Board of Directors in Common - Part 1

Tuesday 13 October 2026, 09:30 - 13:30

Boardroom (The Quay), DHC Headquarters, 2 Nuffield Road, Poole and MS Teams

Agenda

09:30 - 09:30
0 min

Agenda

- 00. Agenda BoD in Common - Part 1 - October 2026.pdf (3 pages)

09:30 - 09:50
20 min

1. Patient Story

Presentation

Information

- 01. Board Report Expert by Experience Dorset Open Door.pdf (5 pages)

09:50 - 10:00
10 min

2. Formalities

- Declarations of Interest Joint (2026-27).pdf (2 pages)
- 02b BoDiC Minutes Part 1 11 08 2026 DCS.pdf (29 pages)
- 02c BoDiC Action Tracker - Part 1 Oct 2026.pdf (1 pages)
- Board in Common Annual Work Plan 2026-27.pdf (2 pages)

10:00 - 10:05
5 min

3. Chair's Comments

Verbal

10:05 - 10:15
10 min

4. CEO Report

- 04. CEO Report Oct 2026 Final.pdf (7 pages)

10:15 - 10:25
10 min

5. Quality Committee Assurance Report

- 05.1 Assurance Report QCIC September 2026 EJ.pdf (9 pages)

10:25 - 10:35
10 min

6. Learning From Deaths Q1 Report

- 05.2a. DHC 26-27 Q1 Learning from Deaths Report.pdf (8 pages)
- 05.2b. DCH 26-27 Q1 Learning from Deaths Report.pdf (6 pages)

10:35 - 10:45
10 min

7. Maternity Report

- 05.3a Front Cover Maternity Neonatal Quality Safety Oct 26 Board.pdf (2 pages)
- 05.3b Maternity Neonatal Quality Safety Report Sept 26 Board version.pdf (26 pages)

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10:45 - 10:55
10 min

8. Joint Health Inequalities Workstream Update (including Integrated Equality and Health Inequalities approach)

05.4. Joint HI Workstream Update Board Oct 2026.pdf (8 pages)

10:55 - 11:05
10 min

9. Patient Carer Race Equality Framework (PCREF)

05.5. PCREF Update Board October 2026.pdf (10 pages)

11:05 - 11:15
10 min

10. Safeguarding Adults and Children Annual Report

05.6a. DHC Safeguarding Service Annual Report Front Sheet 2025-26.pdf (2 pages)
05.6b. DCH Safeguarding Annual report 2025- 2026 Board.pdf (5 pages)

11:15 - 11:25
10 min

11. Thirwall Inquiry - Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018

05.7a Thirlwall Inquiry Report to Board DCH and DHC Final.pdf (4 pages)
05.7b Thirlwall-Inquiry_Recommendations.pdf (9 pages)
05.7c Thirwall Inquiry Letter Sept 26.pdf (4 pages)

11:25 - 11:35
10 min

Break

11:35 - 11:45
10 min

12. Finance and Performance Committee Assurance Report

06.1 Assurance Report September 2026 FPCIC.pdf (7 pages)

11:45 - 12:05
20 min

13. DHC Integrated Corporate Dashboard & Finance Report

06.2a DHC ICD Aug 26 FINAL.pdf (35 pages)
06.2ai DHC ICS - Board Report Summary Oct 26 (Aug 26 Data).pdf (1 pages)
06.2aii DHC CYP MHLD Board Report Summary Oct 26 (Aug 26 data).pdf (1 pages)
06.2b. Finance Report Month 5 August 2026 FPC.pdf (20 pages)

12:05 - 12:25
20 min

14. DCH Integrated Performance Report & Finance Report

06.3 Final Integrated board performance -Front Sheet Exec Summary DD.pdf (3 pages)
06.3 Final DCH ICD_Oct Board v1.pdf (35 pages)
06.3a. DCH Performance Report and front sheet Oct 26 (July and Aug 26 data).pdf (32 pages)
06.3b. DCH Finance Report M5 Oct 26 Board.pdf (2 pages)
06.3bi. DCH Finance Report M5 Oct 26 Board.pdf (11 pages)

