operational Performance Report; May and June data 2026	
Prepared By	Adam Savin, Director of Operations and Performance	
Approved by Accountable Executive	Anita Thomas, Chief Operating Officer	
Previously Considered By	Anita Thomas, Chief Operating Officer	
Action Required	**Approval**	**N**
	Assurance	**Y**
	Information	**N**

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality SR3 Workforce Capacity SR4 Capacity and Demand SR6 Finance	
Financial	Elective Recovery Fund	
Statutory & Regulatory	Reporting against, constitutional and contractual standards	
Equality, Diversity & Inclusion	N/A	
Co-production & Partnership	N/A	

Executive Summary

The Trusts Integrated performance report pulls together each of the domains within the NHS Oversight Framework and provides trend data, analysis and actions for each of the metrics the trust is measured on within the framework.

All indicators are covered in detail in the respective sub-board committees and therefore, this paper does not attempt to duplicate the committees work or the deep dives, but rather provider an oversight of them combined. As agreed at the Finance and Performance committee the pack of Board papers will include the sub-board committee Performance report for the recovery period duration in addition to the key metrics of the balance scorecard.

The National Oversight Framework (NOF) score is from Quarter 4 and it is noted that the NOF is changing and the next performance report may reflect the new standards once we have received the full technical specifications.

Key Points:

Performance

- **Urgent & Emergency Care:**
  - ED attendances are 9.05% higher year-to-date than last year, with a disproportionate growth of ambulance demand
  - Four-hour standard has not met the trajectory, but is improving in July
  - Persistent 12-hour breaches remain a concern, primarily due to bed availability, although in Q1 we have noted the bed pressures extended to high flow areas for non-admitted patients and adversely affected their waiting times leading to higher breaches and poorer ED performance
  - Ambulance handover delays against the mean time, is not meeting trajectory or

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against the 15 and 45min target.

- **Elective Care:**
  - RTT trajectories not meeting trajectory; waiting list size now over 1900 patients larger than plan. Q1 impacted by staffing, equipment failure and two heat waves, impacting the delivery of activity
  - 52+ week breaches did not meet plan for any month in Q1
  - Follow-up backlog reduced to pre-COVID levels.
  - Cancer standards for 28 day and 62 day standard have not been met, for 31 days, 2 months of the quarter it has been met.

- **Diagnostics:**
  - Diagnostic performance improved and trajectory being met, with backlog and total waiting list size reductions.

Quality

Top Assurances

• Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections remain at zero, while Methicillin-susceptible *Staphylococcus aureus*
(MSSA) bloodstream infections continue to remain stable in 26-27, with zero cases recorded in June 2026.
• Gram-negative bloodstream infections (GNBSIs) for *E. coli* and *Klebsiella* have improved compared with the same period last year.
• No IPM outbreaks for Quarter 1
• Dorset County Hospital's pharmacy met all regulatory standards during recent inspection by General Pharmaceutical Council.
• Acquired pressure ulcers overall trend is reducing. Median now set at 25 per month.
• Neonatal services achievement of UNICEF's Stage One Baby Friendly Initiative Accreditation

Key Risks & Concerns

• Hybrid Mattress replacement programme and purchase of new bed frames to comply with MHRA entrapment safety notice. Ongoing QI work may stall due to replacement constraints. Mattress replacement funding is from capital replacement and requires ongoing investment into 27/28 for the supply for the remainder of the Trust beds (over 50%)
• Low MUST assessment compliance (Malnutrition Universal Screening Tool). The Dietetics team have recruited a Band 4 Practitioner to lead completion of MUST on admission wards and units.

People and culture

Trust	Sickness	Vacancy Rate	Turnover Rate	Appraisals	Mandatory Training
DCH	4.58%	9.5%	9.5%	77%	88%

Finance

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- As at June 2026, Dorset County Hospital NHS Foundation Trust (DCH) has delivered a £3.1 million deficit after technical adjustments, an adverse performance against planned levels (£2.968 million deficit) of £0.193 million.
- The Trust plan included a £0.777 million efficiency target for month 3, which was delivered with an overachievement of £0.154 million resulting in a YTD position ahead

of plan of £0.075 million of the £1.962 million planned target

- Agency expenditure in M3 is £0.4m away from planned levels and £1.1m adverse YTD, spend in month 3 is in line with the average for the prior quarter however costs remain high across both nursing and medical categories, noting support of Industrial Action, operational pressures, sickness, heatwave and meningitis support are driving high use this quarter. Medical agency reduction is a strong focus for the Trust alongside continued work on Nursing agency.
- Bank expenditure remains a key focus area noting bank overspend of £0.7m in Month 3, £2.0m YTD. The overspend in Temporary Staffing is driven by the same factors contributing to agency expenditure.
- The Trust is progressing with the capital programme for 2026/27 with month 3 YTD spend totalling £7.8 million, which is behind plan by £4.0 million.
- The cash position at the end of June was £20.0 million, which is £5.2 million behind the submitted plan. This variance is driven by a movement in working capital due to the delay in payment of contract income from Dorset ICB relating to the Sleep Service provided by the Trust during 2025/26 and Depreciation Funding owed to the Trust for Q1 2026/27.

Recommendation

The Board of Directors is asked to:

a) Receive the report for assurance.

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Dorset County Hospital
NHS Foundation Trust

Integrated Board performance report August 2026

Operational Support

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Healthier lives Empowered citizens Thriving communities

Introduction and the NHS Oversight Framework (NoF)

Dorset County Hospital
NHS Foundation Trust

1. Introduction

This paper pulls together each of the domains within the NHS Oversight Framework (NOF) and provides trend data, analysis and actions for each of the metrics the trust is measured on within the framework.

The first iteration of this paper went to the October 2025 Board meeting, where it was approved that the integrated board performance report would focus on the metrics in the NHS Oversight Framework. The order of this paper, follows the metric order of the NOF. Where other metrics are off track, these are included in the sub-board committee escalation reports.

The NOF is updated each quarter. Where this paper falls in between updates, the latest monthly data is provided to give an indication of what to expect at the next published quarter. This means that during the in between months, the data on the slides for each domain, may be different to that of the slides relating to the last quarter results.

2. The NHS Oversight Framework 2025/26- quarter 4 results

The NHS Oversight Framework 2025/26 sets out NHS England's approach to assessing and supporting Integrated Care Boards (ICBs) and NHS trusts/foundation trusts. It aims to ensure transparency, accountability, and improvement across the system, aligning with the 10 Year Health Plan and the 2025/26 NHS priorities and operational planning guidance.

The published league table and domain results can be found here, which now includes quarter 4 results: https://data.england.nhs.uk/dashboard/nofacute

2.1 Summary of Q4 performance against the NoF

DCH ranked 86 out of 134 acute providers this is a fall from 68 in Q3 and 51 in Q2. These are 6 acute types within the league table, DCH is grouped in the "small acute" type. Of the 134 providers, 19 have been designated a small acute provider. In Q4, DCH ranked 12th out of 19, this is a fall from 10th in Q3 and 7th in Q2. There is only 1 other provider designated as small in the South West which is Salisbury who ranked 79 out of 134 and 10th out of the small providers in Q4. The table overpage details each metric within the framework, performance against it, the ranking and the committee through which that the metric is scrutinised.

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Q4 results and movement from Q3

Dorset County Hospital
NHS Foundation Trust

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change		Metric score	Rank	Median	Standard
Access to services	Cancer care	Percentage of patients treated for cancer within 62 days of referral	Q4 2025/26	72.34	%	3.02	3.02	2.39	52 out of 118	70.24	75
Access to services	Elective care	Percentage of patients waiting over 52 weeks for elective treatment	Mar-26	1.13	%	-0.17	0.17	2.07	72 out of 130	0.96	1
Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	Mar-26	61.92	%	-3.83	3.83	3.9	74 out of 78	0.46	
Access to services	Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Mar-26	62.71	%	1.81	1.81	3.05	89 out of 130	64.83	
Access to services	Elective care	Difference between planned and actual 18 week performance	Mar-26	-1.18	%	-0.71	-0.71	2.58	98 out of 130	0.99	0
Access to services	Urgent and emergency care	Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q4 2025/26	77.9	%	-2.18	-2.18	2.02	36 out of 123	74.01	78
Access to services	Urgent and emergency care	Percentage of emergency department attendances spending over 12 hours in the department	Q4 2025/26	14.42	%	3.22	-3.22	3.73	111 out of 122	8.71	
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Mar-26	0.96	days	-0.16	0.16	2.84	79 out of 128	0.8	
Effectiveness and experience	Patient experience	Summary Hospital-level Mortality Indicator	Jan 24 - Dec 25		score			2			
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2024		score			2			
Finance and productivity	Finance	Planned surplus/deficit	2025/26 plan	-3.18	%	0	0	4	92 out of 134	-1.54	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 12 2025/26	0	%	-0.52	-0.52	1	73 out of 134	0.03	
Finance and productivity	Finance	Combined finance	Q4 2025/26					2			
Finance and productivity	Productivity	Implied productivity level	Q3 2025/26 vs Q3 2024/25	-0.38	%	-1.58	-1.58	3.48	111 out of 134	2.57	
Patient safety	Patient safety	Number of MRSA bacteraemia cases (12 months)	Mar-26	3	count	0	0	2.54		3.5	0
Patient safety	Patient safety	Proportion of E. coli bacteraemia	Mar-26	1.16	rate	0.04	-0.04	2.69		1.17	1
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2025	6.46	out of 10	-0.08	-0.08	1.92	42 out of 134	6.32	
Patient safety	Patient safety	Proportion of C. difficile infections	Mar-26	0.84	rate	0.04	-0.04	1		1.09	1
People and workforce	Retention and culture	Sickness absence rate	Q3 2025/26	4.48	%	0.09	-0.09	1.16	11 out of 134	5.59	
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2025	6.92	out of 10	-0.11	-0.11	1.86	39 out of 134	6.8	

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NoF areas of declining metrics for Q4

Dorset County Hospital
NHS Foundation Trust

2.2 Areas of reduced performance

The percentage of emergency department admitted within 4 hours has decreased in Q4 to 77.9% from 80.7% in Q3. For this metric, the trust ranks 36 out of 123. The 12 hours in the department increased in Q4 to 14.42% from 11.2% in Q3. For this metric, the trust ranks 111 out of 122. This follows a 10.60% growth in attendances year to date and a 7.62% increase in admissions. Patients are tracked at the 3 time a day bed meeting, to mitigate 12 hour breaches where possible. Patients are triaged and cared for during the wait and patients prioritised beds based on clinical need, as well as total waiting time..

Implied productivity fell by 1.58% in the reporting period, which moves the trust to a rank of 111/134. Year-to-date implied productivity growth stands at 0.5% at month 10 which is 1.5% below the 2% national ambition. Cost-weighted activity was at 1.7% which is below the peer median of 2.9%. The Trust has applied to amend the 25/26 data submissions to adjust for anomalies found through the work with a Regional Productivity Lead. The 26/27 submissions will include the adjusted data and will be seen later in the year for Q1.

There was an increase in the number of e.coli, c.difficile cases and an increase in staff sickness rate, but there is no significant concern noted for either.

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Introduction and NHS Oversight Framework continued

Dorset County Hospital
NHS Foundation Trust

2.3 Areas of improved performance

The greatest area of improvement was within Cancer care. Performance against the 62-day standard improved by 3.02% in Q4, moving the trust to rank 52/118, compared to 70/118 in Q3.

Performance against the 18 week standard improved by 1.81% and the Trust's ranking was 89/130 in Q4. Performance of the percentage of patients waiting over 52 weeks for elective treatment improved by 0.17%, with ranking at 72/131 but this is a reduction from 51/131 in Q3, suggesting others had a larger gain in this metric in the same period. Performance of the percentage of patients waiting over 52 weeks for community treatment improved by 3.83% with a ranking of 74 out of 78 suggesting others had a larger gain in this metric.

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Domain: Access to Services. Sub domain: Cancer care. Measure: Percentage of patients treated for cancer within 62 days of referral.

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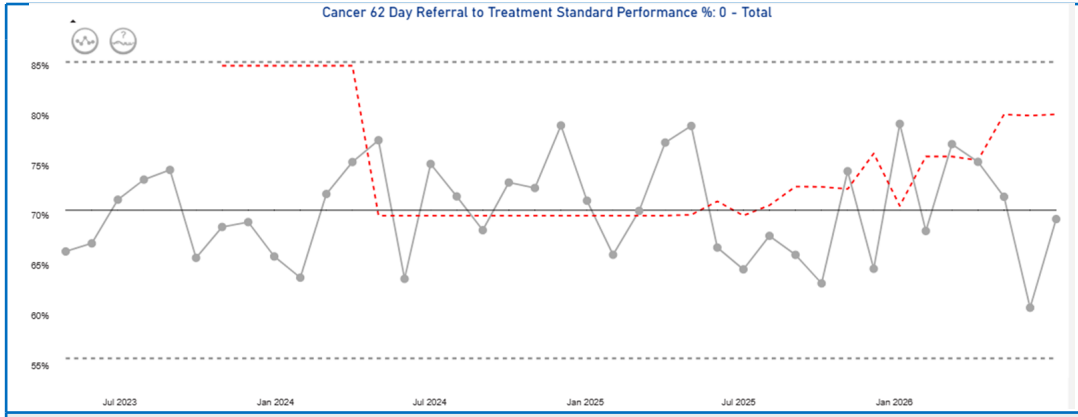

62 day	published Apr-26	published May-26	Total Patients	<62 days	Local Jun-26
Breast	82.00%	51.02%	20.5	16.0	78.05%
Childrens					
Colorectal (LG)	54.55%	52.94%	12.5	6.0	48.00%
Gynaecology	28.57%	25.00%	3.5	3.0	85.71%
Haematology	68.42%	86.67%	7.0	6.0	85.71%
Head & Neck	37.50%	50.00%	4.5	1.5	33.33%
Lung	59.10%	19.05%	9.0	5.0	55.55%
Skin	86.30%	92.31%	20.0	18.0	85.00%
UGI	61.90%	90.45%	8.5	4.5	52.94%
Urology	66.15%	52.94%	29.5	16.0	54.24%
Other	75.00%		4.5	4.5	100.00%
Actual	71.74%	63.10%	119.5	81.5	68.20%
Plan	80.13%	80.00%			80.14%
Variance	-8.39%	-16.90%			-11.94%

Description of metric

Percentage of patients treated for cancer within 62 days of referral.

Contractual target 85%, but 2025/26 planning guidance trajectory is 75% by March 2026

Analysis

Performance of the 62-day combined standard did not achieve the trajectory for any month in Quarter 1. Urology accounts for the largest proportion of 62-day breaches and faces inherent pathway complexity due to the range of tumour types and treatment options involved. Delays can arise from the need for specialist surgical capacity, multidisciplinary decision-making and access to tertiary services. Capacity constraints within the Dorset robotic-assisted surgery pathway continue to impact performance.

Breast performance on the screening pathway was adversely affected by an unusually high number of breaches during the period, driven largely by patients requiring additional investigations following screening. Analysis identified patient understanding and engagement as contributory factors, with compliance issues affecting a small number of cases. May's performance was considered a statistical outlier, with screening volumes varying throughout the year as the mobile screening unit moves across Dorset

Ellis,Kara
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Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Cancer: 62 RTT (combined)	Plan	80.13%	80.00%	80.14%	80.13%	80.41%	80.43%	80.12%	80.58%	80.15%	80.54%	80.45%	80.65%
	actual	71.74%	61.20%	69.44%									
	variance	-8.39%	-18.80%	-10.70%									

Actions

The requirement of the 2026/27 operating plan was to maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%. The trajectory is therefore set at 80% or above for each month of the financial year. The original planning assumptions applied the same methodology to the 31- and 62-day standards. Subsequent review has confirmed that these standards are required to be achieved by March 2027 rather than maintained throughout the year.
A revised trajectory has been submitted to NHSE, which accounts for the change in phasing, to reflect the intent of the operating plan. The modelling includes key actions including:
• Improved patient communication for the Breast screening patients, setting out the urgency of the next stage in the pathway, once passed to DCH
• Review patient communications for all non-cancers and where suitable (and with clinical approval), introduce administration staff phone calls to reduce delays on letter typing/post to communicate outcome.
• New ENT disposal scopes, to move activity to the community, delivering it closer to home and increasing clinic capacity (Wessex funded)

Domain: Access to Services. Sub domain: Cancer care. Measure: Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks (28 days).

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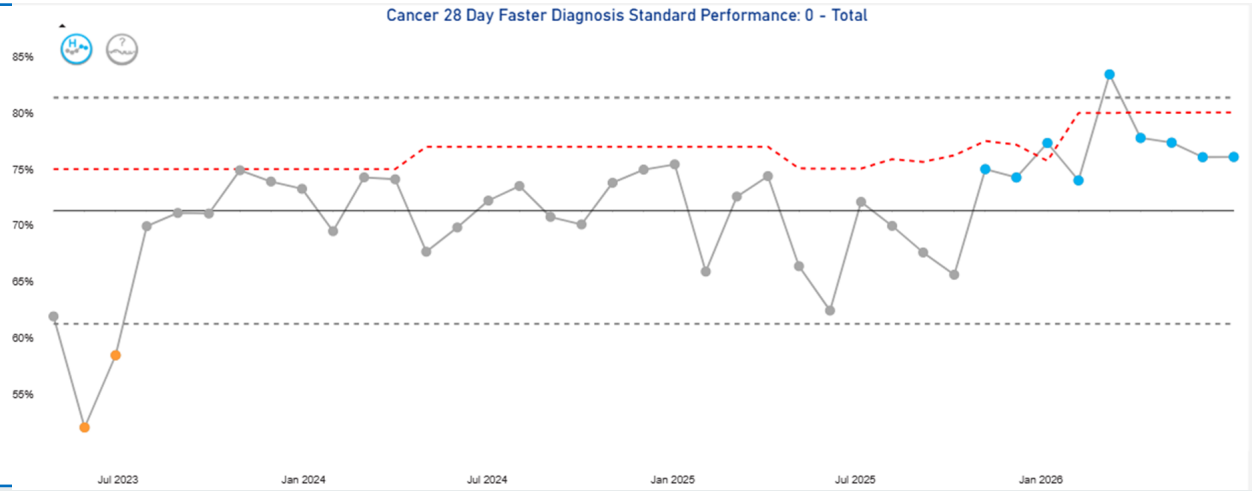

Description of metric

Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks (28 day standard).

Contractual target 80%, but 2025/26 planning guidance trajectory is 80% by March 2026, rather than each month of the year.

Analysis

Performance of the 28-day standard has not meet the trajectory for any month in Quarter 1. At the time of writing this paper, July stands at 77%, a slightly improved position.
Performance of the 28 day standard, while not meeting trajectory, has remained above the median showing positive signs for recovery. Colorectal has been impacted by challenged endoscopy performance. Endoscopy performance is recovering following a targeted NHSE supported improvement programme addressing workforce, booking and capacity issues.
This is positively impacting delivery of the 28-day standard. There remain vulnerabilities within the individual services which are being closely tracked so mitigation can be found at the earliest opportunity but nonetheless unplanned absences continue to have an impact of this measure.

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Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Cancer: 28 days FDS	Plan	80.03%	80.05%	80.06%	80.01%	80.00%	80.04%	80.03%	80.01%	80.08%	79.97%	80.06%	80.03%
	actual	78.15%	76.08%	76.09%									
	variance	-1.88%	-3.97%	-3.97%									

Healthier lives Empowered citizens Thriving communities

Actions

Insourcing where demand is outstripping capacity at the front of the pathway, with capacity now in place for the first 6 months of the new financial year.

Refreshed cancer PTL and performance review meetings at a Care Group level. These combine RTT, cancer and DM01, into one data pack and review session, which enables a full pathway review. Positive feedback for the first two sessions.

Domain: Access to Services. Sub domain: Elective Care. Measure: Difference between planned and actual 18 week performance and Percentage of cases where a patient is waiting 18 weeks or less for elective treatment

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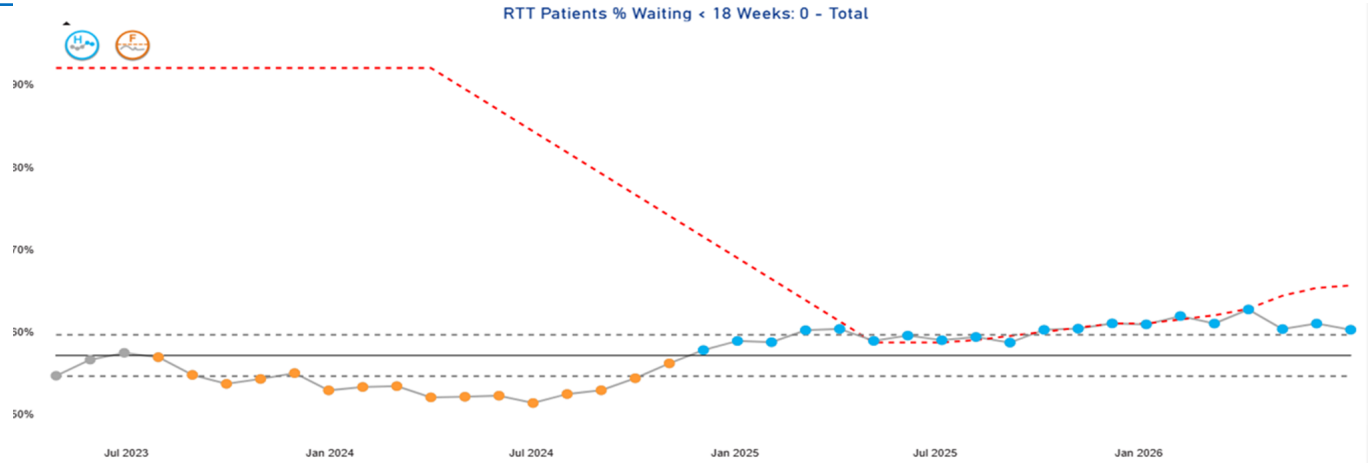
NHS Foundation Trust



Description of metric

Difference between planned and actual 18-week performance:

Hit or miss planning trajectory, as per the operating plan.

Percentage of cases where a patient is waiting 18 weeks or less for elective treatment:

Contractual target 92%

Planning guidance target, 63.89% by March 2026 and then a 7% further improvement in 2026/27.

Analysis

.For 2026/27, every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national performance target of 70%). For DCH, this means achieving 70.89% RTT 18-week performance and 77.69% for 1st activity, by March 2026.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
RTT: % patients waiting <18wks	plan	64.38%	65.32%	65.62%	66.26%	66.84%	67.48%	68.09%	68.64%	68.49%	69.06%	70.31%	70.89%
	actual	60.30%	61.00%	60.50%									
	variance	-4.08%	-4.32%	-5.12%									
RTT: % patients waiting <18wks for 1st Activity	plan	71.65%	71.81%	72.42%	73.06%	73.64%	74.28%	74.89%	75.43%	75.97%	76.57%	77.12%	77.69%
	actual	65.90%	65.66%	65.23%									
	variance	-5.75%	-6.15%	-7.19%									

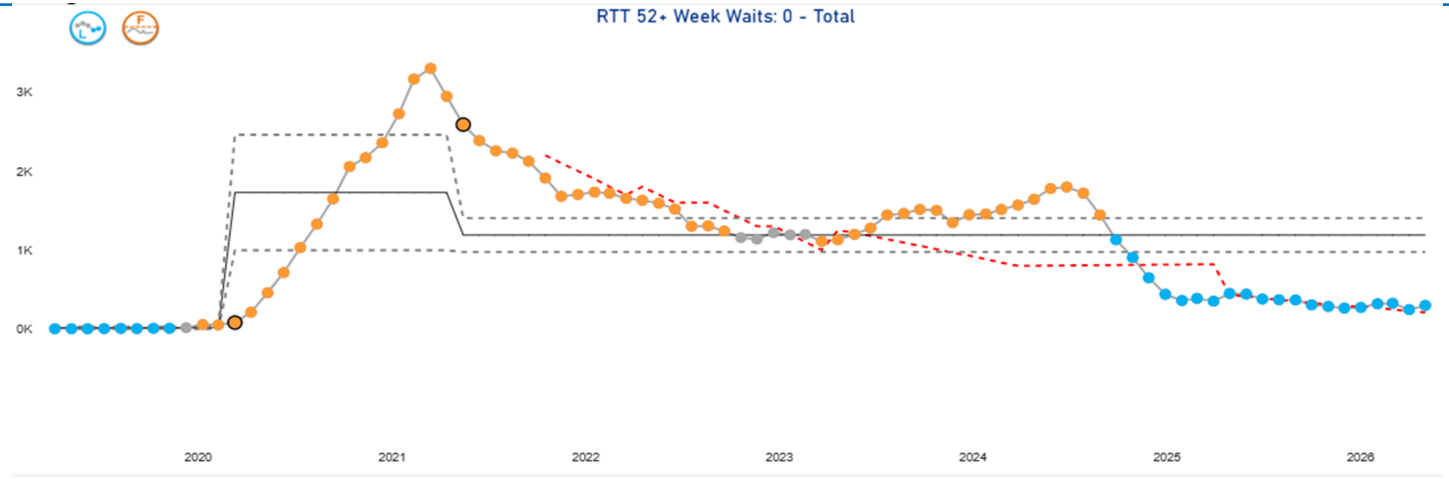
Mr Kara 06/08/2025 15:53:11

Actions

Since the total trust plan has been submitted, specialty-level intervention modelling has been completed. The specialty-level intervention modelling provides a detailed bottom-up assessment of the actions that are in development to reduce the waiting list and long-wait position by March 2027.
The modelling has considered a broad range of interventions across specialties, including validation, pathway redesign, referral management, booking improvements, additional outpatient and theatre capacity, independent sector use and insourcing. Only funded actions have been included in the modelling.
The results of this modelling are shown below. Based on the funded actions, the trust will be able to recover to 65.48%, with 309, 52 week waits and a waiting list size of 23,359.

Domain: Access to Services. Sub domain. Elective Care. Measure: Percentage of patients waiting over 52 weeks for elective treatment

Dorset County Hospital
NHS Foundation Trust



Description of metric

Percentage of patients waiting over 52 weeks for elective treatment

Contractual standard is zero, 52+ week breaches

Planning guidance requests less than 1% of the waiting list waiting over 52+ weeks by March 2026. For 2027, DCH need to achieve zero 52+ week waits.

Analysis

The operational planning guidance required an improvement of 52+ week waiters, while staying within the 1% tolerance of the total waiting list size, which was set last year. Due to the level of activity at trust level that was in this year's plan, the trajectory was set to zero, 52+ week waits by March 2027. Quarter 1 has not met the trajectory, as activity levels are behind plan.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
RTT: 52wk wait	plan	208	189	170	151	137	118	99	80	66	47	28	0
	actual	296	356	399									
	variance	88	167	229									
RTT: 52wk cohort % of Waiting List	plan	0.99%	0.91%	0.82%	0.74%	0.67%	0.58%	0.49%	0.40%	0.33%	0.24%	0.14%	0.00%
	actual	1.35%	1.59%	1.76%									
	variance	0.36%	0.68%	0.94%									

Ellis,Kara
06/08/2026 15:53

Actions

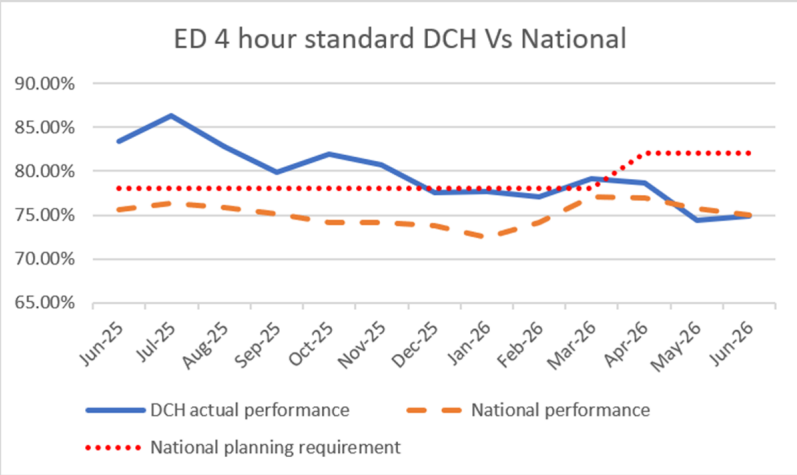
Since the total trust plan has been submitted, specialty-level intervention modelling has been completed. The specialty-level intervention modelling provides a detailed bottom-up assessment of the actions that are in development to reduce the waiting list and long-wait position by March 2027.

The modelling has considered a broad range of interventions across specialties, including validation, pathway redesign, referral management, booking improvements, additional outpatient and theatre capacity, independent sector use and insourcing. Only funded actions have been included in the modelling.

The results of this modelling are shown below. Based on the funded actions, the trust will be able to recover to 65.48%, with 309, 52 week waits and a waiting list size of 23,359.

Domain: Access to Services. Sub domain: UEC. Measure: Percentage of emergency department attendances admitted, transferred or discharged within four hours

Dorset County Hospital
NHS Foundation Trust



Description of metric

Percentage of emergency department attendances admitted, transferred or discharged within four hours.

Contractual target 95%

Planning guidance, For the 2026/27 financial year, NHS England has set a mandatory A&E target requiring every provider to treat, admit, or discharge 82% of A&E attendees within four hours, by March 2026.

Analysis

Performance against the 4-hour standard (including UTC activity data) has not met the trajectory set out in the operational plan, for Quarter 1. Compared to the national performance, DCH has been slightly below the national aggregate performance for the 4- hour standard, in May and June.
For 2026/27, there are three KPIs in the operating plan, to monitor the 4-hour standard. As with 2025/26 these are the 4-hour standard (all activity), 4-hour standard for type 1 (DCH only) activity and the additional measure, is performance against the 4-hour standard for children.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
A&E 4 hour wait %(all)	plan	82.00%	81.89%	81.99%	78.36%	78.34%	77.69%	78.87%	79.97%	80.52%	81.01%	81.43%	82.06%
	actual	78.70%	74.41%	74.91%									
	variance	-3.30%	-7.48%	-7.08%									
A&E 4 hour wait %(DCH)	plan	66.25%	65.82%	66.14%	60.19%	60.41%	60.43%	63.61%	63.40%	64.40%	65.29%	66.16%	67.22%
	actual	60.90%	52.43%	53.56%									
	variance	-5.35%	-13.39%	-12.58%									
A&E Children 4 hour wait %(all)	plan	95.41%	95.83%	95.30%	95.71%	95.49%	95.07%	95.43%	95.46%	95.60%	95.60%	95.15%	95.60%
	actual	93.30%	90.79%	91.44%									
	variance	-2.11%	-5.04%	-3.86%									

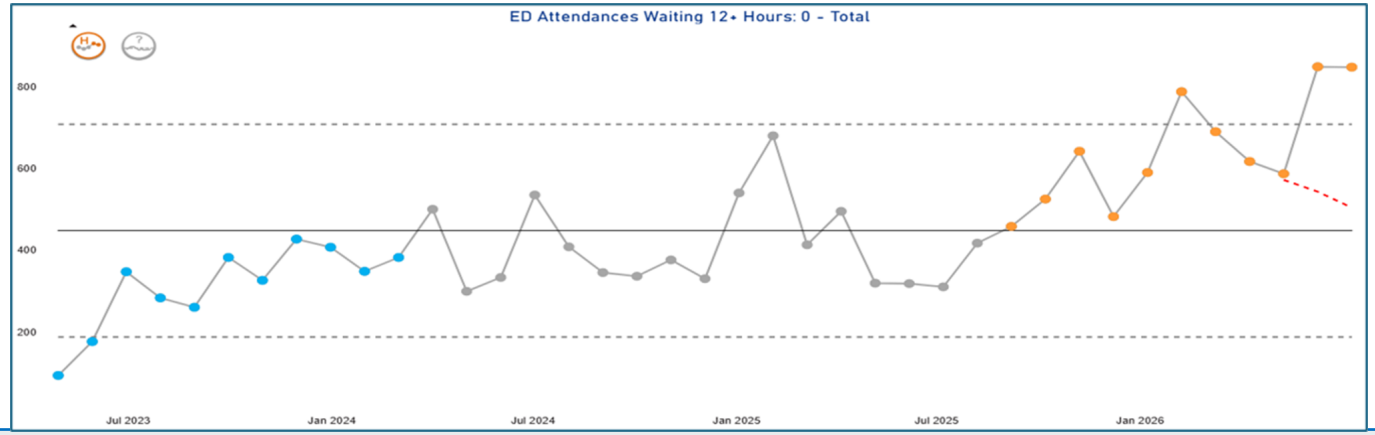
Actions

The trust is working collaboratively with system partners on the following Flow Through ED &
Early Decision Making (Internal Professional Standards) actions:
- Introducing a daily ED MDT first thing in the morning
- Consultant informed bed meetings (improved connections with medics to inform flow
decisions and actions)
- Rapid streaming (minors / majors)
- Deploy EPIC role during peak pressure (Named clinician with specific department
flow related actions and authority)
- Dedicated transfer function with maximum wait standards
- Review and relaunch 'Your Next Patient' policy

The trust is also delivering actions to improve Front Door Pathways and the Service Model
(Frailty). These include:
- Relocate and enhance Frailty SDEC at front door
- Embed CFS scoring and early senior decision maker
- Enhanced oversight of daily Frailty MDT (incl. community teams)
- Escalate long waits for via bed meeting and Neighbourhood Team MDTs
- Establish Senior Manager Led T&F group to reduce P0 LoS for older people
- Re-establish EDAU/EEMAC as high-turnover assessment capacity, also supporting
diagnostic turn-around and clinical decision making

Domain: Access to Services. Sub domain: UEC. Measure: Percentage of emergency department attendances spending over 12 hours in the department

Dorset County Hospital
NHS Foundation Trust



Description of metric

Percentage of emergency department attendances spending over 12 hours in the department.

Contractual target- the isn't one for 2025/26

Planning guidance: a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25

Analysis

For quarter 1, the number of patients that have breached 12 hours, has not met the trajectory. Apart from April, the percentage of A&E attendances that have breached 12 hours, has also not hit plan.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Number of A&E 12 hour breaches	plan	572	543	504	444	501	452	424	386	454	602	427	341
	actual	587	846	848									
	variance	15	303	344									
Percentage of A&E attendances over 12 hours	plan	11.61%	10.57%	9.62%	7.72%	8.69%	8.66%	7.71%	7.29%	8.32%	11.02%	8.62%	6.25%
	actual	11.30%	15.43%	15.69%									
	variance	-0.31%	4.86%	6.07%									

ellis.kara 08/08/2026 14:53:11

Actions

The trust is working collaboratively with system partners on the following Flow Through ED &
Early Decision Making (Internal Professional Standards) actions:
- Introducing a daily ED MDT first thing in the morning
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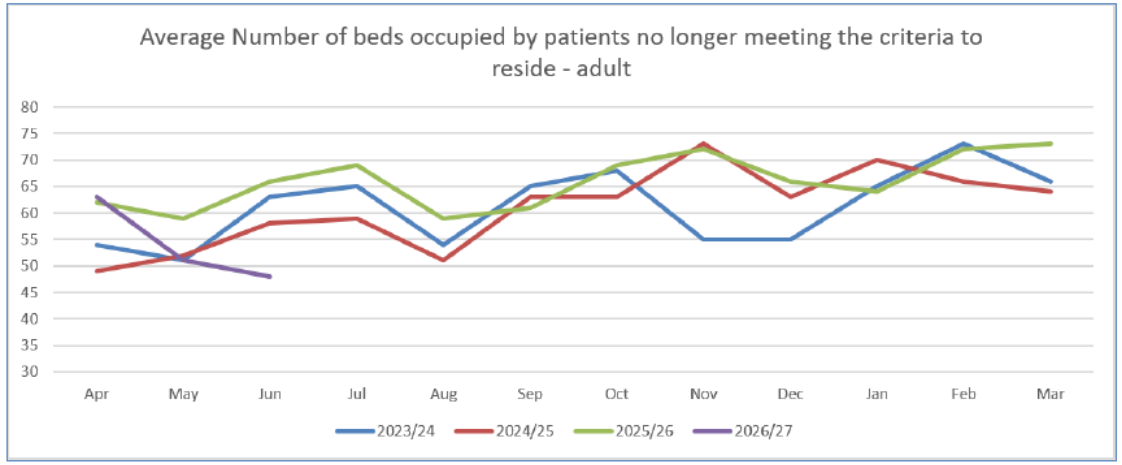
- Enhanced oversight of daily Frailty MDT (incl. community teams)
- Escalate long waits for via bed meeting and Neighbourhood Team MDTs
- Establish Senior Manager Led T&F group to reduce P0 LoS for older people
- Re-establish EDAU/EEMAC as high-turnover assessment capacity, also supporting
diagnostic turn-around and clinical decision making

Domain: Effectiveness and experience. Sub domain: Flow. Measure: Average number of days from discharge ready date to actual discharge date (including zero days)

Dorset County Hospital
NHS Foundation Trust



Description of metric

This measures the extent of delays experienced by patients who are medically ready for discharge but are not able to be discharged from hospital.

The average delay to discharge, from when the patient is ready for discharge to the date of discharge.

Analysis

For 2026/27, the metrics in the Operational Plan relating to flow, are slightly different. The non-elective average length of stay is measured by taking total non-elective bed days (all) and divided by the number of total non-elective admissions. This therefore measures the effectiveness of all non-elective pathways, combined.

For June, Non-elective LoS was 0.82 above plan, driven by 1,012 more bed days and 145 too few discharges than plan. This is the first month it has increased, following 4 months areduction.

The number of patients occupying a bed with no reason to reside was 1 below the locally agreed trajectory. At the end of June, DCH had the lowest number of NCTR patients in the last 4 years. This is positive and while hitting the locally agreed trajectory, it should be noted that this is still high, at 18% of the bed base.

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Actions

Escalation to all system partners, with Executive involvement for patients with extended length of stay.

FutureCare programme, with admission avoidance schemes and the introduction of the Transfer of Care Hub, which is now fully operational.

Roll out criteria led discharge and standardised board rounds.

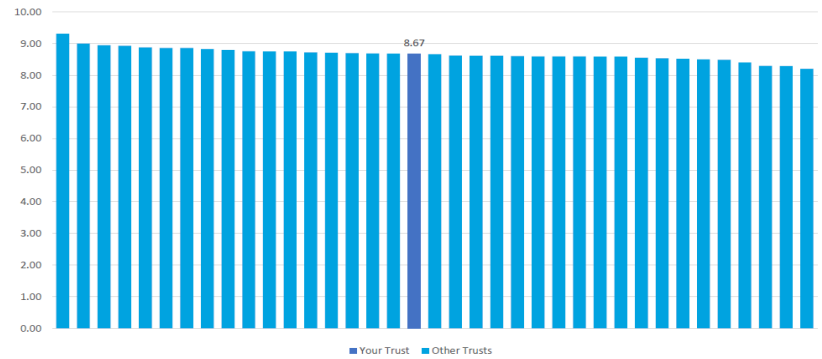
Increase use of Acute Hospital at Home and Hospital at Home (DCH) to facilitate earlier discharge with continued support where applicable.

Executive led review of processes applied through the FutureCare programme this winter to provide further efficiency and productivity through collaborative solutions for community care.

Domain: Effectiveness and experience. Sub domain: Patient experience. Measure: CQC inpatient survey satisfaction rate

Dorset County Hospital
NHS Foundation Trust

Overall Rating 8.67



Description of metric

2023 – 2024 Survey

The survey required a sample of 1,250 consecutively discharged inpatients, working back from the last day of November 2024, who had a stay of at least one night in hospital. There were a number of categories of patients excluded from the survey e.g. psychiatric and maternity patients.

2026 - Awaiting further CQC inpatient survey activity.

Analysis

473 completed questionnaires were returned from the sample of 1105. The final response rate for the Trust was 45%.

At Question level, 2 scores have improved significantly since 2023, 1 significantly declined. When compared to other sector organisations, 8 scores are in the top-20% range, 36 scores in the intermediate – 60% range and 5 in the bottom – 20% range.

The scores for the Trust are mostly in line with the sector scores and stable year on year. The findings highlight areas for recommendation, but it is noted that the Trust should also celebrate areas where scores are higher than the sector benchmark.

Ellis,Kara
06/08/2026 15:53:11

Actions

CARE – Inpatient Quality Improvements

Updated PALS boards with key patient info New Patient Experience leaflet (NHS complaints process) Carer's Pack for unpaid carers HIVE social prescribing hub (since May 2025) Volunteer Ward Reps to resolve quick ward issues

DISCHARGE - Improve patient & care information on discharge

Keyworker training on use of carer/self-funding packs; Self funding packs to support faster decision making; Carer packs with support info and key contacts; Carer's Café for peer support in complex discharges; Volunteer Centre Dorset for welfare calls and practical help; Networking with PCNs & Integrated Neighbourhood Teams for co-ordinated support.

Admission - improve communication around waiting times and admission alongside work going on to reduce waiting lists

Domain: Effectiveness and experience. Sub domain: Patient experience. Measure: Summary Hospital Level Mortality Indicator.

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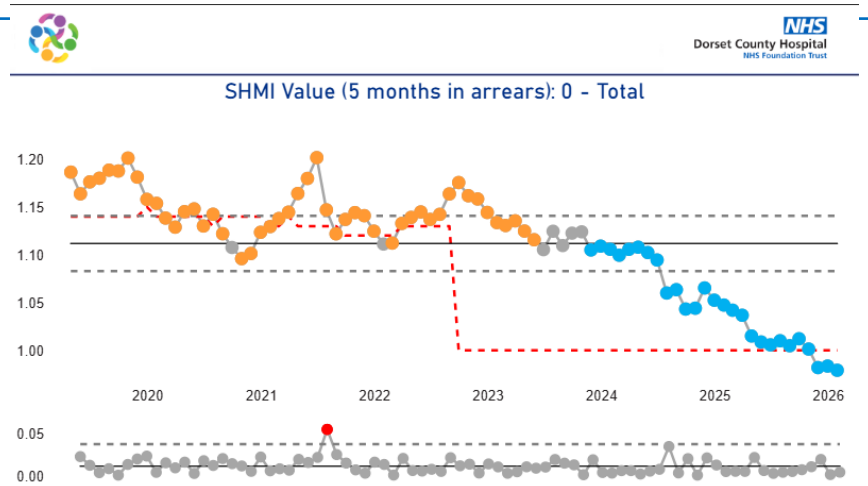


Description of metric

SHMI is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period to the expected deaths (predicted from coding of all admissions).

Analysis

SHMI is published by NHS Digital for a 12-month rolling period, and 5 months in arrears. It takes into account all diagnostic groups, in-hospital deaths, and deaths occurring within 30 days of discharge. It is calculated by comparing the number of observed (actual) deaths in a rolling 12-month period to the expected deaths (predicted from coding of all admissions).

DCH current SHMI is 0.9818. This is the lowest it has been. DCH national ranking position is 27.

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

Chris Hara
06/08/2026 15:53:11

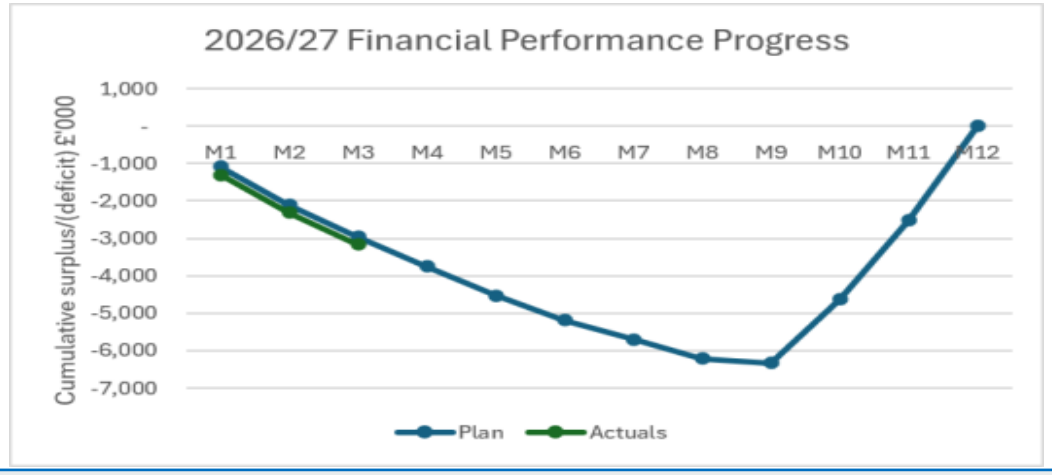
Actions

The Business Intelligence team have produced a dashboard which predicts DCH SHMI aiming to give assurance and the chance to act early if we see a predicted rise in SHMI.

DCH predicted SHMI gives assurance that we are not seeing excess deaths:

Domain: Finance and productivity. Sub domain: Finance. Measure: Combined finance

Dorset County Hospital
NHS Foundation Trust



Description of metric

The combined financial position of the organisation taking into account both planned and actual position metrics (these two individual metrics are detailed in slides below).

Resulting in a score between 1 – 4 (1 being high performing, 4 being low performing)

Analysis

The quarter 4 planned deficit score was a 4 and the actual YTD position against plan was a score of 1, these metrics when considered together were given a combined overall finance score of 2 indicating above average. In summary while our planned deficit of £9.8m is not the break-even Trusts are aiming for, we closed off 2025/26 in line with plan which was positive.

The graph above details the Trust's 2025/26 actual performance in 2025/26 tracked against the original plan and the updated H2 trajectories required to evidence control and improvement on positions.

In 2026/27 the Trust has a planned breakeven plan after the inclusion of £2.6m of deficit support funding (DSF) and as at month 3 is reporting a £0.2m adverse variance to plan as a result of Industrial Action costs incurred in month 1, mainly resulting from additional staff requirements to cover this period. At this stage the Trust has not been notified of funding to support these costs and no available mitigations have been identified to offset this cost pressure.

Ellis Kara
06/08/2026 15:53:11

Actions

As this score is a combination of the following two Finance metrics, actions have been listed against their individual metrics.

Domain: Finance and productivity. Sub domain: Finance. Measure: Planned surplus/deficit

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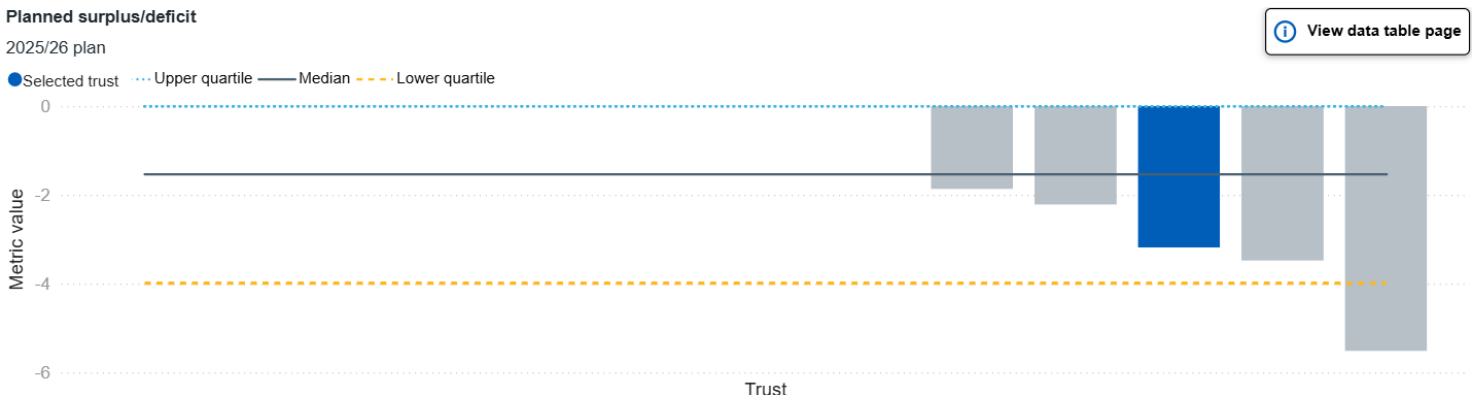


Description of metric

The metric shows the overall level of planned surplus/deficit of the organisation for the financial year once deficit support funding has been removed.

Metric calculates a score between 1-4 (1 being high performing and 4 being low performing).

Analysis

The Trust has a planned breakeven position for 2026/27 after the inclusion of £2.6m deficit support funding (DSF) to deliver this position. Any Trust that is in receipt of DSF can only score a maximum of 3 for this metric, but we await the national published metrics to update on this metric score and positioning for the 2026/27 year.

2025/26 had a score of 4 as a result of the planned £9.8m deficit, the graph above represents the Trusts position/rank within the South West Region.

Ellis,Kara
06/08/2026 15:53:11

Actions

While this metric cannot be changed for the year as it is only calculated annually, work continues to identify areas of saving opportunity and address the underlying deficit.

Continued attention is being given within DCH to address both nationally set target areas and those internally highlighted as an area of opportunity to bring the Trust back into financial balance.

NHS England undertook a funding review to identify trusts that are under or over funded. The review concluded that DCH is currently underfunded. While the planning guidance provided some additional funding to address this position, it did not fully close the funding gap. A further review is expected this year to continue progress towards addressing the remaining underfunding.

Domain: Finance and productivity. Sub domain: Finance. Measure: Variance year-to-date to financial plan

Dorset County Hospital
NHS Foundation Trust

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Plan £'000	- 1,089	- 2,116	- 2,968	- 3,755	- 4,534	- 5,195	- 5,704	- 6,210	- 6,334	- 4,627	- 2,527	0
Actuals £'000	- 1,305	- 2,313	- 3,161									
Variance £'000	- 216	- 197	- 193									

Description of metric

Percentage of variance of the actual financial position year-to-date when compared to the planned position.

Metric calculates a score between 1-4 (1 being high performing and 4 being low performing) based on the % variance against plan.

While timing differences and unexpected activity may lead to monthly variation, Trust is required to meet financial plans by the end of the year.

Analysis

As at month 3, the Trust has a £0.2m adverse variance to plan, the driver of this position is largely due to the cost of supporting Industrial Action in month 1, which at this stage remains unfunded per NHSE advice.

Following a delivery of a £9.8m deficit in line with plan, the Trust ended 2025/26 with a metric score of 1 and ranked 73 out of 134 Trust's and 7th our of the 13 South West Trust's.

Ellis,Kara
06/08/2026 15:53:11

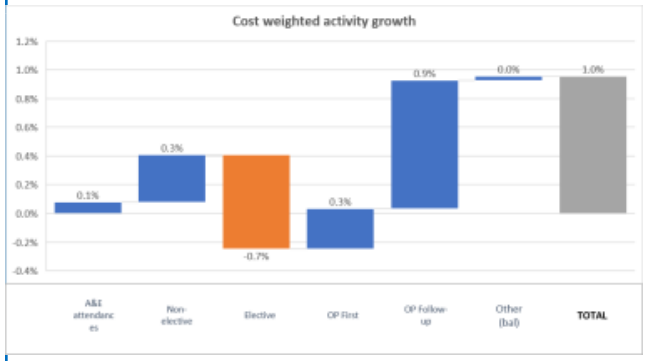
Actions

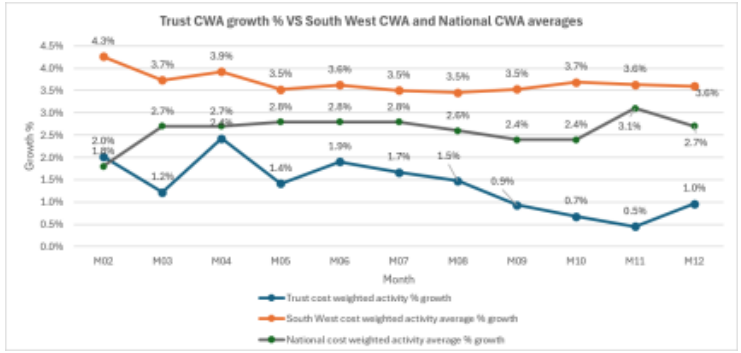
There are a number of challenged performance areas which have significant focus and active mitigations in place noting requirement for the Trust to still deliver to plan for the financial year.

Efficiency delivery is also a high priority in particular closing the unidentified gap and de-risking scheme in addition to the impact of operational pressures and recovery. Further focused work around pay variance control, in particular agency and bank expenditure and sickness levels is under way. The costs incurred supporting Industrial Action still remains unmitigated at this stage.

Domain: Finance and productivity. Sub domain: Productivity. Measure: Implied productivity level

Dorset County Hospital
NHS Foundation Trust





Description of metric

As a core headline metric, improving this value means outputs (cost-weighted activity) relative to inputs (operating expenditure) are improving resulting in an improvement in Implied Productivity.

Analysis

Implied productivity has decreased by 1.0% compared to last year. In M12 this is below the National productivity target and the National and South-West implied productivity averages.

There is an overall increase of 1.0% CWA growth across these Points of Delivery (PoDs). The Trust CWA sits below the South-West and National average in M12.

Expenditure Growth increase in Substantive pay, Supplies and Services and Non-pay has contributed to an overall increase in EG of 2.0%. The Trust has experienced a higher expenditure growth than both the South-West and National average in M12.

Ellis Fara
06/08/2025 10:53:11

Action

Proactive counting and coding exercise, working with clinical services to identify activity they are doing, which isn't being counted.

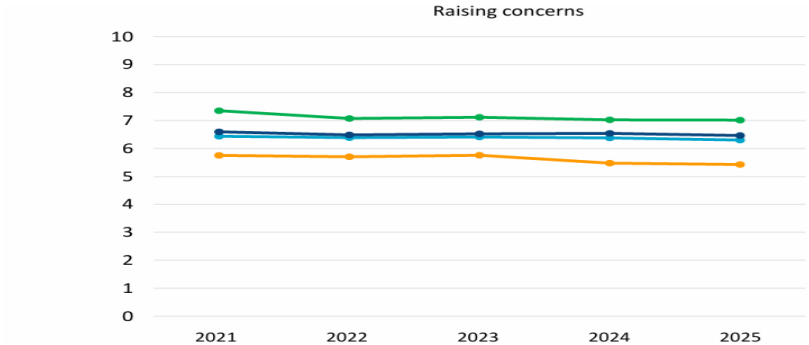
Benchmarking clinic template design, through the GIRFT outpatients work, with the aim of increasing clinic slots.

Delivery of identified CIP, drives improved implied productivity.

DCH has reached out to the national team for support. Following a kick off meeting, it has been identified that there is likely an issue with our activity capture. Early findings suggest this is linked to Radiology systems, but further work is needed to confirm this. A report will be going to the next FPC meet. NHSE are supporting the trust with both data analysis.

Domain: Patient safety. Sub domain: Patient safety. Measure: NHS Staff survey - raising concerns sub-score

Dorset County Hospital
NHS Foundation Trust



	2021	2022	2023	2024	2025
Your org	6.60	6.49	6.53	6.54	6.46
Best result	7.35	7.07	7.12	7.02	7.02
Average result	6.44	6.39	6.41	6.38	6.30
Worst result	5.75	5.70	5.76	5.48	5.43

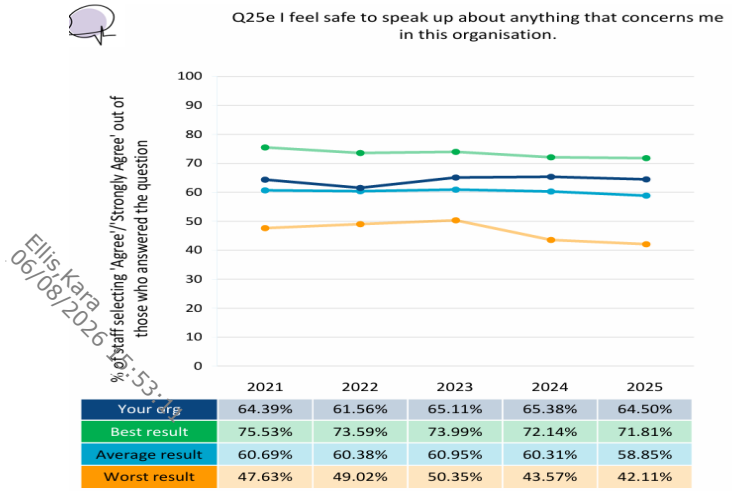
Description of metric

Raising concerns sub-score from 2024 NHS Staff Survey

The DCH score (6.54) is above the average (6.38) and ranks us 45 out of 134.

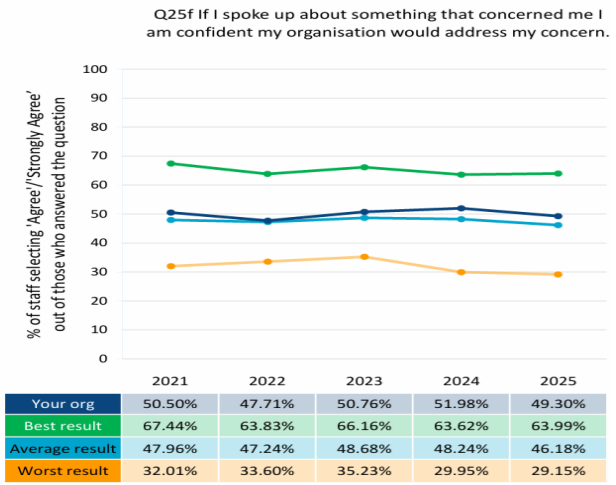
The chart and narrative in this section has been updated to reflect the 2025 results.

Analysis



Ellis,Kara
06/08/2026 15:53:

	2021	2022	2023	2024	2025
Your org	64.39%	61.56%	65.11%	65.38%	64.50%
Best result	75.53%	73.59%	73.99%	72.14%	71.81%
Average result	60.69%	60.38%	60.95%	60.31%	58.85%
Worst result	47.63%	49.02%	50.35%	43.57%	42.11%



	2021	2022	2023	2024	2025
Your org	50.50%	47.71%	50.76%	51.98%	49.30%
Best result	67.44%	63.83%	66.16%	63.62%	63.99%
Average result	47.96%	47.24%	48.68%	48.24%	46.18%
Worst result	32.01%	33.60%	35.23%	29.95%	29.15%

Healthier lives Empowered citizens Thriving communities

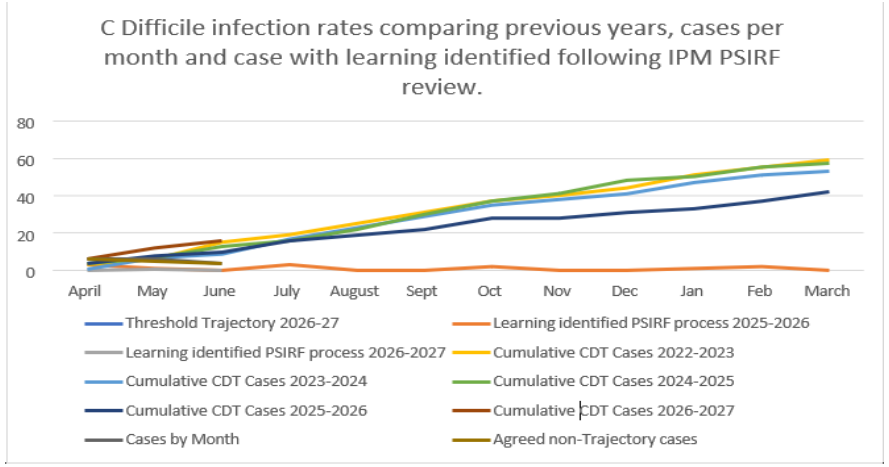
Actions

Since 2022 there have been improvements in both survey questions relating to raising concerns and these scores also remain above average. This improvement can be attributed to the introduction of the Freedom to Speak Up Guardian role and to the implementation of mandatory essential skills training relating to raising matters of concern.

More recently an online reporting tool has been implemented to facilitate anonymous reporting of FTSU and sexual safety issues. Once the tool is embedded within the Trust it will be expanded to capture any issue of concern.

Domain: Patient safety. Sub domain: Patient safety. Measure: Rate of C-Difficile infections

Dorset County Hospital
NHS Foundation Trust



Description of metric

Number of trust apportioned Clostridioides difficile (C. diff) cases to be below the national trajectory for 2026/2027. The trust apportioned trajectory figures are 50 for 2025/2026.

Analysis

Eight Hospital Onset Healthcare Associated (HOHA), and 2 Community Onset Healthcare Associated (COHA) C. difficile cases reported for May and June 2026. This brings the total of HOHA/COHA cases for 2026-2027 to 16. All the cases have followed the newly updated IPM PSIRF (Patient Safety Incident Response Framework) review process.

CDI cases for 25-26 have reduced compared to 24-25 case figures. June figures have improved compared to April and May.

Ellis,Kara
06/08/2026 15:53:11

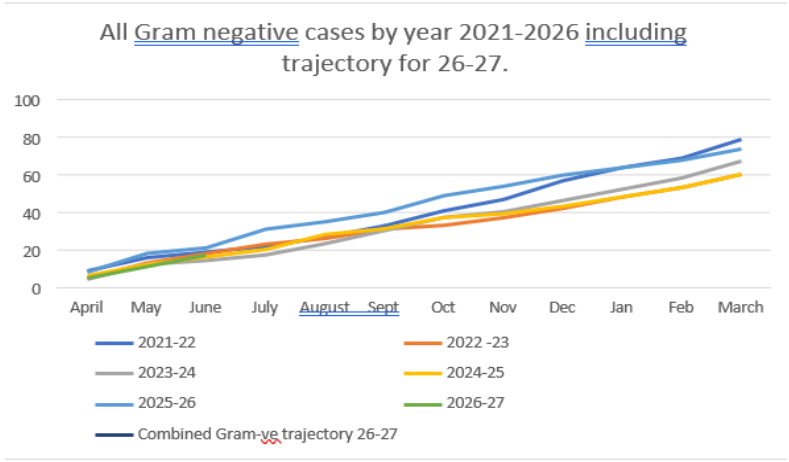
Actions

The IPC Education Framework sets out a vision for the design and delivery of IPC education that supports effective and safe care. The training has a strong Antimicrobial Stewardship (AMS) focus and feedback from the DCH training has been very positive. We are the first Trust in the Integrated Care System, and most of the Southwest, to implement this training using the tiered approach. We are linking with UHD/DHC to share this training program.

The Antimicrobial Consultant Pharmacist delivers AMS training to all the new Resident Dr's.
The Infection Prevention Management team have started performing ward-based face to face scenario training.

Domain: Patient safety. Sub domain: Patient safety. Measure: Rate of E-Coli infections

Dorset County Hospital
NHS Foundation Trust



Description of metric

Number of Trust apportioned Gram-ve cases to be below the national trajectory for 2026/2027.

Threshold: The Trust apportioned trajectory figures are to be 54 as a total for Gram-ve BSI for 2025/2026.

Analysis

Seven Hospital Onset Healthcare Associated (HOHA) & 5 COHA (Community Onset Healthcare Associated) cases gram -ve reportable BSI cases in May and June 2026.

The trajectory levels for 2026/2027 (to be set):
E. coli
P. aeruginosa
Klebsiella spp

In total there were the following HOHA/COHA cases in May and June 2026:
E. coli 5 Running total for this year 8 (26-27).
P. aeruginosa 3 Running total for this year 4 (26-27).
Klebsiella spp 4 Running total for this year 5 (26-27)

Ellis,Kara 06/08/2026 15:53:11

Actions

2026-2027 Gram –ve BSI cases are running at a lower level compared to this time last year.

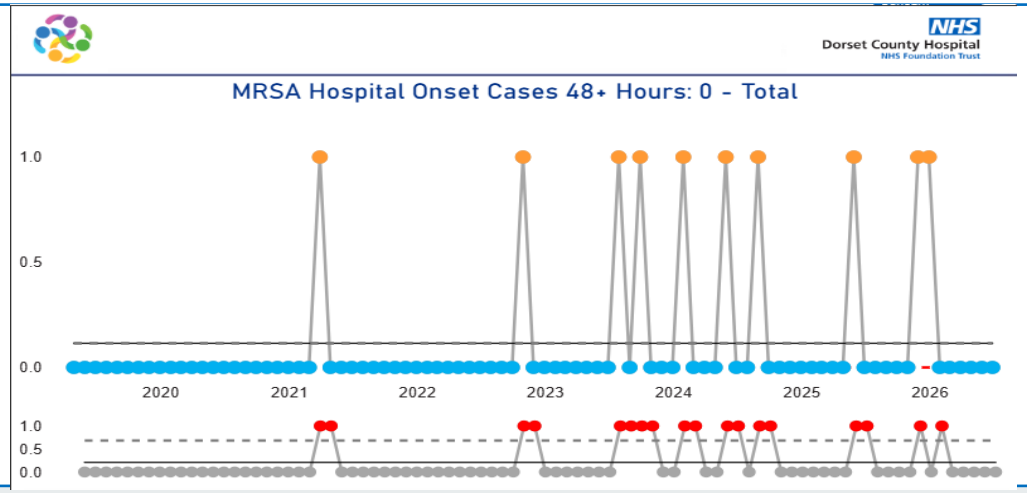
IPM Team have increased our face-to-face teaching over the last few months. This includes ward-based scenario teaching, Dr induction training and housekeeping training.

IPM PSIRF (patient safety incident response framework) process has been

IPM team are performing a scoping exercise to review the use of urine dipsticks across the trust; this will support our system priority to address a call to action from NHS England regarding our future to deliver the AMR National Action Plan. DCH target to ensure no UTI is diagnosed using a urine dipstick alone, with a formal report due March 2027.

Domain: Patient safety. Sub domain: Patient safety. Measure: Number of MRSA infections

Dorset County Hospital
NHS Foundation Trust



Description of metric

Number of Trust apportioned Gram +ve BSI cases to remain low for 2025/2026. There is no trajectory figures set for Gram +ve BSIs.

Analysis

There were 1 Hospital Onset Healthcare Associated (HOHA) & 2 COHA (Community Onset Healthcare Associated) cases gram +ve reportable BSI cases in May and June 2026.

In total there were the following HOHA/COHA cases in May and June 2026:
MRSA 0 Running total for this year 0.
MSSA 3 Running total for this year 7.

Ellis,Kara
06/08/2026 15:53:11

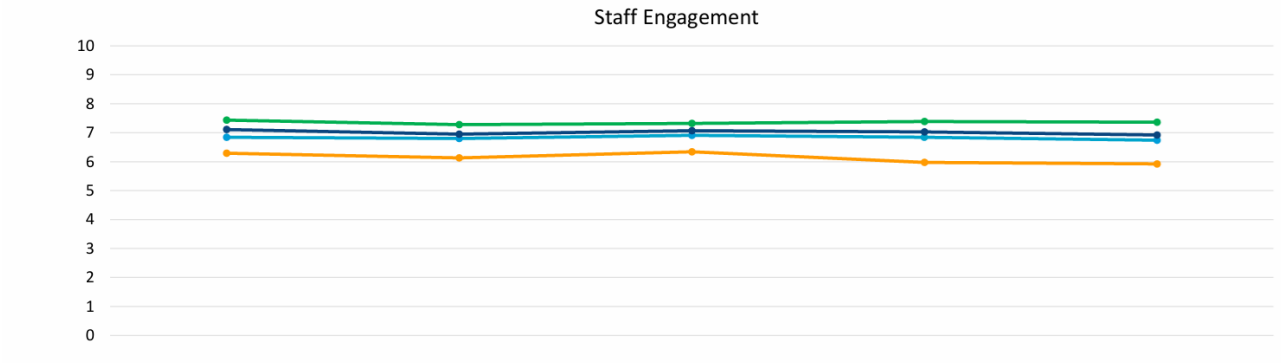
Actions

The Dorset ICB IPC team are carrying out an ongoing in- depth case review of all the MRSA Blood stream infections.

Healthier lives Empowered citizens Thriving communities

Domain: People and workforce. Sub domain: Retention and culture. Measure: NHS staff survey engagement theme sub-score

Dorset County Hospital
NHS Foundation Trust



	2021	2022	2023	2024	2025
Your org	7.11	6.95	7.07	7.03	6.92
Best result	7.43	7.28	7.32	7.39	7.36
Average result	6.84	6.80	6.91	6.84	6.74
Worst result	6.29	6.13	6.34	5.98	5.92
Responses	1515	1402	1418	1746	1621

Description of metric

Engagement theme sub-score from 2024 NHS Staff Survey

The DCH score (7.03) is above the average (6.88) and ranks us 38 out of 134.

The chart and narrative in this section has been updated to reflect the 2025 results.

Analysis

The staff engagement score for DCH has remained stable since 2021 and remains above average.

Ellis,Kara
06/08/2026 15:53:11

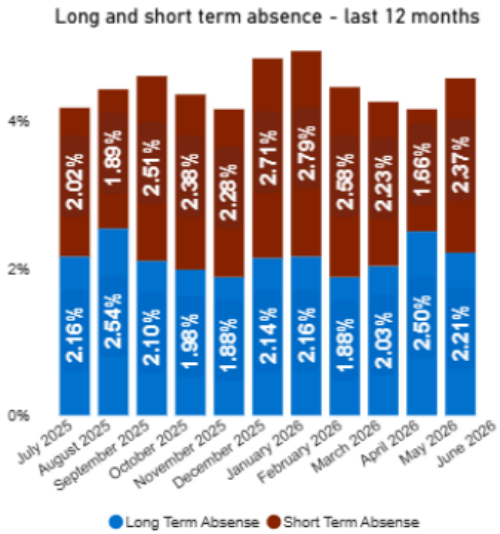
Actions

The full 2025 staff survey results were shared with the Board in April. Local results of the 2025 Staff Survey are being disseminated at present and action plans are being developed. 43.5% of staff participated in the 2025 survey.

A staff voice report is being introduced to triangulate all elements of staff feedback and gain a clearer picture of staff engagement. This new report will be produced twice a year, in November and May and will include insights from the Staff Survey, People Pulse, NETS, GMC Survey, HR, FTSU, Staff Governors, Staff Networks and Union representatives.

Domain: People and workforce. Sub domain: Retention and culture. Measure: Sickness absence rate

Dorset County Hospital
NHS Foundation Trust



Description of metric

NOF Average Sickness Absence Percentage Q2 25-26

The DCH score (4.4%) is below the average (5%) and ranks us 29 out of 134.

Analysis

The overall sickness percentage increased in Month 2 (May) by 0.42% to 4.58%. Long term absence decreased in month by 0.29% to 2.21%. Short term absence increased by 0.71% to 2.37%. Three divisions experienced a small decrease in their overall absence rate (Finance & Resources, Operational Support and Corporate Services). The other divisions saw an increase ranging from 0.28% for Family & Surgical and 1.45% for Director of Nursing.

In Month 2 (May) Finance & Resources was the division with the highest divisional sickness level in month with a decrease of 0.17% to 5.10%. General Office was the area with the highest absence rate in this division who saw their sickness increase from 33.84% to 34.10% in month, this department is made up of three team members one of whom who was absent for the entire month. Only one of the nine staff groups saw a decrease to their absence rates (Admin & Clerical). Additional Clinical Services remained as the staff group with the highest absence rate in month (May) with an increase of 0.80% to 6.89%. In Month 2 three staff groups (Healthcare Scientists, Medical & Dental and Students) recorded sickness below the target 3.75%.

The top reason for absence was unchanged this month. The top reason for absence in Month 2 (May) remained as Anxiety/Stress/Depression. This accounted for 25.2% in month a decrease of 0.8%. The second highest reason for absence in month remained as Other known causes – not elsewhere classified which accounted for 798 days lost.

Actions

HR support is provided in the ongoing management of absence.

A comprehensive health and wellbeing offer is in place for staff, including access to Occupational Health services, a 24/7 Employee Assistance Programme (Vivup), expediated access to Physiotherapy and onsite counselling provision. Over 90 Health and Wellbeing Champions are in place across the organisation, supported by the OD Team.

The Vivup EAP is in the process of being rebranded to Perkbox. A Perkbox launch is scheduled at DCH in September, coinciding with a two-week employee recognition 'thankyou' event.

FT Board 28/05/2026 13:53:1

Report to	Finance and Performance Committee in common	
Date of Meeting	*29th July 2026*	
Report Title	Operational Performance Report; May and June data 2026	
Prepared By	Adam Savin, Director of Operations and Performance	
Approved by Accountable Executive	Anita Thomas, Chief Operating Officer	
Previously Considered By	Anita Thomas, Chief Operating Officer	
Action Required	**Approval**	
	Assurance	x
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	Safety and Quality, capacity and demand and strategic risks	
Financial	ERF	
Statutory & Regulatory	Reporting against, constitutional and contractual standards	
Equality, Diversity & Inclusion	N/A	
Co-production & Partnership	N/A	

Executive Summary

This report provides an overview of Dorset County Hospital's operational performance for May and June 2026 against agreed contractual and regulatory standards. It highlights key risks, progress against improvement trajectories, and actions being taken to maintain compliance and deliver strategic objectives.

Key Points:

- **Urgent & Emergency Care:**
  - ED attendances are 9.05% higher year-to-date than last year, with a disproportionate growth of ambulance demand
  - Four-hour standard has not met the trajectory, but is improving in July
  - Persistent 12-hour breaches remain a concern, primarily due to bed availability
  - Ambulance handover delays against the mean time, is not meeting trajectory or against the 15 and 45min target.

- **Elective Care:**
  - RTT trajectories not meeting trajectory; waiting list size now over 1900 patients larger than plan. Q1 impacted by staffing, equipment failure and two heat waves, impacting the delivery of activity
  - 52+ week breaches did not meet plan for any month in Q1
  - Follow-up backlog reduced to pre-COVID levels.
  - Cancer standards for 28 day and 62 day standard have not been met, for 31 days, 2 months of the quarter has been met.

- **Diagnostics:**
  - Diagnostic performance improved and trajectory being met, with backlog and total waiting list size reductions.

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Overall Position:
Performance standards across UEC and Elective care are not being met, in the face of growing demand for UEC and under delivery on elective activity. The performance levels required in 2026/7 are a significant step up to hit the national ask. Actions are focussed on admission avoidance, length-of-stay reduction, and efficiency improvements across theatres and outpatient services.

Recommendation

The Finance and Performance Committee is asked to:

a) Note the continued growth in A&E attendances and the analysis of what the demand is
b) Note the challenges in Elective performance and the outstanding gap in the revised (modelled) trajectory
c) Note the improved diagnostic position and achievement of trajectory.
d) Receive the report for assurance.

08/08/2026 15:23:46

Operational Performance Report; March and April 2026 data

1. Introduction

This performance report summarises the Trust's position against a range of key performance indicators (KPIs) established nationally through the planning and contracting round. It covers the reporting period of May and June 2026.

The Trust has agreed specific targets for each KPI, as outlined in the 2026/27 Priorities and Operational Planning Guidance. These targets were developed in collaboration with commissioners and the NHS England (NHSE) South West Regional Team. This report evaluates performance against those agreed targets, rather than the standards set out in the NHS Constitution or the NHS Standard Contract.

In some cases, such as internal transformation programmes, KPIs and performance trajectories are set internally. Where this applies, it is clearly noted within the report.

The 2026/27 operating targets are referenced throughout this document. All performance trajectories have been formally accepted by the Integrated Care Board (ICB), NHS England, and Dorset County Hospital.

08/08/2026 15:23:46

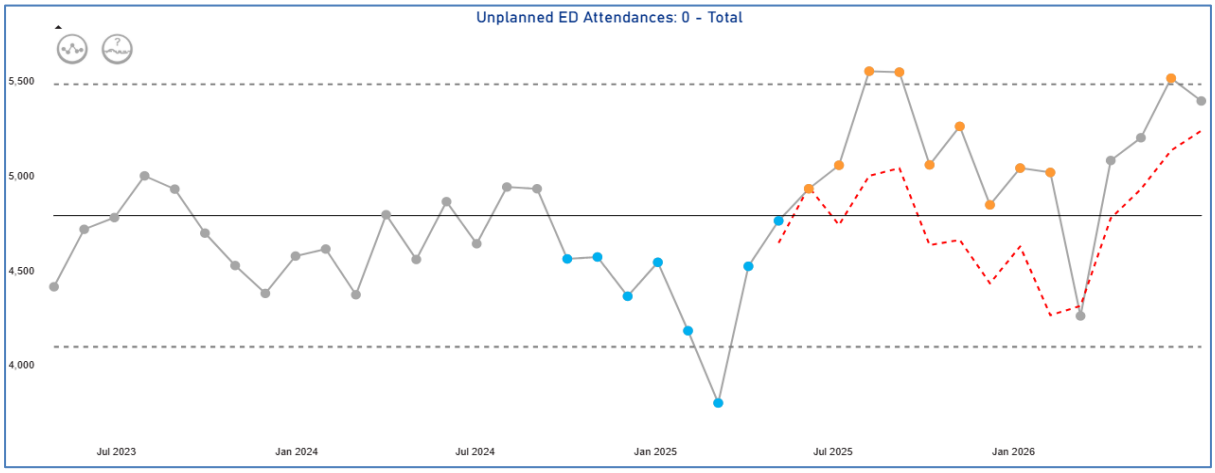
2.0 Operational performance for UEC

2.1 Demand at the front door - ED: 2026/27 year to date

For quarter 1 (April-June) of 2026/27, ED attendances are 9.04% up compared to 2025/26. Against the 2026/27 operating plan, attendances were 5.2% over plan, which translates to an additional 800 patients. This level of demand growth is higher than the South West average of 6.8% up.

Emergency Department (ED) attendances for the full year of 2025/26, was 10.76% up, compared to the previous year.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Number of A&E attendances (DCH)	plan	4928	5132	5236	5742	5769	5216	5493	5291	5461	5461	4952	5461
	actual	5199	5504	5393									
	variance	271	372	157									



Last year's high level of growth, plus demographic growth was included in the operating plan, the level of growth has exceeded expectations. The daily average number of attendances in Q1, 2025/26 was 162, Q1 this year has seen a daily average of 177. There have been significant peaks of very busy days.

Analysis of where the demand is coming from has been completed. Against the operating plan, ambulance demand (all areas) is 7.99% over plan. Growth in Q1 this year, compared to Q1 2025/26, is 9.31% up. Ambulance conveyances from East Dorset increased by 20%, (Q1 25/26 Vs Q1 26/27). East Dorset demand for patient walk-ins has increased by 10.5%, in contrast, attendances to ED from west Dorset (the Trust's traditional catchment area) for both ambulance and walk-ins, has increased by 8%

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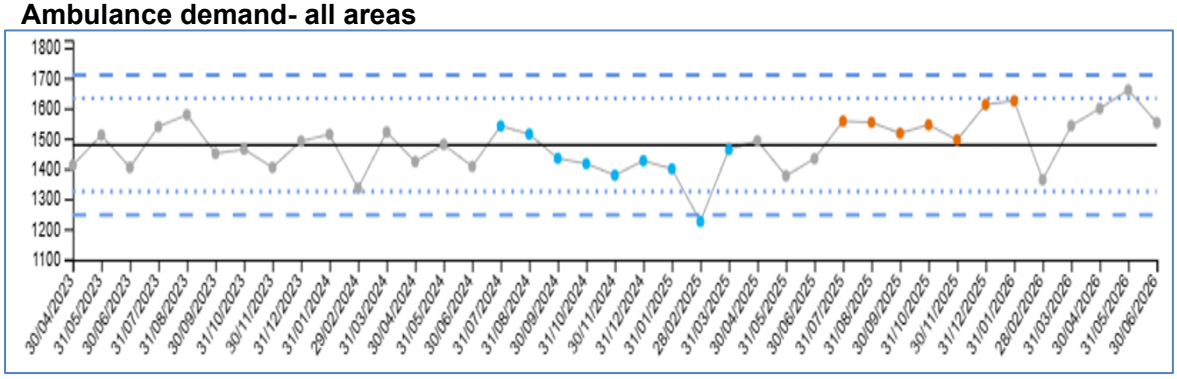
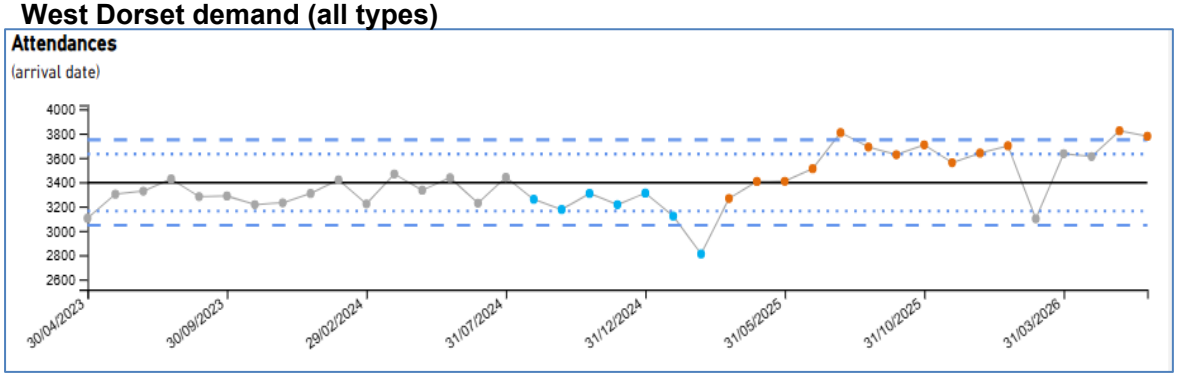
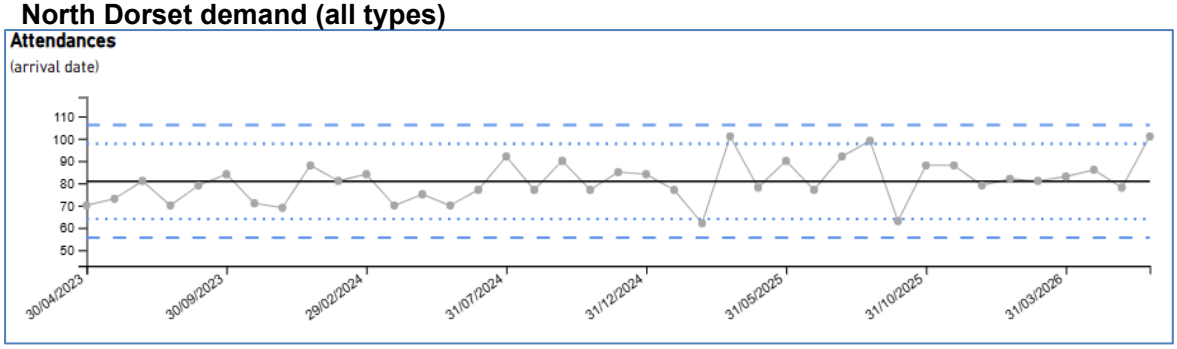
Ambulance demand- all areas



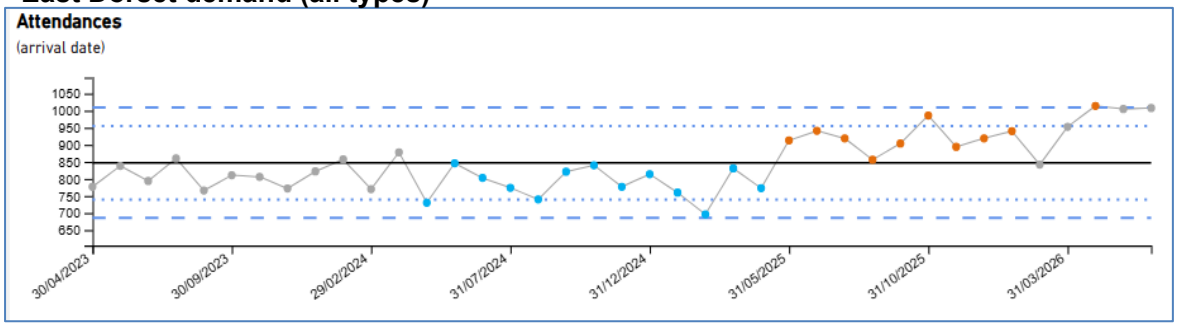
West Dorset demand (all types)



North Dorset demand (all types)



East Dorset demand (all types)



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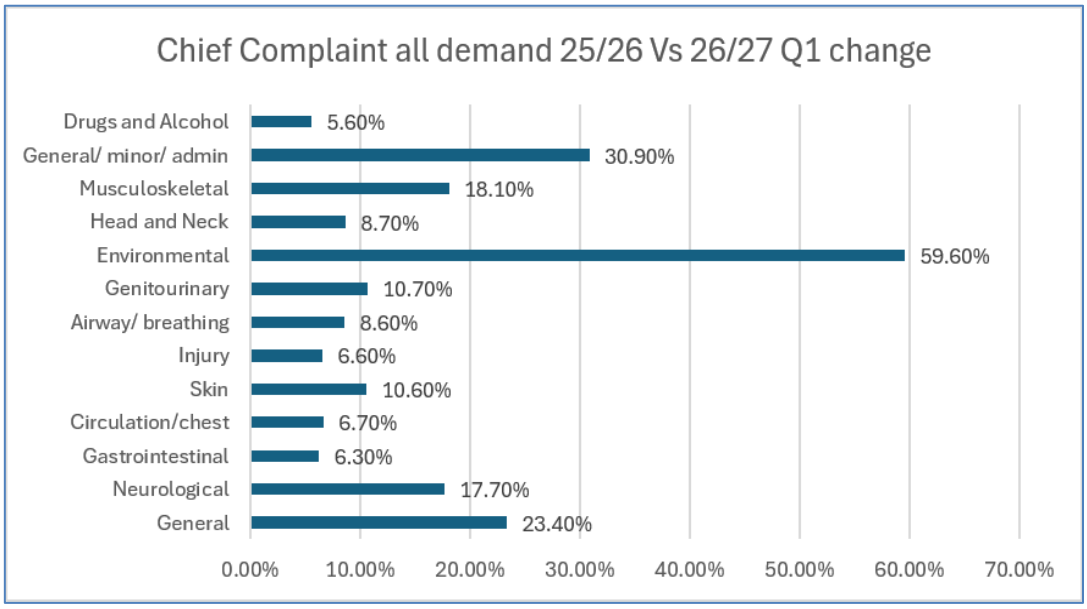
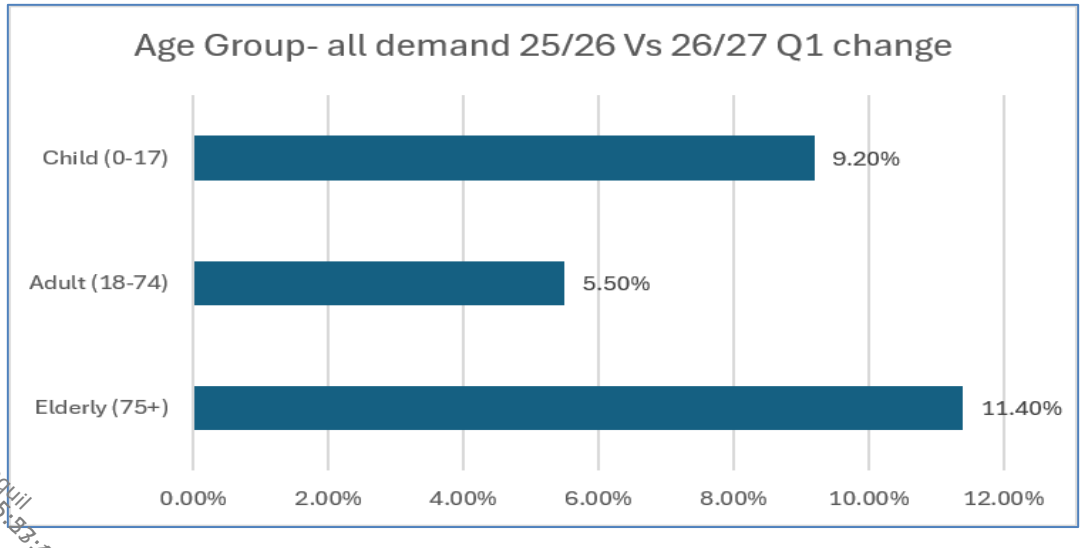
In terms of the type of demand, this has changed as well. Demand from patients aged over 75 (between Q1 2025/26 and 2026/27) has increased by 11.40%, a higher proportion than that of total demand. This cohort of patients, typically have a higher demand on health and social care support before leaving hospital, which in turn directly increases the number of patients who experience an extended length of stay and subsequently become no criteria to reside (NCTR). For the East demand, the growth of patients over 75 years old, is 30% up, for the same period.

During the same comparison period, there has been a 59.60% increase in environmental presentations (Heat), with a heat wave in both May and June. There has been a 30.9% increase in minors and an 18% increase in Musculoskeletal presentation. For the East demand, there has been a 31.3% increase in presentations for psychosocial reasons and a 41.7% increase in airway/breathing difficulties.