12:25 - 12:35
10 min

15. Emergency Preparedness Resilience and Response (EPRR) Self-Assessment

06.4a. DHC Board EPRR Assurance Self Assurance Paper.pdf (4 pages)
06.4b. DCH Board EPRR Oct 26.pdf (4 pages)

12:35 - 12:45
10 min

16. People and Culture Committee Assurance Report

07.1 PCCIC September 2026 Assurance Report EJ.pdf (7 pages)

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12:45 - 12:55
10 min

17. Guardian of Safe Working Report Q1

07.2a. DHC GOSW Q1 Oct 26 Board.pdf (5 pages)

07.2b. DCH GoSW Q1 Oct 2026 Board.pdf (2 pages)

12:55 - 13:10
15 min

18. EDI – WRES and WDES Report

07.3. Joint WRES and WDES Report Board Oct 2026.pdf (55 pages)

13:10 - 13:20
10 min

19. Strategy, Transformation and Partnership Committee Assurance Report

08.1 Assurance Report September 2026 STPCIC.pdf (4 pages)

13:20 - 13:20
0 min

20. Consent Section

20.1. Charitable Funds Committee Assurance Report

09.1. Assurance Report - DCH Charitable Funds Committee (22.9.26).pdf (2 pages)

20.2. Charitable Funds Annual Report and Accounts

09.2. Charitable Fund report For Board 13 Oct 2026.pdf (7 pages)
09.2a. DHCF 2026 Letter of representation.pdf (3 pages)
09.2b. DHCF Final accounts 25-26.pdf (27 pages)

20.3. Premises Assurance Model

09.3. FPCIC PAM Report 15092026.pdf (7 pages)

20.4. DCH SubCo Ltd Assurance report and performance report

09.4a. DCH SubCo Assurance Report 04 09 2026 JM.pdf (3 pages)
09.4b. DCH SubCo Ltd Performance Report Aug 2026.pdf (4 pages)

20.5. Remuneration Committee in Common Proposal

09.5a Development of Remuneration CIC August 2026.pdf (4 pages)
09.5b Remuneration Committee ToR DHC 2026-27 CIC DRAFT.pdf (3 pages)
09.5c Remuneration Committee ToR DCH 2026-27 CIC DRAFT.pdf (3 pages)

20.6. Proposal to Extend Council of Governors Terms

09.6a. DHC Governor Term Extensions BoD.pdf (5 pages)
09.6b. DCH Governor Term Extensions- BoD.pdf (5 pages)

13:20 - 13:25
5 min

21. Questions from the Public

13:25 - 13:30
5 min

22. Any Other Business

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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 13 October 2026 at 9:30 to 1:30
Board Room, DHC Headquarters, 2 Nuffield Road, Poole and via MS Teams

AGENDA

Ref	Item	Trust	Format	Lead	Purpose	Timing
1.	**Patient Story**	DHC	Presentation	Cara Southgate	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 11 August 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.	**Quality**					
5.1.	**Quality Committee Assurance Report**	Joint	Enclosure	Eiri Jones	Assurance	10:15-10:25
5.2.	**Learning from Deaths Q1 Report** (September QC)	DHC DCH	Enclosure	Lucy Knight Rachel Wharton	Assurance	10:25-10:35
5.3.	**Maternity Report** (September QC)	DCH	Enclosure	Pam O'Shea	Assurance	10:35-10:45
5.4.	**Joint Health Inequalities Workstream Update (including Integrated Equality and Health Inequalities approach)** (September QC)	DHC DCH	Enclosure	Lucy Knight Pam O'Shea	Assurance	10:45-10:55
5.5.	**Patient Carer Race Equality Framework (PCREF)** (September QC)	DHC	Enclosure	Lucy Knight	Assurance	10:55-11:05
5.6.	**Safeguarding Adults and Children Annual Report** (September QC)	DHC DCH	Enclosure	Cara Southgate Pam O'Shea	Assurance	11:05-11:15
5.7.	**Thirwall Inquiry - Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018**	Joint	Enclosure	Jenny Horrabin	Assurance	11:15-11:25
	Break 11:25-11:35					
6.	**Finance and Performance**					