All demand





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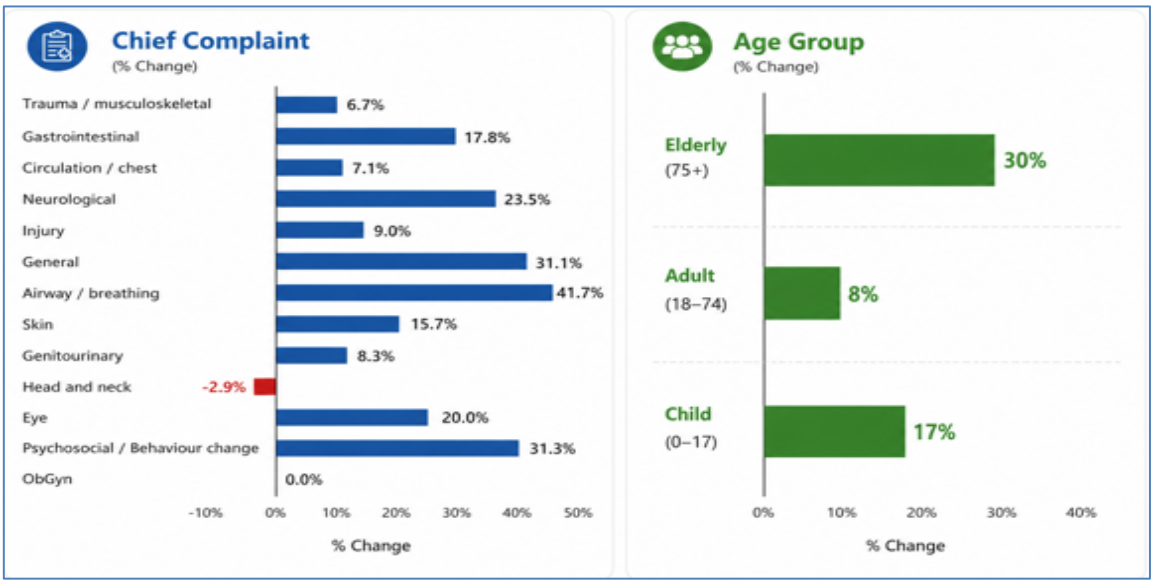
East Demand



2.1.1 Actions to address the demand

This level of demand growth has had a direct impact on performance against the four-hour standard, 12-hour breaches and hospital flow. All analysis has been shared with the ICB and NHS England.

The trust is working collaboratively with system partners on the following out of hospital and Alternatives to Admission actions:

- Deliver a Heart Failure Hospital and Home pathway (PDSA), (for older people) in partnership with DHC. Status: Pilot activated
- Increase referrals into community services directly from ED (Pilot) linked to Frailty Transformation Programme, first PDSA completed, second PDSA in study phase.
- Trial Virtual Ward pharmacist to increase capacity (DCH)

Ensuring 'Care in the Right place at the right time', is achieved will support the trust in manging the demand increase. Actions here include:

- Redesign the inpatient model to eliminate corridor care, manage demand and reduce outliers. This will be achieved by the bed reconfiguration project conclusion in Q3, with the aim of realigning inpatient bed base to fit with demand and establishing an Ortho-Geriatrics Service; implementation of Front door QI programme aims through daily MDT and application of criteria to admit, delivery of the Frailty Transformation in conjunction with DHC services and if funding can be agreed with ICB a trial of a UTC Front Door in Dorchester. A commissioned diagnostic to be carried out by an external expert in early August will support and enhance the required actions to improve internal flow.
- Optimise and extend the model for Acute Assessment to improve flow and reduce avoidable admissions. This will be achieved by expanding the Acute Assessment

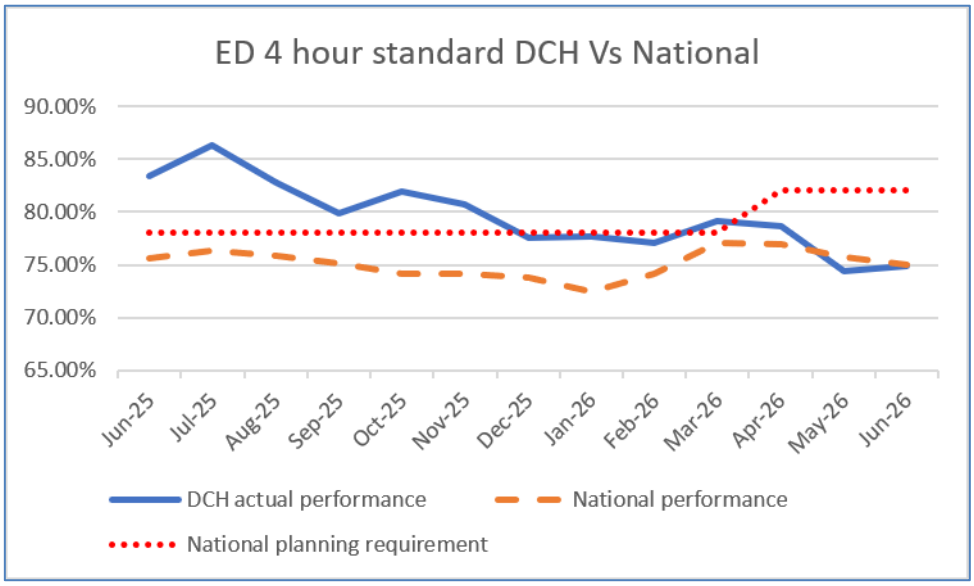
08/08/2026 15:33:26

Unit (AAU) capacity (14 → 24 beds), this is linked to the bed reconfiguration work. The implementation of the Hot Clinic model (admission avoidance) and Strengthen specialty pathways into AAU.

2.2 A&E performance against the four-hour standard 2026/27 year to date

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
A&E 4 hour wait % (all)	plan	82.00%	81.89%	81.99%	78.36%	78.34%	77.69%	78.87%	79.97%	80.52%	81.01%	81.43%	82.06%
	actual	78.70%	74.41%	74.91%									
	variance	-3.30%	-7.48%	-7.08%									

Performance against the 4-hour standard (including UTC activity data) has not met the trajectory set out in the operational plan, for Quarter 1. Compared to the national performance, DCH has been slightly below the national aggregate performance for the 4-hour standard, in May and June.



For 2026/27, there are three KPIs in the operating plan, to monitor the 4-hour standard. As with 2025/26 these are the 4-hour standard (all activity), 4-hour standard for type 1 (DCH only) activity and the additional measure, is performance against the 4-hour standard for children.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
A&E 4 hour wait % (all)	plan	82.00%	81.89%	81.99%	78.36%	78.34%	77.69%	78.87%	79.97%	80.52%	81.01%	81.43%	82.06%
	actual	78.70%	74.41%	74.91%									
	variance	-3.30%	-7.48%	-7.08%									
A&E 4 hour wait % (DCH)	plan	66.25%	65.82%	66.14%	60.19%	60.41%	60.43%	63.61%	63.40%	64.40%	65.29%	66.16%	67.22%
	actual	60.90%	52.43%	53.56%									
	variance	-5.35%	-13.39%	-12.58%									
A&E Children 4 hour wait % (all)	plan	95.41%	95.83%	95.30%	95.71%	95.49%	95.07%	95.43%	95.46%	95.60%	95.60%	95.15%	95.60%
	actual	93.30%	90.79%	91.44%									
	variance	-2.11%	-5.04%	-3.86%									

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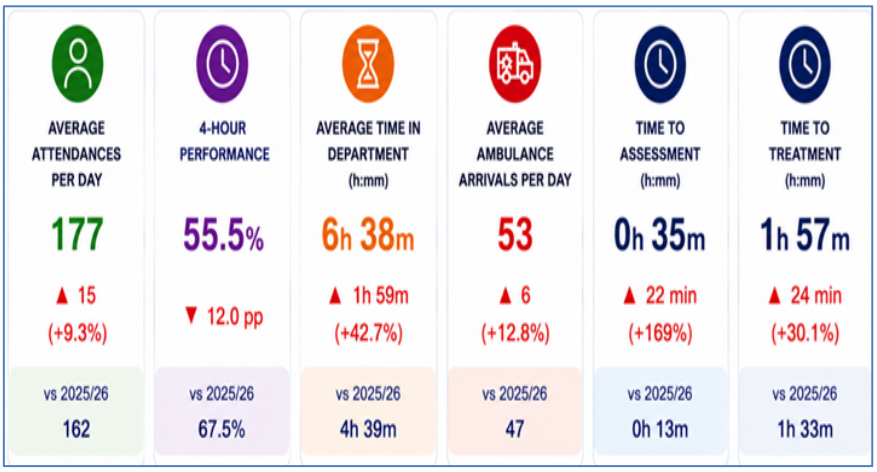
For the three months of quarter 1, DCH has not met trajectory against these three metrics. This was due to demand increase, above the level set in the plan, as detailed in section 2.1 above.

The comparative data between Q1 2026/27 and Q1 2025/26 outlines that all time-based operational metrics within the ED have also deteriorated, alongside the Operational Planning KPIs for Q1 2026/27. This indicates that current demand levels exceed the department's designed operating capacity. This is also as a result of using high turnover, non-admitting areas such as SDEC, Frailty SDEC and EDAU/EEMAC for inpatients, in response to the demand increase. The average time in the department has increased by 1 hour and 59mins, with a waiting to assessment increase of 22mins and a time to treatment increase of 24mins.



2.3 A&E performance 12-hour breaches; 2025/26 full year and 2026/27 year to date

The 2026/27 operating plan required a trajectory for patients waiting in A&E over 12 hours.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Number of A&E 12 hour breaches	plan	572	543	504	444	501	452	424	386	454	602	427	341
	actual	587	846	848									
	variance	15	303	344									
Percentage of A&E attendances over 12 hours	plan	11.61%	10.57%	9.62%	7.72%	8.69%	8.66%	7.71%	7.29%	8.32%	11.02%	8.62%	6.25%
	actual	11.30%	15.43%	15.69%									
	variance	-0.31%	4.86%	6.07%									

For quarter 1, the number of patients that have breached 12 hours, has not met the trajectory. Apart from April, the percentage of A&E attendances that have breached 12 hours, has also not hit plan.

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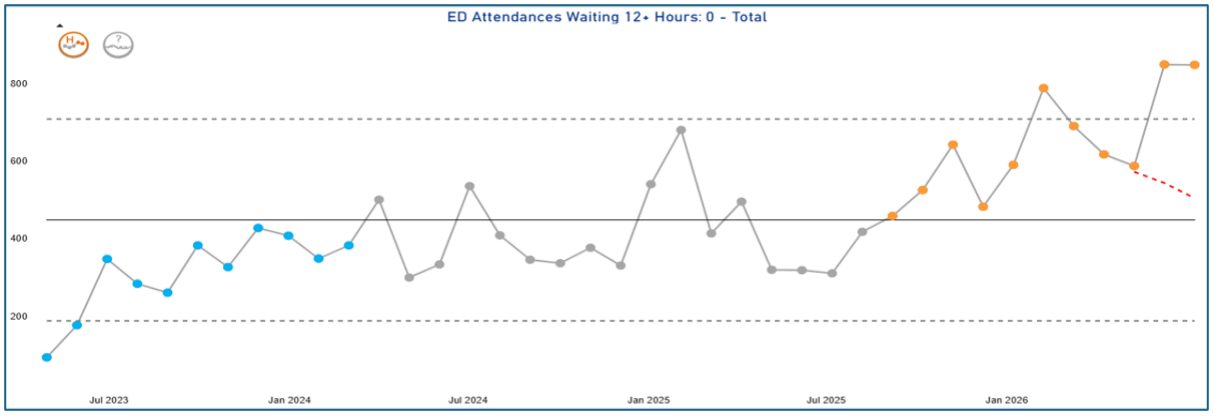

The largest cause of these breaches is waiting for a bed, however, there are improvements that can be made where patients breach 12 hours but are not admitted.

2.3.1 Actions to address 4 hour performance and 12 hour breaches

The impact of increasing levels of demand, directly correlates with the declining performance against the 4 hour performance metrics and 12 hour breaches.

The trust is working collaboratively with system partners on the following Flow Through ED & Early Decision Making (Internal Professional Standards) actions:

- Introducing a daily ED MDT first thing in the morning
- Consultant informed bed meetings (improved connections with medics to inform flow decisions and actions)
- Rapid streaming (minors / majors)
- Deploy EPIC role during peak pressure (Named clinician with specific department flow related actions and authority)
- Dedicated transfer function with maximum wait standards
- Review and relaunch 'Your Next Patient' policy

The trust is also delivering actions to improve Front Door Pathways and the Service Model (Frailty). These include:

- Relocate and enhance Frailty SDEC at front door
- Embed CFS scoring and early senior decision maker
- Enhanced oversight of daily Frailty MDT (incl. community teams)
- Escalate long waits for via bed meeting and Neighbourhood Team MDTs
- Establish Senior Manager Led T&F group to reduce P0 LoS for older people
- Re-establish EDAU/EEMAC as high-turnover assessment capacity, also supporting diagnostic turn-around and clinical decision making

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2.3.2 Forward look at performance, 4 hour and 12 hour breach standard

The trust has submitted a set of recovery trajectories to NHSE, which are modelled on the actions set out in the plan.

Looking ahead, at the time of writing this report, performance against the 4 hour standard and the percentage of attendance that breach 12 hours is meeting the July recovery trajectory.

		Recovery forecast UEC								
Metric	Ops plan 26/27	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
4 hour wait (all)	Recovery plan	73.50%	75.00%	76.50%	77.40%	78.50%	80.52%	81.01%	81.43%	82.06%
	actual	79.93%								
	variance	6.43%								
4 hour wait (DCH)	Recovery plan	53.20%	54.50%	59.60%	62.20%	63.00%	65.00%	65.29%	66.16%	67.22%
	actual	62.93%								
	variance	9.73%								
% of attendances 12+ hours	Recovery plan	13.50%	12.50%	10.40%	9.70%	8.60%	8.32%	11.02%	8.62%	6.25%
	actual	12.59%								
	variance	-0.91%								

2.3 Non-Elective Admissions; 2025/26 full year and 2026/27 year to date

The conversion rate (% admitted from attendance) has remained static at 22%. With a static conversion rate and increased attendances, non-elective admissions would increase. Despite this, current contractual reporting is showing non-elective admission volumes have reduced compared to last year. The data definitions have changed between the two financial years, with a change to the way SDEC activity is counted (nationally). The Business Intelligence team is working through the data definitions and calculations, alongside the ICB, to ensure we have comparable data sets. This will be completed for the next meeting of the committee.

For the first quarter of 2026/27, total non-elective spells are 379 patients under plan.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Non-elective spells with a LoS of 1+ days	plan	1448	1440	1388	1506	1455	1416	1439	1425	1471	1471	1333	1471
	actual	1425	1268	1372									
	variance	-23	-172	-16									
Non-elective spells with a zero day LoS	Plan	1142	1085	1267	1408	1147	1113	1302	1193	1232	1232	1116	1232
	actual	1089	843	1078									
	variance	-53	-242	-189									
Total Non-elective spells	Plan	2590	2525	2655	2914	2602	2529	2741	2618	2703	2703	2449	2703
	actual	2519	2422	2450									
	variance	-71	-103	-205									

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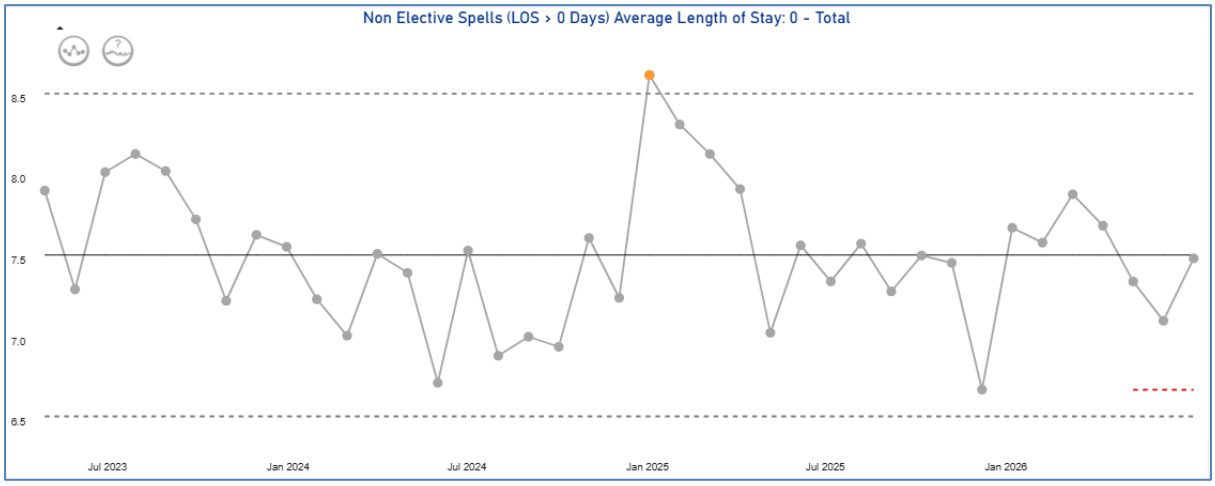
2.4 No reason to reside and non-elective length of stay (flow); 2026/27 year to date

For 2026/27, the metrics in the Operational Plan relating to flow, are slightly different. The non-elective average length of stay is measured by taking total non-elective bed days (all) and divided by the number of total non-elective admissions. This therefore measures the effectiveness of all non-elective pathways, combined.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Total bed days for non-elective admissions	Plan	9702	9648	9300	10090	9749	9487	9641	9548	9856	9856	8931	9856
	actual	10521	10023	10312									
	variance	819	375	1012									
Total number of discharges for non-elective admissions	Plan	1448	1440	1388	1506	1455	1416	1439	1425	1471	1471	1333	1471
	actual	1303	1268	1243									
	variance	-145	-172	-145									
Non elective LoS (non-elective bed days/ non-elective discharges)	Plan	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7	6.7
	actual	7.38	7.13	7.52									
	variance	0.68	0.43	0.82									

For June, Non-elective LoS was 0.82 above plan, driven by 1,012 more bed days and 145 too few discharges than plan. This is the first month it has increased, following 4 months a reduction.



A trajectory was not required for patients with no criteria to reside the operating plan however, tracking this is key in understanding the drivers of LoS and bed occupancy. Locally, a target of 49, NRTR has been set as part of the FutureCare work.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Percentage of pts discharged on discharge ready date	Plan	91.70%	90.43%	90.85%	91.23%	90.55%	91.12%	88.91%	90.74%	90.67%	90.67%	90.67%	90.67%
	actual	88.10%	90.62%	88.66%									
	variance	-3.60%	0.19%	-2.19%									
Average day delay past discharge ready date (excluding zero)	Plan	8.62	7.28	9.54	11.22	11.93	9.66	7.72	9.29	9.59	9.59	8.66	9.59
	actual	8.83	7.03	7.52									
	variance	0.21	-0.25	-2.02									
Average number of NRTR pts (local target, not in Ops plan)	Plan	49	49	49	49	49	49	49	49	49	49	49	49
	actual	63	51	48									
	variance	14	2	-1									

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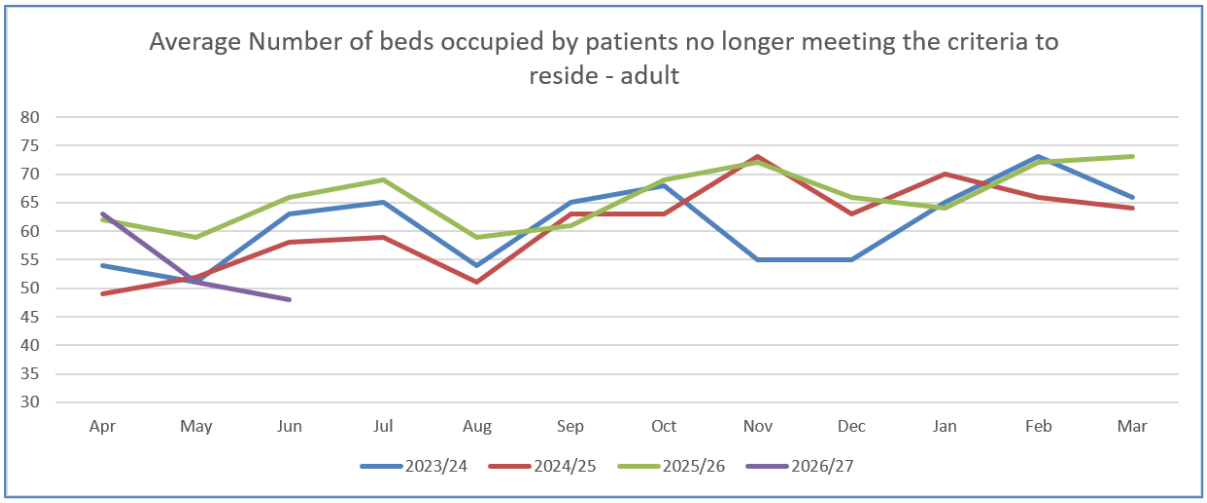
The number of patients occupying a bed with no reason to reside was 1 below the locally agreed trajectory. At the end of June, DCH had the lowest number of NCTR patients in the last 4 years.



This is positive and while hitting the locally agreed trajectory, it should be noted that this is still high, at 18% of the bed base.

2.5 Occupied beds; 2026/27 year to date

For Quarter 1, the number of occupied beds has been over plan. The number of open beds were 11 above plan for June, this variance is lower than occupied, which is why the bed occupancy percentage is higher than plan.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Bed occupancy %	plan	97.65%	97.37%	97.70%	99.67%	96.38%	99.67%	100.00%	98.03%	100.00%	100.00%	97.04%	97.37%
	actual	98.10%	99.10%	99.07%									
	variance	0.45%	1.73%	1.37%									
Average number of overnight GA beds occup	plan	291	296	297	303	293	303	304	298	304	304	295	296
	actual	299	307	308									
	variance	8	11	11									
Average number of GA beds open	plan	298	304	304	304	304	304	304	304	304	304	304	304
	actual	305	310	311									
	variance	7	6	7									

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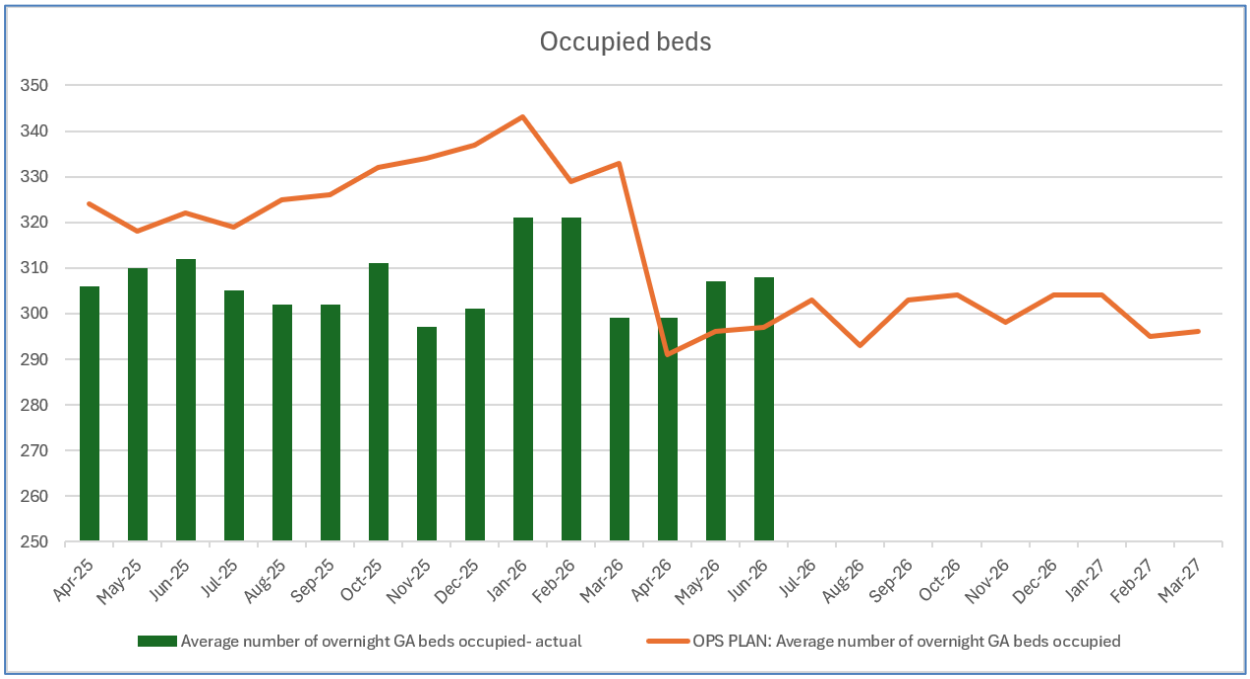

2.5.1 Actions to address no reason to reside and bed occupancy

The trust is developing plans, with system partners for a “drive to 35” for no reason to reside. This is being supported by an external diagnostic, conducted by Dr Ian Sturgess as described above. Other actions underway include:

- Criteria to Admit Audit to be undertaken with action plan for further change
- Audit patients leaving until after 16:00, create actions to release capacity earlier in the day
- Remove discharge lounge barriers (TTOs, EDS, CDs; engage RDs)
- Other actions set out above will improve length of stay, delivering better bed turnover and in turn, reducing the demand on the bed stock

2.6 Ambulance handover delays

Ambulance handover delays are a major contributing factor to the under performance of the ambulance response times. In the operating plan for 2026/27, ambulance handovers delays over 15mins, those over 45mins, the mean handover time and the number of ambulances arrivals have been included as a metric.

For quarter 1, the ambulance handover time metrics were not met. As previously noted, demand is above plan and proportionately, ambulance demand has seen the largest increase in arrivals at DCH, particularly with demand from East Dorset.

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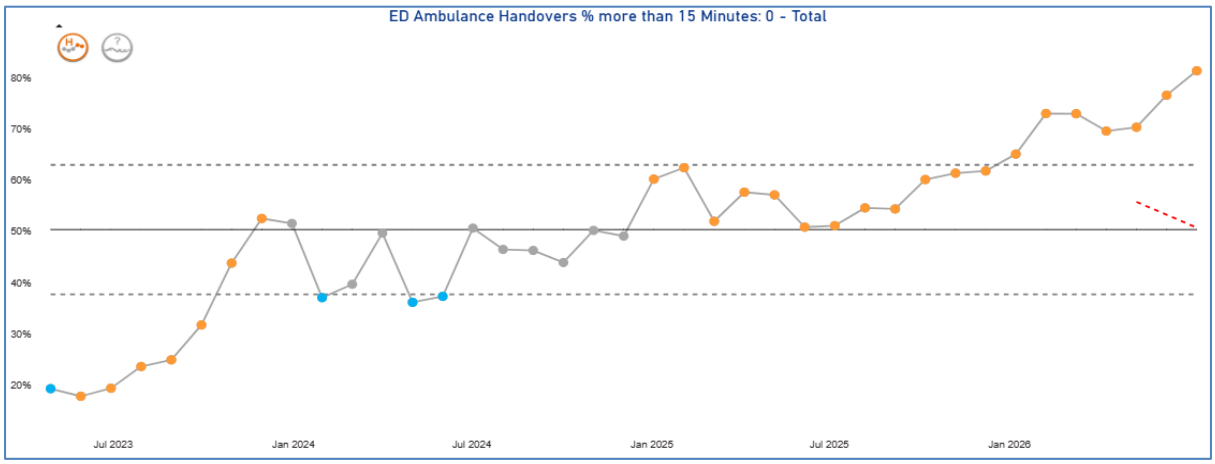
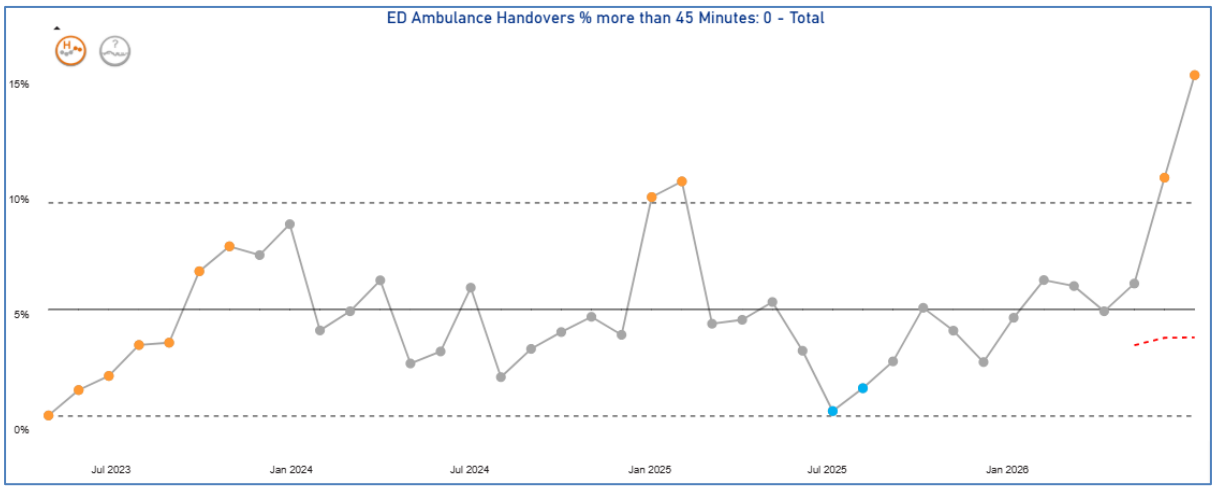
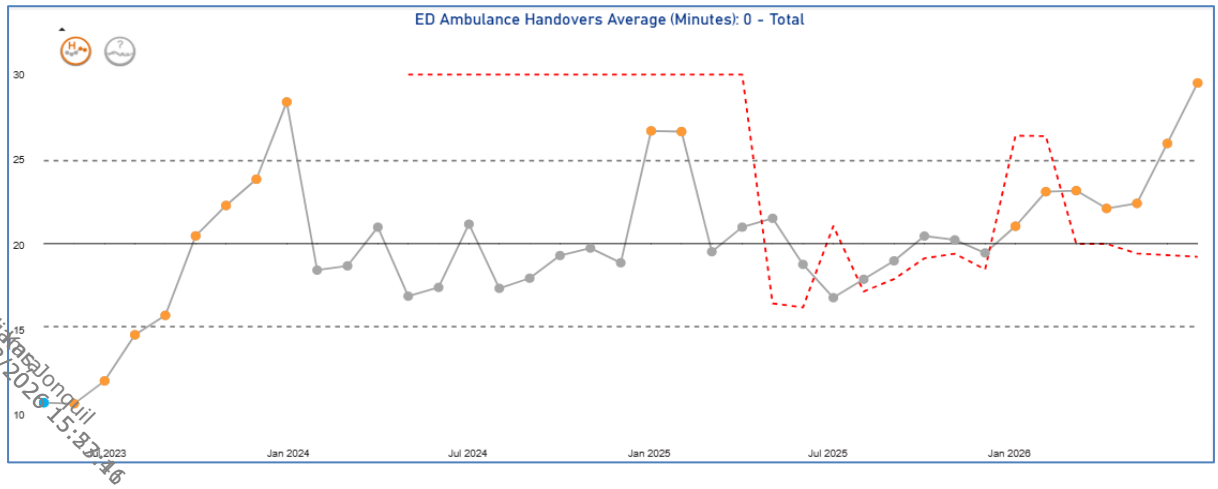
Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Total ambulance arrivals	plan	1552	1454	1497	1845	1825	1794	1823	1759	1810	1810	1658	1810
	actual	1625	1667	1571									
	variance	73	213	74									
Average ambulance(mean) handover time	plan	00:19:30	00:19:24	00:19:18	00:19:12	00:19:00	00:18:48	00:18:42	00:18:30	00:18:12	00:18:06	00:18:00	00:18:00
	actual	00:22:40	00:22:57	00:29:51									
	variance	00:03:10	00:03:33	00:10:33									
%of ambulance handovers over 45mins	plan	3.67%	3.99%	4.01%	4.01%	4.00%	3.01%	3.02%	1.99%	1.99%	0.99%	1.03%	0.00%
	actual	6.34%	10.91%	15.36%									
	variance	2.67%	6.92%	11.35%									
%of ambulance handovers over 15mins	plan	55.73%	53.23%	50.70%	48.24%	45.70%	43.20%	40.70%	38.20%	35.69%	33.20%	30.70%	28.23%
	actual	70.30%	76.54%	81.29%									
	variance	14.57%	23.31%	30.59%									







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2.7 UEC risk statement

The principal risk is that the Trust remains above plan for demand at the front door, which is hindering the ability to deliver the key performance metrics, as set out in the Operating Plan.

Demand risk– Emergency demand may continue to grow above current forecasts, particularly from East Dorset, with the anticipated relocation of Poole ED. The ICB has not commissioned any changes in patterns of presentation as a result of this

Capacity risk– Planned improvements are dependent on additional ED and inpatient capacity being delivered as planned

Flow risk– Persistent high occupancy and escalation could delay the recovery of effective flow through ED, assessment and inpatient services.

Workforce risk– Sustained escalation places pressure on staffing and increases reliance on temporary workforce arrangements

System dependency risk – Delivery of benefits relies on community, social care and partnership agreements delivering change with a background of challenges with sustained historical delivery

Financial risk– Several capacity solutions (for example the Urgent Treatment Centre) require recurrent funding and estate investment to deliver their full impact. A Capital funding submission will be made on 3/7/2026 to NHSE. Revenue funding will be dependent on funding changes aligned to UHD changes and contract triggers associated with growth of demand.

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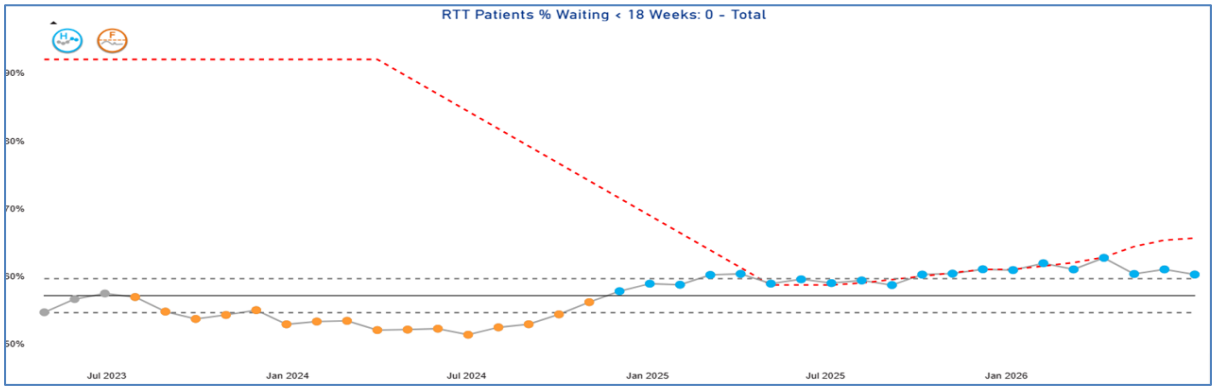
3.0 Operational performance for Elective Care

3.1 Referral to treatment constitutional and contractual standard (RTT)

For 2026/27, every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national performance target of 70%). For DCH, this means achieving 70.89% RTT 18-week performance and 77.69% for 1st activity, by March 2026.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
RTT: %patients waiting <18wks	plan	64.38%	65.32%	65.62%	66.26%	66.84%	67.48%	68.09%	68.64%	68.49%	69.06%	70.31%	70.89%
	actual	60.30%	61.00%	60.50%									
	variance	-4.08%	-4.32%	-5.12%									
RTT: %patients waiting <18wks for 1st Activity	plan	71.65%	71.81%	72.42%	73.06%	73.64%	74.28%	74.89%	75.43%	75.97%	76.57%	77.12%	77.69%
	actual	65.90%	65.66%	65.23%									
	variance	-5.75%	-6.15%	-7.19%									



Quarter 1 has been challenging for elective care, with activity volumes impacted for a variety of reasons. This is the primary cause of underperformance. Other factors include:

- In ENT and Orthopaedics, the two areas with significant backlogs to treat suffered 3 unplanned consultant absences. Similarly, Consultants having to cover clinically urgent nurse injection lists in Ophthalmology due to unplanned absences in the nurse-led service.
- Equipment failures in key services resulting in lost activity and cancellations
- Delays in the delivery of planned insourcing activity, with unstable capacity being provided by the companies and poor weekend utilisation.
- The inability to fully reinstate activity paused during industrial action.
- The Red Alert Heatwave, with high humidity (over 75%) causing patient safety risks resulting in the loss of theatre activity over 3 days. High humidity impacts the physical theatre space and the theatre packs, due to increased moisture levels, creating an infection risk.

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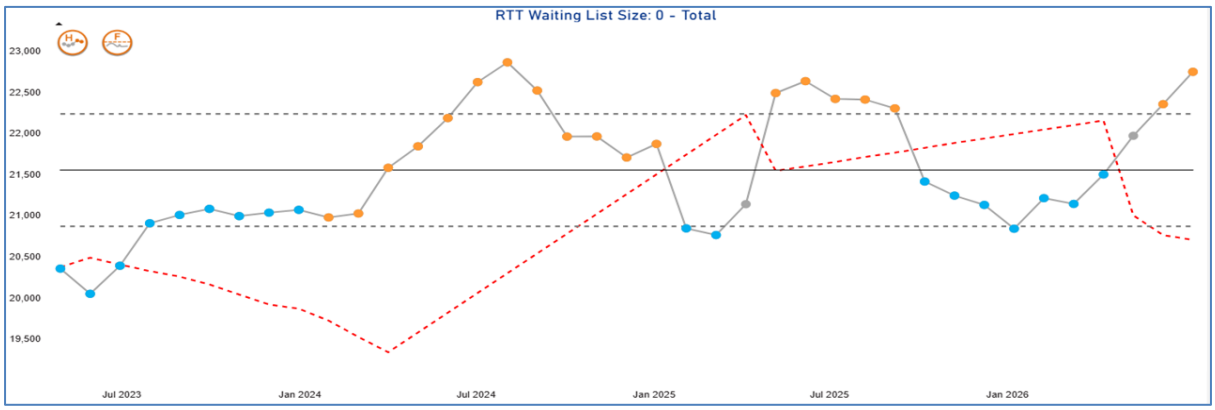
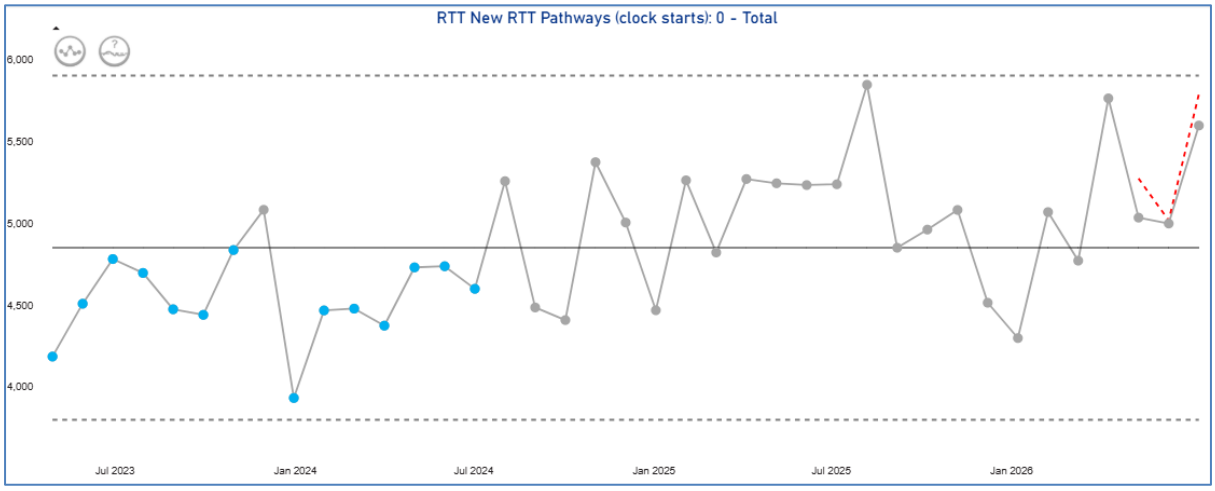
3.2 Waiting list size

The size of the waiting list has not met trajectory in Quarter 1. At the end of June, the waiting list was 1,942 patients larger than planned and increased by 677 patients since April 2026.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
RTT: Total Waiting List	plan	21,000	20,760	20,702	20,539	20,366	20,213	20,043	19,879	19,784	19,642	19,432	19,287
	actual	21,967	22,351	22,644									
	variance	967	1,591	1,942									



A 4% referral growth factor was applied as part of the operating plan, year to date referrals are 1% up, with April and May being low, although June has seen a large spike.



The other factor impacting the size of the waiting list, is the amount of activity undertaken.

The ERF definition of activity counting has been retired for 2026/27, which means activity is counted as per the contractual definition. Against the Quarter 1 operating plan, activity levels for consultant led (RTT) activity are below plan. Total lost activity due to key staffing variables mentioned in the prior section is 680 OPAs and 120 theatre cases. Total lost activity due to equipment failure is 215 OPAs, and 102 theatre cases.

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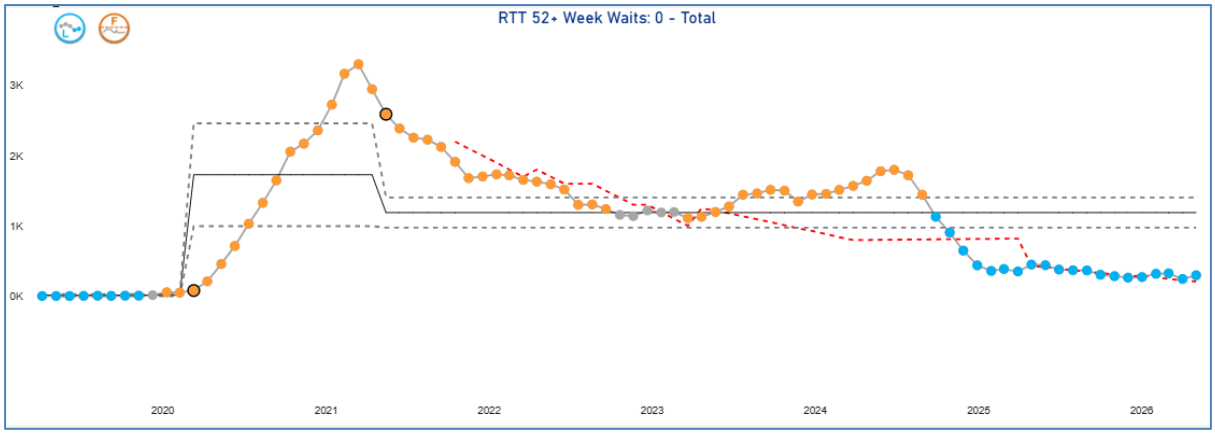
Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Total year to date June
Consultant-led first outpatient attendances (Spec acute)	plan	5,311	5,152	5,962	6,245	5,456	5,951	5,987	5,704	5,655	5,419	5,438	5,685	16,425
	actual	4,790	4,721	5,231										14,742
	variance	-521	-431	-731										-1683
Consultant-led follow-up outpatient attendances (Spec acute)	plan	8461	8088	9338	9785	8502	9330	9357	8916	8866	8509	8504	8925	25,887
	actual	8819	8407	9511										26,737
	variance	358	319	173										850
Consultant-led follow-up outpatient attendances - of which Outpatient Procedures	plan	1529	1462	1687	1768	1536	1686	1691	1611	1602	1538	1537	1613	4,678
	actual	1528	1290	1468										4,286
	variance	-1	-172	-219										-392
Total number of specific acute elective day case spells in the period	plan	2,512	2,433	2,801	2,929	2,569	2,797	2,811	2,683	2,664	2,555	2,562	2,676	7,746
	actual	2,388	2,476	2,711										7,575
	variance	-124	43	-90										-171
Total number of specific acute elective ordinary spells in the period	plan	198	193	223	234	205	223	224	214	211	203	204	213	614
	actual	183	179	206										568
	variance	-15	-14	-17										-46
Total number of specific acute elective spells in the period	plan	2,710	2,626	3,024	3,163	2,774	3,020	3,035	2,897	2,875	2,758	2,766	2,889	8,360
	actual	2,571	2,655	2,917										8,143
	variance	-139	29	-107										-217

3.3 Long waits performance

The operational planning guidance required an improvement of 52+ week waiters, while staying within the 1% tolerance of the total waiting list size, which was set last year. Due to the level of activity at trust level that was in this year's plan, the trajectory was set to zero, 52+ week waits by March 2027. Quarter 1 has not met the trajectory, as activity levels are behind plan.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
RTT: 52wk wait	plan	208	189	170	151	137	118	99	80	66	47	28	0
	actual	296	356	399									
	variance	88	167	229									
RTT: 52wk cohort % of Waiting List	plan	0.99%	0.91%	0.82%	0.74%	0.67%	0.58%	0.49%	0.40%	0.33%	0.24%	0.14%	0.00%
	actual	1.35%	1.59%	1.76%									
	variance	0.36%	0.68%	0.94%									



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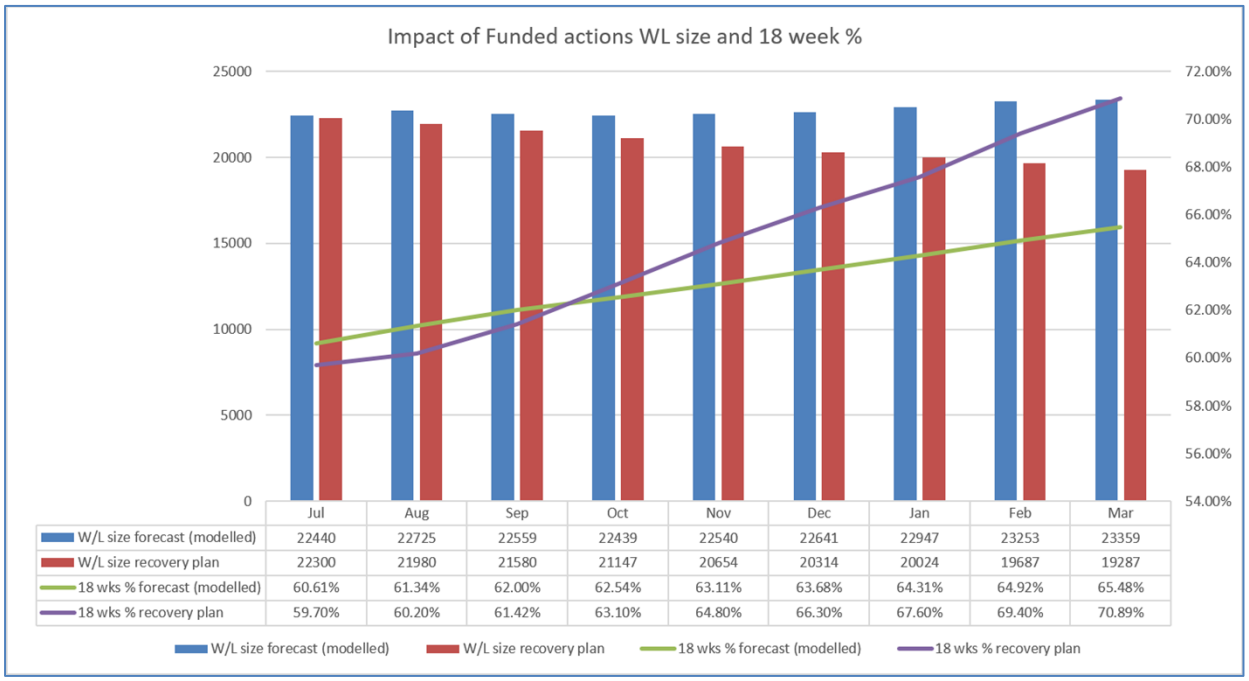
3.4 Actions to address RTT performance

Since the total trust plan has been submitted, specialty-level intervention modelling has been completed. The specialty-level intervention modelling provides a detailed bottom-up assessment of the actions that are in development to reduce the waiting list and long-wait position by March 2027.

The modelling has considered a broad range of interventions across specialties, including validation, pathway redesign, referral management, booking improvements, additional outpatient and theatre capacity, independent sector use and insourcing. Only funded actions have been included in the modelling.

The results of this modelling are shown below. Based on the funded actions, the trust will be able to recover to 65.48%, with 309, 52 week waits and a waiting list size of 23,359.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
W/L size forecast (modelled)	22440	22725	22559	22439	22540	22641	22947	23253	23359
W/L size recovery plan	22300	21980	21580	21147	20654	20314	20024	19687	19287
18 wks % forecast (modelled)	60.61%	61.34%	62.00%	62.54%	63.11%	63.68%	64.31%	64.92%	65.48%
18 wks % recovery plan	59.70%	60.20%	61.42%	63.10%	64.80%	66.30%	67.60%	69.40%	70.89%

The trust submitted a draft recovery plan to NHSE, which delivered on the original ask of the waiting list size (19,287) and RTT performance (70.89%), but with 192, 52 week waits (1% of the waiting list size, if the waiting list size trajectory was met). This was following advice from NHSE on the minimum level of performance that would be acceptable.

The modelling of funded actions demonstrates this will not be achievable without further work to identify actions to close the gap and negations with the ICB on funding arrangements need to be concluded. Re-profiling of the ERF spend is a key action, to determine if the current financial envelope could be utilised to optimise activity levels while recognising clinical priority.

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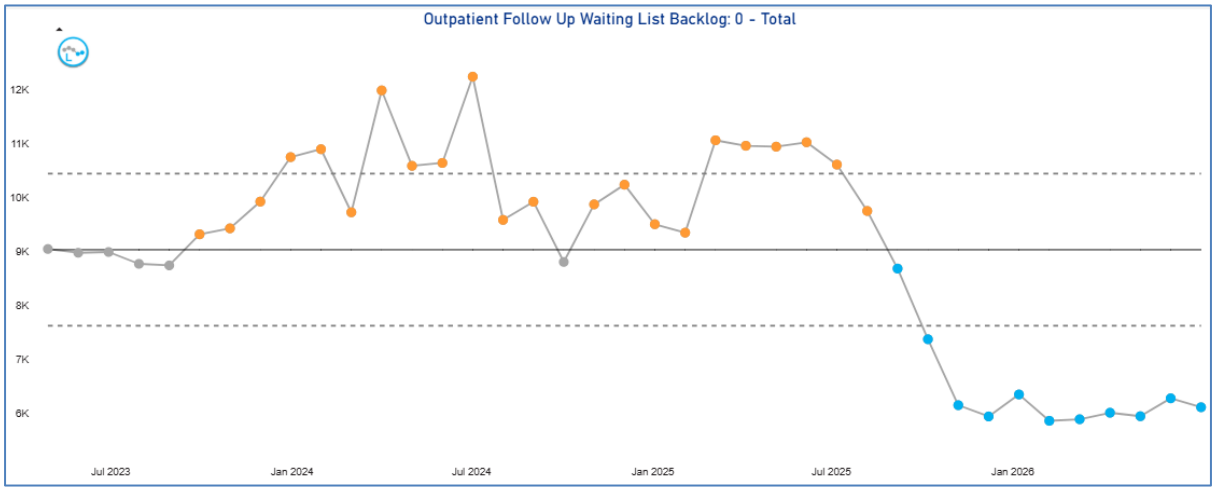
3.5 Follow up backlog

The follow up backlog has slightly increased since the start of the financial year, but has returned to pre COVID levels. This has been delivered through higher activity levels tackling the clinically urgent and delivery of the PIFU programme last year.



Some specialties have paused PIFU in February and March to complete a clinical audit, following some concerns over patient selection. This went to Clinical Reference Group in May but was not approved and further work was required, to satisfy clinical governance concerns. This has been completed and a restart planned from August 2026.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
PIFU	Plan	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%
	actual	3.20%	3.27%	3.68%									
	variance	-4.80%	-4.73%	-4.32%									

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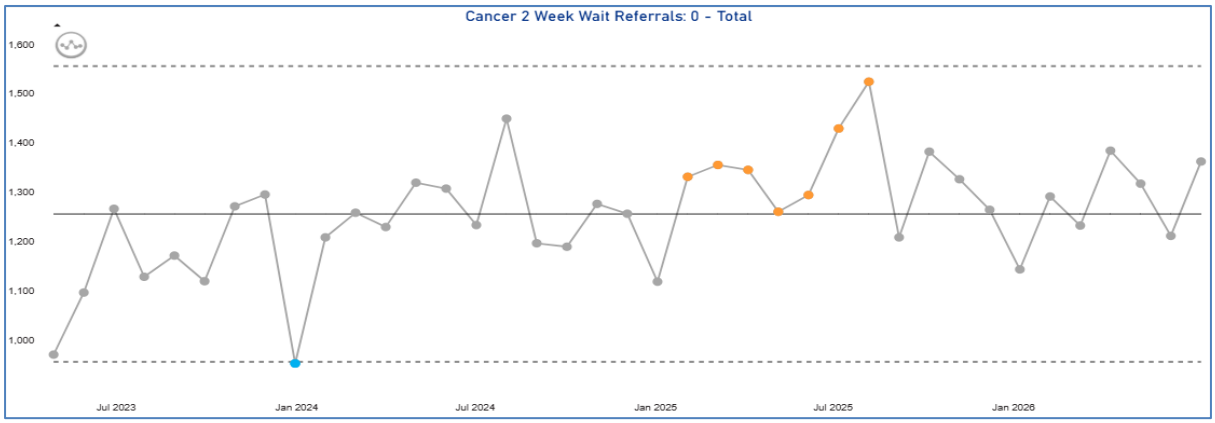
3.6 Cancer waiting times standards

For April and May, the Trust did achieve the 31-day (combined) trajectory but slightly missed the standard for June. The trust has not achieved the 28 day to diagnosis standard and the 62-day treatment trajectory (combined) for any month in quarter 2.

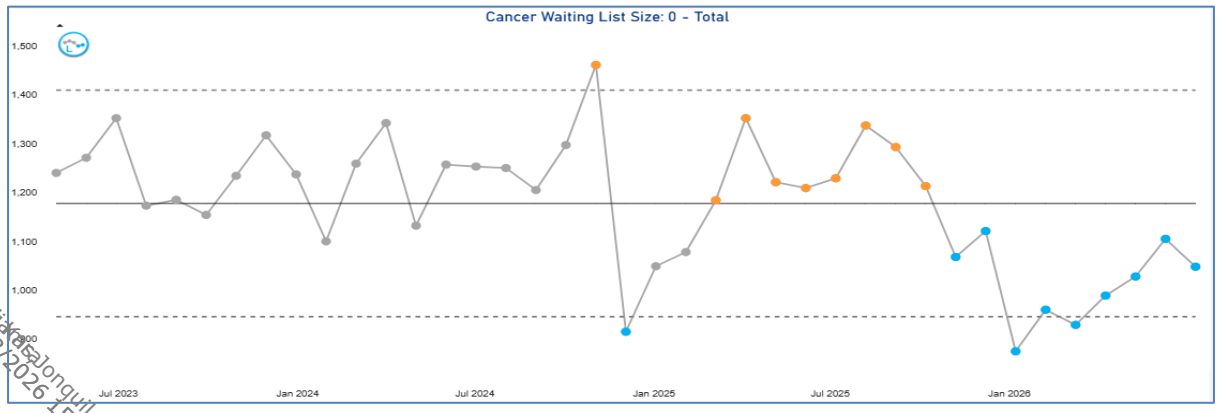
Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Cancer: 28 days FDS	Plan	80.03%	80.05%	80.06%	80.01%	80.00%	80.04%	80.03%	80.01%	80.08%	79.97%	80.06%	80.03%
	actual	78.15%	76.08%	76.09%									
	variance	-1.88%	-3.97%	-3.97%									
Cancer: 31 day DTT (combined)	Plan	94.04%	94.07%	94.52%	94.23%	94.59%	94.20%	94.41%	94.24%	94.66%	94.63%	94.07%	95.68%
	actual	94.07%	94.62%	91.67%									
	variance	0.03%	0.55%	-2.85%									
Cancer: 62 RTT (combined)	Plan	80.13%	80.00%	80.14%	80.13%	80.41%	80.43%	80.12%	80.58%	80.15%	80.54%	80.45%	80.65%
	actual	71.74%	61.20%	69.44%									
	variance	-8.39%	-18.80%	-10.70%									

2 week wait referrals for 2025/26, were 2.41% up on the previous year. Compared to 2023/24, referral growth was 12.67%.

Referrals are 1.06% lower than last year; however, specialty-level performance varies significantly. Gynaecology for example, has seen a 16.6% increase on Q1 2025/26.



The total waiting list (cancer) has reduced signicantly over the last year. Quarter 1 saw a rise, for June it has decreased and remains below the median.



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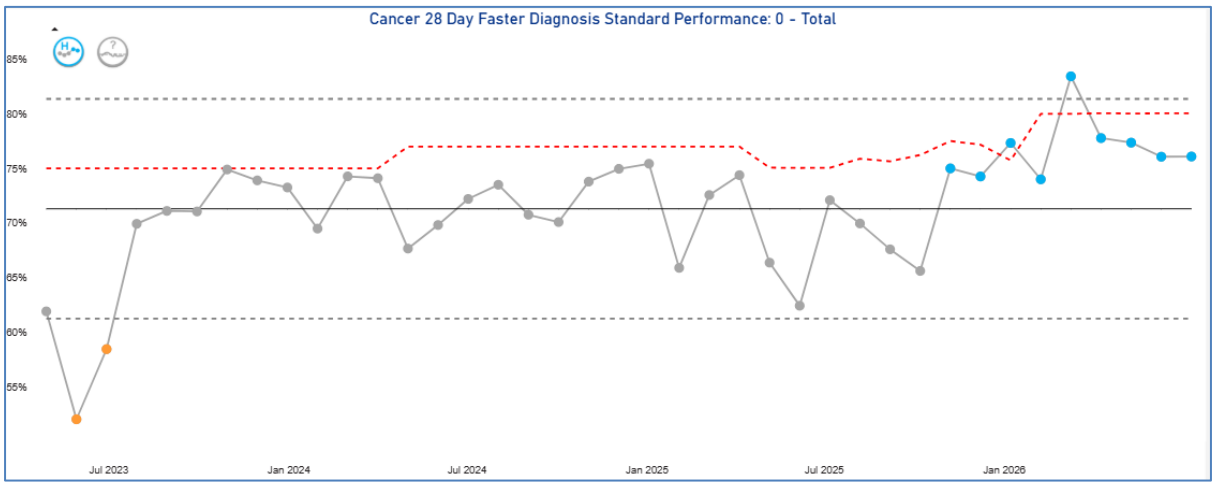
3.6.1 Faster Diagnosis Standard (28 days)

Performance of the 28-day standard has not meet the trajectory for any month in Quarter 1. At the time of writing this paper, July stands at 77%, a slightly improved position.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Cancer: 28 days FDS	Plan	80.03%	80.05%	80.06%	80.01%	80.00%	80.04%	80.03%	80.01%	80.08%	79.97%	80.06%	80.03%
	actual	78.15%	76.08%	76.09%									
	variance	-1.88%	-3.97%	-3.97%									



Performance of the 28 day standard, while not meeting trajectory, has remained above the median showing positive signs for recovery. Colorectal has been impacted by challenged endoscopy performance. Endoscopy performance is recovering following a targeted NHSE-supported improvement programme addressing workforce, booking and capacity issues. This is positively impacting delivery of the 28-day standard. There remain vulnerabilities within the individual services which are being closely tracked so mitigation can be found at the earliest opportunity but nonetheless unplanned absences continue to have an impact o this measure.

3.6.2 31-day Referral to Treatment (combined)

31-day performance, has it the trajectory for the first two months of the year, but missed it for June.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Cancer: 31 day DTT (combined)	Plan	94.04%	94.07%	94.52%	94.23%	94.59%	94.20%	94.41%	94.24%	94.66%	94.63%	94.07%	95.68%
	actual	94.07%	94.62%	91.67%									
	variance	0.03%	0.55%	-2.85%									

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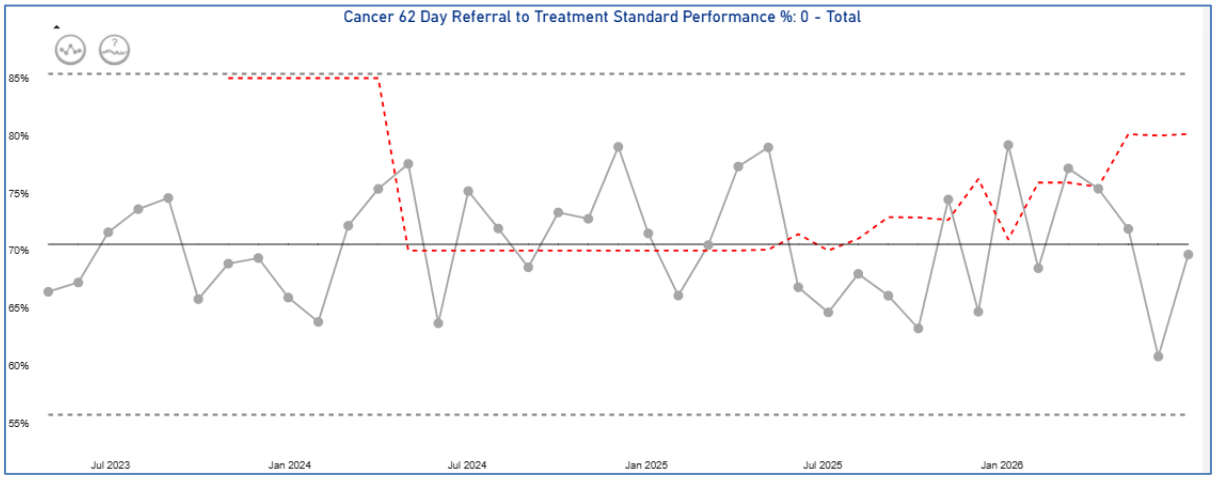
3.6.3 62-day Referral to Treatment (combined)

Performance of the 62-day combined standard did not achieve the trajectory for any month in Quarter 1. Urology accounts for the largest proportion of 62-day breaches and faces inherent pathway complexity due to the range of tumour types and treatment options involved. Delays can arise from the need for specialist surgical capacity, multidisciplinary decision-making and access to tertiary services. Capacity constraints within the Dorset robotic-assisted surgery pathway continue to impact performance.

Breast performance on the screening pathway was adversely affected by an unusually high number of breaches during the period, driven largely by patients requiring additional investigations following screening. Analysis identified patient understanding and engagement as contributory factors, with compliance issues affecting a small number of cases. May's performance was considered a statistical outlier, with screening volumes varying throughout the year as the mobile screening unit moves across Dorset.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Cancer: 62 RTT (combined)	Plan	80.13%	80.00%	80.14%	80.13%	80.41%	80.43%	80.12%	80.58%	80.15%	80.54%	80.45%	80.65%
	actual	71.74%	61.20%	69.44%									
	variance	-8.39%	-18.80%	-10.70%									



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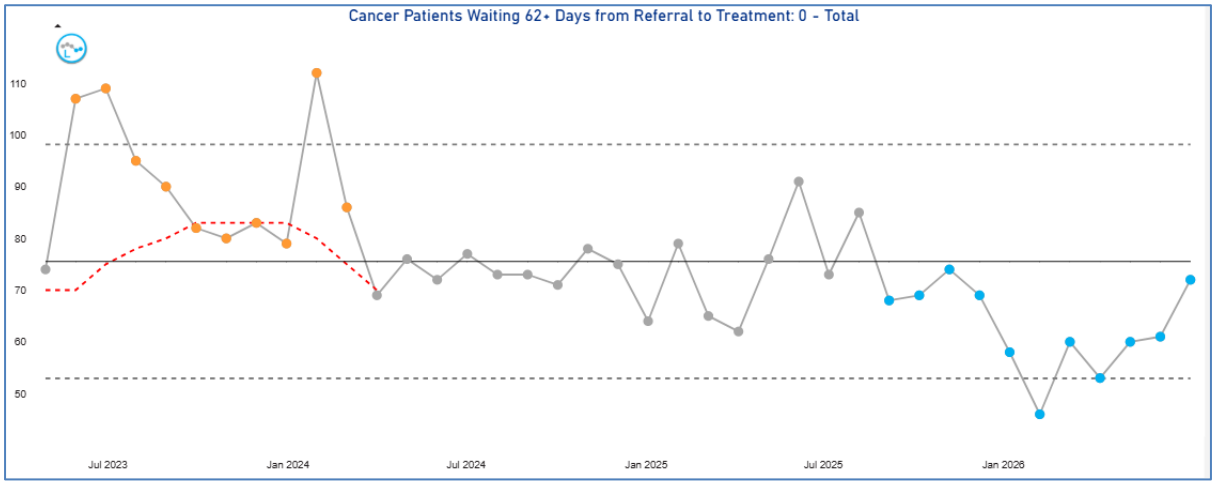
The backlog (the number of patients waiting over 62 days) remains materially lower than last year and is

being actively managed through clinical prioritisation.



Tumour site performance for the three metrics can be found below, for cancer, performance isn't finalised until 6 weeks after the end of the month.

28-day FDS	published Apr-26	published May-26	Total Patients	≤28 days	Local Jun-26
Breast	92.27%	91.57%	195	184	94.36%
Childrens	83.33%	100.00%	4	2	50.00%
Colorectal (LG)	48.62%	39.78%	198	99	50.00%
Gynaecology	71.84%	69.52%	125	75	60.00%
Haematology	100.00%	100.00%	11	7	63.64%
Head & Neck	85.47%	89.09%	142	116	81.69%
Lung	89.58%	83.33%	42	37	88.10%
Skin	94.27%	89.06%	265	243	91.70%
UGI	64.60%	70.10%	91	48	52.75%
Urology	66.67%	73.23%	114	95	83.33%
Other	100.00%		2	1	50.00%
Actual	78.15%	75.90%	1189	907	76.28%
Plan	80.03%	80.05%			80.06%
Variance	-1.88%	-4.15%			-3.78%

31 day	published Apr-26	published May-26	Total Patients	≤31 days	Local Jun-26
Breast	98.48%	96.43%	56	51	91.07%
Childrens					
Colorectal (LG)	76.92%	100.00%	17	13	76.47%
Gynaecology	100.00%	50.00%	6	4	66.67%
Haematology	100.00%	85.71%	9	9	100.00%
Head & Neck	100.00%		3	3	100.00%
Lung	100.00%	100.00%	12	12	100.00%
Skin	94.12%	97.44%	41	40	97.56%
UGI	91.67%	92.30%	10	8	80.00%
Urology	92.11%	91.48%	32	29	90.63%
Other	100.00%	100.00%	3	3	100.00%
Actual	95.07%	94.55%	189	172	91.01%
Plan	94.04%	94.07%			94.52%
Variance	1.03%	0.48%			-3.51%

62 day	published Apr-26	published May-26	Total Patients	≤62 days	Local Jun-26
Breast	82.00%	51.02%	20.5	16.0	78.05%
Childrens					
Colorectal (LG)	54.55%	52.94%	12.5	6.0	48.00%
Gynaecology	28.57%	25.00%	3.5	3.0	85.71%
Haematology	68.42%	88.67%	7.0	6.0	85.71%
Head & Neck	37.50%	50.00%	4.5	1.5	33.33%
Lung	59.10%	19.05%	9.0	5.0	55.56%
Skin	96.30%	92.31%	20.0	19.0	95.00%
UGI	61.90%	95.45%	8.5	4.5	52.94%
Urology	66.15%	52.94%	29.5	16.0	54.24%
Other	75.00%		4.5	4.5	100.00%
Actual	71.74%	63.10%	119.5	81.5	68.20%
Plan	80.13%	80.00%			80.14%
Variance	-8.39%	-16.90%			-11.94%

3.6.4 Actions to address cancer performance

The requirement of the 2026/27 operating plan was to maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%. The trajectory is therefore set at 80% or above for each month of the financial year. The original planning assumptions applied the same methodology to the 31- and 62-day standards. Subsequent review has confirmed that these standards are required to be achieved by March 2027 rather than maintained throughout the year.

A revised trajectory has been submitted to NHSE, which accounts for the change in phasing, to reflect the intent of the operating plan. The modelling includes key actions including:

- Improved patient communication for the Breast screening patients, setting out the urgency of the next stage in the pathway, once passed to DCH
- Review patient communications for all non-cancers and where suitable (and with clinical approval), introduce administration staff phone calls to reduce delays on letter typing/post to communicate outcome.
- New ENT disposal scopes, to move activity to the community, delivering it closer to home and increasing clinic capacity (Wessex funded)

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- The purchase of additional Urology scopes, moving to dual biopsy lists (Wessex funded)
- The purchase of different type of scopes in Gynaecology, increasing the number that can be done in a LA setting
- A new one stop neck lump clinic in ENT, starting from August
- A targeted increase in the number of Derm treatments that are directly listed from the AI platform, supported by new clinical leadership

The revised trajectory is set out below and is rag rated against the original operating plan. All cancer revised trajectories, meet the national ask.

					Recovery forecast Cancer								
Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Cancer: 28 days FDS	plan (March submission)	80.03%	80.05%	80.06%	80.01%	80.00%	80.04%	80.03%	80.01%	80.08%	79.97%	80.06%	80.03%
	actual (forecasted)	78.15%	75.90%	*76.28%*	*78.20%*	*78.00%*	*80.04%*	*80.03%*	*80.01%*	*80.08%*	*79.97%*	*80.06%*	*80.03%*
	variance	-2.05%	-3.97%	-3.78%	-1.81%	-2.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cancer: 31 day DTT (combined)	plan (March submission)	94.04%	94.07%	94.52%	94.23%	94.59%	94.20%	94.41%	94.24%	94.66%	94.63%	94.07%	95.68%
	actual (forecasted)	95.07%	94.55%	*91.01%*	*92.40%*	*92.20%*	*92.00%*	*93.70%*	*93.90%*	*94.10%*	*92.70%*	*93.40%*	*94.00%*
	variance	1.03%	0.48%	-3.51%	-1.83%	-2.39%	-2.20%	-0.71%	-0.34%	-0.56%	-1.93%	-0.67%	-1.68%
Cancer: 62 RTT (combined)	plan (March submission)	80.13%	80.00%	80.14%	80.13%	80.41%	80.43%	80.12%	80.58%	80.15%	80.54%	80.45%	80.65%
	actual (forecasted)	71.74%	63.10%	68.20%	69.40%	69.00%	71.20%	74.88%	76.10%	77.80%	75.72%	78.61%	80.00%
	variance	-8.39%	-16.90%	-11.94%	-10.73%	-11.41%	-9.23%	-5.24%	-4.48%	-2.35%	-4.82%	-1.84%	-0.65%

Of the current 62-day backlog 35% is waiting for either a diagnostic +/- treatment at a tertiary centre, and a further 20% are awaiting oncological appointments (Oncology service is a Dorset System service) which could result in onward tertiary referral for treatment or treatment at DCH. A second trajectory for the 62d standard is shown below. This alternative trajectory demonstrates the impact on DCH performance should tertiary providers be unable to deliver the required capacity.

					Recovery forecast Cancer								
Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Cancer: 62 RTT (combined)	plan (March submission)	80.13%	80.00%	80.14%	80.13%	80.41%	80.43%	80.12%	80.58%	80.15%	80.54%	80.45%	80.65%
	actual (forecasted)	71.74%	63.10%	68.20%	69.40%	65.00%	66.20%	69.88%	71.10%	72.80%	70.72%	73.61%	75.00%
	variance	-8.39%	-16.90%	-11.94%	-10.73%	-15.41%	-14.23%	-10.24%	-9.48%	-7.35%	-9.82%	-6.84%	-5.65%

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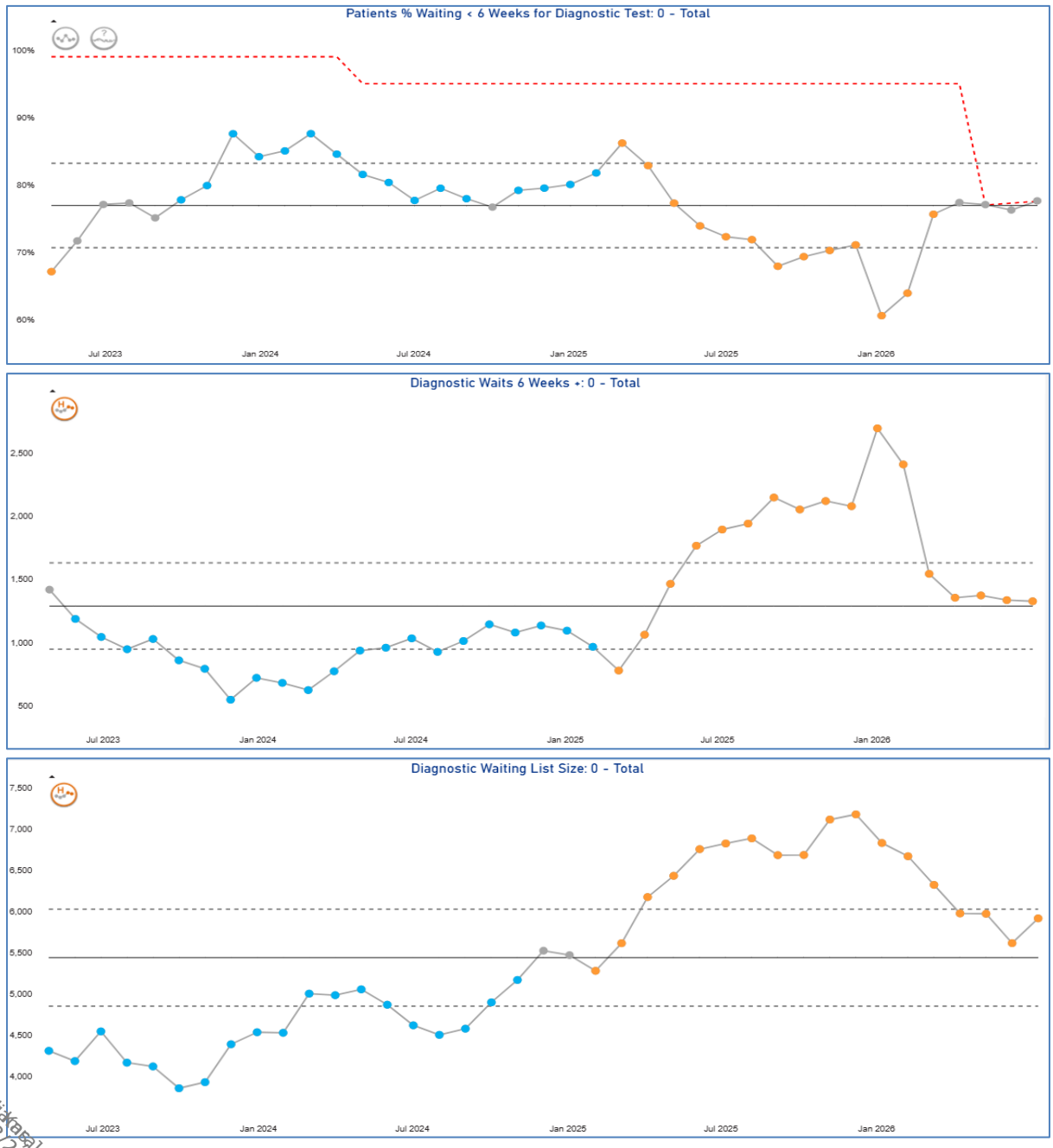
3.7 Diagnostic waiting times

The trust has met the diagnostic performance trajectory in April and June for quarter 1.

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
DM01 %	Plan	76.98%	77.26%	77.54%	77.82%	78.08%	78.33%	78.60%	78.86%	79.14%	79.42%	79.70%	80.00%
	actual	77.00%	76.20%	77.60%									
	variance	0.02%	-1.06%	0.06%									

The backlog and total waiting list size has reduced, giving a sustainable performance improvement.



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Performance by modality

Procedure	April - 2026	May - 2026	June - 2026
Cardiology	67.5%	61.0%	54.2%
Colonoscopy	54.5%	61.5%	65.6%
Computed Tomography (Imaging)	98.3%	96.4%	95.6%
Cystoscopy	66.5%	66.0%	65.0%
Dexa Scan	87.8%	80.7%	84.2%
Flexi Sigmoidoscopy	65.3%	60.3%	84.7%
Gastroscopy	48.7%	58.9%	64.7%
Magnetic Resonance Imaging (Imaging)	97.6%	94.0%	97.3%
Neurophysiology	78.3%	81.1%	87.3%
Non-Obstetric Ultrasound (Imaging)	98.8%	99.3%	98.9%
Sleep Studies	91.1%	92.1%	86.4%
Urodynamics Gynacology	66.7%	50.0%	75.0%
Urodynamics Urology	61.5%	44.4%	50.0%
Total	**77.0%**	**76.2%**	**77.6%**

4.0 Introduction to Productivity and Efficiency

Productivity is defined as the ratio of cost to output for example, the number of elective admissions per clinical full-time equivalent (FTE), or implied productivity measured as total costs over total outputs. It focuses on the quantity of output delivered relative to the resources used.

Efficiency, on the other hand, evaluates how resourcefully a process operates. A key example is capped theatre utilisation, which measures how effectively planned theatre sessions are used.

While distinct, productivity and efficiency are closely interconnected. Efficient processes often underpin high productivity. Improvements in efficiency can lead to increased productivity, and vice versa. The optimal goal is to be both productive and efficient, maximising output while minimising waste and optimising resource use.

Assessing productivity at the level of individual services or specialties can help identify opportunities for improvement. However, it presents challenges when used as a baseline for driving change. No service operates in isolation, access to centralised functions such as administration, theatres, outpatient services, HR, finance, and other support services is not accounted for when evaluating services independently. This can lead to misleading conclusions about performance and potential.

Model Health (formerly Model Hospital) has published a suite of productivity metrics at the trust level, enabling benchmarking across providers. These metrics are used to drive improvement by comparing performance against regional, national, and local peers. This report includes those metrics and highlights how DCH compares across these benchmarks.

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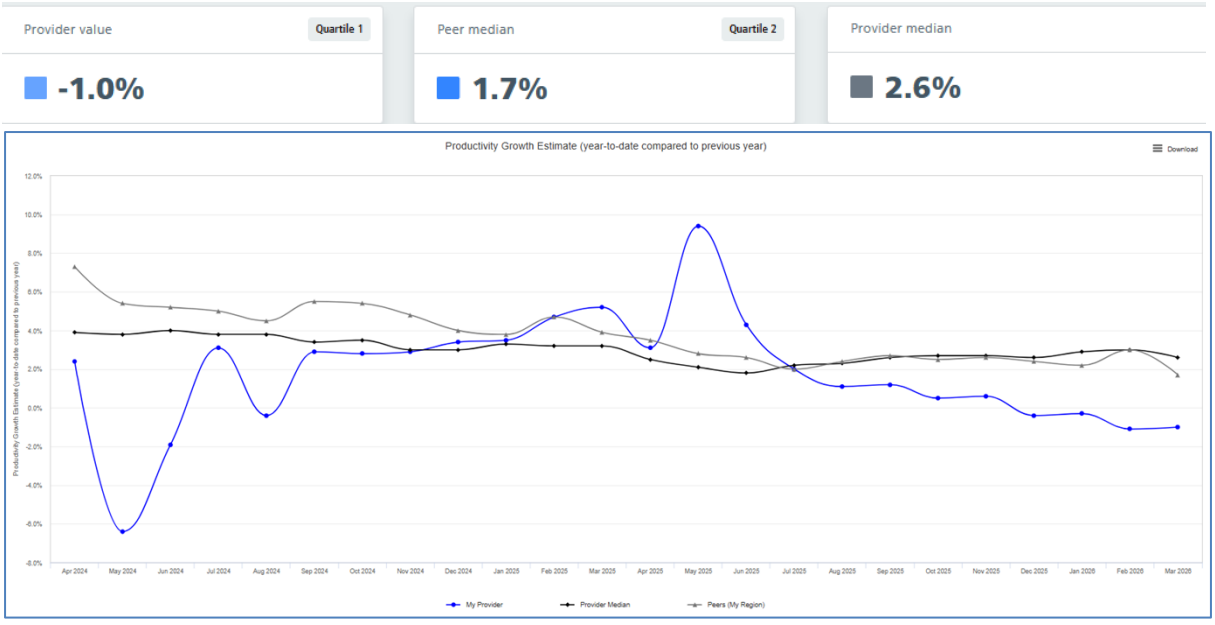
4.1 Headline metric- Implied Productivity Growth (year-to-date compared to last year). Latest data March 2026

As a core headline metric, improving this value means outputs (cost-weighted activity) relative to inputs (operating expenditure) are improving resulting in an improvement in Implied Productivity.

Implied Productivity of acute and specialist trusts is calculated by comparing output growth (cost-weighted activity) to input growth (based on expenditure costs) against a baseline period. The measure examines the current year's YTD activity and costs to the same period in the previous financial year. A negative value implies decreased productivity whilst positive implies productivity growth. The target is to see positive year on year change in this value and reduce / eliminate any negative distance from the same value calculated for same period last year.

DCH has seen a reduction in this metric, falling below the regional and national median.



The line graph above- blue is DCH, black is the national provider median, and grey is the South West region median.

4.2 New Implied Workforce Productivity Growth (year-to-date compared to last year). Latest data March 2026

As a core headline metric, improving this value means outputs (cost-weighted activity) relative to inputs (workforce) are improving resulting in an improvement in Implied Workforce Productivity.

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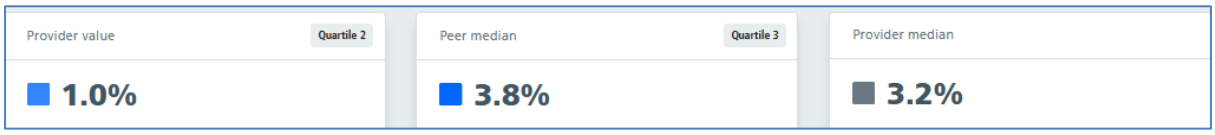
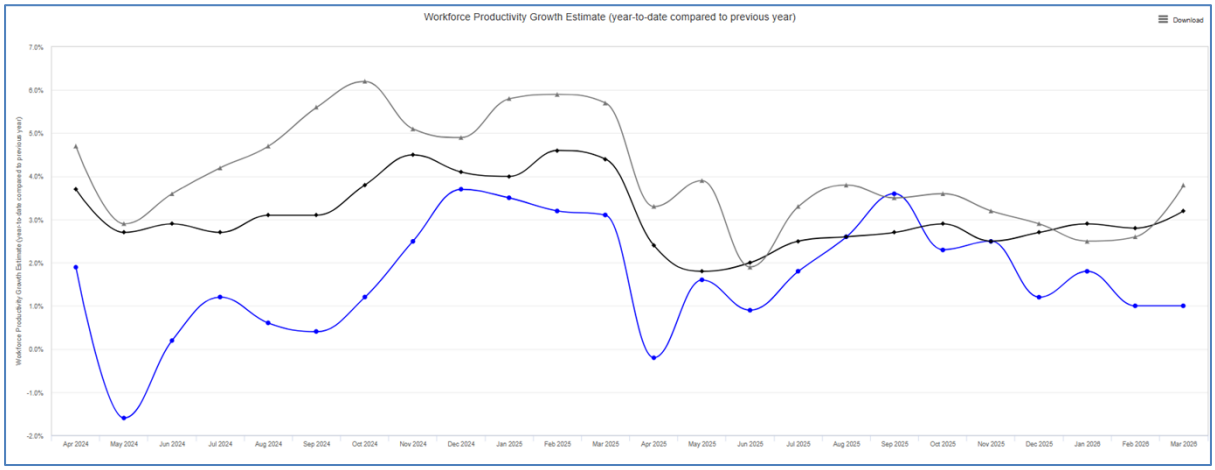
Implied Workforce Productivity Growth of acute and specialist trusts is calculated by comparing output growth (cost-weighted activity) to input growth (workforce) against a baseline period. The measure examines the current year's YTD activity and costs to the same period in the previous financial year.

A negative value implies decreased productivity whilst positive implies productivity growth.

The target is to see positive year on year change in this value and reduce / eliminate any negative distance from the same value calculated for same period last year.

In the last few months, DCH has seen this fall to below the provider median (national).





4.3 Non-elective admissions per clinical WTE. Latest data March 2026

Increasing this value means outputs (non-elective admissions) relative to inputs (clinical WTEs) are improving and more non-elective admissions are being treated per clinical WTEs.

Calculated by dividing the number of non-elective admissions in month by the number of clinical WTEs (nursing plus consultants). This includes substantive, bank and agency staff.

The Provider Workforce Return (PWR) data used includes substantive, bank and agency staff. The non-elective admissions per clinical WTE calculation uses the monthly Provider Workforce Return (PWR) data for clinical WTEs and activity using SUS data, adjusted for data quality issues.

DCH has a higher number of non-elective admissions, per clinical WTE compared to the national provider and regional median.

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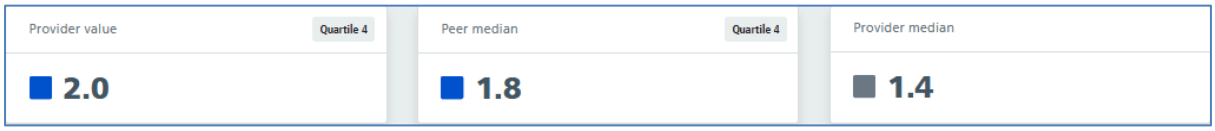
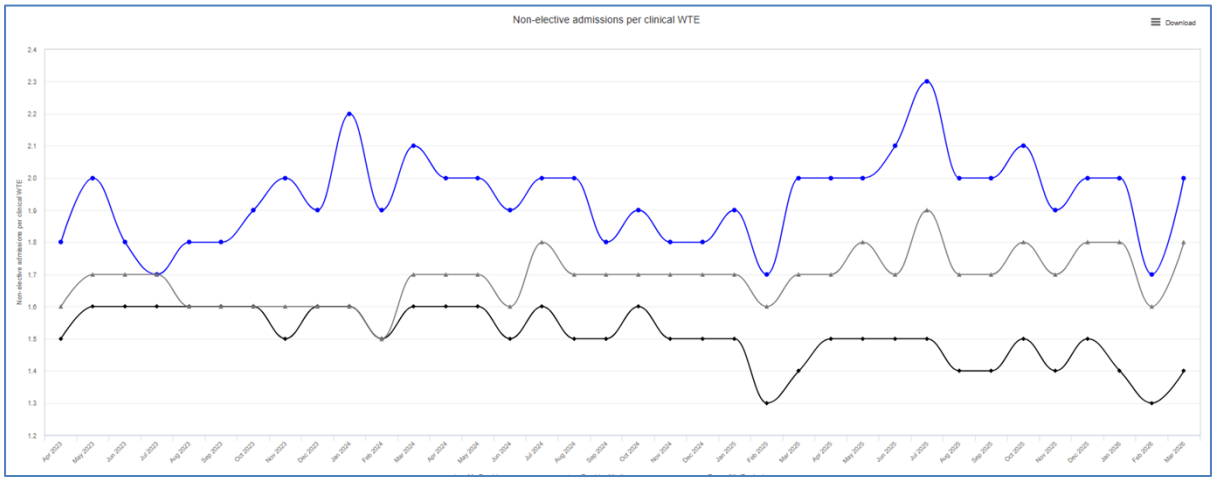




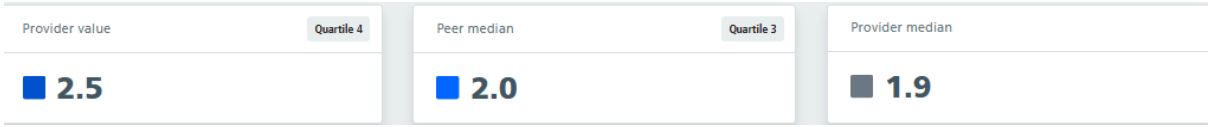
4.5 Elective admissions per clinical WTE. Latest data March 2026

Increasing this value means outputs (elective admissions) relative to inputs (clinical WTEs) are improving and more elective admissions are being treated per clinical WTEs.

Elective admissions per clinical WTE is calculated by dividing the number of elective admissions (day case and ordinary elective inpatients) in month by the number of clinical WTEs (nursing and consultants). The Provider Workforce Return (PWR) data used includes substantive, bank and agency staff.

The elective admissions per clinical WTE calculation uses the monthly Provider Workforce Return (PWR) data for clinical WTEs and activity using SUS data, adjusted for data quality issues.

DCH has a higher number of elective admissions, per clinical WTE compared to the national provider and regional median.



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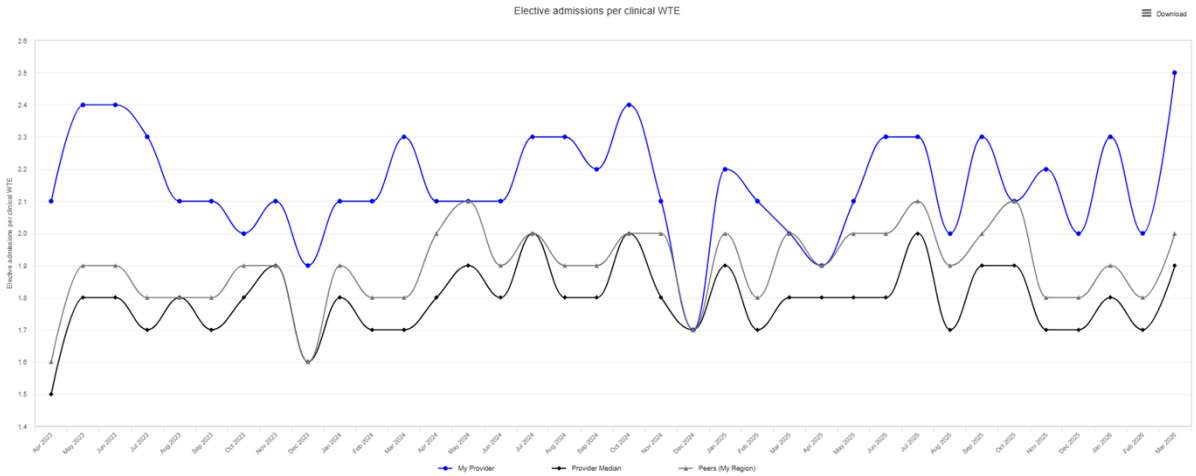

4.6 Outpatient attendances per consultant WTE. Latest data March 2026

Increasing this value means outputs (total first and follow-up outpatient attendances and outpatient procedures) relative to inputs (consultant WTEs) are improving and more outpatient attendances are being carried out per consultant WTEs.

Outpatient attendances and procedures per consultant WTE is calculated by dividing the number of outpatient attendances (new and follow-up and outpatients with a procedure) in month by the number of consultants. The Provider Workforce Return (PWR) data used includes substantive, bank and agency staff.