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6.1.	**Finance and Performance Committee Assurance Report**	Joint	Enclosure	Dave Underwood	Assurance	11:35-11:45
6.2.	**DHC** • **Integrated Corporate Dashboard** • **Finance Report**	DHC	Enclosure	Chris Hearn	Assurance	11:45-12:05
6.3.	**DCH** • **Integrated Performance Report** • **Finance Report**	DCH	Enclosure	Anita Thomas Chris Hearn	Assurance	12:05-12:25
6.4.	**Emergency Preparedness Resilience and Response (EPRR) Self-Assessment** (September FPC)	DHC DCH	Enclosure	Rachel Small Anita Thomas	Assurance	12:25-12:35
7.	**People and Culture**					
7.1.	**People and Culture Committee Assurance Report**	Joint	Enclosure	Eiri Jones	Assurance	12:35-12:45
7.2.	**Guardian of Safe Working Report Q1** (September PCC)	DHC DCH	Enclosure	Lucy Knight Rachel Wharton	Assurance	12:45-12:55
7.3.	**EDI – WRES and WDES Report** (September PCC)	DHC DCH	Enclosure	Nicola Plumb	Assurance	12:55-13:10
8.	**Strategy, Transformation and Partnership**					
8.1.	**Strategy, Transformation and Partnership Committee Assurance Report**	Joint	Enclosure	Andreas Haimboeck-Tichy	Assurance	13:10-13:20
9.	**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.					
9.1.	**Charitable Funds Committee Assurance Report**	DCH	Enclosure	Dave Underwood	Assurance	
9.2.	**Charitable Funds Annual Report and Accounts**	DHC	Enclosure	Chris Hearn	Approval	
9.3.	**Premises Assurance Model** (September FPC)	DHC DCH	Enclosure	Chris Hearn	Approval	
9.4.	**DCH SubCo Ltd Assurance report and performance report** (September FPC)	DCH	Enclosure	Anita Thomas	Assurance	
9.5.	**Remuneration Committee in Common Proposal** (August Remuneration Committee)	DHC DCH	Enclosure	Jenny Horrabin	Approval	
9.6.	**Proposal to Extend Council of Governors Terms**	DHC DCH	Enclosure	Jenny Horrabin	Approval	
11.	**Questions from the Public**	All	Verbal	David Clayton-Smith		13:20-13:25
	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.baker6@nhs.net					

12.	**Any Other Business** Nil notified	All	Verbal	David Clayton-Smith	Information	13:25-13:30
13.	**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 08 December** in **Board Room, DHC Headquarters, 2 Nuffield Road, Poole 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
- Dorset County Hospital Mid-Year Review
- NHSE Transforming People Services Update
- ODPC Assurance Report
- South West Provider Collaborative (SWPC) Business Case
- Remuneration Committee Assurance Report

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Dorset HealthCare University
NHS Foundation Trust

Report to	Board in Common	
Date of Meeting	13 October 2026	
Report Title	Expert by Experience & Dorset Open Door	
Prepared By	Rachael Pankhurst - Patient Experience Facilitator	
Approved by Accountable Executive	Cara Southgate – Interim Chief Nursing 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		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety SR2 Culture SR5 Estates SR8 Transformation and Improvement	
Financial	No implication	
Statutory & Regulatory	No implication	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary

This report highlights the work of Trish McLennan, an Expert by Experience with Dorset HealthCare and Peer Specialist within Dorset Open Door, who is due to present her personal experiences in person to the Board as a carer, parent bereaved by suicide, and a lived experience contributor.

Her presentation highlights the value of lived experience in informing service improvement, staff learning, compassionate communication and peer support. It demonstrates how personal experience can influence organisational learning, support recovery, and help improve services for patients, carers and families across Dorset.

It is hoped that Trish's presentation will further demonstrate the impact of Experts by Experience and Peer Specialists in shaping services, supporting meaningful co-production, and ensuring the voice of patients, carers and families informs service development. The presentation also highlights the importance of providing appropriate private and confidential spaces for people accessing support, enabling individuals to engage openly and safely during periods of vulnerability.

Recommendation

Members are requested to: Consider and discuss Trish's story and consider her experience.

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Patient Story

1. Executive Summary

1.1. Whilst reflecting on significant personal challenges, this presentation provides a positive account of the impact lived experience can have in supporting recovery, influencing services and improving outcomes for others.

2. Introduction

2.1. This report is produced by Patient Experience and provides context to the presentation and is a regular item at Board meetings.

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

2.3. The Expert by Experience and Peer Specialist has been supported in giving her story by Rachael Pankhurst, Patient Experience Facilitator.

3. Main narrative

3.1. Trish McLennan is an Expert by Experience with Dorset HealthCare and a Peer Specialist with Dorset Open Door. She brings extensive lived experience of caring for family members, supporting her late husband, through his dementia journey and her son, who sadly died by suicide. Trish courageously also reflects on her own diagnosis of PTSD and recovery journey.

3.2. The presentation explores the challenging experience of bereavement following a serious incident investigation. Trish describes the impact that investigation processes, terminology, and communication can have on individuals and families during periods of grief and the lack of support available.

3.3. Trish explains how she became involved with Experts by Experience and met another parent sadly bereaved by suicide, both important milestones in her recovery. She discusses her contribution as an Expert by Experience, sharing her lived experience and expertise through a range of forums and improvement activities.

3.4. As a Peer Specialist with Dorset Open Door, the support that Trish provides to others bereaved by suicide is described by some individuals as “life-saving”. Trish mentions the reach of people affected, including staff members. She describes Dorset Open Door’s wider activities with partner organisations and local communities, including work in schools, prisons and creating accessible signposting information.

3.5. The use of inappropriate and insensitive language can have a deep impact on people bereaved by suicide. Trish has been involved in developing a Suicide Prevention Language Guide, which is a valuable resource that has been widely circulated across services.

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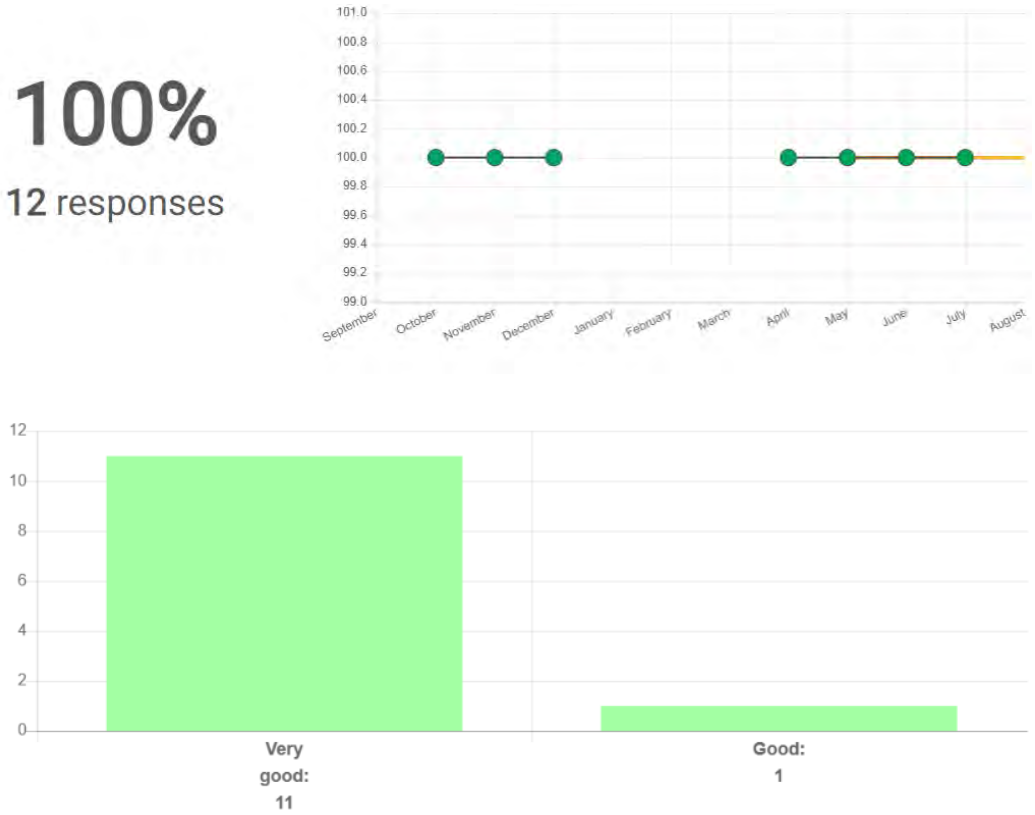
3.6. Trish reflects on the positive impact that her roles as an Expert by Experience and Peer Specialist have had on her recovery and wellbeing. She describes how these roles have enabled her to contribute to service improvement and support others affected by similar experiences.