The outpatient attendances per consultant WTE calculation uses the monthly Provider Workforce Return (PWR) data for consultant WTEs and activity using SUS data, adjusted for data quality issues.

DCH does not perform well in this metric and is lower than the national provider and regional median however, the gap between DCH and the national median has closed in recent months, demonstrating improvement.

Provider value	Quartile 2	Peer median	Quartile 2	Provider median
89.2		92.3		105.7

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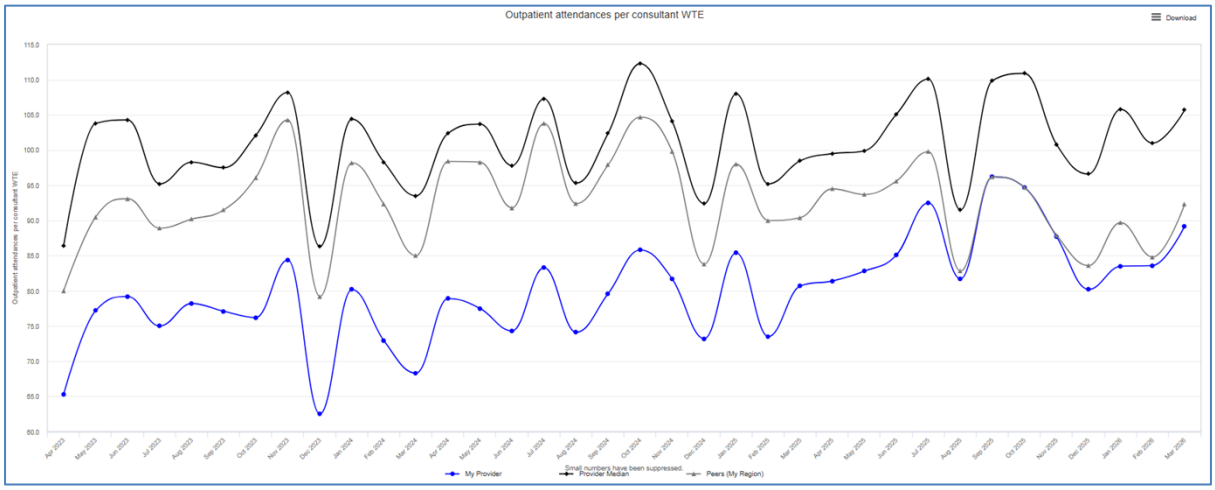
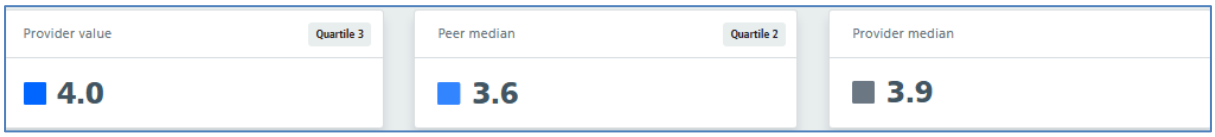
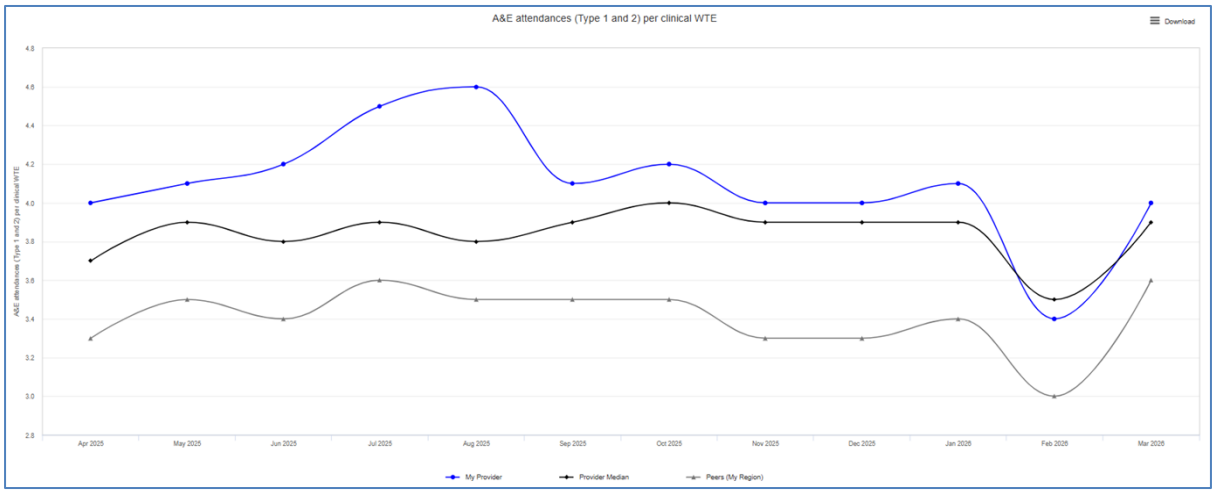


4.7 A&E attendances (Type 1 and 2) per clinical WTE. Latest data March 2026

A&E attendances (Type 1 and 2) per clinical WTE is calculated by dividing the number of A&E attendances (Type 1 & 2) in month by the number of the number of clinical WTEs (nursing and consultants). The Provider Workforce Return (PWR) data used includes substantive, bank and agency staff.

DCH performs well in this metric, exceeding both the national and regional median. This is a new metric for this contractual year.





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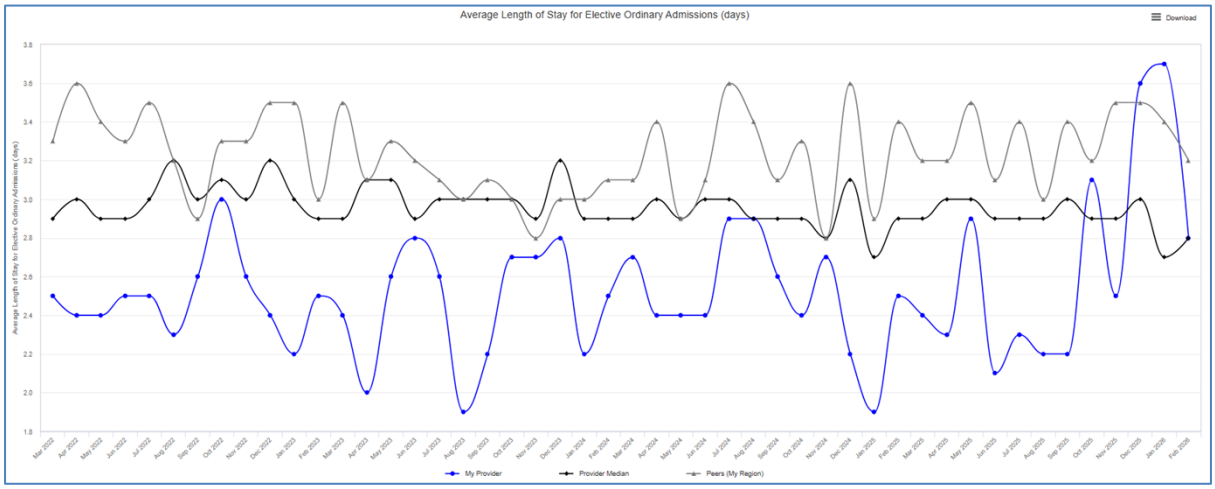
4.8 Average LOS for elective admissions (excluding day cases). Latest data February 2026

The analysis is carried out by calculating average lengths of stay for all patients (excluding those with a COVID diagnosis and those with zero-day lengths of stay) admitted during a week, capping length of stay at a maximum of 60 days.

DCH performances well for elective length of stay, with the second lowest average length of stay in the South West Region (grey bars in the graph below, represent the SW providers).

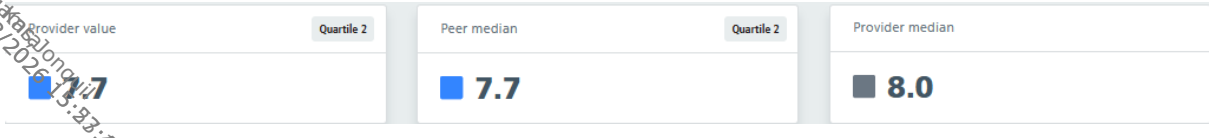


4.9 Average length of stay (days) of emergency admissions, excluding admissions with a length of stay of 0 or 1 day. Latest data March 2026.

Average length of stay for emergency admissions (days) was selected as an efficiency metric by the Getting it Right First time Oversight Group. The metric is provided both monthly and on a rolling 6 month basis. Six-monthly data is meant to support organisations in monitoring improvement, whereas the monthly metric can help understand seasonal variations.

A lower average length of stay is considered best practice.

DCH has improved in this area and is equal to Region, but slightly lower compared to the national median.



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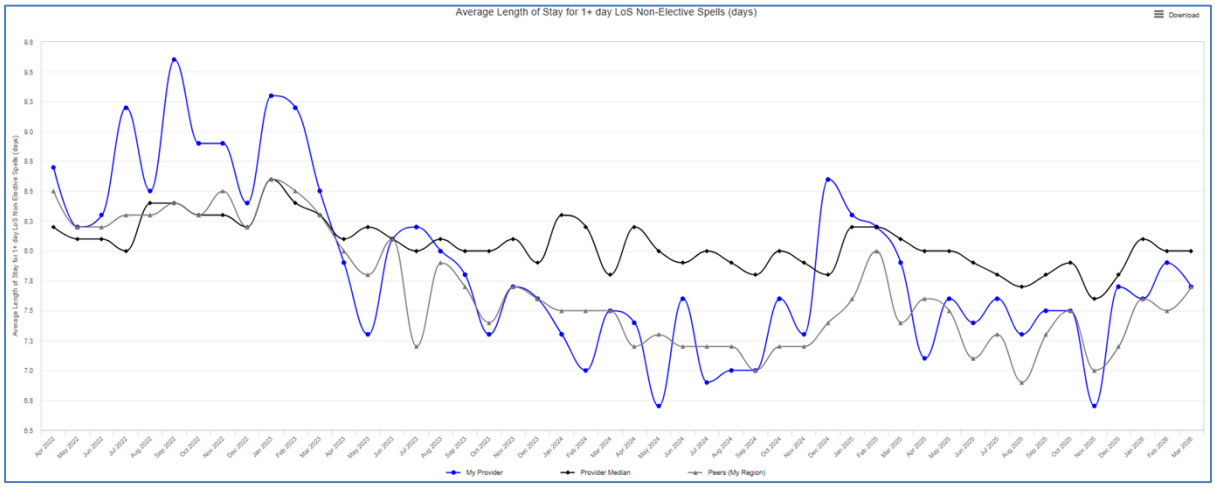
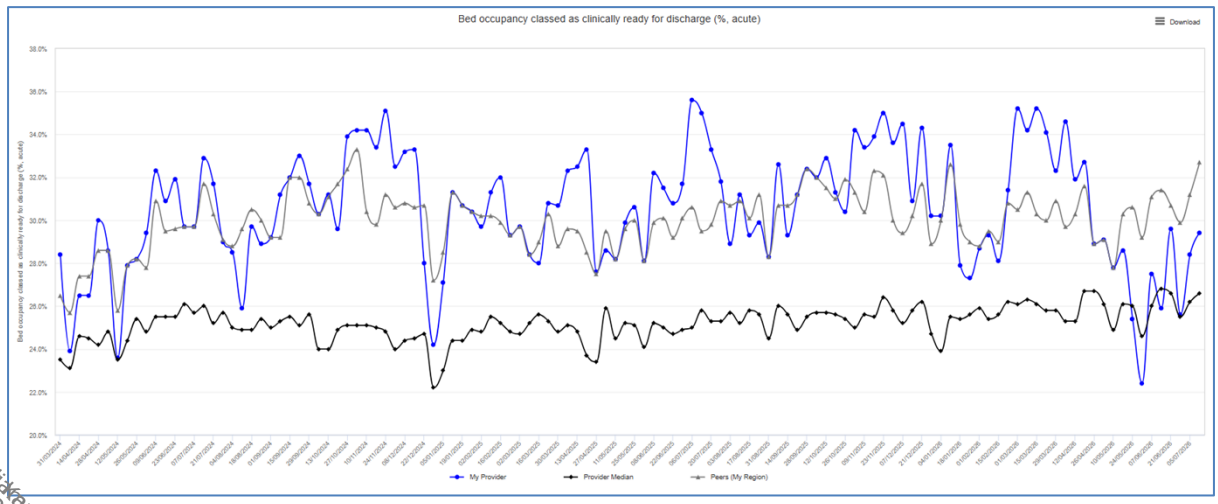


4.10 Bed occupancy classed as clinically ready for discharge (%, acute). Latest data week ending 12/07/26

This metric allows the tracking of the proportion of patients who do not meet the criteria to reside and therefore are clinically ready for discharge but are inhibited by other contributing factors. A decrease in this proportion can be seen to release much-needed capacity in acute hospital settings.

The longer length of stay is driven by a high proportion of DCH beds being occupied with patients with no reason to reside, with DCH now lower than the Regional median but higher than the National median.

Provider value	Peer median	Provider median
Quartile 3	Quartile 4	
29.4%	32.7%	26.6%



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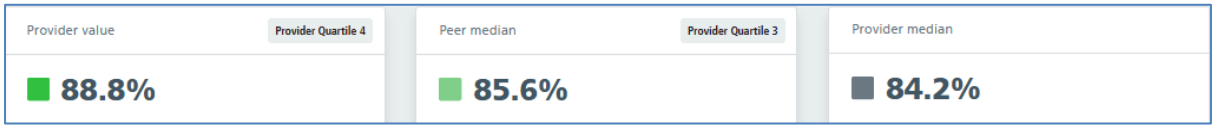
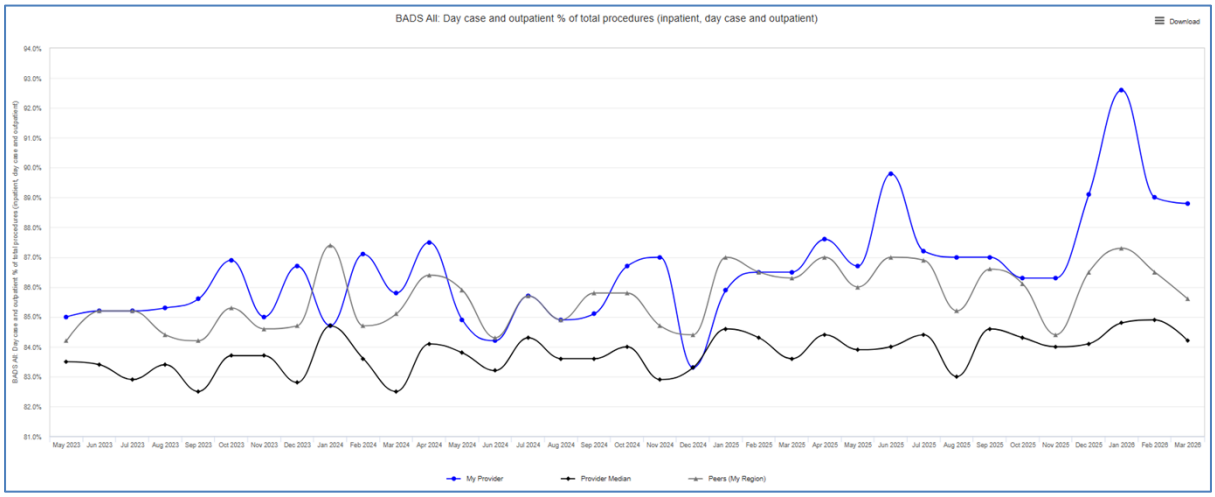
4.11 BADS All: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period end) Latest data March 2026

This metric shows the proportion of procedures completed in outpatients or as day case in the 3mths to period end. This metric allows organisations to understand variation in their combined day case and outpatient procedure rate in the BADS (British Association of Day Surgery) basket of procedures. A low rate can indicate an opportunity to release inpatient bed days and cost savings. This rate includes day cases (planned as a day case, with no overnight stay) and outpatient procedures.

DCH has consistently performs better than the national median and typically tracks the regional median.





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Dorset County Hospital
NHS Foundation Trust

Report to	Board in Common	
Date of Meeting	11th August 2026	
Report Title	DCH Finance Report – Month 3 2026/27	
Prepared By	Claire Abraham, Deputy CFO DCH	
Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	Finance & Performance Committee in Common	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	Identify risks and mitigations associated with plan delivery, financial sustainability	
Financial	Value for money and financial sustainability	
Statutory & Regulatory	Monitoring, active intervention to deliver operational plan	
Equality, Diversity & Inclusion	n/a	
Co-production & Partnership	Federation working and organisational financial plan delivery	

Executive Summary

Dorset County Hospital NHS Foundation Trust (DCHFT) submitted a break even plan to NHS England (NHSE) on 18th April 2026 for the financial year 2026/27, noting the inclusion of £2.6 million Deficit Support Funding to reach balance.

Key Messages

Month three delivered a deficit of £3.1 million after technical adjustments, being £0.193 million away from the planned deficit of £2.9 million. The driver of this position is largely due to the cost of supporting Industrial Action in month, which at this stage remains unfunded per NHSE advice.

Temporary workforce agency costs incurred of c.£0.6m and whilst over June plan, this plan reflects expected reduced expectation of 30% reductions in temporary workforce spend. Actual in month demonstrates a slight improved run rate from March (£684k and Feb £660k), however worsening from April and May actuals (£499k and £605k), reflective of pressures described in both performance and finance report details. The year to date position is £1 million ahead of plan, noting budgets reflect the reduced levels of expenditure expected. Month three Off framework usage of £135k has been incurred noting break glass limited usage in place, and the highest spend incurred in this area this month with the quarter now totaling £277k. Actions linked to performance recovery detailed in relevant reports.

Bank remains a challenged area with increased usage noting month three challenges and plan caveat as mentioned above. In month actual spend of £1.4 million is currently higher than prior month run rate actual spend with March incurring £1.237 million, February £1.199 million, April £1.351 million and May £1.287million. Industrial action (no offset currently), meningitis support (offset by income), heatwave impact, bank holidays and increased operational performance pressures are key driving factors with active oversight in place to review and recover the latter.

BWKKSa
06/08/2026 15:53:11

Efficiency delivery for the year is £23.3m at 6.5%, with in month delivery of £0.931 million against a plan of £0.777 million being £0.154 million ahead of plan with 40% delivered recurrently (£0.8 million), noting essential focus in this area to support recovery of the Trust's underlying deficit.

NHSE has requested that by end of quarter one, no unidentified scheme levels remain, and with no more than 20% of identified schemes classed as high risk. At month three, the Trust has 15% unidentified (£3.4m) and 17% of high risk schemes (£3.9m).
Recognising the high risk that remains in this area, the Trust has provided a detailed update to NHSE confirming the actions being taken with timescales, which was shared with Trust Board in July for information.

Cash is currently behind plan due to timing of contract income and depreciation funding due from Dorset ICB which has been escalated to the Deputy Chief Financial Officer for prompt resolution. Whilst the Trusts currently has a reasonably healthy cash balance which enhances the Trust's short term cash resilience, ongoing daily granular monitoring is in place for early indications of cashflow issues and swift intervention required.

Capital expenditure is progressing however £4.1 million behind plan year to date largely due to impact of internally funded schemes and donated schemes behind plan (£2m) and timing of New Hospital Programme (NHP) works behind plan (£2.1m).

Key Actions
There are a number of challenged performance areas which have significant focus and active mitigations in place noting requirement for the Trust to still deliver to plan for the financial year. Efficiency delivery is also a high priority in particular closing the unidentified gap and de-risking scheme in addition to the impact of operational pressures and recovery. Further focused work around pay variance control, in particular agency and bank expenditure and sickness levels in under way. The costs incurred supporting Industrial Action still remains unmitigated at this stage.

Careful cash monitoring remains a high priority with active system and NHSE discussions to address longer term mitigations ongoing.

The Trust's Finance Recovery Board chaired by the Chief Executive and supported by the Improvement Director has clear focus and oversight in these areas, with active engagement from all areas in place, however noting the significant risk that remains to close the unidentified gap and de-risk plans at pace.

Key focus on discretionary expenditure monitoring remains in place. Continued emphasis on the efficiency programme including recurrent scheme delivery to support reducing the Trust's underlying deficit position remains a key priority.

Recommendation

The Board is recommended to

- Receive the report for **assurance**

Ellis,Kara
06/08/2026 15:53:11

Dorset County Hospital
NHS Foundation Trust

Financial Position Update 2026/27

June 2026 - Month 3

Chris Hearn
Chief Financial Officer

Healthier lives Empowered citizens Thriving communities

Ellis,Kara
06/08/2026 15:53:11

Financial Position Update June 2026 - Month 3

Executive Summary

Dorset County Hospital NHS Foundation Trust

A summary of progress for June 2026 is presented against the plan submitted to NHS England (NHSE) on 18 March 2026, which outlined a breakeven position including £2.6m of Deficit Support Funding.

As at June 2026, Dorset County Hospital NHS Foundation Trust (DCH) has delivered a £3.1 million deficit after technical adjustments, an adverse performance against planned levels (£2.968 million deficit) of £0.193 million. This variance is the direct result of costs incurred supporting Industrial Action in month 1, at this stage there is no funding to support the spend impact and no mitigiations have been identified to date. The position also includes £0.399m of costs arising directly from the continued support following the temporary closure of Yeovil maternity service noting this has been offset by assumed income at this stage, further validation of spend is underway to confirm critical for patient safety and to support further funding discussions.

The Trust plan included a £0.777 million efficiency target for month 3, which was delivered with an overachievement of £0.154 million resulting in a YTD position ahead of plan of £0.075 million of the £1.962 million planned target. Savings were mainly the result of efficiencies in pay slippage, Bank Interest and biosimilar drugs savings with further traction needed to commence identified efficiency schemes. The total efficiency plan for the year is £23.3 million and 15% of this remains unidentified and a further 17% at high risk of delivery. By the end of Q1, NHS England required Trusts to identify a fully developed efficiency programme addressing the full £23.3 million savings target, with no more than 20% of schemes assessed as high risk. As the Trust has not yet met this requirement, enhanced Executive oversight, scrutiny and support are being applied to accelerate scheme development and strengthen delivery confidence, with NHSE kept up to date of progress.

Agency expenditure in M3 is £0.4m away than planned levels and £1.1m adverse YTD, spend in month 3 is in line with the average for the prior quarter however costs remain high across both nursing and medical categories, noting support of Industrial Action, operartional pressures, sickness, heatwave and meningitis support are driving high use this quarter. Medical agency reduction is a strong focus for the Trust alongside continued work on Nursing agency.

Bank expenditure remains a key focus area noting bank overspend of £0.7m in Month 3, £2.0m YTD. The overspend in Temporary Staffing is driven by the same factors contributing to agency expenditure. At this stage, the financial impact is partially mitigated by vacancy related underspends. Reduction in agency and bank expenditure requires essential focus on enhanced controls across the Trust to manage spend and will continue to be an area of focus with NHSE throughout 2026/27 via the bi monthly Workforce Oversight Meetings (WOM).

Elements of Non Pay is overspending at M3 which includes increased spend against the Trusts external security provision whilst recruitment to the new structure is ongoing. Backdated rates, drugs spend, and increased reporting services for out of hours external CT scanning reports due to vacancies within the team have been seen in M3, although mitigated by increases in out of contract income.

The Trust is progressing with the capital programme for 2026/27 with month 3 YTD spend totalling £7.8 million, which is behind plan by £4.0 million. Externally funded projects are £2.1 million behind of plan due to timing of expenditure on the New Hospital Programme (NHP) construction works. Internally funded, leased and donated schemes are collectively £1.9 million behind plan. This variance is mainly attributable to the generator project, which continues to fall behind plan and the timing of replacement of medical and digital equipment. This has been partially offset by acceleration of expenditure on the Digital Healthset (EHR) programme. The 2026/27 capital programme was set with the 5% over-programming allowance permitted by NHS England. The total plan of £61.776 million includes £0.775 million of over-programming, which will need to be recovered from slippage or further funding bids during the year.

The cash position at the end of June was £20.0 million, which is £5.2 million behind the submitted plan. This variance is driven by a movement in working capital due to the delay in payment of contract income from Dorset ICB relating to the Sleep Service provided by the Trust during 2025/26 and Depreciation Funding owed to the Trust for Q1 2026/27. Discussions are underway to facilitate the prompt processing of the cash payment.

Ellis Kara
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Key Risks

Dorset County Hospital
NHS Foundation Trust

Efficiency Delivery Risk
Forecast delivery is currently highlighted as a risk, noting unidentified and high risk schemes which remain at M3. NHSE requests that all organisations have a fully identified efficiency plan with no more than 20% schemes rated as high risk by the end of June 2026. The Trust continues to deploy targeted support towards this achievement with an Improvement Director across the Federation, led by the CEO as part of the Financial Recovery Board (FRB) and supported by the wider Executive team in order to continue to de risk and accelerate schemes into delivery.

Cash Position
There is a risk to cash levels throughout the year as a result of planned deficits in the first 9 months of the year and challenging efficiency targets, which if not delivered would have further negatively impact cash levels . Detailed cashflow workings are in place to provide granular monitoring of cash levels and to give early indication of cashflow problems.

Deficit Support Funding (DSF)
While NHS England has confirmed the release of DCH's Quarter 1 and Quarter 2 DSF funding following regional engagement and review of the Trust's latest financial position, it should be noted that revisions to the national Nominated Oversight Framework (NOF) remain under development and are expected to be implemented from the next quarter. Adverse performance against the revised NOF metrics may impact the release of future DSF funding support imapcting our ability to deliver the planned position and also significantly increasing the risk to cash levels.

Capital Programme
In line with the tolerances set out in the planning guidance, the Trust has over-programmed its capital programme by 5% (£0.775 million) against the approved capital envelope to mitigate the impact of scheme slippage, which typically arises during the course of the year. In addition, there remains ongoing pressure to incorporate further projects into the programme in response to emerging urgent requirements.
The Trust is required to remain within its agreed capital allocation by the year end. Although internally funded schemes are currently behind plan, this reflects timing differences in delivery rather than a reduction in the overall programme, and there is no anticipated slippage of schemes into 2027/28 at this stage.
Further opportunities have been identified to secure additional capital funding through national bids, and historically additional capital allocations have become available during the second half of the financial year. The Capital Programme Space Utilisation Group (CPSUG) remains sighted on this risk, continues to monitor the position closely, and will implement mitigating actions later in the year should they be required.

Ongoing Risk of Cost Pressures re Yeovil Maternity support
On 19th May 2025 Yeovil District Hospital took the decision to close the Maternity and Special Care Baby Unit. Given approximately 20% of activity in these units was attributable to Dorset residents, and with some Somerset residents being more local to Dorchester than Taunton or Bath, a significant increase in the number of mothers and babies requiring care at DCH has been experienced. While Yeovil Maternity has now reopened, the Trust is not expecting a immediate cessation of the additional activity seen in 2025/26, as a result cost pressures continue to ensure safe levels of staffing are provided. At this stage there is an assumed funding in the position to offset the incurred costs, with discussions taking place to confirm and agree funding levels.

Ellis Kara
06/08/2026 15:53:11

Financial Position Update June 2026 - Month 3

Key Risks

Dorset County Hospital NHS Foundation Trust

Red Risks:

The Trust has an efficiency delivery requirement of £23.3m to achieve the planned full year breakeven position. Of which c.£2.7m is planned efficiencies relating to reduction in Bank and Agency.

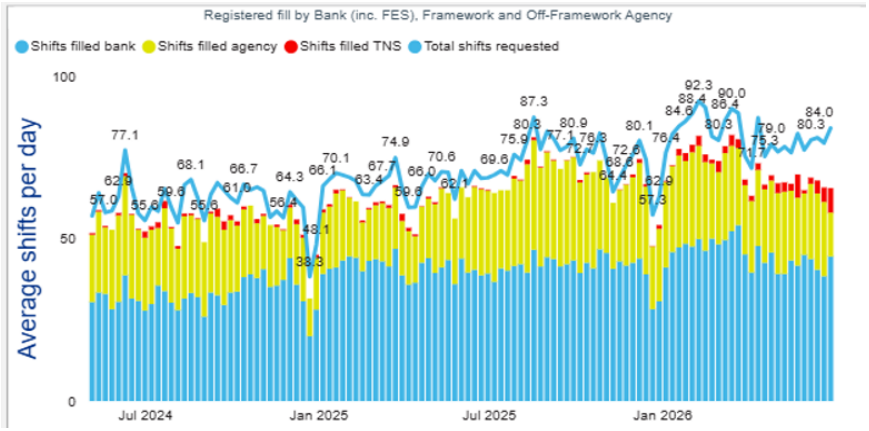
At Month 3, agency expenditure finished £0.4m overspent (£0.7m actual vs £0.2m plan), and YTD of £1.8m spend against a plan of £0.7m. The overspend is primarily driven by Nursing (£1.0m adverse YTD) and Medical (£0.02m adverse), partially offset by favourable positions within Other Clinical and Admin & Clerical. Total agency usage remains concentrated within Nursing, which accounts for the majority of spend (£0.4m in-month). Compared to plan, this reflects early year pressure on frontline staffing groups, noting support for Industrial Action not funded at this stage.

NHSE mandated that all off-framework agency spend ceased from July 2024. In Month 3, off-framework agency is being increasingly utilised across ED, Purbeck and SCBU with a YTD spend of £142k. This remains an area of high focus going in to 2026/27. Internal controls through the High Cost Agency Reduction Group remain in place, with a continued focus on reducing nursing agency usage and optimising bank utilisation where appropriate. Agency notice periods remain at 48 hours to support bank fill rates.

Bank expenditure in Month 3 finished £0.7m overspent (£1.4m actual vs £0.7m plan). The overspend is largely driven by Nursing (£0.9m adverse) and Medical (£0.7m adverse), with further pressure across Admin & Clerical (£0.3m adverse) and Other Clinical (£0.04m adverse). Bank usage continues to be deployed to support safe staffing across vacancies, sickness and operational pressures and the continued approach to utilise bank staffing ahead of agency.

Bank spend represents 6.9% of total pay, consistent with run-rate expectations however above plan, reflecting continued reliance on temporary staffing at the start of the year. Work continues to ensure bank usage is appropriate, with rosters aligned to demand and booking controls reinforced through standard operating procedures.

Looking ahead, the Month 3 position highlights early year pressure across both agency and bank, particularly within Nursing and Medical workforces. If sustained, this trajectory presents a financial risk against the 2026/27 plan. Reducing reliance on temporary staffing remains a key priority, with delivery of planned cost improvement programmes and strengthened workforce controls critical to mitigating cost pressures over the remainder of the year.



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Key Risk Status
Red - Significant risk of non-delivery. Additional actions need to be identified urgently.
Amber - Medium risk of non-delivery which requires additional management effort to ensure success
Green -. Low risk of non-delivery – current actions should deliver.

NHS
Dorset County Hospital
NHS Foundation Trust

Key Risks

Amber Risk:

For 2026/27 NHS England has revised the Aligned Payment and Incentive (API) approach to all NHS standard contracts. This approach now splits the payment mechanism for the majority of NHS contracts into three envelopes, Fixed, Variable & UEC Blended.

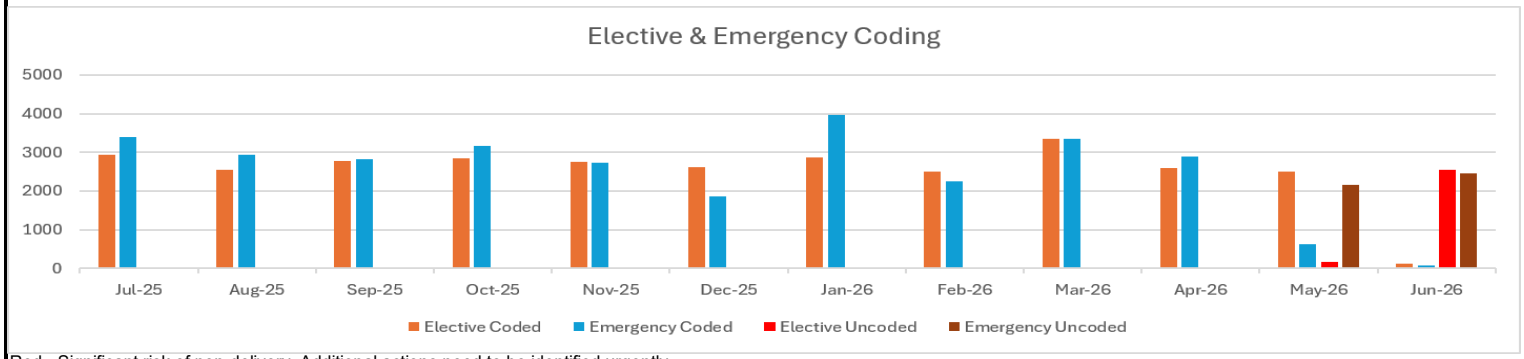
The fixed element of the contract will be agreed between NHS providers and commissioners for the provision of specified services, this will be paid on a block basis across the year regardless of activity delivery. The fixed element of the contract will pay for any activity not covered under the variable or UEC blended elements.

The variable element of the contract will cover most elective activity: Elective inpatients, Day cases, Outpatient first attendances, Outpatient procedures, Chemotherapy delivery and Diagnostics. An income envelope will be agreed between NHS commissioners and providers to an agreed baseline level of activity, this will then be adjusted for actual performance using the National Tariff. Any underperformance against baseline will be repaid at 100% of the national tariff and any over performance will be received at 100% of the national tariff.

The UEC blended element covers non-elective inpatients and A&E activity (incl Minor Injury Units). An income envelope will be agreed between NHS commissioners and providers to an agreed baseline level of activity, this will then be adjusted for actual performance using the National tariff. The contracting expectations for 2026/27 state that any under or over performance will be paid at a marginal % of the national tariff, negotiations are underway with the ICB to agree what marginal %'s will apply.

The tariff for each patient is calculated based on their clinical coding assessment. Coding is operated on a flex/freeze model where final coding must be completed by the freeze date to qualify for payment. The freeze date is typically 7 weeks after the end of the month in which the activity occurred, the full timetable is included for information. Any activity that remains uncoded after the applicable freeze date represents a loss of income for the Trust.

The Trust has 2,718 uncoded elective spells & 4,614 uncoded non-elective spells. There is typically a 2 month lag at the end of each period where coding is completed to meet the applicable freeze dates. Based on coding trends captured over a rolling 12 month period, month 3 continues to see a significant increase in uncoded activity which risks our income being under reported and the ICB clawing back income.



Month	Flex	Freeze
Apr-26	20/05/2026	17/06/2026
May-26	17/06/2026	17/07/2026
Jun-26	17/07/2026	19/08/2026
Jul-26	19/08/2026	17/09/2026
Aug-26	17/09/2026	19/10/2026
Sep-26	19/10/2026	18/11/2026
Oct-26	18/11/2026	16/12/2026
Nov-26	16/12/2026	20/01/2026
Dec-26	20/01/2027	17/02/2027
Jan-27	17/02/2027	17/03/2027
Feb-27	17/03/2027	19/04/2027
Mar-27	19/04/2027	20/05/2027

Red - Significant risk of non-delivery. Additional actions need to be identified urgently.
Amber - Medium risk of non-delivery which requires additional management effort to ensure success
Green -. Low risk of non-delivery – current actions should deliver.

Kate Kara
06/08/2026 15:53:11

Healthier lives Empowered citizens Thriving communities

Financial Position Update June 2026 - Month 3
Income & Expenditure

Dorset County Hospital
NHS Foundation Trust

Income and Expenditure

The overall revenue position of the Trust at Month 3 is a deficit of £3.1 million, which is £0.193 million adverse to a plan of £2.9 million.
The adverse position is largely driven by unplanned costs incurred supporting Industrial Action during month 1.

Temporary staffing is experiencing significant adverse variances with Agency expenditure being £1.1 million overspent (£1.8m actual vs £0.7m plan) and Bank expenditure £2.0 million overspent (£4.0m actual vs £2.1m plan). This can be linked to the additional staffing required to support Yeovil maternity closure, sickness, heatwave, meningitis support and increased operational pressures especially seen in ED which have continued into the new financial year.

The bank overspend continues to represent the most significant pressure, with utilisation across nursing, medical and support services remaining high to maintain safe staffing levels. Agency usage also remains above plan, largely within Nursing and Medical staffing groups.

These have been partly offset by non-pay; however, pressures in drugs and clinical supplies have also been impacted by the factors identified above, alongside additional costs from the timing of insourcing activity. During the month, the impact was largely mitigated through over-delivery of efficiency savings, non pay offsets and private patient income.

The Trust's financial plan for 2026/27 remains challenging, including delivery of a significant cost improvement programme and mandated reductions in agency and bank usage. The Month 3 position highlights early year risk against these targets, with continued reliance on temporary staffing. Focus remains on strengthening workforce controls, reducing agency utilisation, optimising bank usage, and delivering planned efficiency schemes to mitigate cost pressures over the remainder of the year.

Statement of comprehensive income	In Month			YTD		
	Current Plan £'000	Actual £'000	Variance £'000	Current Plan £'000	Actual £'000	Variance £'000
Operating income from patient care activities	27,972	28,316	344	82,177	83,925	1,748
Other operating income	2,471	2,409	(62)	7,510	7,124	(386)
Employee expenses:	0	0	0	0	0	0
- Substantive	(18,259)	(17,662)	597	(54,823)	(52,635)	2,188
- Bank	(689)	(1,402)	(713)	(2,066)	(4,040)	(1,974)
- Agency	(221)	(658)	(437)	(677)	(1,762)	(1,085)
Operating expenses excluding employee expenses	(11,690)	(11,485)	205	(33,775)	(34,656)	(881)
OPERATING SURPLUS/(DEFICIT)	**(416)**	**(482)**	**(66)**	**(1,654)**	**(2,044)**	**(390)**
FINANCE COSTS						
Finance income	91	119	28	272	348	76
Finance expense	(60)	(60)	0	(181)	(187)	(6)
PDC dividend expense	(460)	(460)	0	(1,381)	(1,381)	(0)
NET FINANCE COSTS	**(430)**	**(401)**	**29**	**(1,290)**	**(1,220)**	**70**
Other gains/(losses) including disposal of assets	0	0	0	0	0	0
Share of profit/(loss) of associates/joint ventures	0	0	0	0	0	0
Gains/(losses) from transfers by absorption	0	0	0	0	0	0
Movements in fair value of investments, investment property, financial liabilit	0	0	0	0	0	0
Corporation tax expense	(2)	0	2	(7)	0	7
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(848)**	**(883)**	**(35)**	**(2,951)**	**(3,264)**	**(313)**

Adjusted financial performance	In Month			YTD		
	Current Plan £'000	Actual £'000	Variance £'000	Current Plan £'000	Actual £'000	Variance £'000
Surplus/(deficit) for the period/year	(848)	(883)	(35)	(2,951)	(3,264)	(313)
Add back all I&E impairments/(reversals)	0	0	0	0	0	0
Adjust (gains)/losses on transfers by absorption	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	**(848)**	**(883)**	**(35)**	**(2,951)**	**(3,264)**	**(313)**
Retain impact of DEL I&E (impairments)/reversals	0	0	0	0	0	0
Remove capital donations/grants/peppercorn lease I&E impact	(5)	35	40	(17)	103	120
Adjusted financial performance surplus/(deficit) including PSF as per a	**(853)**	**(848)**	**5**	**(2,968)**	**(3,161)**	**(193)**
Adjusted financial performance surplus/(deficit)	**(853)**	**(848)**	**5**	**(2,968)**	**(3,161)**	**(193)**

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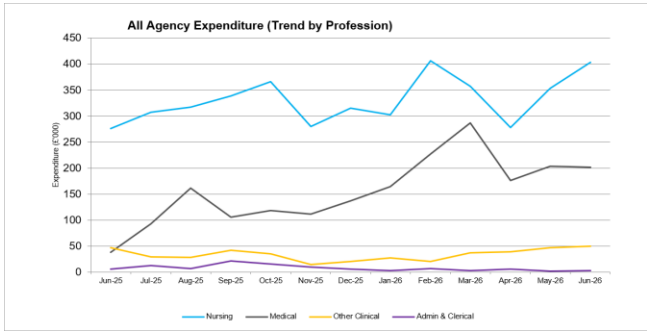
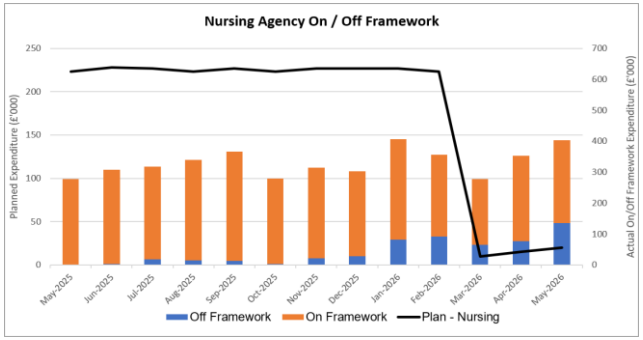
Financial Position Update June 2026 - Month 3
Trust Wide Performance: Agency

Pay Analysis - Agency
Agency costs in month 3 were £0.658 million against a plan of £0.221 million. This is a deterioration of £0.3m against spend in June last year (£367k) and a deterioration against prior months spend of £53k. Plans included a nationally set 30% reduction in agency spend from 2025/26 outturn, requiring a reduction of c.£1.7 million across the year, and driving the significant reduction to planned levels in the first 6 months of the year before the Trust feels the impact of winter pressures. Medical agency usage is due to rota gaps and costs supporting Industrial Action. Nursing agency spend was worse than June of 25/26 by £127k, use of nursing agency continues to be linked to 1-2-1 staffing requirements for mental health patients, increased activity linked to ED attendances, sickness, heatwave, meningitis and significant operational pressures.





Agency Spend by Profession (£'000)	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Nursing	276	307	317	339	366	280	315	302	406	357	278	353	403
Medical	38	93	161	106	118	111	137	164	227	287	176	203	202
Other Clinical	47	29	28	42	35	15	20	27	20	37	39	47	50
Admin & Clerical	6	13	7	21	16	10	6	3	7	3	6	2	3
Total	**367**	**442**	**513**	**508**	**535**	**416**	**478**	**496**	**660**	**684**	**499**	**605**	**658**
Plan - Total Agency	*456*	*548*	*464*	*548*	*500*	*492*	*387*	*426*	*404*	*354*	*259*	*197*	*221*
Variance to Plan	**89**	**106**	**-49**	**40**	**(35)**	**76**	**(90)**	**(70)**	**(256)**	**(330)**	**(240)**	**(408)**	**(437)**

Nursing Agency Category	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Off Framework	1	4	19	15	14	3	22	28	81	92	65	77	135
On Framework	276	303	298	324	352	277	293	274	325	265	213	276	268
Total	**276**	**307**	**317**	**339**	**366**	**280**	**315**	**302**	**406**	**357**	**278**	**353**	**403**
Plan - Nursing	*223*	*228*	*227*	*223*	*227*	*223*	*227*	*227*	*227*	*223*	10	*15*	*20*
Variance to Plan - Nursing	**-53**	**(79)**	**(90)**	**(116)**	**(139)**	**(57)**	**(88)**	**(75)**	**(179)**	**(134)**	**(268)**	**(338)**	**(383)**

YTD Actual	YTD Plan	Variance
1,034	45	(989)
581	560	(21)
136	57	(79)
11	15	4
1,762	**677**	**(1,085)**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	3.3%	3.0%
Off framework expenditure as % of total agency	17.6%	14.6%

Areas Using Nursing Agency Including Off Framework YTD (£'000)				
Area	**On Framework**	**Off Framework**	**Total Nursing Agency**	**%**
Emergency Dept Main Dept	176	57	232	**22%**
Purbeck Wd	117	49	166	**16%**
Day Surgery Unit	87	6	93	**9%**
Maternity Unit	77	-	77	**7%**
Kingfisher Ward	31	30	61	**6%**
Sdec	10	36	46	**4%**
Crcu	1	45	46	**4%**
Scbu	0	45	45	**4%**
Abbotsbury Ward	37	3	39	**4%**
Moreton Ward - Respiratory	35	-	35	**3%**
Ilchester Integrated Assessmen	33	1	34	**3%**
Lulworth Ward	28	3	31	**3%**
Frailty Sdec	29	(0)	28	**3%**
Fortuneswell Ward	22	-	22	**2%**
Stroke Unit	21	-	21	**2%**
The Mary Anning Unit	15	1	16	**2%**
Ridgeway Wd	13	3	16	**2%**
Prince Of Wales	15	-	15	**1%**
Surge Area	5	-	5	**1%**
Cardiology Care Ward	4	-	4	**0%**
Theatre Suites	1	-	1	**0%**
Grand Total	**757**	**277**	**1,034**	

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Financial Position Update June 2026 - Month 3
Trust Wide Performance: Bank

NHS
Dorset County Hospital
NHS Foundation Trust

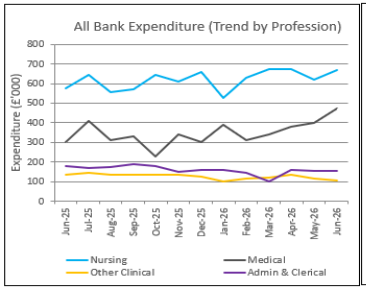
Pay Analysis - Bank

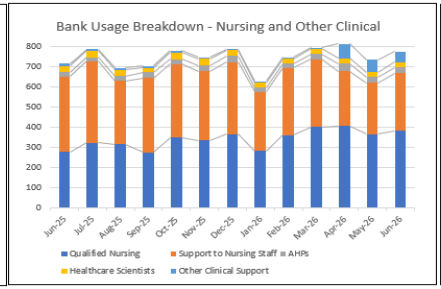
Bank costs in month 3 were £1.402 million against a plan of £0.689 million, higher than the levels seen in 25/26 - in Month 3 in part due to costs incurred supporting Industrial Action, holiday cover, sickness and operational pressures.