4. Triangulation data: 01/09/2025 – 31/08/2026

4.1. **Friends & Family Test** – Dorset Open Door received 12 responses from feedback with an FFT score of 100% during this triangulation period.



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

4.3. **Compliments -** A total of two compliments were received for the service.

Dorset Open Door Bereavement Service	Thank you so much for sharing my journey with me again this year. It is a great gift you have given me, I respect and admire you greatly, for all you are.
Dorset Open Door Bereavement Service	Thank you so much for being there for the people like me. It really helps to be able to share the feelings with the knowledge that you will understand. I'm ever so grateful for what you're doing.

4.4. **Survey Comments & Sentiment Analysis** - Of the 40 comments received the majority were positive. The themes indicate respondents place great value with the top two themes of **'communication'** and **'staff attitude'**. Feedback is centred on compassionate communication, feeling listened to, and timely support. Respondents valued the empathy and professionalism of staff, the provision of practical information and signposting, and the follow-up contact offered following initial engagement. Many

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described the service as providing reassurance during periods of crisis and bereavement, with several commenting that the support received helped them feel less alone and better able to navigate difficult circumstances.

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

4.6. **Online Comments** - Nil.

5. Conclusion

5.1. Key points raised in this report are:

- Impact and on families and carers
- Compassionate communication
- Access to support services
- Suitable meeting environments
- Lived experience
- Recovery and resilience
- Co-production and service improvement

5.2. **Response to the story from Samantha Adkins, Team Lead, Dorset Open Door Bereavement Service:**

Dorset Open Door provides peer support, guidance and signposting for people looking for support following sudden, unexpected loss including suicide. The service is delivered in partnership between Dorset HealthCare and Dorset Mental Health Forum and in both design and delivery the service has always been informed by individuals with lived experience of traumatic loss. Working with lived experience in this way creates a parallel process as we shape and develop our services and processes, informed by, and ultimately changed in response to the insights shared by people who show such bravery and courage.

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The need for timely and effective support for individual's bereaved by suicide is stated in the national suicide prevention strategy and as such Trish often supports by sharing her

lived experience expertise in our local suicide prevention groups. Trish does this in a way which has compassion for staff, individuals struggling with their mental health and their families, but at the same time offers challenge to existing ways of working. Working alongside people with lived experience is about more than hearing their stories or inviting their perspectives into our work. It challenges us to listen differently, to reflect honestly on what we do, and to be willing to change. It is a privilege to work alongside people like Trish who bring such courage, honesty and compassion to that process, and whose experiences can help us create services that are more understanding, responsive and humane for those who need them.