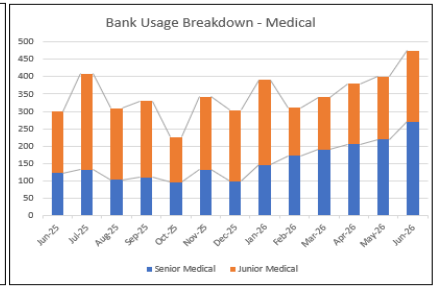
Reduction in bank expenditure is a key focus area nationally, with a minimum of 7.5% bank reduction expected, equating to a cost reduction of c.£1.0m.

Workforce engagement is in place in this area to deliver enhanced booking controls across the Trust, and is being supported by NHSE to provide independent review and appropriate support.

This area requires key focus and will remain a strong area of scrutiny, with the same levels of rigour applied to the agency cost reduction programme developed.







Bank Spend by Profession (£'000)	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Nursing	577	642	556	571	644	609	660	527	631	674	676	619	667
Medical	300	410	309	329	226	342	304	391	311	341	379	400	475
Other Clinical	137	143	137	133	134	137	126	99	114	120	136	114	107
Admin & Clerical	177	171	174	191	177	148	161	158	143	102	160	154	153
Total	**1,191**	**1,366**	**1,176**	**1,224**	**1,181**	**1,236**	**1,251**	**1,175**	**1,199**	**1,237**	**1,351**	**1,287**	**1,402**

YTD Actual	YTD Current Plan	Variance
1,962	1,029	(933)
1,254	558	(696)
357	319	(38)
467	160	(307)
4,040	**2,066**	**(1,974)**

Bank Category	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Qualified Nursing	277	324	315	276	350	334	366	282	360	401	406	366	383
Support to Nursing Staff	375	402	315	368	362	343	357	293	333	336	270	253	284
AHPs	21	19	23	28	24	29	30	22	23	26	39	30	29
Healthcare Scientists	31	33	32	22	34	32	28	23	22	26	27	23	25
Other Clinical Support	10	8	8	9	8	8	5	6	7	5	70	61	53
Management / Admin	176	171	174	191	177	148	161	158	143	102	160	154	153
Senior Medical	123	133	104	111	96	132	100	147	172	191	206	219	270
Junior Medical	177	276	205	219	130	210	204	244	139	150	173	181	205
Total	**1,190**	**1,366**	**1,176**	**1,224**	**1,181**	**1,236**	**1,251**	**1,175**	**1,199**	**1,237**	**1,351**	**1,287**	**1,402**
Plan	*801*	*917*	*867*	*855*	*715*	*676*	*702*	*739*	*657*	*857*	*688*	*690*	*689*
Variance to Plan	(389)	(449)	(309)	(369)	(466)	(560)	(549)	(436)	(542)	(380)	(663)	(597)	(713)

Pay Metrics	In Month Actual	YTD Actual
Bank expenditure as % of total pay	7.1%	6.9%

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Financial Position Update June 2026 - Month 3
Sustainability & Efficiency continued

NHS
Dorset County Hospital
NHS Foundation Trust

Efficiency & Sustainability Programme Update

The annual efficiency target for the Trust is £23.3 million, made up of the following elements:
- Core annual requirement £15.6 million
- Central stretch £7.7 million

The total efficiency plan for the year is £23.3 million and 15% of this remains unidentified and a further 17% at high risk of not delivering. By the end of Q1, NHS England required Trusts to identify a fully developed efficiency programme addressing the full £23.3 million savings target, with no more than 20% of schemes assessed as high risk. As the Trust has not yet met this requirement, enhanced Executive oversight, scrutiny and support are being applied to accelerate scheme development and strengthen delivery confidence, with NHSE kept updated of progress.

In addition, NHS England assesses the level of delivery risk within efficiency programmes by applying expected delivery assumptions to each scheme status category. Based on this methodology, the Trust's current efficiency delivery risk is estimated at £11.9 million. Focus on scheme assessment and acceleration is in place to de-risk the programme, overseen by FRB.

Work continues to reduce this risk through the identification and development of additional efficiency opportunities, the progression of existing schemes to more mature delivery stages, and the implementation of mitigating actions to strengthen delivery confidence.

Status	Pay £'000	Non-Pay £'000	Income £'000	Totals £'000	%	NHSE determination of delivery	Status Assessed Estimated Delivery position £'000	Estimated Risk £'000
Unidentified	276	2,451	770	**3,497**	15%	0%	-	3,497
Opportunity	1,935	5,630	806	**8,371**	36%	25%	**2,093**	6,278
Plans in Progress	1,268	1,662	700	**3,630**	16%	50%	**1,815**	1,815
Fully developed	206	763	245	**1,214**	5%	75%	**910**	303
Fully Developed - in progress	1,997	3,925	715	**6,637**	28%	100%	**6,637**	-
Totals	**5,681**	**14,431**	**3,235**	**23,348**	**100%**		**11,455**	**11,893**

Division	Target Allocations £'000	Identified £'000	(Unidentified) / over £'000	% identified	Of identified: Risk level Low £'000	Medium £'000	High £'000	R/NR Recurrent	Non Recurrent	YTD delivered Plan £'000	Actual £'000	(Under)/ Over delivered £'000	Recurrent	Non Recurrent
Core - 5%														
Urgent & Integrated Care	6,349	6,349	-	100.0%	2,468	2,851	1,031	90.9%	9.1%	955	475	(480)	99.2%	0.8%
Family & Surgical Services	5,938	5,938	-	100.0%	2,578	2,120	1,240	88.8%	11.2%	342	487	145	61.6%	38.4%
Corporate & Commercial	229	188	(41)	82.2%	116	72	-	19.7%	80.3%	3	23	20	36.5%	63.5%
Director of Nursing	126	126	-	100.3%	126	-	-	57.3%	42.7%	-	45	45	36.8%	63.2%
Finance	372	372	-	100.0%	356	16	-	8.1%	91.9%	156	162	6	0.0%	100.0%
Estates & Facilities	1,196	1,196	-	100.0%	322	695	180	63.3%	36.7%	198	43	(155)	30.6%	69.4%
Digital	776	776	-	100.0%	685	-	91	17.1%	82.9%	33	-	(33)	0.0%	0.0%
Operational Support	256	256	-	100.0%	256	-	-	0.0%	100.0%	21	24	3	0.0%	100.0%
HR & Workforce	383	383	-	100.0%	150	233	-	100.0%	0.0%	36	4	(32)	100.0%	0.0%
Subtotal	**15,625**	**15,585**	**(41)**	**99.7%**	**7,057**	**5,986**	**2,542**	**79.9%**	**20.1%**	**1,744**	**1,264**	**(480)**	**64.4%**	**35.6%**
Central Stretch	7,722	4,266	(3,456)	55.2%	1,850	1,035	1,381	49.1%	50.9%	218	773	555	0.0%	100.0%
Total	**23,347**	**19,851**	**(3,497)**	**85.0%**	**8,907**	**7,021**	**3,923**	**63.0%**	**37.0%**	**1,962**	**2,037**	**75**	**39.9%**	**60.1%**

Ellie Vara
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Financial Position Update June 2026 - Month 3

Cash

Dorset County Hospital NHS Foundation Trust

Cumulative cash balance	Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000
2026/27 Submitted Plan	18,849	24,402	25,196	26,281	24,394	23,039	23,593	25,102	23,831	24,952	27,224	16,623
2026/27 Adjusted Plan	18,137	23,691	24,485	25,570	23,683	22,329	22,882	24,392	23,120	24,241	26,513	15,912
2025/26 Actual	23,738	16,880	20,010									

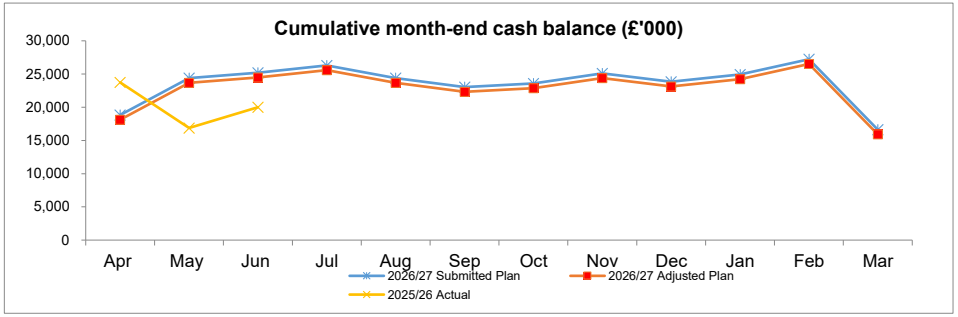
Cash Balance incl Forecast

The cash balance at the end of June was £20 million, which is £4.5 million below the adjusted plan. The adjusted plan reflects the application of the planned monthly cash trajectory to the confirmed opening cash balance for the financial year. This variance is driven by a movement in working capital due to the delay in payment of contract income from Dorset ICB relating to the Sleep Service provide by the Trust during 2025/26 and Depreciation Funding owed to the Trust for Q1 2026/27. Discussions are underway to facilitate the prompt processing of the cash payment.

Whilst the Trust currently has a healthy cash level, there is still a risk to cash flows as we head into 2026/27 as a result of planned deficits at the beginning of the year and a challenging CIP programme of £23.3 million noting any shortfall delivering monthly planned targets will further negatively impact cash. This is reflected in internal BAF and risk register reporting.

The Trust is continuing to carefully monitor cash inflows and outflows through regularly updating and reviewing the cashflow forecast. System colleagues and NHSE are being kept up to date and aware of the potential risks.

'The graph shows the trajectory of the actual year to date cash balance during the year, with identified direct intervention taking place to mitigate shortfalls in cash.



Working Capital Ratios	Target	2025/26 Actual	M2 Actual	YTD Actual
Current Ratio (Net Current Assets / Current Liabilities)	Above 1	1.07	0.94	1.06
Quick Ratio (As above excluding Inventories from current assets)	Above 1	0.94	0.83	0.97
Creditor Days (Average days to pay creditors)	30-60	159	132	134
Debtor Days (Average days to receive payment for debtor invoices)	Below 30	23	26	28
Inventory Holding Days (Average days inventory is held)	Below 30	40	34	29

Both the current and quick ratios have improved since last month, driven primarily by a higher closing cash balance and reduced inventory holdings. Creditor days have increased sightly from 132 to 134 during the month and remain substantially above the target Debtor days have increased from 26 to 28 in month which reflects a slight slowdown in payment of invoices but still within target. Inventory holding days reduced from 34 days to 29 in month bringing the measure within target. The reduction in stock holdings has released working capital and contributed to the improvement in both the current and quick ratios.

Ellis Kara
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Financial Position Update June 2026 - Month 3
Public Sector Payment Policy: Better Payment Practice Code

Dorset County Hospital
NHS Foundation Trust

Public Sector Payment Policy: Better Payment Practice Code
The Trust performance against the Public Sector Payment Policy in June was just below the target of 95% at 94.4% for invoices paid within 30 days. The year to date figure of 93.3% against the target is below last years performance of 96%, largely due to this financial years increased focus on internal cash management and monitoring cash flows carefully to ensure the benefits of the best cash position during the year are realised. The performance on NHS invoices can be seen on the table opposite, which runs significantly lower than 95% due to the management of the historical cash position and timing of NHS creditors in order to ensure the Trust makes payments to suppliers.

Better Payment Practice Code	In Month		Year to Date	
Non-NHS Invoices	**No.**	**£'000**	**No.**	**£'000**
Total bills paid	4,977	9,546	47,501	93,032
Total bills paid within target	4,709	9,108	44,410	86,380
Percentage of bills paid within target	**94.6%**	**95.4%**	**93.5%**	**92.8%**
NHS Invoices				
Total bills paid	91	900	947	14,222
Total bills paid within target	74	795	780	11,170
Percentage of bills paid within target	**81.3%**	**88.3%**	**82.4%**	**78.5%**
Total				
Total bills paid	5,068	10,446	48,448	107,254
Total bills paid within target	4,783	9,903	45,190	97,550
Percentage of bills paid within target	**94.4%**	**94.8%**	**93.3%**	**91.0%**

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Financial Position Update June 2026 - Month 3

Capital

NHS
Dorset County Hospital
NHS Foundation Trust

Capital Programme Narrative

Capital expenditure year to date to the end of June was £7.8 million, which is behind plan by £4.1 million.

Internally Funded

Internally Funded schemes are behind plan at the end of June by £1.8 million.

Medical Equipment Schemes are behind plan due to the timing of expenditure associated with the installation of X-Ray Room 1 and CT Cone, together with the timing of the purchase of replacement of minor medical equipment items.

Estates schemes are behind plan in month due to expenditure on sterilisers and the generator.

Digital Schemes are behind plan for June due to VM Hardware replacement, which was purchased at the end of 2025/26. This has been used to patially offset the timing of the payment to Somerset NHS FT for Digital Healthset (EHR).

Donated expenditure is also behind plan linked to timing of expenditure on New Hospital Programme from the ED/ICU Appeal run by DCH Charity.

Externally Funded

Externally funded capital expenditure was £2.1 million behind plan, primarily due to the timing of expenditure on the New Hospital Programme (NHP).

2026/27 Capital Plan – 5% Over-Programming

The 2026/27 capital programme was approved with the 5% over-programming allowance permitted by NHS England. The total capital plan of £61.776 million includes an over-programming provision of £0.775 million. This over-programming is intended to provide flexibility in the delivery of the capital programme; however any expenditure incurred above the organisation's capital allocation will need to be managed and recovered during the financial year, with slippage and further funding bids options to mitigate.

CAPITAL	CURRENT MONTH			YEAR TO DATE			FULL YEAR 2026/27			
	Plan	Actual	Variance	Plan	Actual	Variance	Committed Spend	Forecast	Annual Plan	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Estates										
Generator	200	-	200	600	-	600	2,400	2,400	2,400	-
Estates Schemes	248	121	127	744	286	458	885	2,830	2,830	-
Digital Services										
EHR Matched Funding	285	38	247	855	1,722	-867	2,404	3,423	3,423	-
IT Schemes	886	91	795	1,108	457	651	1,305	2,259	2,259	-
Equipment										
CT Scanner (2nd Machine)	-	-	-	-	-	-	-	1,800	1,800	-
Other Equipment	398	47	351	1,192	190	1,002	799	2,650	2,650	-
Sub-Total Internally Funded Expenditure	**2,017**	**297**	**1,720**	**4,499**	**2,655**	**1,844**	**7,793**	**15,362**	**15,362**	**-**
Donated										
Other Donations	40	-	40	120	-	120	20	480	480	-
Sub-Total Planned Donated Expenditure	**40**	**-**	**40**	**120**	**-**	**120**	**20**	**480**	**480**	**-**
IFRS 16 Lease Additions										
MSCP Lease remeasurement	-	-	-	-	-	-	-	500	500	-
CEF Lease remeasurement	-	-	-	-	-	-	-	400	400	-
Accommodation & Vehicle Lease Remeasurements	-	-	-	-	-	-	-	50	50	-
Sub-Total Planned IFRS 16 Expenditure	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**950**	**950**	**-**
Total Internal & Leased Capital Expenditure	**2,057**	**297**	**1,760**	**4,619**	**2,655**	**1,964**	**7,813**	**16,792**	**16,792**	**-**
Additional funded schemes										
NHP Works	2,500	512	1,988	7,000	5,045	1,955	42,118	42,118	42,118	-
CIR Funding - Generator	90	2	88	190	60	130	1,000	1,000	1,000	-
CIR Funding - Fire	10	-	10	30	-	30	-	360	360	-
Acute Assessment Unit Development	-	16	-16	-	16	-16	89	300	300	-
ED Diagnostic Equipment	-	-	-	-	-	-	-	750	750	-
ENT Stacks	-	-	-	-	-	-	-	200	200	-
MH suite fit out (Dorchester)	-	-	-	-	-	-	-	256	256	-
Total Externally Funded Capital Expenditure	**2,600**	**530**	**2,070**	**7,220**	**5,121**	**2,099**	**43,207**	**44,984**	**44,984**	**-**
Total Capital Expenditure	**4,657**	**826**	**3,831**	**11,839**	**7,776**	**4,063**	**51,020**	**61,776**	**61,776**	**-**
Expenditure as a % of Plan			18%			66%				0%

Lisa Kara
04/08/2026 15:53:11

Dorset County Hospital
Dorset HealthCare

Report to	Board in Common	
Date of Meeting	11th August 2026	
Report Title	Joint Green Plan 2026-2029 Annual Report	
Prepared By	Bev Lagden, Patrick McDermott, DCH & DHC Sustainability Managers	
Approved by Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	Finance and Performance Committee in Common, 29 July 2026	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care		No
Colleagues		No
Communities		No
Sustainability	**Yes**	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR5 – Estates SR7 – Partnership and Transformation	
Financial	Climate change impact on operations	
Statutory & Regulatory	Climate Change Act 2008/Health & Care Act 2022/Environment Act 2021.	
Equality, Diversity & Inclusion	EIA completed for the plan	
Co-production & Partnership	DCH and DHC and external delivery partners e.g. Dorset Council, Centre for Sustainable HealthCare, working with UHD	

Executive Summary

The paper updates the communication, engagement of the first Joint Green Plan

- The trusts have worked together to produce the first Joint Green plan setting out pathways to reduce our impact on public health and the environment and map a route to Net Zero Carbon emissions targets. The work of the previous 12 months was to assimilate SMART actions across the 11 focus areas working with focus area expertise and lead colleagues.

- This work has supported the update and development of a Joint Social Value Action Plan Greener and more sustainable sections, as these areas coalesce. This work has informed the Estates and Facilities Strategy.

- A simple communication plan will be further developed with communications colleagues, and in consideration of achieving some of the Equality and Diversity considerations of the EDI assessment. A plan on a page is drafted, ready to add both to the trust's websites, and link a soft launch with a nature connection summer flipbook that will be made available to the staff of all the trusts. A later fuller launch with virtual and in person drop ins for Sustainability Day in the autumn, engaging with green and wellbeing networks, sustainability champions, green networks made up of groups such as Critical Care, Greener Theatres, and the 11 focus areas of the plan.

- Work is underway on a *Joint Travel Plan* and a Joint (Dorset trusts) *Climate Change Adaptation report* of which a suitable summary of both will be appended to the Joint Green Plan in December 2026.

Ellis Kara 06/08/2026 10:53:14

The plan supports the Sustainability pillar and working better together elements of '*working together, improving lives*,' contributes to the *Greener and Sustainable* elements of the draft *joint Social Value Plan* and content of the DCH *Estates and Facilities Strategy*

- Work is underway on a Joint Travel Plan and a Joint (Dorset trusts) Climate Change Adaptation report of which a suitable summary of both will be appended to the Joint Green Plan in December
- The work of the previous 12 months was to assimilate SMART actions across the 11 focus areas working with focus area expertise and lead colleagues
- The actions will be collated into a tracker workbook, and data collection across energy, waste, water and projects to monitor carbon emission reductions, avoidance and management and the wider sustainability goals that combine to support good health and wellbeing
- A soft launch will take place in the summer, with a Nature Connection (summer version) of the Well-being flip book that can be shared across all the trusts in Dorset further sustainability day, harder launch in the autumn and combining this with a 'T-urn off Lights and Close doors TLC project, aiming to engage and empower staff and resources around climate change feelings are being sought
- The trusts are working with other public sector sustainability leads, particularly through Public Sector Decarbonisation and Energy Group, have linked with the Local Nature Partnership, are working with Centre for Sustainable HealthCare hosting 1 of 9 Nature Recovery Rangers
- The trusts have sought funding and achieved success with projects in Solar, Submetering (measure you'll manage it), LED replacement and EVCP, while some projects were not funded
- A Greener theatres group are working to the Intercollegiate and Surgeons Greener Theatres Checklist 2.0 and there is an emerging Greener Critical Care Group
- A Greenspaces Group has seen success for funding and the Recovery Ranger delivering greenspace projects, we have moved 2 benches to create cool spots on site.

The following reports and appendices are in the Board in Common Reading Room on Admincontrol:
'8.4.2 Joint Green Plan and Net Zero Carbon Progress Report'
'08.4.3 Green plan refresh focus 2026 for Green Strat Net Zero Report - July 2026'

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

Ellis,Kara
06/08/2026 15:53:11

Report to	Board in Common	
Date of Meeting	11 August 2026	
Report Title	Dorset County Hospital (DCH) and Dorset Healthcare (DHC) Winter Planning 2627	
Prepared By	Jonquil Williams, Joint Business Manager to Deputy CEO and CEO	
Approved by Accountable Executive	Anita Thomas, Chief Operating Officer (DCH)	
Previously Considered By	Nil	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR4: Capacity and Demand (for both DCH and DHC)	
Financial	NA	
Statutory & Regulatory	Comply with timeline set out by NHSE to produce robust Winter plans for 2026/27	
Equality, Diversity & Inclusion	EQIA will be completed as part of planning if appropriate	
Co-production & Partnership	The Winter Plans will be co-produced with all partners in the system and the ICB will have oversight of all provider plans.	

Executive Summary

On 17 July 2026 the trusts received the *Winter Planning 2026/27 – expectations and assurance* letter from NHSE.

The letter asks for every local areas to have a robust and clinically led and deliverable winter plan and the core expectations are:

- draft winter plans completed by the end of August, developed jointly by all local partners: acute, ambulance, community, mental health, primary care, local authorities, social care and the third sector
- a named Executive Winter Lead in every ICB and provider, accountable for preparedness and response
- plans tested at the NHS England regional stress test exercises in September
- plans signed off by boards using the attached Board Assurance Statements (BAS), submitted to england.eecpmo@nhs.net by 30 September 2026

Responsibilities for winter reflect the new operating model set out in the Model ICB and Model Region Blueprints: ICBs commission, providers deliver, and regions oversee. The Board assurance templates set out in full what boards will be asked to assure; use them now to shape your plans rather than as a retrospective checklist. In summary:

ICBs

ICBs are responsible for the winter plan for their area, agreed with all partners and signed off by their board. Plans must be built on a whole-area demand and capacity analysis with robust planning

Kara Ross
06/08/2026 15:58:41

assumptions, tested against surge and extreme surge scenarios. . As strategic commissioners, ICBs must lead prevention now – vaccination uptake (particularly maximising uptake in children to help reduce spread), and proactive support for people most at risk from winter viruses and cold weather – and commission the right level of activity for winter so that people are treated closer to home wherever possible. That means sufficient commissioned capacity across:

- primary care: same day urgent appointments, enhanced access, NHS 111 direct booking, community pharmacy and out-of-hours provision including during holidays and over Christmas, alongside delivery of the seasonal vaccination campaigns
- community services: urgent community response, virtual wards and Hospital at Home, with senior clinical decision-making accessible through a single point of access at least 12 hours a day, 7 days a week
- mental health: resilient all-age crisis services, including urgent mental health helplines via NHS 111, crisis alternatives and liaison psychiatry, with crisis plans in place ahead of winter for high-risk patients and frequent attenders
- social care and intermediate care: commissioned jointly with local authorities, with discharge planned together, sufficient capacity through winter and agreed plans to reduce hospital occupancy ahead of Christmas
- infection prevention and control (IPC): commissioning safe IPC practice in care homes and the wider care sector

NHS trusts and foundation trusts

Providers are accountable for operational delivery through winter. Trusts must:

- complete an organisational winter plan by the end of August, with staff flu vaccination programmes ready to launch and preparatory actions under way now
- implement the Model Emergency Department, Model Acute Pathway and Model discharge pathway requirements ahead of winter, with the elimination of corridor care treated as a patient safety priority, while maintaining elective capacity throughout the winter period
- assure tested arrangements for escalation, infection prevention and control, on-call leadership and staff welfare, and protect delivery of agreed 2026/27 trajectories

Due to the timing of the return to NHSE the board as asked to approve the following governance routes to sign off the final plan:

1. **Draft DCH and DHC plans shared with Board at the Board Development session on 08 September 2026**
2. **Final DCH and DHC plans to be signed off at the Finance and Performance committee on 30 September (delegated responsibility from the Board of Directors)**

Recommendation

Members are requested to:

- **Approve** the governance route to sign off the plan and to delegate sign off responsibility to Finance and Performance committee

Ellis Kara
06/08/2026 15:53:11

To:
- All NHS trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
- ICB:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
- Primary care networks
- Local government chief executives
- Directors of Adult Social Services
- Directors of Public Health

cc.
- Regional:
  - directors
  - chief operating officers
  - medical directors
  - chief nurses
  - directors of commissioning
  - chairs

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

17 July 2026

Dear colleagues

Winter planning 2026/27 – expectations and assurance

Last winter was the best in 3 years for 4-hour performance and ambulance response times, despite an early flu season, a January norovirus peak and industrial action. That was the result of early planning and strong collaboration across health and care, for which we thank you. This letter sets out the national approach to winter 2026/27 and the actions we need every part of the NHS and local government to take, starting now.

EM-Ltrs 09/04/26 15:53:11

Every local area must have a robust, clinically led and deliverable winter plan. The core expectations are:

- draft winter plans completed by the end of August, developed jointly by all local partners: acute, ambulance, community, mental health, primary care, local authorities, social care and the third sector
- a named Executive Winter Lead in every ICB and provider, accountable for preparedness and response
- plans tested at the NHS England regional stress test exercises in September
- plans signed off by boards using the attached Board Assurance Statements (BAS), submitted to england.eecpmo@nhs.net by 30 September 2026

Responsibilities for winter reflect the new operating model set out in the Model ICB and Model Region Blueprints: ICBs commission, providers deliver, and regions oversee. The BAS templates set out in full what boards will be asked to assure; use them now to shape your plans rather than as a retrospective checklist. In summary:

ICBs

ICBs are responsible for the winter plan for their area, agreed with all partners and signed off by their board. Plans must be built on a whole-area demand and capacity analysis with robust planning assumptions, tested against surge and extreme surge scenarios. As strategic commissioners, ICBs must lead prevention now – vaccination uptake (particularly maximising uptake in children to help reduce spread), and proactive support for people most at risk from winter viruses and cold weather – and commission the right level of activity for winter so that people are treated closer to home wherever possible. That means sufficient commissioned capacity across:

- primary care: same day urgent appointments, enhanced access, NHS 111 direct booking, community pharmacy and out-of-hours provision including during holidays and over Christmas, alongside delivery of the seasonal vaccination campaigns
- community services: urgent community response, virtual wards and Hospital at Home, with senior clinical decision-making accessible through a single point of access at least 12 hours a day, 7 days a week
- mental health: resilient all-age crisis services, including urgent mental health helplines via NHS 111, crisis alternatives and liaison psychiatry, with crisis plans in place ahead of winter for high-risk patients and frequent attenders
- social care and intermediate care: commissioned jointly with local authorities, with discharge planned together, sufficient capacity through winter and agreed plans to reduce hospital occupancy ahead of Christmas
- infection prevention and control (IPC): commissioning safe IPC practice in care homes and the wider care sector

ICBs must also co-ordinate the winter response day-to-day through their co-ordination centre, operating 7 days a week and using the OPEL framework, with tested escalation, surge and mutual aid arrangements agreed by all partners.

NHS trusts and foundation trusts

Providers are accountable for operational delivery through winter. Trusts must:

Eva Kara
28/08/2026 09:55:51

- complete an organisational winter plan by the end of August, with staff flu vaccination programmes ready to launch and preparatory actions under way now
- implement the Model Emergency Department, Model Acute Pathway and Model discharge pathway requirements ahead of winter, with the elimination of corridor care

treated as a patient safety priority, while maintaining elective capacity throughout the winter period
- assure tested arrangements for escalation, infection prevention and control, on-call leadership and staff welfare, and protect delivery of agreed 2026/27 trajectories

Ambulance services

- Plan to deliver the 2026/27 Category 2 response time trajectory, maximising hear and treat, see and treat and referral into alternatives to ED, to reduce conveyance rates.
- Work with acute partners to deliver 15-minute handovers, with none exceeding the 45-minute maximum.

Regional teams

In line with the Model Region Blueprint, regional teams will oversee winter preparedness and performance across providers and ICBs, arrange the September stress test exercises, assure plans across their geographies and co-ordinate mutual aid across ICB boundaries where needed, including specialised services and pathways commissioned outside of ICB arrangements.

Support available

We will share performance data to support planning by the end of July via NHS Futures, run online sessions in July on improving vaccination uptake, and publish further guidance on Urgent Community Response and community beds shortly. We will continue to work with ICBs and providers to support communication on 111, Pharmacy First, vaccination, and alternatives to ED.

Thank you for everything you and your teams are doing to prepare. Early, collaborative planning delivered a better winter for patients last year; together we can do so again.

Yours sincerely

Sarah-Jane Marsh CBE
NHS England Chief Operating Officer

Ellis Kara
06/08/2026 15:53:11

Dorset County Hospital
Dorset HealthCare

People and Culture Committee in Common Assurance Report for the meetings held on Monday 29 June 2026 (informal) Monday 27 July 2026 (formal)

Chair	Eiri Jones, NED
Executive Lead	Nicola Plumb, Joint Chief People Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Discussion of the Board Assurance Framework and Corporate Risk Register as described below • Recommendation for the Board to approve the DCH and DHC Revalidation Reports • Recommendation for Board to have a discussion around the Mann Review and the Trusts' response to the review
Key issues / matters discussed at the meeting	**The informal meeting of the committee held 29th June 2026 was a staff engagement session:** • A presentation on the national **transformation people services** programme, which was noted as an area of high risk for the Trust in relation to delivering the strategic change whilst continuing business as usual • A presentation on the **support for locally employed doctors at DCH** • A presentation on **EDS2** for both Trusts • Receipt of the **People and Culture Committee in Common governance structure** **The meeting held 27th July 2026 received, discussed and noted the following reports:** **Chief People Officer Update** highlighting: • Publication of NHS Staff Standards noting alignment with existing local practices • Publication of NHS Leadership and Management Framework. An assessment of how the trusts meet those requirements to follow. • Transforming People Services programme progressing with speed in the south west region • Nursing job evaluation update, noting progress at each of the trusts

Ellis Kara 06/08/2026 15:53:11

Board Assurance Framework Q1 Review (Joint) noting updated risks for People and Culture Committee in Common. SR2 has changed from 'culture' to 'empowerment'. All elements of the Board Assurance Framework have been refreshed and reframed in line with the updated risks. For both Trusts the two strategic risks (SR2 Empowerment and SR3 Workforce Capacity) have a risk appetite of 'seek'. At both trusts, SR2 has a target score of 12 and a mitigated score of 12 and SR3 has a target of 12 and a mitigated score of 16.

Robust discussions around the evidence and controls in place which contribute to an accurate mitigated risk score, with agreement for a future informal session to look in detail at the controls and assurances.

Corporate Risk Register (DHC/DCH)

DHC:

- Work to improve the harm described in risks
- Key risks for the Committee's attention include recruitment to Reconnect service, and Waterstone remains in safer staffing, with additional support during period of challenge. Recruitment of new staff is ongoing.
- All long-standing risks to be reviewed by the new Risk Management Group

DCH:

- Key long standing risks include risk 2012 regarding the revalidation officer which had been open since 2024 and was a vulnerable position for the trust, and risk 876 re maternity staffing which had been open since 2021.
- Long standing risks were to be reviewed to consider if they needed closing or refreshing to provide an accurate, up to date picture.

Workforce KPI Dashboard (Joint) noting the below KPIs for month 3:

Trust	Sickness	Vacancy Rate	Turnover Rate	Appraisals	Mandatory Training
DCH	4.58%	9.5%	9.5%	77%	88%
DHC	5.45%	7.35%	8.6%	77.7%	94%

- Positive improvements in DHC appraisal rates, but a slight reduction at DCH.
- Stretched employee relations teams with a very high number of sickness employee relations cases in both trusts.
- Discussion around the high rate of turnover in the 31-35 year old age range, noting the impact on pipeline for staff development
- DHC 53 WTE worse than plan (on plan for substantive, but deficit seen in bank and agency)
- DCH better than plan by 119 WTE. Substantive is better than plan by 174 WTE, largely due to delays in recruitment. Bank and agency still higher than planned, particularly in CAMHS, St Brelade's and Waterstone.

Ellis Kara
06/08/2026 15:53:11

- Positively, 21 nurses had qualified across DHC and DCH in quarter one and there were 201 and 174 apprentices in DHC and DCH respectively. This was noted as a positive number.
- Work ongoing to improve reporting consistency and thresholds across both trusts
- One fifth of occupational health capacity is lost due to 'did not attends'. Work is ongoing to support staff to attend appointments, including working with managers to ensure staff could be released to attend.

Medical Appraisal and Revalidation Annual Report (and statement of compliance) (DHC/DCH)
DHC:

- 125 doctors with a prescribed connection to DHC. All doctors with a prescribed connection were allocated a trained appraiser and have had an appraisal meeting or a valid reason for exception for the 2025/2026 appraisal year.
- The report is recommended to the Board for approval.

DCH:

- 352 doctors with a prescribed connection to DCH.
- LK continued to the Responsible Officer for DCH as well as DHC, with RW the Deputy Responsible Officer at DCH.
- Approval from SLG to increase remuneration for appraisers from 0.188 PA to 0.25 PA.
- Suggestion from the committee that the Revalidation Policy in development is a joint policy, if this is appropriate for the two organisations.
- The report is recommended to the Board for approval.

National Education and Training Survey (NETS) Results (DHC/DCH) as an important part of understanding staff experience. The report noted sustained improvement in the quality of the learning environment across Dorset HealthCare and Dorset County Hospital. Learners report better support, improved facilities and a more positive culture, reflecting progress against the Safe Learning Environment Charter. Result scores at DHC exceeded ICB benchmarking and improved in 12 of 13 domains. At DCH scores were above national average in 12 of 13 indicators with 10 showing improvements from 2024. Sexual safety remains below benchmark at DCH mirroring regional performance. Focused improvement plans are in place to address the remaining challenges around wellbeing, workload discrimination and sexual safety.

Sexual Safety Update (Joint) noting progress against the charter implemented in January 2025. Most actions are now completed and embedded within routine business processes. Strong progress has been made in strengthening governance arrangements, policies, mandatory training, specialist investigator capability, reporting mechanisms and

Ellis Kara
06/08/2026 15:53:11

support available to staff who experience inappropriate sexual behaviours at work. Sexual safety is now increasingly embedded within the workforce development, employee relations, safeguarding and inclusion and belonging work. Questions around the variation in processes and policies between the two trusts and how improvement metrics could be evidenced. Discussion around the specialist investigators in the trusts with the option of utilising external investigators when required.

Lord Mann Review – Response and next steps (Joint) noting that Trusts are well positioned with most recommendations from the review already included in existing work programmes. National guidance is awaited for some of the recommendations. A gap analysis highlights a need for a standalone anti-racism policy. The committee had a detailed, nuanced conversation about the implications of the Mann report, what our response will be and the next steps. The Committee requested that the Board discusses the review and the Trusts' response.

The below items were taken under consent, without discussion:

Assurance reports from below sub-groups of the People and Culture Committee in Common

DHC:

- Trade Union Partnership Forum
- Local Negotiating Committee

DCH:

- Partnership Forum
- Health and Wellbeing Steering Group

Question re support for change management. OD team working on material for change management, with that training initially focused on the departments that had experienced the most change.

- Local Negotiating Committee
- Equality, Diversity, Inclusion and Belonging Steering Group

Joint:

- Culture and Inclusion Reference Group

Decisions made at the meeting	• Recommendation for Board to approve the Medical Appraisal and Revalidation Statement of Compliance
Issues / actions referred to other committees / groups	• Referrals to Quality Committee in Common regarding the quality impact of staffing challenges, and to Finance and Performance Committee in Common regarding the ability to recruit staff in light of the headcount reduction targets

Ellie Jarvis 02/08/2023 15:53:11

Quoracy and Attendance						
	27 May 2026	28 Jul 2026	29 Sept 2026	24 Nov 2026	26 Jan 2027	23 Mar 2027
Quorate?	Y	Y				
Suresh Ariaratnam	Y	Y				
Margaret Blankson	Y	Y				
Dawn Dawson (to 27/07/26)	A					
Eiri Jones	Y	Y				
Lucy Knight	Y	Y				
Nicola Plumb	Y	Y				
Rachel Wharton	Y	A				
Cara Southgate						
Jo Howarth						

Ellis,Kara
06/08/2026 15:53:11

Dorset HealthCare University
NHS Foundation Trust

Report to	Board in Common (DHC)	
Date of Meeting	11 August 2026	
Report Title	Medical Staff Revalidation – Annual Update and Statement Of Compliance (DHC)	
Prepared By	Dr Sudipto Das, Associate Medical Director & Lead for Revalidation and Medical Appraisal Helen Young, Medical Appraisal, Revalidation & Job Plan Coordinator	
Approved by Accountable Executive	Dr Lucy Knight Chief Medical Officer & Responsible Officer	
Previously Considered By	Senior Leadership Group & People & Culture Committee – July 26	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality SR2 Empowerment SR3 Workforce Capacity	
Financial	No implication	
Statutory & Regulatory	Statement of Compliance to be signed by CEO once approved in preparation for submission to NHSE/I. RO holds statutory role in medical regulation.	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	Appraisal and revalidation are mandated by the GMC and opportunities for co-production and partnership are limited.	

Executive Summary

The report sets out the Medical Appraisal and Revalidation process the Trust has in place in line with GMC guidelines. It provides the Board with the following updates:

- The number of prescribed connections to the Trust and number of doctors who have had an appraisal for the 2025/2026 appraisal year
- The number of Trust Appraisers and how their learning and development is supported
- The systems in place to support the appraisal and revalidation process and provide quality assurance
- The number of doctors who have revalidated in 2025/2026 and the number of doctors who were deferred
- Recruitment and Background checks
- Responding to concerns and remediation

At the end of the 2025/2026 appraisal year there were 125 doctors with a prescribed connection to Dorset HealthCare University NHS Foundation Trust.
All doctors with a prescribed connection were allocated a trained appraiser and have had an appraisal meeting or a valid reason for exception for the 2025/2026 appraisal year.

Ellis (ICB) 06/08/26 5:19:11

I continue to be assured that the Trust has a well-run medical appraisal and revalidation system with no risks or issues.

Recommendation

Members are requested to:

- **Approve the signing of the statement of compliance.**

Ellis,Kara
06/08/2026 15:53:11

Dorset HealthCare University
NHS Foundation Trust

MEDICAL STAFF REVALIDATION – UPDATE

11 August 2026

1 PURPOSE OF REPORT

1.1 To provide assurance the Trust has a system that meets GMC requirements for appraisal and revalidation of medical staff with a connection to the Trust.

1.2 Revalidation of doctors is an established national process. The enhanced appraisal which supports the revalidation process within Dorset HealthCare University NHS Foundation Trust, has been in place since 2011.

1.3 This update report covers the calendar year April 2025-April 2026.

2 BACKGROUND

2.1 Medical Revalidation was launched in 2012 to strengthen regulation of doctors, develop the quality of care provided to patients, improve patient safety and increase public trust in the medical system.

2.2 Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations. It is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations
- checking there are effective systems in place for monitoring the conduct and performance of their doctors
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

3 GOVERNANCE ARRANGEMENTS

3.1 The Trust has in place the following key personnel to support the appraisal and revalidation process:

- Responsible Officer – Lucy Knight
- Deputy Responsible Officer – Andy Dean
- Medical Appraisal and Revalidation Lead – Sudipto Das
- Medical Appraisal and Revalidation Co-ordinator – Helen Young

Ellis Kara
06/08/2026 15:53:11

3.2 Progress of the appraisal and revalidation process during 2025/2026 was monitored via regular reporting as follows:

- Bi-monthly reports are provided for the Responsible Officer and discussed at bi-monthly meetings by the Responsible Officer, Deputy Responsible Officer, Medical Appraisal & Revalidation Lead and Medical Appraisal Revalidation Co-ordinator
- Annual Organisational Audit (AOA) has been stood down since 2020. Compliance is now achieved through completion of the table within the NHS England Framework for Quality Assurance.

3.3 The Trust plans to submit the Responsible Officers Framework for Quality Assurance including the Statement of Compliance to NHS England. This is included for Board approval as Appendix A.

4 MEDICAL APPRAISAL

4.1 Doctors with a prescribed connection

4.1.2 As of 31 March 2026, there were 125 doctors with a prescribed connection to the Trust. In the 2025/2026 appraisal year, 118 doctors had an appraisal meeting with the Trust.

16 doctors connected with the Trust as of 31 March 2026 did not require appraisals for valid reasons: 1 appraisal was an approved miss due to maternity leave. 2 appraisals were approved miss due to sickness absence. 11 doctors were new to the Trust and did not require an appraisal for the 2025-2026 year. 2 doctors were connected in error as they are no longer working for the Trust which has now been corrected.

11 doctors who were appraised were no longer connected by 31 March 2026 due to leaving the Trust. 1 doctor was not appraised as they left the Trust before their appraisal was due.

In the 2025/2026 appraisal year, 21 Appraisals were defined as postponed; 97 were completed within the required time. All postponements were agreed for appropriate reasons, including sickness, planned absence and workload.

4.1.3 All doctors have access to multi-source feedback, once within a five year revalidation cycle to meet minimum revalidation requirements. This no longer requires funding as it is included in the SARD contract with no additional cost. Edgecumbe licences are no longer being purchased. Infrequently, there are circumstances that require additional multi-source feedback to be undertaken, and this is carefully considered on a case-by-case basis. The 360º feedback from colleagues and patients is discussed, with reflection forming an important part of the appraisal process. The uptake of multi-source feedback and the output from this process is monitored and assured at the time of a revalidation recommendation.

4.1.4 In the 2025/2026 appraisal year, all doctors were required to submit their appraisal data on the online toolkit Strengthened Appraisal and Revalidation Database (SARD). This enables monitoring, audit and quality assurance of appraisal outputs and revalidation recommendations.

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4.2 **Appraisers**

4.2.1 The Trust had 19 trained medical appraisers at the end of 2025/2026 year.

4.2.2 Appraisers are supported in their role in the following ways:

- access to support and guidance from Medical Appraisal and Revalidation Lead as required
- allocated peer group of appraisers
- individual meetings with Appraisal and Revalidation Lead to receive feedback on review of appraisal outputs using the NHS E & I Appraisal Summary and PDP Audit Tool form (ASPAT) and feedback received from appraisees. This is used as an opportunity to plan any personal development, including peer review process of appraisal outputs.
- Bi-annual Appraiser Support and Development Forum half days.

4.3 **Quality Assurance**

4.3.1 An internal audit of the appraisal and revalidation system was not deemed necessary in 2025 as an NHS England Higher Level Responsible Officer review took place in July 2024.

4.3.2 It has been decided by the RO that we will not collect annual declaration forms for doctors with another responsible officer.

4.3.3 Under the Framework of Quality Assurance, an Independent Verification Review by NHS England took place on 23 July 2024.

4.3.4 The HLRO Review made eight recommendations. Two of these ‘must’ be implemented and six are for our consideration.

4.3.5 The Trust Board ‘must’ be aware that it is a key responsibility of the Board to ensure adequate resources for provision of a Trust Appraisal service for doctors. The HLRO Review report is available on request.

4.3.6 The Trust ‘must’ ensure that there are no single points of failure within the Trust Appraisal and Revalidation processes and systems. This will be achieved by agreement of adequate resource and capacity within the Revalidation team.

4.3.7 Individual qualitative feedback on the value of appraisal has been collated for sharing with appraisers to focus development. This also enables the Trust to identify the broader benefits of the medical appraisal system. Overall feedback was very positive. A summary report outlining the full audit of the 2025/2026 feedback, Audit of Medical Appraisal Feedback 2025/2026 is available on request.

4.3.8 The Trust Lead for Medical Appraisal and Revalidation meets individually with Trust appraisers annually to reflect on the role, receive feedback and consider further areas for development.

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4.3 **Access, Security and Confidentiality**

4.4.1 All staff appraisal information and evidence is stored on the Trust's Medical Revalidation drive and the SARD online toolkit. Access is limited to staff involved in the co-ordination and delivery of the appraisal and revalidation process.

4.4.2 The Revalidation Team work closely with the Trust Information Governance Team and have improved and developed the link with the Revalidation Team.

4.4 Clinical Governance

4.5.1 The following data is provided to doctors and their appraisers to facilitate their appraisal and revalidation:

- individual complaint data is forwarded to all involved doctors
- Serious Untoward Incident data and reports are forwarded to individual medical staff for inclusion in their appraisal documentation.
- it is expected that doctors will reflect on the data provided and include this in their annual appraisal documentation.

4.5.2 Collated information on numbers of complaints and Serious Untoward Incidents for individual doctors is shared with their appraiser to enable triangulation and ensure appropriate reflection occurs.

4.5.3 Doctors are also supported to complete mandatory training.

5 REVALIDATION RECOMMENDATIONS

5.1 Between 1 April 2025 and 31 March 2026 the Responsible Officer made revalidation recommendations for 9 doctors. 7 doctors were successfully revalidated. 2 doctors were deferred due to insufficient evidence.

6 RECRUITMENT AND ENGAGEMENT BACKGROUND CHECKS

6.1 Medical HR has a robust process in place to verify ID and qualifications and obtain references for all medical staff employed by Dorset HealthCare. The Trust uses the NHSE process for Transfer of Information to ensure we have complete information when doctors are employed.

6.2 Locums are recruited using Government Procurement Service agencies. The locum agency is required to provide the Trust with the following information:

- GMC confirmation that the doctor has a licence to practice (inclusion on the Specialist Register for all consultant posts).
- up-to-date CV
- name of the doctor's Responsible Officer
- date of last appraisal (must be within 12 months)

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- two references to be provided, which would include 1 from the most recent assignment
- Section 12 approval (Psychiatry only)
- enhanced DBS disclosure
- photographic ID and right to work documentation.
- up to date Basic Life Support Certificate
- Occupational Health Fitness to Practice Certificate with full immunisation details
- must be able to drive with own vehicle (if applicable for the role)
- Approved Clinician status (if required for the role).

6.3 The locum doctor is given a 'Welcome Pack' on commencement of employment. The pack contains the following:

- induction checklist for locum doctors.
- Fitness to Practice Form
- Confidentiality declaration
- DBS declaration and form for completion
- Prescription Signature
- Day 1 Agency Worker's letter.

6.4 At the end of the locum's assignment an end of assignment form is completed by the appropriate medical manager.

7 RESPONDING TO CONCERNS AND REMEDIATION

7.1 Only one formal investigation of medical staff took place during 2025/2026 which was still ongoing on 31 March 2026.

7.2 A Joint Responsible Officer Advisory Group (ROAG) provides independent oversight and professional advice to support the Responsible Officer in fulfilling their statutory duties under the Medical Profession (Responsible Officers) Regulations 2010. The group ensures that decisions related to medical revalidation are consistent, evidence-based, and subject to appropriate scrutiny. Acting as a source of professional challenge and assurance, the ROAG helps maintain high standards of governance, promotes fairness and transparency, and supports the Responsible Officer in managing complex or sensitive cases effectively.

7.3 A Fitness to Practice group provides a structured multidisciplinary forum for reviewing and managing concerns about a doctor's ability to practice safely and effectively. This group supports the organisation's duty to protect patients and maintain professional standards by identifying, assessing, and overseeing concerns related to conduct, capability, health or performance. It typically advises on appropriate actions such as investigation, support, remediation, or referral to the regulatory body and ensures concerns are managed fairly, consistently and in line with relevant policies and legal

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frameworks. The group may also monitor ongoing cases and identify themes to inform learning and system improvement.

7.4 The Trust has the following relevant policies in place:

- Handling of Concerns and Disciplinary Procedures for Medical Staff (IN-768)
- Medical Staff Return to Practice Policy (IN-187)
- Medical Staff Appraisal to Support Revalidation (IN-122)
- Policy for the Management of Medical Locums (IN-153)

8 RISKS AND ISSUES

8.1 No risks identified in relation to the appraisal and revalidation process.

Dr Lucy Knight, Responsible Officer & Chief Medical Officer 2026

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Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of: Dorset HealthCare

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Y
Action from last year:	No changes planned
Comments:	Dr Lucy Knight became Chief Medical Officer and Responsible Officer October 2024.

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Action for next year:	No changes planned

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Y
Action from last year:	Continue
Comments:	Nil
Action for next year:	Continue

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Y
Action from last year:	Continue to maintain up to date records
Comments:	The Medical Appraisal, Revalidation and Job Plan Coordinator keeps an accurate record of all licensed registered medical practitioners with a prescribed connection to Dorset HealthCare. This record is subject to continual updates as circumstances change. The SARD electronic toolkit has been used for this for the last four years.
Action for next year:	Continue to maintain up to date records

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

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Y/N	Y

Action from last year:	IN-153 due for review March 2025, IN-187 due for review May 2025, IN-768 due for review February 2026
Comments:	IN-153 due for review June 2028, IN-187 due for review July 2028, IN-768 currently under review April 2026, IN-122 due for review July 2027, IN-587 due for review July 2028
Action for next year	Nil

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Y
Action from last year:	Continue work towards meeting recommendations
Comments:	The HLRO visit took place on 23 July 2024. The following recommendations were made: 1. The RO must secure additional resources for appraisal in order to have adequately deliver effective appraisal 2. To bring the newly configured model of operating Revalidation and Appraisal in line for both organisations in the federated group 3. To formalise a Responsible Officer Advisory Group (ROAG) 4. It is recommended to outsource Appraisal externally for the Appraisal & Revalidation Lead to ensure there is no Conflict of Interest within the organisation 5. To undertake a review of doctors on the Performers List and explain that they no longer need to be on the Performers List if not undertaking any general medical services so can align to your organisation's Responsible Officer to Appraise and Revalidate 6. To review the `make up' of Appraisers, ensuring there is an equal, diverse and balanced team and a wider range of disciplines. Review number of Appraisals undertaken and set a minimum to 5-6 per year. 7. Ensure any retired and returned doctors are suitable to undertake Appraisal; ensuring they remain trained and up to date.

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8. To ensure there is no single point of failure by establishing cross cover of those tasks within the appraisal system, there is a potential to link with DCH to help mitigate these risks

The report received concluded with the following:

Dr Michael Marsh, and his team, would like to thank you for your engagement in this process and for providing written evidence/information and discussion with regards to systems in place, this has assured Dr Marsh, as your Higher-Level Responsible Officer and he has no concerns regarding the performance of Responsible Officer functions. The recommendations made above, previously informed verbally at the meeting, are intended to be supportive and developmental.

Work has been undertaken to progress towards meeting each of the above recommendations. These include:

Rec 2 – A combined CPD/development afternoon for appraisers from across Dorset took place in Nov 2025. There are significant challenges inherent in aligning our processes across the federated organisation given the substantial differences in job roles, systems and processes. SPA time to be allocated for Appraisers is now aligned with UHD. DCH is in process of also aligning with this provision. Best practice is being shared and adopted where appropriate.

Rec 4 – The Appraisal & Revalidation Lead had his appraisal undertaken in Cornwall in the 2025/2026 appraisal year.

Rec 6 – The Appraiser role was advertised and we have successfully recruited 5 new appraisers. This has increased the number of physical health appraisers. We have chosen not to set a minimum number of appraisals to be undertaken per appraiser since even a small contribution to the system can be invaluable and this encourages involvement by senior medical leaders.

Rec 8 – The Medical Appraisal, Revalidation & Job Planning Coordinator is now managed by the DCH Associate Director

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	of HR. This involves working more closely with the Revalidation Coordinator for DCH.
Action for next year:	Continue work to meet ongoing recommendations

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Y
Action from last year:	**Nil**
Comments:	IN-153 due for review June 2028
Action for next year	Nil

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Y
Action from last year:	Further develop our utilisation of electronic systems.

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Comments:	Review of electronic systems to take place and decision to be made regarding renewal of the SARD system in October 2026. Now using SARD for MSF.
Action for next year:	Continue to develop our utilisation of the electronic tool kit.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	N/A
Action from last year:	For the Trust to provide adequate resource to ensure that there are sufficient trained appraisers to provide appraisals for all our doctors.
Comments:	Arrangements for SPA time and remuneration for our Trust Medical Appraisers has been clarified. This has assisted with recruitment and retention. A separate Appraisal budget has been identified.
Action for next year:	Continue to provide adequate resource to ensure that there are sufficient trained appraisers to provide appraisals for all our doctors.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Y
Action from last year:	Update IN-122 if necessary and review July 2027
Comments:	IN-122 was reviewed and updated to reflect the changes to the SPA provision in March 2026.
Action for next year:	Update IN-122 if necessary and review July 2027

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1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Y
Action from last year:	Ensure that there are sufficient trained appraisers to provide appraisals for all of our doctors.
Comments:	A new framework for job planning SPA time for appraisal work has been implemented. This should assist with both recruitment and retention of medical appraisers. The role of Trust Appraiser has been advertised.
Action for next year:	Ensure that there are sufficient trained appraisers to provide appraisals for all of our doctors.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Y
Action from last year:	Continue to develop our provision of training and development for our Trust Appraisers.
Comments:	Joint Trust Appraiser Development Afternoons for UHD, DCH and DHC were held 19 November 2025 and 23 April 2026. A local meeting will be held on Wednesday 15 July 2026.

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[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action for next year:	Continue to develop our provision of training and development for our Trust Appraisers to include support for new appraisers.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Y
Action from last year:	Continue submission of a regular medical staff revalidation report on an annual basis for the Trust board
Comments:	The Medical Staff Revalidation Update to the Board is shared with the People & Culture Committee and the Trust Board
Action for next year:	Continue submission of a regular medical staff revalidation report on an annual basis for the Trust board

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Y
Action from last year:	The Trust will continue to operate in line with GMC requirements and the Responsible Officer Protocol.
Comments:	Revalidation recommendations are made to the GMC in line with expected requirements. In the appraisal year 2025/2026 the Responsible Officer made 9 revalidation recommendations. 7 doctors were successfully revalidated. 2 were deferred due to insufficient evidence.

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Action for next year:	The Trust will continue to operate in line with GMC requirements and the Responsible Officer Protocol.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Y
Action from last year:	Continue with current system
Comments:	The Deputy Responsible Officer (DRO) or the Trust Lead for Medical Appraisal & Revalidation discusses with the doctor the reasons for a proposed deferral or non-engagement decision before the recommendation is submitted to the GMC. However, in the case of the outcome being to revalidate the RO would not routinely contact the doctor. The administrative revalidation team informs the doctor of the RO's recommendation. Following on from this the doctor will hear directly from GMC Connect.
Action for next year:	Continue with current system

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Y
Action from last year:	Continue to progress live face to face training and CPD, where appropriate, alongside opportunities for virtual training in suitable areas.

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Comments:	Dorset HealthCare has established systems for clinical governance. These processes encompass a number of different departments and are supported by required policies. Important components in this include the following: a. A system for medical appraisal. All appraisers in the Trust are familiar with the requirements for Revalidation and the need for doctors to be actively involved in Quality Improvement activities (including audit). b. Operational line management arrangements have been re-organised with a new structure created. The CMO is supported by two Medical Directors, one for the Directorate of Mental Health, Learning Disabilities, Children & Families Services and the other for Integrated Community services (ICS). The MD for ICS also acts as the deputy RO. There are a number of Associate Medical Director (AMD) posts each with a specific defined portfolio of responsibilities and designated time to do the work. The Medical Leadership team also includes Lead Consultants for specific areas. The Medical Leadership team works closely with the department of Human Resources. c. A new AMD role with a focus on patient safety has been created. This will involve close collaboration with the Nursing, Therapies and Quality Directorate and involve work that includes suicide prevention, PSIRF and our Culture of Care. d. Specific individual members of staff within the Human Resources department have defined responsibilities for medical staffing. e. A system for medical education led by the Director of Medical Education (DME) with dedicated administrative support. The DME is assisted by an Associate DME. Medical education covers all grades of doctor employed by the Trust which includes Consultants, NHS Locums, SAS doctors and all trainees on rotation. There is an educational programme which runs weekly,

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	and the Trust also provides a placement for undergraduates from Southampton University. The DME is supported by education leads for consultants, SAS & Locally Employed doctors and for postgraduate and undergraduate medical trainees. Members of the medical education team participate in regional Annual Review of Competence Progression (ARCP) panels run by the Wessex Deanery, which support the revalidation of doctors in training. f. All Consultants and SAS doctors within mental health are required to join a peer group to support Continuing Professional Development (CPD) activities. g. The Trust supports the system for consultant staff to come together as a body for two days a year for learning, CPD, updates from conferences attended and sharing of good practice. Following the Covid-19 pandemic these meetings resumed on 1 December 2022 with subsequent meetings held roughly every 6 months. These events take place at an external venue and are now funded by resource drawn from the senior doctors' study leave budgets. h. Those doctors employed by the Trust who work in the community hospitals also have access to CPD opportunities. For doctors in the community hospitals, there are bimonthly meetings that last for an hour and are concerned with clinical governance and CPD. Each of the hospitals also organise monthly multi-disciplinary mortality review meetings. The Contraception and Sexual Health doctors meet for CPD activities. All CPD is considered at annual appraisal to ensure that it is relevant and addresses the whole scope of practice for each individual practitioner. i. Doctors employed by the Trust and linked to a Medical Royal College must be in good professional standing for CPD.

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j. In addition to medical staff requirements to undertake CPD that covers the whole scope of practice, the Trust has internal standards for mandatory training. Compliance with mandatory training requirements is monitored and upheld by the Executive PA to the Chief Medical Officer.

k. The Nursing, Therapies and Quality Directorate is headed by the Chief Nursing Officer. The portfolio includes the system for patient safety incident investigations as well as responses to complaints, incident reporting and risk. There are close links with the Learning and Development Service where specific modules have been developed concerned with clinical risk. There are audit facilitators within the Directorate available to help, advise and support doctors and other staff with clinical audits.

l. All doctors employed on substantive NHS contracts with the Trust must undertake a 360-degree appraisal within each 5 year Revalidation cycle. This includes feedback from patients as well as colleagues. There is a requirement that the outputs receive focus within appraisal meetings and that any learning feeds into the development of Personal Development Plans (PDPs) for individual doctors. The Trust is now using the integrated SARD MSF tool. This has the advantage of a single system and has also been associated with a small cost saving.

m. Annual appraisal must include consideration of any significant events, patient safety incident investigations, complaints etc. Such information is collated and provided for Trust doctors together with their allocated appraiser.

n. The Trust is working to improve the quality, reliability and usefulness of the data we hold concerned with patient outcomes. Alongside reports from serious incidents,

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	this will enable individuals and teams to reflect on performance and seek opportunities for improvement.
Action for next year:	Continue to progress live face to face training and CPD, where appropriate, alongside opportunities for virtual training in suitable areas.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Y
Action from last year:	Implement improvements identified by reviews regarding sharing information about SIs and complaints with doctors for appraisal and revalidation
Comments:	Any serious incidents or complaints in which the individual doctor has been named must be brought to annual appraisal for discussion and reflection on any learning points. Individual doctors sometimes choose to discuss less formal complaints communications or difficulties they may have encountered. The Trust has a policy for the Handling of Concerns and Disciplinary Procedures relating to the Conduct and Performance of Doctors (IN-768). Medical line managers work closely with other management colleagues should problems arise and are supported in this by the Department of People and Culture. (Human Resources). Whenever possible concerns about conduct or performance are managed and resolved locally. However, it is sometimes necessary to seek guidance from the Employment Liaison Advisor (ELA) and rarely this results in a GMC referral.
Action for next year:	Improve information sharing from Patient Safety to the Revalidation Team.

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1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Y
Action from last year:	Review our current process and align with Dorset County Hospital
Comments:	Complaints are shared by the Complaints team to the Revalidation team who share with the doctor and their appraiser is informed. Since the change to PSIRF serious incidents (now Tier 2 and Tier 3 information) requires development of a reporting process. An interim solution using AAR reports will be used until the introduction of a new electronic system in December 2026.
Action for next year:	Improve information sharing from Patient Safety Team to the Revalidation Team with introduction of HealthGuardian system in December 2026.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Y
Action from last year:	Nil
Comments:	There is a Policy for Handling Concerns and Disciplinary Procedures relating to the Conduct and Performance of Doctors and Dentists (IN-768), this is currently under review and will be issued as a "Maintaining High Professional Standards" policy. This policy covers arrangements that apply should concerns about a doctor or dentist be raised. This includes circumstances in which remedial and supportive action is appropriate as well as what to do in the event of more serious concerns.

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	All concerns about employed medical practitioners are brought to the attention of the Chief Medical Officer. The policy describes issues around exclusion or restriction on the doctor's practice and when such sanctions are considered appropriate. There are sections which deal with misconduct, capability issues, health of doctors as well as the investigation process. The Trust has a Joint RO Advisory Group (ROAG) with Dorset County Hospital which supports consistent decision-making in this area. Fitness to Practice issues are discussed at the Responsible Officer (RO)-Chief Medical Officer (CMO) & GMC Employer Liaison Adviser (ELA) meetings which are held regularly. The GMC ELA is available for informal and formal discussions by telephone between face-to-face meetings.
Action for next year:	Nil

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Y
Action from last year:	Continue to monitor ethnic origin and gender balance of medical workforce and of our Trust Appraisers. Continue to encourage colleagues from diverse backgrounds to be involved in this work. Share information with the Trust Directorate of People and Culture to inform the ongoing dialogue and Equality, Diversity and Inclusion (EDI) work of the Trust.
Comments:	The Trust has agreed the SPA time allocation for our medical appraisers and Dorset County Hospital are seeking a consistent approach with DHC. Further recruitment has been undertaken, keeping in mind the expectation of an appraiser group which is representative of the medical workforce as a whole.

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Action for next year:	Continue to monitor ethnic origin and gender balance of medical workforce and of our Trust Appraisers. Continue to encourage colleagues from diverse backgrounds to be involved in this work. Share information with the Trust Directorate of People and Culture to inform the ongoing dialogue and Equality, Diversity and Inclusion (EDI) work of the Trust.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Y
Action from last year:	Nil
Comments:	The medical practice information transfer form (MPIT) is routinely used for communication between organisations when a doctor connects for the first time to Dorset Healthcare. The MPIT will also be used in the event that another RO at a different Trust requests information about a doctor who undertakes work in Dorset Healthcare.
Action for next year:	Nil

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Y
Action from last year:	The Department for People & Culture is involved with Trustwide EDI work. Information concerned with investigations and other disciplinary processes involving our Trust doctors will be monitored by HR.

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Comments:	HR policies include an Equal Opportunities Impact Assessment
Action for next year:	The Department for People & Culture is involved with Trustwide EDI work. Information concerned with investigations and other disciplinary processes involving our Trust doctors will be monitored by HR.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Y
Action from last year:	Nil
Comments:	**Resident Doctors** We have established a 10 point Plan for resident doctors, which sets out key priorities for supporting their training, wellbeing, and professional development. The plan includes areas such as: • Structured supervision and mentoring • Clear training objectives and assessment processes • Access to wellbeing and support services • Feedback and appraisal mechanisms • Workforce planning and rota management • Communication and engagement with supervisors • Learning and development opportunities • Performance monitoring and review • Addressing concerns and grievances effectively • Ensuring alignment with regulatory and organisational standards We have an action tracker in place to monitor progress against the 10 points and we are broadening our programme to encompass all elements of Resident Doctors' working lives. **IMGs**

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	To reduce dependence on expensive Locum consultants we have established a GMC sponsorship approved scheme to recruit senior psychiatrists from abroad . We will support them to obtain S12 and then AC approval via the portfolio route. This is proving successful we have had 4 IMGs start already and we are reducing dependency on Locums for our hard to fill roles. **MLT Re-organisation** We have re-organised the Medical leadership team, creating additional operational and strategic leadership roles including Associate Medical Director posts for fixed term of 3 years, which will be embedded in the services in partnership with the operational leaders. They will be responsible for line management of the medical lead posts and for professional regulation for the doctors in their service areas. **Neighbourhood Health & Wellbeing Programme** The Neighbourhood Leadership Team is a partnership between Primary Care, Dorset Health Care, Social Care and the representative for People & Communities who work together to: Support teams to come together in a way that supports the principles of integrated working Empower teams to identify and address the barriers Engage with the programme to: Influence and shape Neighbourhood Team development Share learning and make connections with other Neighbourhoods to work on shared priorities or 'at scale' solutions Provide progress updates, request support and escalate barriers
Action for next year:	Nil

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

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Action from last year:	Nil
Comments:	A ROAG is in place
Action for next year:	Nil

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Y
Action from last year:	Nil
Comments:	There is a system in place to ensure appropriate pre-employment background checks are undertaken for all doctors who come to work for Dorset HealthCare including Locum doctors. This process is led by Human Resources working in collaboration with medical managers. In addition to pre-employment checks there are systems to share information once a doctor has been offered a contract: Sharing of information regarding new doctors entering employment occurs via MPIT forms from RO to RO. GMC processes also allow appropriate information sharing when there are Fitness to Practice concerns. Information sharing processes adhere to Caldicott principles.
Action for next year:	Nil

Ellis, Kyla
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1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Y
Action from last year:	Continue to improve our systems and work in collaboration with Dorset County Hospital to share best practice. Undertake a project to publicise and disperse the important messages of Civility Saves Lives for all clinical staff in the organisation.
Comments:	We have a robust appraisal and revalidation system which includes evidencing quality improvement activity and a Maintaining High Professional Standards Framework. The updated Good Medical Practice professional standards were shared with the Trust Appraisers at the Appraiser Development Forum in September 2023 and with the Medical Leadership Team in June 2025. Building on previous work within mental health in the Trust, the Appraisers' Support & Development Forum held a meeting in November 2024 involving presentation, reflection and a discussion concerned with Civility Saves Lives. This was raised again at the Senior Doctors Peer Day in June 2025 following which the CMO and the AMD for Appraisal & Revalidation met with one of the National Leads. The Civility Saves Lives presentation was given at the first Joint Medical Appraisers meeting for UHD, DCH and DHC in November 2025. In the future we aim to undertake a larger piece of work in the Trust to roll out the Civility Saves Lives agenda to all staff groups involved in clinical care.
Action for next year:	Continue to improve our systems and work in collaboration with Dorset County Hospital to share best practice. Undertake a project to publicise and disperse the important messages of Civility Saves Lives for all clinical staff in the organisation. This will be led by the Patient Safety Medical Lead.

Ellis,Kara
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1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Y
Action from last year:	Nil
Comments:	Promoted within Trust values and within policies. Wellbeing Champions in each area. ED and I training is mandatory for all staff. Sexual safety charter released with training mandated for all staff Compassionate & Inclusive Leadership training Respect and Resolution policy We all belong campaign initiated April 2026
Action for next year:	Nil

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Y
Action from last year:	All staff to complete new mandatory Freedom to Speak Up training

Ellis, Mara
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Comments:	The FTSU Guardian provides quarterly and annual reports to the Board all contacts are treated confidentially but themes are shared in the reports. The FTSU Guardian also has a six monthly senior meeting where they meet with the Exec Chief people officer / the Chief Nurse / and NED where they discuss high level emerging themes so if there was something they were concerned about regarding any staff group they would raise it here but the reality is it wouldn't wait for a meeting they would be attending to it immediately.
Action for next year:	All staff to complete mandatory Freedom to Speak Up training

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Y
Action from last year:	Nil
Comments:	Formal complaints are handled in line with national guidelines by the Nursing, Therapies and Quality Directorate. The Trust is now using the MSF tool that is integral to SARD.
Action for next year:	Nil

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Ellis Kay
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Y/N	Y
Action from last year:	Nil
Comments:	ROAG in place
Action for next year:	Nil

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Y
Action from last year:	Nil
Comments:	The Lead for Medical Appraisal and Revalidation attends RO network meetings organised by NHS England. The Medical Appraisal, Revalidation & Job Plan Coordinator attends Revalidation network meetings.
Action for next year:	Nil

Ellis,Kara
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Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	125
Total number of appraisals completed	118
Total number of appraisals approved missed	3
Total number of unapproved missed	0
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	9
Total number of late recommendations	0
Total number of positive recommendations	7
Total number of deferrals made	2
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	14
Total number of trained case managers	3
Total number of concerns received by the Responsible Officer[2]	1
Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March (working days)	11 months
Median duration of concerns processes closed	0
Total number of doctors excluded/suspended during the period	1
Total number of doctors referred to GMC	0

Ellis Kara
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[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	10
Total number of new employment checks completed before commencement of employment	10
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[3]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
SARD is now used for MSF which is included with the SARD contract at no additional cost. This represents a saving as Edgecumbe licences are no longer being purchased
Actions still outstanding
None
Current issues
Due to successful recruitment initiatives such as the IMG project and doctors coming off the performers list, we have an increased number of doctors connected. We need to continue to recruit appraisers to meet this need and to be in a position to re-allocate appraisees when appraisers step down. Appraisers are now required to give 3 months' notice.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

Ellis Kara
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[3] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Continue ongoing work in relation to HLRO recommendations. Further develop our utilisation of electronic systems and digitisation of processes. Ensure that there are sufficient trained appraisers to provide appraisals for all of our doctors. Review our current processes and align with Dorset County Hospital. Update IN-122 if necessary and review in July 2027. Continue to develop our provision of training and development for our Trust Appraisers to include more support for new appraisers. Improve information sharing from Patient Safety Team to Revalidation Team with introduction of HealthGuardian system in December 2026. Continue to improve our systems and work in collaboration with Dorset County Hospital to share best practice. Undertake a project to publicise and disperse the important messages of Civility Saves Lives for all clinical staff in the organisation.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
We comply with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013). There is a new Lead for Medical Appraisal & Revalidation Dr Sudipto Das since the last Board report.

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Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Dorset HealthCare University NHS Foundation Trust

Name:	Matthew Bryant
Role:	CEO
Signed:	
Date:	

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Report to	Board in Common (DCH)	
Date of Meeting	11th August 2026	
Report Title	Medical Revalidation Annual Report (DCH)	
Prepared By	Rachel Wharton, Chief Medical Officer	
Approved by Accountable Executive	Rachel Wharton, Chief Medical Officer	
Previously Considered By	People and Culture Committee in Common July 2026	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1: Safety and Quality SR2: Empowerment SR3: Workforce Capacity	
Financial	No implications.	
Statutory & Regulatory	Statement of Compliance to be signed by CEO once approved in preparation for submission to NHSE/I. RO holds statutory role in medical regulation.	
Equality, Diversity & Inclusion	A review of our case investigation and management systems to support EDI and 'Just Culture' / 'Fair to Refer' will be completed in year 25/26.	
Co-production & Partnership	Appraisal and revalidation are mandated by the GMC and opportunities for co-production and partnership are limited.	

Executive Summary

Dorset County Hospital NHS Foundation Trust remains compliant with the Medical Profession (Responsible Officers) Regulations 2010 and maintains effective systems for medical appraisal, revalidation and management of concerns about doctors. Significant progress has been made during 2025/26 including substantial changes in senior leadership with the appointment of a new Deputy Responsible Officer and Appraisal and Revalidation Lead.

Key achievements during the year included:

- Successful transition of Responsible Officer arrangements, with Dr Rachel Wharton appointed Deputy Responsible Officer (DCHFT) and Dr Lucinda Knight continuing as Responsible Officer for the Federation.
- Appointment of Dr Alison Rigler as Appraisal and Revalidation Lead, strengthening organisational resilience
- Increased remuneration for appraisers from 0.188 PA to 0.25 PA, supporting recruitment and retention supported by the Senior Leadership Group (SLG)
- Establishment of a formal Responsible Officer Advisory Group (ROAG) to provide additional quality assurance and oversight.

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- Completion of an Equality, Diversity and Inclusion (EDI) audit of referrals to Medical HR processes showing that there is not significant over representation of non white British doctors in Medical HR processes.

Key Metrics:

During the reporting period (Apr 25 to Mar26):

Metric	Performance
Doctors with prescribed connection	352
Appraisals completed	269
Approved missed appraisals	76
Unapproved missed appraisals	7
Revalidation recommendations submitted	29
Positive recommendations	29
Deferrals	1
Non-engagement referrals	0
Late revalidation recommendations	0
Concerns received by RO	32
Concerns processes completed	22
Doctors excluded/suspended	1
Appeals against professional standards processes	0
Employment tribunal claims	0

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Principal Risks and Controls

1. Appraiser Workforce Sustainability

Risk: A number of experienced appraisers are approaching retirement or resigning which will affect future capacity.

Controls

- Increased appraiser remuneration to 0.25 PA
- Recruitment campaign resulting in new appraisers.
- Joint Dorset-wide appraiser education events.

2. Administrative Capacity

Risk: Rising workload associated with appraisal administration and LED ARCP processes is creating pressure on existing administrative arrangements

Controls

- Review of working practices of current administrator – may result in a decrease in appraisal compliance

3. Oversight of Locum Locally Employed Doctors

Risk: Short-term and locum LEDs are difficult to supervise consistently due to movement between departments and organisations

Controls

- Educational supervisors allocated to fixed-term LEDs.
- Formal induction and statutory training processes for all doctors.
- Planned supervision action plan for locum LEDs.

Priorities for 2026/27

The following actions represent the most significant priorities for the coming year:

1. Review future Responsible Officer arrangements, including consideration of Dr Rachel Wharton assuming full Responsible Officer responsibilities.
2. Undertake formal review of the Medical Appraisal Policy due in December 2026, including arrangements for Physician Associates and Anaesthetic Associates.
3. Strengthen oversight and supervision arrangements for locum LEDs.
4. Continue appraiser recruitment and retention initiatives and evaluate the impact of increased remuneration.
5. Complete external quality assurance through an HLRO review visit.
6. Strengthen EDI monitoring through further audit including primary medical qualification and age analysis.

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Conclusion

Robust arrangements are in place for medical appraisal, revalidation and the management of concerns regarding medical practitioners. DCHFT remains compliant with statutory Responsible Officer requirements

Recommendation

Board are requested to:

- **Approve the signing of the statement of compliance.**

Ellis,Kara
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Designated Body Annual Board Report and Statement of Compliance
Period covered: 1 April 2025 – 31 March 2026

Report author: Dr Alison Rigler, Appraisal and Revalidation Lead.

Reviewed and updated by: Dr Rachel Wharton (deputy Responsible Officer DCH).

The report sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of: Dorset County Hospital NHS Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

	Yes
Action from last year:	*Options for RO role being presented to Board 31 July 2024*
Comments:	Dr Rachel Wharton (CMO DCHFT) and deputy RO (DCHFT) since 1st April 2025.

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	Dr Lucinda Knight is Responsible Officer Dr Alison Rigler, Appraisal and Revalidation Lead DCHFT from September 2025. From September 2025 Dr Alison Rigler has delegated authority for revalidation recommendations, alongside Dr Wharton to maintain resilience in case of absence from work.
Action for next year:	Consideration of Dr Wharton taking on full responsibility for DCHFT. Discussion will be included in Dr Wharton's management appraisal in August 2026 with the CEO and the Responsible Officer (Dr Knight).

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	*Ongoing recruitment drive to attract & retain appraisers. Discussion at Board on 31 July 2024 regarding resource allocation to RO.*
Comments:	Dorset wide review of PA allowance to appraisers has led to increase to 0.25PA remuneration agreed March 2026, to improve recruitment. "*SLG endorse with the following action AM and SC to discuss with CA to understand how to fund and see if it's possible to have a central budget".* This led to 6 new appraisers being approved and 2 now undergoing training. Divisional Director support continues to be welcomed. No additional resources required for RO as role prioritised in CMO time. The appraisal administration burden continues to increase, especially in the administration of the LED ARCP panels and is an area of inadequate resource.
Action for next year:	Review the appraisal administration system to automate where possible and reduce demand on administration time. Seeking additional administration time is unlikely to be successful given current restrictions on recruitment.

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1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	No
Action from last year:	nil
Comments:	Ongoing excellent maintenance of records by appraisals revalidation administrator with support from appraisal and revalidation lead and the Responsible Officer.
Action for next year:	Nil.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Nil
Comments:	Medical Appraisal Policy due for review in December 2026.
Action for next year	Medical Appraisal Policy due for review in December 2026.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	No
Action from last year:	*Create action plan from informal HLRO visit in July 2025*
Comments:	This visit did not happen
Action for next year:	HLRO visit with Dr Smith requested.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

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Y/N	Yes
Action from last year:	No
Comments:	Locally Employed Doctors (LEDs) on fixed term contracts are allocated an Educational Supervisor, who receives 0.125 PA allowance in their job plan. This ES is responsible for completion of input form for LED appraisal panel and should oversee complaints, risks and CPD for that doctor. LEDs receive Trust induction as well as local induction on arrival to the Trust and are expected to complete mandatory and statutory training. Locums all receive a local induction including introduction to the clinical digital systems. The locum LEDs who are connected to DCHFT are a particularly difficult group to supervise as they move around departments (and hospitals) and there is no time in job planning available for their supervision and preparation for appraisal.
Action for next year	Produce an action plan for the supervision of locum LEDs to ensure that there is oversight of practice.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	*Work with the LED Tutor to support timely appraisal of Locally Employed Doctors which is supported by regular supervision meetings with named supervisors.*
Comments:	Timeliness of LED appraisal has improved. Locally employed Doctors appraisal panel has now become an embedded process. Consultant and SAS doctors appraisals continue as previously.
Action for next year:	nil

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1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	*Liaison with divisional directors to improve management of postponement of appraisal relating to workforce capacity or absence of appraisers.* *Support doctors within local investigation processes to hold an appraisal in line with their appraisal anniversary.*
Comments:	Divisional Managers receive monthly updates of appraisal compliance for earlier identification of those at risk of missing appraisal anniversaries. Those where there is a risk of non engagement (either overdue by more than 3 months or previous non engagement) are escalated through the senior medical leadership (clinical leads, care group leads and Divisional Directors). Regular updates are sent and individuals are supported to complete appraisals within timescales.
Action for next year:	Strengthening of use of RO powers through REV6 mechanism to give clear messages that engagement with appraisal is non-negotiable.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	nil
Comments:	Due for review December 2026
Action for next year:	Appraisal policy to be reviewed December 2026.

Ellis, Maria
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1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance

Y/N	Yes
Action from last year:	*Undertake a review with DHC of appraiser capacity to investigate whether appraisals could be carried out across the Federation*
Comments:	No current plans to share appraisers across the Federation. The portfolios are different (SARD versus PREP IT) which is stated as the barrier. Sufficient appraisers currently in post for all eligible doctors to have an allocated appraiser. A number of appraisers are approaching retirement or have already retired and doing some ad hoc appraisals. Recruitment supported by the increased PA rate with 2 new doctors recruited and improved appraiser training to improve retention and quality of appraisal.
Action for next year:	Assess recruitment and retention statistics of appraisers in line with the improvements in time allowance and appraiser development.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	*Continue provision of ongoing peer support & CPD opportunities for medical appraisers*
Comments:	Quarterly appraiser peer review meetings led by the appraisal and revalidation lead. New appraisal and revalidation leads in the 3 Dorset providers have offered more opportunities for collaboration.Joint training for appraisers with UHD and DHUFT has been held twice with a plan to continue 3 times a year. Very well received.

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between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action for next year:	*Evaluate combination of DCH internal appraiser quarterly short peer support meetings and longer, joint, CPD meetings with other Dorset trusts.*

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	*The HLRO visit for peer review will provide another source of QA*
Comments:	The HLRO visit did not happen The Board receive this annual report on medical appraisal and revalidation. Appraisees provide feedback on their appraiser. Appraisers output is quality assured using ASPAT
Action for next year:	HLRO visit with HLRO requested.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	N/A
Comments:	All recommendations made within timescales. Number of revalidations: 29 Number of deferrals:1 Non engagement referrals:0 REV6 notifications :0 Decisions are recorded.

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Action for next year:	nil

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	nil
Comments:	Not all positive revalidation decisions have been separately communicated to doctors in the period September 2025 to June 2026 due to time pressures and lack of awareness of this requirement as the new Appraisal and Revalidation Lead came into post. The deferral recommendation was discussed with the doctor prior to the submission. One deferral was continued from 25/26. Doctor has subsequently been dismissed with self referral to GMC.
Action for next year:	To reinstate separate emails to individual doctors at the time of revalidation recommendations.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	yes
Action from last year:	No actions from last year
Comments:	Doctors are expected to submit evidence of clinical audit, attendance at mortality and morbidity meetings and

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	evidence of risks, complaints or legal claims in the previous year. The clinical effectiveness committee, the Hospital Mortality Group and the divisional learning and sharing meetings provide oversight of clinical governance. Departmental clinical governance meetings occur monthly in all areas. There is a well defined governance structure for escalation of outputs from committees and groups to Quality Committee and then to Board. Concerns are also raised through Datix, Freedom to Speak Up Guardians and clinical leads. The medical leadership structure is well established with posts filled and escalation routes clearly defined. Recent CQC visit of emergency and general medicine graded as “good”
Action for next year:	nil

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	*To evaluate ROAG function in September 2025.*
Comments:	The ‘Effectiveness of Joint ROAG – briefing note’ was presented for assurance at the People and Culture Committee in Common on 24th November 2025. The ROAG was found to be operating effectively and recommendation made to repeat the review in 12 months. In addition to the monthly ROAG meeting, there are weekly Medical HR meetings. The meetings are attended by the Lead of Medical HR and the medical senior leadership team including the revalidation and appraisal lead. Guided by Trust policies (such as disciplinary, whistle blowing, job planning) and MHPS. New ToR were agreed in April 2026. When necessary, Fitness to Practice concerns are discussed with the GMC ELA and PPA. Three cases were discussed in the last year.

Ellis,Kara
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	The appraisal administrator keeps an up to date spreadsheet of doctors at all stages of their appraisal and revalidation and sends regular reminders to doctors as they approach appraisal anniversaries.
Action for next year:	Review the appraisal administration system to automate where possible and reduce demand on administration time. Seeking additional administration time is unlikely to be successful given current restrictions on recruitment.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	*Work with the Risk/ Complaints and Legal team to reduce their workload in conducting manual searches of Datix for each doctor*.
Comments:	There is a new datix system (Healthcare Guardian) which will be in place in December 2026. It is not likely to allow doctors to conduct searches for their own information initially but may be possible as familiarity with the system evolves. The head of risk has confirmed that responding to information requests manually is easily achievable and is always done within 24 hours. Action removed.
Action for next year:	Nil

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	Nil
Comments:	Maintaining High Professional Standards is the approved policy used for responding to concerns.

Ellis,Kara
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	The GMC ELA is available for informal / formal discussion by MS Teams / telephone. Practitioner Performance Advice (PPA) service is an additional support for the CMO / deputy CMO (RO). Weekly Medical HR meetings are held to encourage early intervention in any emerging concerns to ensure timely progression of investigations.
Action for next year:	nil

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y	Yes
Action from last year:	*Site RO to carry out ED and I audit of doctors involved in case investigations*
Comments:	EDI audit of doctors referred to Medical HR meeting completed and presented at July 2026 ROAG. Quality assurance of decision making by the DCH Medical HR group is offered by the Joint (with DHC) Responsible Officer Advisory Group. Other QA is offered by ensuing advice from the ELA and PPA. There was one capability hearing this year as a result of a case investigation and this was attended by an external deputy RO from the Somerset Foundation Trust.
Action for next year:	The Responsible Officer Advisory Group to report annually to People and Culture Committee and then on to Board.

Ellis Kara
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1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible

officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	no
Action from last year:	Nil
Comments:	MPIT forms (national process) are used. Telephone conversations or virtual meetings via MS Teams have occurred where there were higher level concerns potentially likely to impact on patient safety / outcomes. There is documented evidence of discussions and decision making / outcomes kept by the medical HR team.
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Y
Action from last year:	*Site RO to conduct an EDI audit of doctors undergoing formal MHPS processes and produce an action plan based on the findings.*
Comments:	Findings showed 68% of cases discussed involved doctors with non white British ethnic origin versus a baseline of 55% of all doctors who identify as non white British. Small data set so statistical significance not assured. Agreed that group will not target interventions specifically on those of non white British ethnic origin as most of these doctors have no difficulties. Instead the focus will be on educating clinical leads to make early interventions when doctors appear to struggling with conduct or capability concerns.
Action for next year:	Introduce HR training for clinical leads to ensure early HR interventions made to try and reduce escalation to a point where MHPS must be used.

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1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	nil
Comments:	RO and Appraisal lead attendance at national and regional RO meetings. The Chief Medical Officer and deputy Chief Medical Officer attended Responsible Officer training this year as both were new into post.
Action for next year:	Nil

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	*GMC requirements for appraisal and revalidation for PA and AA (Physicians Associates and Anaesthetic Assistants) now published*.
Comments:	Local arrangements being formalised. Numbers are small (2)
Action for next year:	Arrangements for PAs and AAs will be included in the medical appraisal policy when it is reviewed in December 2026.

1E – Employment Checks

Ellis Karen
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1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term

doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	*LED tutor to submit a business case to secure self development time for all Locally Employed Doctors to support skills and knowledge acquisition.*
Comments:	Action completed. All LEDs have SDT in rotas. In addition to pre-employment check there are systems to share information once a doctor has been offered a contract with DCHFT. Sharing of information regarding new doctors entering employ occurs via MPIT forms from RO to RO. Such forms are also used to share concerns (RO to RO) which arise during employment at DCHFT of any doctors who also practice elsewhere (e.g locum doctors; doctors with private practice) HPANs (Health Professional Alert Notices) may also be used to share significant concerns about a doctor who has disconnected from DCHFT and not yet made a connection to a new Designated Body. Not used this year. Information sharing processes adhere to Caldicott principles. The site Responsible Officer is the Caldicott guardian and attends relevant update training. (GMC handbook Principles 4e & f). Resident doctors in training posts have educational and clinical supervisors and follow specialty specific training programmes. Substantively employed LEDs have clinical supervisors and are expected to attend local teaching. They also hold a study budget and are entitled to 10 days per year of study leave
Action for next year:	Nil.

Ellis, Sara
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1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	*Ongoing promotion of positive clinical environment & culture* *New staff recognition scheme being introduced across the federated Trusts in 2025/26.*
Comments:	This has been introduced but doctors have not been nominated. The Trust values and organisational culture support a strive for excellence in clinical care. Success is celebrated weekly with the “celebrating success” update sent to all staff.Doctors are often included in this.
Action for next year:	Nil

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	Nil
Comments:	As previous section-within trust values. Wellbeing champions and Freedom to Speak Up Champions present in all departments.
Action for next year:	Nil

Ellis Kelly
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1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	Nil
Comments:	Promoted within Trust values and within policies. Behaviours not aligned with Trust values are challenged. Learning culture demonstrated in a variety of ways including outputs from PSIRF investigations, departmental morbidity and mortality meetings and escalation reports to the Guardian of Safe Working. Freedom to Speak Up Guardian in post with champions in all areas. FTSUGs report to People and Culture Committee with escalation to Board.
Action for next year:	Nil

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	Nil
Comments:	Feedback from connected doctors occurs in a number of ways including exit interviews, complaints and appeals processes & procedures.
Action for next year:	Nil

Ellis, Kate
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1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	yes
Action from last year:	*RO to audit EDI data of doctors involved in Fitness to Practice concerns and produce an action plan based on findings*
Comments:	Audit data described above. To be presented and action plan discussed at July ROAG.
Action for next year:	Re audit – to include county of primary medical qualification and to explore relationship to age as a protected characteristic.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	yes
Action from last year:	*Working group to be set up with UHD and DHC to share learning and benchmark RO processes including appraisal*.
Comments:	Regular meetings with UHD and DHCFT in place with 2 half day learning and networking sessions already taken place.
Action for next year:	Nil

Ellis Kara
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Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	352
Total number of appraisals completed	269
Total number of appraisals approved missed	76
Total number of unapproved missed	7
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	29
Total number of late recommendations	0
Total number of positive recommendations	29
Total number of deferrals made	1
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	10 clinical and 3 non clinical
Total number of trained case managers	6
Total number of concerns received by the Responsible Officer[2]	32
Total number of concerns processes completed	22
Longest duration of concerns process of those open on 31 March (working days)	Not available

Ellis Kara
06/08/2026 09:31:54

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

Median duration of concerns processes closed (working days)[3]	Not available
Total number of doctors excluded/suspended during the period	1
Total number of doctors referred to GMC	0 (2 self referrals)
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	Division A= 9 Division B = 24
Total number of new employment checks completed before commencement of employment	33 (all)
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Change in RO with Dr Wharton now the Deputy RO for DCH with Dr Knight the RO for the Federation. Appointment of Dr Rigler as the Appraisal and Revalidation Lead. Strengthened LED appraisal process using an ARCP style panel. Enhanced remuneration for appraisers 0.188 PAs to 0.25 PAs. Supported at Senior Leadership Group on 19th March 2026.