5.3. **Response to the story from Jenny Purcell, Participation Development Lead:**

It is an honour to have worked alongside Trish for the past 7 years, to witness her bravery, compassion, expertise and dedication in all that she does to improve the lives of others. It is always humbling to hear her narrative and to reflect on her incredible achievements.

The Expert by Experience programme offers the opportunity for people to bring their perspectives in an informal, contained and supported way. It aims to provide safe, accessible and flexible opportunities, to capture the experience of a wide range of people, who may not have the confidence, time or desire to pursue a more formal role. It also provides a stepping stone to those who do, and we are delighted that Trish is among several other Experts by Experience who have taken up roles as Peer Specialists, Participation Facilitators and Governors.

Trish's narrative has touched the hearts of many hundreds of colleagues across Dorset HealthCare, through her talks at the Corporate Orientation Day, staff training, learning sets and her impactful Duty of Candour video. As a Patient Safety Partner, she plays a vital role holding the Trust to account and bringing her expertise to the governance and oversight of patient safety. As an Expert by Experience, she has also been involved in the co-production of staff training, policies and practical resources. Trish is an active member of the Expert by Experience Monday Morning group, which offers the opportunity for any team across the Trust to engage with a diverse group of people with Lived Experience. These sessions take place every fortnight, for one hour and cover a wide range of topics.

6. Recommendations

6.1. The Board is recommended to:

a. Receive the report for information.

Name and Title of Author: Rachael Pankhurst, Patient Experience Facilitator
Date: 02/10/2026

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

					Type of Interest				Date of Interest
First Name	Surname	Trust	Current Position Held	Declared Interest (Name of the Organisation and nature of the business)	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect	Declaration reviewed
David	Clayton-Smith	Joint	Joint Trust Chair	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust Chair		✓			16/03/2026
				Unity Insights Ltd, Director and Chair		✓			16/03/2026
				National Centre for Creative Health		✓			16/03/2026
Matthew	Bryant	Joint	Joint Chief Executive Officer	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			26/03/2026
				Member of Dorset Integrated Care Board (Mental Health Partner Representative).		✓			26/03/2026
				Trustee, NHS Providers (NHS Alliance but will NHS providers will remain until Summer 2026_		✓			26/03/2026
				Trustee, NHS Alliance		✓			26/03/2026
Dawn	Dawson	Joint	Joint Chief Nursing Officer and Deputy CEO for Dorset HealthCare	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			25/03/2026
				Son is a sales representative for Stryker IVS South & Southwest				✓	25/03/2026
				Daughter is Associate Director of People & Transformation in NHS Somerset				✓	25/03/2026
				Daughter in law is Assistant Divisional Management Accountant at Royal Devon and Exeter NHS Foundation Trust				✓	25/03/2026
				Son in law is a RMN in Dorset Healthcare				✓	25/03/2026
Chris	Hearn	Joint	Joint Chief Finance Officer	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			18/03/2026
Jenny	Horrabin	Joint	Joint Executive Director of Corporate Affairs	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			16/03/2026
				Trustee – Coventry Sports Foundation			✓		16/03/2026
				Independent Audit Committee Member - Citizen Housing	✓				16/03/2026
				Member of HFMA Audit and Governance Committee		✓			16/03/2026
Nicola	Plumb	Joint	Joint Chief People Officer	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			01/04/2026
Anita	Thomas	Dorset County Hospital	Chief Operating Officer	Director at DCH Pharmacy SubCo Ltd		✓			16/03/2026
Rachel	Wharton	Dorset County Hospital	Chief Medical Officer	Nil					17/03/2026
Lucy	Knight	Dorset HealthCare	Chief Medical Officer	Husband is Locality Manager in Dorset Social Care				✓	16/03/2026
Rachel	Small	Dorset HealthCare	Chief Operating Officer	Magistrate in HM Courts and Tribunals Service			✓		16/03/2026
				Sister-in-Law works as a district nurse in Bournemouth team				✓	16/03/2026
Eiri	Jones	Joint	Joint Non-Executive Director	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			18/03/2026
				Non-Executive Director at Salisbury NHS Foundation Trust	✓				18/03/2026
				Interim Chair at Salisbury NHS Foundation Trust	✓				18/03/2026
Claire	Lehman	Joint	Joint Non-Executive Director	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			18/05/2025
				Non-Executive Director at Southwest Ambulance	✓				08/04/2026
				Non-Executive Director at Great Western Hospital	✓				08/04/2026
				Advocacy for Parkinson's Disease				✓	08/04/2026
Dave	Underwood	Joint	Joint Non-Executive Director	Role is a joint role with Dorset HealthCare and Dorset County Hospital NHS Foundation Trust		✓			17/03/2026
				Chair of Royal British Legion Club West Hill Ltd Registered IP23677R on the FCA Mutuals Public Register			✓		17/03/2026
				Policy Board member of the SW Business Council - The economic partnership for the South West of the UK			✓		17/03/2026
				Member of the University of Exeter Digital Advisory Network			✓		17/03/2026
Margaret	Blankson	Dorset County Hospital	Non-Executive Director	Nil					01/04/2026
Stuart	Parsons	Dorset County Hospital	Non-Executive Director	Nil					22/03/2026
Stephen	Tilton	Dorset County Hospital	Non-Executive Director	Director and Chairman of DCH Pharmacy SubCo Ltd		✓			01/04/2026
Suresh	Ariaratnam	Dorset HealthCare	Non-Executive Director	Director, Sprung Sultan	✓				01/04/2026
				Director, Norland College			✓		01/04/2026
				Trustee, Trussell			✓		01/04/2026
				Honorary Fellow, Royal Society of Literature			✓		01/04/2026
				Member, Advisory Council of The British Library			✓		01/04/2026
				Trustee, Literature Works South West			✓		01/04/2026
				Deputy Lieutenant, Somerset Lieutenancy			✓		01/04/2026
				PLACE Associate Non-Executive Member (Swindon) NHS Bath and North-East Somerset, Swindon and Wiltshire ICB, NHS Dorset ICB, NHA Somerset ICB	✓				01/05/2026
				Board Advisor The 87 Press	✓				01/05/2026
				Independent Committee Member - Public Affairs Committee (Office for Students)	✓				01/05/2026
Andreas	Haimböeck-Tichy	Dorset HealthCare	Non-Executive Director	Director, Harbour View (Swanage) Management Company Ltd	✓				22/03/2026
				Managing Director and shareholder of Accenture Plc	✓				22/03/2026
				Wife is HR Director for DJO Ltd, a Medical Device Company				✓	22/03/2026
				Wife is HR Director for ThermoFisher Scientific				✓	22/03/2026
Nikki	Rowland	Dorset HealthCare	Non-Executive Director	Deputy Chair and NED at Care Dorset Limited and Care Dorset Holdings Limited	✓				23/03/2026
				Joint Audit Committee (JAC) member of Avon and Somerset Police	✓				09/07/2026
Beverley	Bryant	Joint	Joint Chief Information Officer	Director, Wildtrack Telemetry Systems Ltd	✓				07/04/2026
Nick	Brailsby	Joint	Non-Executive Director						

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First Name	Surname	Trust	Current Position Held	Declared Interest (Name of the Organisation and nature of the business)	Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect	Declaration reviewed
Jonty	McNuff	Dorset County Hospital	Non-Executive Director						
Louise	Dickinson	Dorset County Hospital	Associate Non-Executive Director						
Kay	Taylor	Dorset County Hospital	Non-Executive Director	Close family member employed at a local GP Practice				✓	25/09/2026
Carly	Stuart	Dorset HealthCare	Appointed Non-Executive DIrector						
Alexander	Priest	Dorset HealthCare	Non-Executive Director	Chief Executive of MIND in Somerset	✓				20/07/2026
				Non Executive Director of Somerset NHS Foundation Trust	✓				20/07/2026
				Director of Halfway House Consulting Ltd	✓				20/07/2026
				Deputy Lieutenant of Somerset			✓		20/07/2026

Definitions

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

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Dorset County Hospital
Dorset HealthCare

NHS

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 11 August 2026 at Board Room, Dorset HealthCare HQ, Dorset HealthCare University Foundation Trust and via MS Teams videoconferencing.