Ellis Kara
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[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Continued excellent appraisal status monitoring via appraisal and revalidation administration (Suzanne Hill) Responsible Officer Advisory Group established with terms of reference and membership. Reviewed in September 2025 at People and Culture Committee EDI audit of referral to Medical HR group completed.
Actions still outstanding
1. Establish a peer support group for case investigators at DCHFT – this should be across the Dorset wide system and should focus on a mentor system especially supporting new investigators. 2. Work with the Risk/ Complaints and Legal team to reduce their workload in conducting manual searches of Datix for each doctor. A new system should be able to give automated outputs for appraisal which are also more accurate.
Current issues
Appraiser retention will be affected by the numbers of appraisers retiring so recruitment efforts need to continue. Establish and enhance appraisal processes including appraiser peer support across all 3 local trusts. Hindered currently by different portfolios used by DHC (SARD vs PREP IT) Administration support for appraisal and revalidation is insufficient to meet increasing demand; especially of the LED ARCP panel.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
1. Consideration of Dr Wharton taking on full responsibility for DCHFT. Discussion will be included in Dr Wharton's management appraisal in August 2026 with the CEO. 2. Medical Appraisal Policy due for review December 2026. 3. HLRO visit with Dr Smith requested.

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4. Produce an action plan for the supervision of locum LEDs to ensure that there is oversight of practice.

5. Strengthening of use of RO powers through REV6 mechanism to give clear messages that engagement with appraisal is non-negotiable.

6. Assess recruitment and retention statistics of appraisers in line with the improvements in time allowance and appraiser development.

7. Evaluate combination of DCH internal appraiser quarterly short peer support meetings and longer, joint, CPD meetings with other Dorset trusts.

8. To reinstate separate emails to individual doctors at the time of revalidation recommendations.

9. Use the new Datix system to allow risk, complaint and legal data to be easily available to the doctor to support appraisal inputs.

10. The Responsible Officer Advisory Group to report annually to People and Culture Committee and then on to Board.

11. Introduce HR training for clinical leads to ensure early HR interventions made to try and reduce escalation to a point where MHPS must be used

12. Arrangements for PAs and AAs will be included in the medical appraisal policy when it is reviewed in December 2026.

13. LED tutor (with Chief Registrar) to benchmark SDT for LEDs and work with rota coordinators to ensure parity with trainees.

14. Re audit EDI data – to include county of primary medical qualification and to explore relationship to age as a protected characteristic

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

The last year has had a complete change of leadership of the Responsible Officer and Appraisal and Revalidation functions. Over this year confidence and experience in the management of Fitness to Practice concerns and of appraisal and revalidation has increased.

The weekly Medical HR meetings function effectively with good attendance and input from the senior medical leadership team supported by Medical HR and invited contributors (for example senior management).

An external quality assurance visit from the HLRO would be welcomed in the next year.

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Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Dorset County Hospital NHS Foundation Trust

Name:	Matthew Bryant
Role:	CEO
Signed:	
Date:	

Name of the person completing this form:	Rachel Wharton
Email address:	Rachel.wharton@dchft.nhs.uk

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Dorset County Hospital
Dorset HealthCare

Strategy Transformation and Partnerships Committee Assurance Report for the meeting held on Monday 26th July 2026

Chair	David Clayton-Smith, Chair
Executive Lead	Dawn Dawson, Chief Nursing Officer Nicola Plumb, Chief People Officer Chris Hearn, Chief Finance Officer Beverley Bryant, Chief Digital Information Officer
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework

- Advance Foundation Trust workstream report to become a routine agenda item on the committee workplan.
- Workforce capacity issues continue to constrain delivery of the full transformation and improvement agenda, with plans in place to mitigate.
- Positive NED engagement to attend the forthcoming Quality Improvement Week planned for September 2026.
- Committee approved Dorset HealthCare's membership of the Dorset Strategic Estates Partnership (subject to legal review) and delegated authority to the Committee Chair and Finance, Performance and Commercial Committee Chair to give final approval on its behalf.
- The Committee has requested a future update on cyber resilience and recovery arrangements, including learning from business continuity exercises and oversight of third-party supplier risks.
- Committee Chairmanship is transferring from David Clayton-Smith to Andreas Tichy-Haimbock

Key issues / matters discussed at the meeting

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An informal committee meeting took place 29th June 2026 covering the following topics for discussion:

- Deep Dive into Neighbourhood Programme.
- Digital Strategy Update.
- Update on the New Hospital Programme followed by a walk-around of the Emergency Department.

The committee received and considered the following reports:

Board Assurance Framework Assigned Risks
Committee members received the Quarter 1 Board Assurance Framework report for assurance noting the revised structure following the merger of the previous Collaboration and Partnership and Transformation strategic risks, reducing the risks assigned to the Committee from four to three. There are no overdue actions, and all carried-forward actions were either

complete or on track. Committee members discussed the increasing alignment of assigned risks across both organisations, reflecting joint working arrangements and shared leadership. Assurance was provided that separate Board Assurance Frameworks remain necessary to reflect Trust-specific risks where required.

Corporate Risk Register Assigned Risks
DHC - Reporting no risks scoring 15 or above within the Committee's remit. noting the closure of the risk relating to the handover of new hospital buildings following successful completion of the transfer process.

DCH - The Committee noted a new risk relating to electronic discharge summaries and a required system upgrade. Assurance was provided that appropriate mitigations and communication arrangements are in place. Updates were also received on existing digital risks relating to infrastructure, legacy systems and digital support arrangements. Members sought assurance on mitigating actions, system resilience, and operational workarounds (endoscopy), with assurance provided that risks continue to be actively managed through established governance arrangements and that primary care colleagues continue to be updated.

Advanced Foundation Trust
The Committee received an update on Dorset HealthCare's Advanced Foundation Trust (AFT) status for assurance noting the opportunities arising from the new operating freedoms. Members noted the strategic ambition to accelerate the shift of care from hospital settings into communities through strengthened neighbourhood working and enhanced partnership with primary care, local authorities and acute providers. The Committee discussed the opportunities presented by AFT status, including increased flexibility in the use of capital and transformation resources, a revised relationship with NHS England and the potential to explore future Integrated Health Organisation arrangements. Members also considered the strategic importance of the Dorset Intelligence and Insight Service (DiiS) platform and received assurance regarding its ongoing role. The Committee welcomed the opportunities presented by AFT status to accelerate innovation, co-production and service transformation.

Strategy in action: Safe Delivering the Green Plan
A comprehensive update on the Joint green plan delivery was provided for assurance with the committee commending the breadth of activity underway across both organisations. Carbon emissions have reduced by investing in energy efficiency measures, solar power and digital transformation. greener clinical practice has been supported through initiatives such as lower carbon anaesthetic options and improved waste reduction, while embedding sustainability and social value considerations into procurement and commissioning decisions. In addition, colleagues, patients and partners have been empowered to play an active role in

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creating a more sustainable health and care system. Assurance was provided that sustainability and net zero considerations are reflected within the organisations' risk management arrangements and estate strategies, including mitigation of climate-related risks such as rising temperatures and the resilience of the estate.

One Transformation Approach Highlight Report & Improving Together Programme Update

The Committee received the report for assurance noting the replacement of the Dorset County Hospital Inpatient Flow Programme with the Frailty Model Programme. Members noted that the four programmes within the portfolio continue to progress broadly as planned, with assurance provided that work is underway to strengthen strategic outcome measures and reporting, including clearer alignment between strategy, transformation activity and demonstrable impact. The Committee discussed programme capacity, noting workforce pressures within both the transformation team and operational services. The Committee also noted plans for the forthcoming Quality Improvement Week in September 2026.

Joint Social Value Plan

The Committee received the Joint Social Value Pledge and Annual Plan 2026/27 for approval. Members welcomed the development of a single approach across Dorset County Hospital and Dorset HealthCare, recognising the opportunity to strengthen collaboration as anchor institutions and maximise social value through employment, procurement, sustainability, community engagement and partnership working. Assurance was provided that governance arrangements are in place through the Joint Social Value Programme Group, with regular monitoring and reporting to support delivery of the programme. Members welcomed the ambition of the joint plan and the opportunities to further support local employment, skills development, inclusion and community engagement across Dorset. The Committee noted that the plan will continue to mature as delivery progresses and approved the Joint Social Value Pledge and Annual Plan 2026/27.

Our Dorset Provider Collaborative

The Committee received an update on the Our Dorset Provider Collaborative and the emerging transformation programme informed by the Vista Health review. Members noted the significant opportunity to improve patient outcomes, patient experience and system sustainability through a long-term programme of change focused on proactive and preventative care, neighbourhood working, urgent and emergency care, planned care and greater service standardisation across Dorset. Assurance was provided that work is underway to develop a phased implementation roadmap, with the Provider Collaborative aligning its transformation priorities to support delivery of this programme. Members discussed the importance of clinical, staff and stakeholder engagement as the

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programme develops, together with arrangements for non-executive oversight and assurance. The Committee noted that detailed implementation plans are still in development and welcomed assurance that engagement with clinicians, staff-side representatives and partner organisations is being embedded throughout the programme. The Committee agreed that regular updates should be brought to future meetings to support ongoing oversight of this significant system-wide transformation programme.

DHC Membership of the Dorset Estate Partnership

The Committee received a report seeking approval for Dorset HealthCare to join the Dorset Strategic Estates Partnership (DEP). Members noted that Dorset County Hospital has been a member of the partnership since 2017 and has successfully utilised the arrangement to support the delivery of strategic estate developments. Assurance was provided that membership would support a more coordinated federated approach to estate planning and development whilst maintaining existing procurement, governance and Standing Financial Instruction requirements. Members discussed the importance of ensuring transparency and maintaining a level playing field for future procurement exercises. Assurance was provided that DEP membership does not commit the Trusts to exclusively using current providers and that all future projects would continue to be subject to established procurement and approval processes. Subject to final legal review, the Committee approved Dorset HealthCare's membership of the Dorset Strategic Estates Partnership and delegated authority to the Committee Chair and Finance, Performance and Commercial Committee Chair to give final approval on its behalf.

Digital Strategy Delivery Roadmap and Artificial Intelligence Governance Overview

The Committee received the Digital Strategy Delivery Roadmap for approval. Members noted that the roadmap translates the previously approved digital strategy into a deliverable programme of work, structured around enabling activity, delivery of the Healthset programme and realisation of benefits through an integrated digital environment. Assurance was provided that feedback from previous Committee discussions had been incorporated, including greater emphasis on information sharing across partner organisations, risk management and primary care integration. Members also noted progress in developing a more consistent approach to AI governance across the Dorset system. The Committee discussed digital inclusion, public adoption, programme interdependencies and the importance of aligning digital transformation with wider strategic and clinical change programmes. Assurance was provided that arrangements are in place to monitor dependencies and that further work is underway to strengthen data and digital governance arrangements. The Committee approved the Digital Strategy Delivery Roadmap and noted that

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future progress reports will include updates on the development of AI governance arrangements.

Cyber Security and Risks Update
The Committee received the cyber security update for assurance. Members noted progress in strengthening cyber resilience across the Dorset system, including the successful migration of Dorset County Hospital to NHSmail, achievement of Data Security and Protection Toolkit standards and ongoing investment in maintaining modern infrastructure. Assurance was provided that arrangements are in place to manage cyber risks within the organisations' low-risk appetite, whilst balancing affordability and operational priorities. The Committee also noted plans to introduce a consistent cyber security reporting framework across all three Dorset Trusts under unified leadership arrangements. Assurance was provided that cyber incident response and business continuity plans have been tested through recent exercises and that lessons learned continue to inform ongoing preparedness. The Committee requested a future update on cyber resilience and recovery arrangements, including learning from business continuity exercises and oversight of third-party supplier risks.

Data Security and Protection Annual Compliance
The Committee received an update on the 2025/26 Data Security and Protection Toolkit (DSPT) submissions for assurance. Members noted that both Dorset HealthCare and Dorset County Hospital had achieved the required standards, with all mandatory outcomes met. Assurance was provided that robust arrangements remain in place to support information governance, data protection and cyber security compliance across both organisations, including oversight of third-party providers and partner organisations that handle NHS information. The Committee noted that both organisations continue to make progress against the evolving cyber assurance requirements of the DSPT, with a clear understanding of the remaining risks and associated mitigations. Assurance was provided that these risks have been reviewed through established governance processes and are considered acceptable and appropriately managed.

The following escalation reports from subgroups were received for assurance by the committee members:
Joint

- Joint Transformation and Improvement Board Meeting Assurance Report
- DHC & DCH New Hospitals Programme Board Assurance Report
- DHC & DCH Information Governance Group Meeting Assurance reports

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Decisions made at the meeting

Approvals by DCH and DHC committees:

	• Joint Social Value Plan • Digital Strategy Delivery Roadmap • DHC Membership of the Dorset Estate Partnership – approved subject to legal review.
Issues / actions referred to other committees / groups	• None

Quoracy and Attendance						
	28/05/2026	**27/07/2026**				
Quorate?	**Y**	**Y**				
David Clayton-Smith	N	Y				
Eiri Jones	Y					
Dave Underwood	Y	Y				
Andreas Haimbock-Tichy	Y	N				
Claire Lehman	Y	Y				
Chris Hearn	Y	Y				
Dawn Dawson	Y	Y				
Nicola Plumb	N	Y				

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Dorset HealthCare University
NHS Foundation Trust

Audit Committee Assurance Report for the meeting held on 31 July 2026

Chair	Nikki Rowland, Non-Executive Director
Executive Lead	Chris Hearn, Joint Chief Finance Officer
Quoracy met?	Yes
Purpose of the report	To assure the Board on the main items discussed by the Committee and, if necessary, escalate any matter(s) of concern or urgent business which the Committee is unable to conclude.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Detailed discussions around the Board Assurance Framework and Corporate Risk Register as described below. Of note, consideration to be given to whether there is need for cross committee discussion and dedicated Board Development time around the Board Assurance Framework. • Verbal update provided to committee on the very recently published ward identity checks internal audit, with the full audit to be returned to the next committee meeting. The audit was referred to the next meeting of the People and Culture Committee in Common.
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: **Board Assurance Framework** presented including the revised risks agreed by Board, with all content updated to reflect the updated risks. Target scores have been aligned to the agreed risk appetite statements, and all committees have this week reviewed the risks for which they are responsible. A number of actions had been carried forward from 2025/26. Additional assurance was sought on risks relating to people and culture, with plans to do a rotating approach in future meetings for other committees to gain insight and assurance. The conclusion was that more needed to be done in committees to address the 'so what' and 'now what' question and that the Audit Committee also discussed the need for triangulation across committees and consideration of whether there is a need for cross committee discussion and dedicated Board Development time around the Board Assurance Framework. **Corporate Risk Register** dated 13th July 2026. Noted the introduction of a Risk Management Group and the positive impact they are already having in improving the trust's approach to risk. The report detailed five risks with a score of 15; this is a new low and reflects the level of work being undertaken in relation to risks. The committee discussed how to link the Corporate Risk Register to the Trust's strategic risks to ensure clarity on the work of the sub committees

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as part of the management of those risks. The work undertaken to swiftly reduce the risks relating to Seastone and CAMHS High Intensity Unit was commended.

Internal Audit – Progress Report noting that the 2025/26 audit work is nearing completion. The report of the financial recovery processes audit has been received with 'moderate' rating for design and effectiveness. Once the actions identified by the audit had been addressed, it was requested that BDO review again to consider if the rating can be changed to 'substantial', which is agreed. This is a timely audit following feedback from the CQC, particularly in relation to the findings regarding tracking variance reporting.

Verbal update provided on the very recently published ward identity checks audit, with the full audit to be returned to the next committee meeting. The audit was referred to the next meeting of the People and Culture Committee in Common.

Internal Audit Follow-up Report received, noting four outstanding actions relating to the cyber security, patient falls and data security protection toolkit (DSPT) audits. Discussion around the challenges relating to AI, the additional governance required, and the impact on cyber security requirements which will need to increase alongside any increased utilisation of AI.

Annual Clinical Audit Assurance Report noting that 65 audits were undertaken in the reporting period including 18 national priority-one audits all submitted by the deadline. This work supports the trust in its continuous quality improvement journey.

External Audit Client Technical Update citing areas for consideration by the committee and the trust, on AI, payroll, contract management, national minimum wage compliance, linked to salary sacrifice. Agreed that the report will be shared with all sub-committees for taking forward as necessary.

Counter Fraud Progress Report. 17 new fraud referrals were received in quarter one, with 14 resulting from Project Wise data. It is a joint project involving five trusts using big data and machine learning. As a result, 11 criminal investigations were opened, one of which has now been picked up as a national case.

2025/26 Counter Fraud Annual Report. In 2025/26 there were 19 cases received five of which resulted in criminal investigations. Submission of the 2025/26 counter fraud functional standard return was noted with all areas marked as green.

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	Tender Waiver Report for the six-month period ending the 30th June a total of 65 waivers were approved. A request for further trend analysis to be included for future reports to provide additional assurance. Further requests for future reports to include single tender waiver as a proportion of total procurement spend and the largest proportion in monetary terms related to rapid funding receipts. **Freedom of Information Requests Compliance** noting that the trust achieved 80% against a target of 95% for 2025/26 and 79% for quarter one, 2026/27. However, performance is comparative to trusts in the South West and nationally. The Trust is not complacent and is still looking to make improvements, with suggestion from the committee to determine what areas could be published for areas that consistently come up as requests versus the FOI request route.
Decisions made at the meeting	• Nil
Issues / actions referred to other committees / groups	• Internal audit on identity checks referred to People and Culture Committee in Common • External Audit Client Technical Update to be shared with other sub-committees to consider if there are any elements they need to explore further

Quoracy and Attendance					
	29/05/2026	31/07/2026	27/11/2026	29/01/2026	25/03/2026
Quorate?	Y	Y			
Nikki Rowland	Y	Y			
Eiri Jones	Y	Y			
Dave Underwood	Y	Y			

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Dorset County Hospital
NHS Foundation Trust

Audit Committee Assurance Report
for the meeting held on 03 August 2026

Chair	Stuart Parsons, NED
Executive Lead	Chris Hearn, Chief Finance Officer Jenny Horrabin, Director of Corporate Affairs
Quoracy met?	Y
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• Receipt of the Board Assurance Framework and Corporate Risk Register with updates as described below • Limited assurance on the ward identity checks audit • Great improvement in FOI reporting, but still not achieving the ICO's target for response times.
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: **Board Assurance Framework** presented including the revised risks agreed by Board, with all content updated to reflect the updated risks. Target scores have been aligned to the agreed risk appetite statements, and all committees have this week reviewed the risks for which they are responsible. The publications of national maternity reviews and the National Quality Strategy would be referenced in the Q2 Board Assurance Framework. **Corporate Risk Register**, with detailed description provided of four new high scoring risks. Assurance provided that high score risk areas were being reviewed by the appropriate committees. Improvements in the update notes of risks was requested. Lack of funding is impacting the trust's ability to replace end of life equipment, particularly within DTI, which may cause greater risks in the near future. **Internal Audit progress, and follow up,** noting: • Good progress in the delivery of the plan for the year so far. The Committee agreed to amend the internal audit plan for 2026/27; adding the Maternity Incentive Scheme and delaying the outpatient follow up audit. • Update on the financial recovery advisory audit, with moderate rating for design and effectiveness.

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	• Verbal update received on the recently published ward identity checks audit, noting the limited assurance offered by the audit. Management responses are in hand and will be reviewed to ensure they are timely. • One action from the equality quality impact assessment audit was overdue but assurance was provided that the revised date would be achieved. **Counter Fraud Progress Report and Annual Report** noting two allegations of fraud in Q1 with neither warranting criminal investigation. Over the last year there had been a 14% increase in reported fraud. **Tender Waiver Report** noting zero procurement breaches in the reporting period. 65% of single tender waivers were low value under £25,000 and the majority were driven by estates compliance work **Freedom of Information Requests Compliance.** Whilst there had been improvements in performance, with 71% of requests responded to within 20 working days, the Trust was still not in line with the Information Commissioners Office (ICO) target of 95% response rate. The improvement was noted and thanks extended to Dorset HealthCare colleagues for their work to reach this position. **Annual Clinical Audit Assurance Reports** noting improvements in clinical audit governance and oversight, and that key priorities have been set for the coming year **KPMG Client Technical Update** taken under consent without discussion.
Decisions made at the meeting	• Approval of a change to the internal audit plan – adding the Maternity Incentive Scheme and delaying the outpatient follow up audit.
Issues / actions referred to other committees / groups	• Nil

Quoracy and Attendance						
	01 Jun 2026	25 June 2026 (Extraordinary)	03 Aug 2026	30 Nov 2026	01 Feb 2027	30 Mar 2027
Quorate?	Y	Y	Y			
Stuart Parsons	Y	Y	Y			
Dave Underwood	Y	Y	Y			
Vacancy						

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Dorset County Hospital
Dorset HealthCare

Mental Health Legislation Committee in Common (MHLCiC) Assurance Report for the meeting held on Thursday 30 July 2026

Chair	Andreas Haimböck-Tichy, NED
Executive Lead	Lucy Knight, Chief Medical Officer
Quoracy met?	Yes
Purpose of the report	To assure the Board on the main items discussed by the Committee and, if necessary, escalate any matter(s) of concern or urgent business which the Committee is unable to conclude.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework

- Positive CQC report received about Alumhurst Ward, the Committee would like to commend the work of the Alumhurst Team.
- Committee discussed the impact of MHA reform, whilst there are no immediate risks to the organisation, it will be reviewed when the Code of Practice becomes available.
- Deep dive review of delays relating to S136
- Committee was not quorate from DCH side.
- Noted no Governor attendance, this is under review.
- Supreme Court ruling actions were discussed and the Committee view is that it is a positive arrangement.
- Work that colleagues have been doing around the brevity of the reports, we are now reporting by exception in the dashboard.

Key issues / matters discussed at the meeting

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Lived Experience of Being Detained:
The Committee heard about a patient in his 30s who lives with his parents and occasionally works with his father. He enjoys walking the family dog, driving when able, and spending time with friends. His longer-term aspirations include developing a relationship, living independently, and obtaining employment outside the family business. The patient has a nine-year history of mental health difficulties. Although he initially presented with depression, it subsequently became clear that he is living with schizophrenia. Over the past five years he has experienced four significant relapses. During periods of illness he becomes increasingly confused and disengaged from those around him. When untreated, his mental state deteriorates further, resulting in preoccupation with internal experiences, self-neglect, and episodes of verbal aggression, particularly towards his mother.

Following an eight-month period with the Acute Day Therapy Service, the patient made significant progress and remained well for approximately three months. His treatment involved a multidisciplinary approach including occupational therapy, vocational support, psychological intervention, and

medication. Over the last five years, he has required two admissions under the Mental Health Act and two episodes of support from the Home Treatment Team. He was most recently discharged in March on a Community Treatment Order (CTO), which is now subject to a renewal decision.

The Responsible Clinician discussed the CTO with the patient. The patient stated that, on one level, being subject to a CTO does not particularly trouble him; however, he also reported that it serves as a reminder of his hospital admissions and the legal restrictions placed upon him, which he would prefer not to experience. When asked about barriers to achieving his future goals, the patient identified both his illness and being sectioned as equally significant obstacles.

The Committee heard that, while the patient recognises that his illness has adversely affected his life, he has struggled to consistently acknowledge the role medication has played in maintaining his wellbeing. Following previous periods of recovery and discharge from hospital, home treatment, or the day therapy service, he has repeatedly sought to reduce or discontinue his medication. On each occasion, a relapse has followed within a period of two to three months. The patient is currently prescribed depot medication, which ensures adherence with treatment. The Responsible Clinician reported that he has now returned to his positive baseline and is demonstrating improved stability. Although the patient continues to dislike taking medication and remains uncertain that he requires it, the Responsible Clinician considered there remains a significant risk of relapse should treatment be discontinued.

Having considered the patient's clinical history, his pattern of relapse associated with discontinuation of medication, and the views of both the patient and his family, the Responsible Clinician has requested renewal of the Community Treatment Order. The stated rationale is to provide the patient with a sustained period of stability and wellbeing, enabling him to begin making progress towards his personal goals and aspirations. The renewal request has triggered a Managers' Hearing. The patient has expressed a wish to attend and participate in the hearing, which was viewed positively and as evidence of his engagement with the process.

Corporate Risk Register Assigned Risks:
No risks identified that meet the threshold for committee consideration.

DHC and DCH Mental Health Legislation Assurance Dashboards
DHC

- Committee reporting has moved to an exception-based approach, reflecting consistently strong compliance and assurance from routine monitoring.

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- MHA use has continued to increase across the organisation, largely attributed to improved reporting of Section 135 and Section 5(2) activity.
- An increase in Section 5(2) use within inpatient services was observed in June, contributing to the upward trend seen over the last quarter.
- MHA use at RBH continues to decrease, which is thought to be related to the interpretation and application of DoLS eligibility criteria.
- Section 132 rights performance remains positive and within expected levels. Eight patients were discharged before their rights could be fully delivered, most of whom were subject to Section 5(2) and either moved to another section or were discharged before this could occur.
- Section 136 performance remains fully compliant, with cases managed within legislative timeframes.
- Patient appeal processes continue to improve, with most renewal meetings taking place before the next period of detention begins.
- A slight increase in DoLS activity was recorded, consistent with changes following the overturning of the Cheshire West judgment.
- Overall statutory requirements have been met, with strong performance across key priority areas and continued assurance of compliance.

DCH

- MHA use continues to decline, with a downward trend observed since 2024.
- Section 132 rights remain a key area of focus. Compliance percentages are impacted by the small number of patients affected. Work is underway to strengthen internal processes and review the SLA to expand responsibility for reading rights beyond Site Managers. Paediatric Matrons and other staff groups are being engaged to support this work.
- Performance against Section 136 timeframes was challenged over the May Bank Holiday period, with nine patients experiencing delays in ED, resulting in a poor patient experience over the three-day holiday period.
- A clinical case review has been commissioned to examine the nine delayed cases (seven adults and two children) to identify learning and opportunities for improvement.
- A Section 5(2) application breach was identified and is linked to wider patient flow challenges.
- Current processes require patients to be admitted to a bed before being detained under the MHA. The use of EDAU beds for this

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purpose has necessitated moving patients from ED to a physical bed solely to facilitate detention.

- To address these issues, bed reconfiguration plans are being developed to improve patient flow. The EDAU space will be removed as part of the wider redesign.
- The new Emergency Department model will include dedicated assessment areas, mental health rooms and 12-hour assessment spaces, reducing reliance on traditional bed-based pathways.
- Patient pathways will be redesigned for individuals presenting in mental health crisis without physical health needs, ensuring more appropriate assessment and care.
- Additional assessment capacity is being explored through the reconfiguration of space within the current ED footprint when the new build opens.
- Ongoing work is taking place with Dorset HealthCare (DHC) to ensure the appropriate application of legal frameworks and to clarify whether patients require assessment or admission pathways.

Mental Health Act Reform Update (for onward submission to Board)

- The Committee received an update on the Mental Health Act (MHA) reforms, including a summary of the key legislative changes and the associated risks to the organisation.
- The reforms came into force at the beginning of the year and are expected to be implemented over a ten-year period.
- A summary table was presented showing the reforms in chronological order of implementation, together with an assessment of the risks relevant to the Trust.
- The elements due for implementation by February do not currently apply to the Trust and were therefore assessed as presenting a low organisational risk (green rating).
- Similarly, the reforms introduced in April are largely not applicable to the Trust at this stage and have also been assessed as low risk.
- A consultation on the new MHA Code of Practice is currently underway, with publication expected within the next year.
- The forthcoming Code of Practice may present future risks and operational implications for the Trust; however, these cannot yet be fully assessed until the final guidance is available.
- A proposed serious harm detention threshold is expected to raise the threshold for detaining patients under the MHA, although the practical implications remain unclear pending publication of the Code of Practice.

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- The Committee agreed that a further update should be brought back once the Code of Practice has been published, enabling a fuller assessment of risks, impacts and any required actions.

Mental Health Act Care Quality Commission (CQC) Inspections Assurance Report (including individual reports following inspections)

- Herm Ward OPMH
  Mental Health Act monitoring visits identified 4 actions that have been completed, and two remain in progress. These relate to the building work, one relates to the removal of dormitory accommodation, and second one relates to the requirement to have lockable storage for patients. Agreement to extend these deadlines was gained at QGG on 7th July.
- Alumhurst Ward OPMH
  This related to an unannounced CQC MHA visit on 10 June. During that visit the CQC noted some really good practice and no actions were identified which is unusual for a MHA Visit.

Strategic Mental Health Legislation Multi-Agency Group Update

- The multi-agency Mental Health Act group continues to provide oversight and collaborative working across partner organisations.
- The Right Care, Right Person (RCRP) programme continues to be progressed by Police colleagues, with a focus on improving patient outcomes while reducing unnecessary police involvement in mental health responses.
- There was an increase in Section 136 detentions during February and April (27 detentions), including some involving children and young people.
- Performance against the three-hour assessment target for Section 136 detainees is improving, demonstrating progress in timely assessments.
- Attendance and engagement at Multi-Agency Risk Management (MARM) meetings has improved.
- Recurring themes and trends arising from Section 136 activity are being reviewed, with findings and recommendations to be reported back through the group.
- The revised multi-agency Section 135 policy is progressing through the governance and ratification processes of each partner organisation.

Review of Section 136 days

- Compliance with Section 136 assessment times remains stable, performing within established control limits, with a mean compliance rate of 91.4%.

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	• While performance is stable, it is not yet optimised, and opportunities for further improvement continue to be explored. • The main cause of delays is the period between a patient's arrival and the initial request for assessment. Contributing factors include Section 136 suite capacity, coding categorisation issues, and patients being too distressed to participate in an assessment. • Medical availability remains a challenge, as while an on-call doctor is available, a second doctor is often required to complete the Mental Health Act assessment. • Some delays are attributed to data coding and classification issues. The Mental Health Law Office has identified that unclear narrative information can result in delays being grouped under broad categories, highlighting the need for further work to improve coding consistency and accuracy. • Delays can sometimes be clinically appropriate, particularly when patients present during the early hours of the morning and are expected to recover sufficiently for assessment within a short period, such as following intoxication. Intoxication may also contribute to heightened distress or aggression, making immediate assessment inappropriate. • The service operates two dedicated Section 136 suites. On occasions when both are occupied, delays may occur if a third patient requires assessment; however, teams work proactively to identify alternative arrangements and minimise waiting times, including reducing the length of time police officers are required to remain with detained individuals. • Current performance monitoring includes a 20-minute target for contacting an Approved Mental Health Professional (AMHP), after which a delay is recorded. Work is underway to review whether this threshold remains realistic.
Decisions made at the meeting	Nil
Issues / actions referred to other committees / groups	Nil

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Quoracy and Attendance				
	28/05/2026	30/07/2026		
Quorate?	DHC Y | DCH Y	DHC Y | DCH N		
Andreas Haimböck-Tichy (DHC)	Y	Y		
Dawn Dawson (or deputy)	Y	Y		
Lucy Knight (DHC)	Y	Y		
Rachel Wharton (DCH)	Y	N		
Margaret Blankson (DCH)	Y	N		
Nikki Rowland (DHC)	Y	Y		
Suresh Ariaratnam (DHC)	Y	N		
Stuart Parsons (DCH)	Y	Y		
Jenny Horrabin	N	Y		

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DCH Charitable Funds Committee Assurance Report for the meeting held on 21.7.26

Chair	Dave Underwood, NED
Executive Lead	Chris Hearn, Chief Finance Officer
Quoracy met?	**Yes**
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework	• **Charity Spend and Health Inequalities Analysis Report:** report on DCHC charity spend 23/24 and 24/25 and DIIS health inequality data (all patients) produced by BI team. Report reviewed by committee and agreed to request BI team to analyse spend v. patient data per care area.
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: • **CFC Minutes (19.5.26)** – Minutes approved. • **CFC Actions (19.5.26)** – All actions completed or in progress. • **Charity Spend and Health Inequalities Analysis Report:** report on DCHC charity spend 23/24 and 24/25 and DIIS health inequality data (all patients) produced by BI team. Report reviewed by committee and agreed to request BI team to analyse spend v. patient data per care area. • **DCH Innovation Fund**: DoN to check on progress of set up of Trusts' Innovation Forum which will triage innovation bids. Committee agreed to consider applications for funding on case-by-case basis. • **Charity applications (£10K+):** - **Arts in Hospital lead (NHP):** committee agreed funding from ED/CrCU Appeal Fund of £15,483 for B8a/0.2WTE/18mth employed contract. - **PES catheters:** committee agreed funding from General Purpose Fund of £27,000. This will be one off support as DCHC does not support recurring costs. • **DCH Charity Financial Reports 26/27 (M3)** – reports were received. Total income as of end June 2026 £342,362. Unrestricted funds were £285,662 with a reserves surplus of £12,662 against the approved reserves target of £273,000. • **DCHC Annual Report & Accounts 25/26:** audit in final stages, no concerns. • **Lottery proposal:** committee supported DCH Charity joining the new NHS Charities Together Health Lottery.

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	• **£2.5M Capital Appeal (ED/CrCU) report (June 2026)** – report received. £1.86M income and pledges received as of June 2026. Buckham Fair in Aug targeted to raise c.£100K. Appeal forecast to achieve £2M milestone by end Aug 2026. • **Fundraising & Communications report** – overview of current key fundraising activities and communications. The following report is available in the Board in Common document folder on Admincontrol for the August 2026 meeting, titled: '*12.2.1 DCHC Fundraising Communications Update July 2026*' • **Lillian Martin legacy** – Actions carried forward - Email from lead charity re-land management issues from Knight Frank to be circulated to committee for response. Awaiting update re-payment of c£30K from sale of parcel of land. • **AOB:** None.
Decisions made at the meeting	• **Charity applications (£10K+):** - **Arts in Hospital lead (NHP):** committee agreed funding from ED/CrCU Appeal Fund of £15,483 for B8a/0.2WTE/18mth employed contract. - **PES catheters:** committee agreed funding from General Purpose Fund of £27,000. This will be one off support as DCHC does not support recurring costs. • **Lottery proposal:** committee supported DCH Charity joining the new NHS Charities Together Health Lottery.
Issues / actions referred to other committees / groups	• None

Quoracy and Attendance					
	19.5.26	**21.7.26**			
Quorate?	Y	Y			
Dave Underwood	Y	Y			
Chris Hearn	N	N			
Jo Howarth	N	Y			
Anita Thomas	N	Y			
Margaret Blankson	Y	Y			
Stephen Tilton	Y				

Approved
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Dorset HealthCare University
NHS Foundation Trust

Report to	Board Meeting	
Date of Meeting	11 August 2026	
Report Title	Dorset HealthCare Charitable Fund Legacy Variation	
Prepared By	Nicky Norris, Head of Financial Services	
Approved by Accountable Executive	Chris Hearn, Joint CFO Sarah Day, Director of Operational Finance (delegated charity trustee)	
Previously Considered By		
Action Required	**Approval**	Y
	Assurance	
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR6 Finance	
Financial	Varying the use of £258k of legacies received by the Charitable Funds	
Statutory & Regulatory	Requirement to meet legal and Charity Commission guidance for releasing funds for general use	
Equality, Diversity & Inclusion	None	
Co-production & Partnership	None	

Executive Summary

St Leonards Hospital have received £258k in two large legacies but there are only limited opportunities to spend on the St Leonards site. Guidance has been sought from DAC Beachcroft Solicitors to explore whether the use of these funds can be varied for wider purposes within the Trust Charity.

Recommendation

Members are requested to:

- Receive the DAC Beachcroft advice on this issue for **information/assurance**
- **Approve** The wider use of the St Leonards legacy funds within the Trust Charity

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Request for Charitable Fund Legacy Variation

1. Introduction

1.1 Dorset HealthCare's Charitable Fund has received two large legacies, totalling £258k for St Leonard's Hospital. The wills that bequeath the legacies were signed in 1985 and 1986.

1.2 St Leonard's Hospital no longer operates as a Community Hospital but now hosts the Dorset Bladder and Bowel Continence Service, the Dorset Wheelchair Service, the Memory Assessment Service, Outpatients Physiotherapy, Podiatry and an Integrated Community Rehab Team.

1.3 It is proposed that these legacies would be of more benefit to the Charity and to the Trust if they were varied to become general funds.

1.4 The Charity has sought advice from DAC Beachcroft Solicitors on varying the use of these legacies so they can be used more widely within the Trust Charity (appendix 1)

2. The legacies

2.1 The Beryl Williams legacy for £135K was received in May 2025 and states it is for the "general purposes absolutely" of St Leonards Hospital (appendix 2).

2.2 The Patricia Ranson legacy for £123K was received in October 2025 and states the legacy is "for St Leonards Hospital" (appendix 3).

2.3 No further clauses or restrictions are shown on either will.

3. Can the gifts proceed?

3.1 As St Leonards Hospital remains open and hosting NHS services (although no longer operating as a Community Hospital) the gift can proceed as DAC Beachcroft "do not consider the change in the nature of the activities that take place at the hospital to have a bearing on the validity of the gift, providing the hospital itself remains open".

4. How can the gift be spent?

4.1 DAC Beachcroft advised that under Section 218(3) of the National Health Service Act 2006 the funds should, as far as practicable, be used for the purpose specified in the will – St Leonards Hospital. However, the Charity Commission views section 218(3) as holding an implied discretion to cease to apply the funds to St Leonards hospital when it is no longer practicable to do so. This applies to both legacies.

4.2 When choosing to vary the use of the legacies this decision should be taken by the Corporate Trustee (the Trust Board) and minuted carefully, as per Appendix 1, as advised by DAC Beachcroft.

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5. Why vary the legacies?

5.1. As at 31 March 2026, Dorset HealthCare's total charitable funds equalled £724k, meaning that these two legacies represent over a third of the funds available.

5.2. Charitable funds should be used to augment services by the provision of additional items which are not paid for by the NHS. It is intended that such expenditure will improve the conditions under which patients are cared for and treated, or the conditions in which staff work.

5.3. Given the change in use of St Leonard's since these wills were written, it is believed that the legacies will be of greater benefit to patients and staff, if they were reclassified into general funds.

5.4. The Trust's general fund, which can be used to support any initiative that meets the conditions of charitable expenditure, currently stands at just under £9k, meaning that there is very little flexibility to support new projects. For example, when the Trust bids for charitable grant funding, we often have to commit a small amount of funds to the project to be eligible for the grant but currently struggle to do so.

5.5. A recent successful bid to NHS Charities Together awarded the Federation £50k to support staff networks and marginalised staff. In order to receive this, the Trust committed £5k of its own charitable funding to the work.

5.6. Varying these two legacies to general funds would give Dorset HealthCare's charitable fund much greater flexibility to support initiatives throughout the Trust and improve our ability to receive grant funding for projects from other bodies.

6. Recommendations

6.1. It is recommended that the Board

a. Consider the advice given by DAC Beachcroft
b. Approve (using its discretion as the Corporate Trustee of the Charity) the wider use of the St Leonards legacy funds within the Trust Charity

Nicky Norris
Head of Financial Services
14 May 2026

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Report to	Board in Common	
Date of Meeting	11 August 2026	
Report Title	National Cost Collection Post-Submission Report	
Prepared By	Chris Badminton, Head of Income and Costing DHC; Fred Day, Head of Income and Costing DCH	
Approved by Accountable Executive	Chris Hearn, Chief Financial Officer	
Previously Considered By	Finance and Performance Committee in Common	
Action Required	**Approval**	Y
	Assurance	N
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR6: Finance. If we do not submit an annual National Cost Collection we break the terms of our Provider Licence.	
Financial	As above	
Statutory & Regulatory	Statutory Requirement	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	Yes, linked to federated working	

Executive Summary

The National Cost Collection (NCC) is an NHS England annual requirement. All NHS Trusts are required to submit actual costs for care delivered at patient level, as detailed in the Approved Costing Guidance publication.

The Costing teams from both Dorset HealthCare (DHC) and Dorset County Hospital (DCH) are responsible for submitting the NHSE mandated NCC on behalf of their respective organisations.

A pre-submission report was shared with FPC and board on 27th May detailing the timeline and process for the 2025-26 collection in line with Approved Costing Guidance. The next stage of this process is a final report confirming adherence to the Approved Costing Guidance and signed-off submission of the National Cost Collection.

For the 2025-26 collection both Trusts followed the Approved Costing Guidance in calculation of their respective submissions, noting the following:

- All data validations have been reviewed and verified
- Activity has been reconciled to national datasets
- Financial quantum's have been reconciled to the final audited accounts
- All minimum standards in the costing guidance have been delivered, recognising appendix 1 highlights areas where each organisation has identified improvements beyond the minimum standard for subsequent submissions.

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The Chief Finance Officer (CFO) reviewed both submissions on the 29th of June 2026 and they were agreed and successfully submitted to NHSE ahead of the 3rd of July 2026 deadline.

Recognising both Trusts have followed the Approved Costing Guidance and with sign-off from the CFO, this paper confirms the process was followed to successfully submit the NCC submission. It is recommended the Committee approve the 2025-26 NCC submissions for both organisations, ahead of approval at the Joint Board of Directors on 11th August.

Recommendation

Board are requested to:

- **Ratify** the Chief Financial Officer's approval of the 2025-26 National Cost Collection submission prior to submission to the Joint Board of Directors for final approval.

National Cost Collection Post-Submission Report

1. Executive Summary

1.1. The Finance and Performance Committee in Common is asked to review and approve the National Cost Collections for Dorset HealthCare and Dorset County hospital for 2025-26 ahead of board final approval.

1.2. The data collected is the source data for work by the Model Health System. Therefore, the board assurance process has been updated to reflect the importance of cost submissions and raise the profile of costing across the organisations, especially at a senior level.

1.3. The Approved Costing Guidance requires an increased level of board assurance. This is the second of two reports taken to the Finance and Performance Committee in Common on the process for producing the National Cost Collection, required under the NHS Provider Licence. The first report updated the Committee on the plan for completing the submission.

1.4. This final report confirms the plan in the pre-submission report was followed and that the submissions were made adhering to the Approved Costing Guidance.

2. Introduction

2.1. The National Cost Collection is an NHS England annual requirement for all NHS Trusts to submit actual costs for care delivered at patient level.

2.2. The Chief Financial Officer is the executive lead sponsor for all work undertaken by the Costing Teams. The CFO is included in the submission for validation and sign-off purposes.

2.3. The 2025-26 collection covers the financial period 1st April 2025 – 31st March 2026.

2.4. The collection period for this year's National Cost Collection runs from the 8th of June 2026 until 3rd July 2026 and submissions were sent on time.

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3. Main narrative

3.1. The Committee is asked to note:

a. The costing submission has been completed in line with the Approved Costing Guidance:

3.1.a.1. All data validation engine (DVE) failures and warnings have been reviewed and verified.

3.1.a.2. The information included in the submission – both cost and activity – is being reviewed and verified with services and has been reconciled on the submission of activity to national datasets.

3.1.a.3. The quantum of costs has been reconciled to the audited financial accounts and other exclusions have been verified with NHS England.

3.2. Appendix 1 includes a summary of improvements we have identified for future collections, and we will bring an update to this Committee on progress against these requirements in the pre-submission report for the 2026-27 National Cost Collection.

4. Conclusion

4.1. The Committee is being asked to recommend approval of this report ahead of final approval at Trust board for both organisations.

5. Recommendations

5.1. The Board / Committee is recommended to:

a. Approve the process in place as sufficient to provide assurance to the board on the plan to complete the mandated costing submissions for 2025/2026.

Name and Title of Author: Chris Badminton & Fred Day
Date: 15th July 2026

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6. Appendices

6.1. Appendix 1 - Areas where the Trusts can improve upon quality of National Cost Collection

Trust	Costing Standard	Issue	Raised with NHS England	Actions this year	Plan for future submissions
DHC	Exclusions	There are five services which we request for exclusion from the submission due to absence of patient level activity data, these are – a) Veterans, b) Retreats and Community Front Rooms, c) Open Door Bereavement, d) Eating Disorder Day Programme and e) Medical Termination of Pregnancy.	Yes	a) Veterans are collected on AWP's EHR instance, so I will be progressing a link or manual dataset. b) Work with B&P to understand MHSDS requirements c) Work with B&P to understand MHSDS requirements d) Now being recorded and included in MHSDS e) Understand how we include this activity	a) Include in submission b) Once understood a plan will be put in place to address for future returns c) Once understood a plan will be put in place to address for future returns d) Include in submission e) Once understood a plan will be put in place to address for future returns
DCH	Exclusions	DCH had to request two exclusions from this year's NCC	Yes	a) Identify and develop datasets for both services	a) Submit patient level data for both services with

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		return for the below services: - Community Midwifery - Insulin Pumps It was identified that the data was not being captured sufficiently to be able to include within the NCC submission.		to meet the minimum dataset requirements. b) Review with services to ensure data is accurate and reflective of service provision. c) Incorporate data into both income and costing submissions for monthly and annual submissions.	appropriate allocated costs.
DCH & DHC	Integrated	Due to the implementation of EPIC, both Trusts will need to develop new processes to ensure data flows for EPIC align to the requirements for NCC.	No	a) Work with EPIC colleagues to process map and develop data outputs for the NCC return.	a) Aligned EPIC datasets used for NCC submission.

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