Present:		
Joint Board Members		
David Clayton-Smith	DCS	Joint Trust Chair (Chair)
Nick Braisby	NB	Joint Non-Executive Director
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
Eiri Jones	EJ	Joint Non-Executive Director (Joint Deputy Chair)
Claire Lehman	CL	Joint Non-Executive Director
Nicola Plumb	NP	Joint Chief People Officer
David Underwood	DU	Joint Non-Executive Director
DCH Board Members		
Margaret Blankson	MBl	Non-Executive Director (DCH)
Louise Dickinson	LD	Non-Executive Director (DCH)
Jo Howarth	JoH	Interim Chief Nursing Officer (DCH)
Jonty McNuff	JM	Non-Executive Director (DCH)
Stuart Parsons	SP	Non-Executive Director (DCH)
Kay Taylor	KT	Non-Executive Director (DCH)
Anita Thomas	AT	Chief Operating Officer (DCH)
Rachel Wharton	RW	Chief Medical Officer (DCH)
DHC Board Members		
Suresh Ariaratnam	SA	Non-Executive Director (DHC)
Andreas Haimboeck-Tichy	AHT	Non-Executive Director (DHC) (via videoconference)
Lucy Knight	LK	Chief Medical Officer (DHC)
Nikki Rowland	NR	Non-Executive Director (DHC)
Alex Priest	AP	Non-Executive Director (DHC)
Carly Stuart	CSt	Non-Executive Director (DHC) (via videoconference) (from BoDiC26/128)
Cara Southgate	CSo	Interim Chief Nursing Officer (DHC)
In Attendance:		
Abi Baker	AB	Corporate Governance Manager (DCH)
Kathy Beaven	KB	Specialist Paediatric Feeding Team Lead (DCH) (BoDiC26/109)
Mandy Ford	MF	Joint Deputy Director of Corporate Affairs
Alastair Matthews	AM	UHD Non-Executive Director (via videoconference)
Morad Margoum	MM	Service Director Children and Young People Mental Health and LD
Raphaella Rookes	RR	Chief Dietician (DCH) (BoDiC26/109)
Rose Verrico	RV	Patient story mother (BoDiC26/109)
Members of the Public (observing via videoconference):		
Becky Alridge	BA	DCH Governor
Ben Bullingham	BBu	DCH Graduate Management Trainee

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David Dickson	DDi	DHC Lead Governor
Kathryn Harrison	KH	DCH Lead Governor
Jean-Pierre Lambert	JPL	DCH Governor
Lynn Taylor	LT	DHC Governor
Apologies:		
Rachel Small	RS	Chief Operating Officer (DHC)

BoDiC26/109	**Patient Story**	
	JoH introduced the patient story, which would focus on Avoidant Restrictive Food Intake Disorder (ARFID), with RV telling her son's story. This was a joint story between DCH and DHC, but DHC colleagues were not able to be present today. A presentation was shared to support the story. KB outlined that ARFID was not just picking eating and described the differences between the two. Since 2013 ARFID had been a diagnosable eating disorder and was gaining more attention in media nationally and worldwide. People could develop it at any age, and it could be triggered by traumatic events, but was often developed at a young age. ARFID was characterised by an apparent lack of interest in eating or food, avoidance based on sensory aspects of food, and concern regarding the aversive consequences of food. KB described that there was limited ability to diagnose and treat ARFID in Dorset. Patients with ARFID may only be able to eat one type of food and this can lead to nutritional deficiency and, in some cases, death. RR shared learning from Coroner's reports, noting common themes of bouncing between services and falling through gaps, lack of a dedicated service, lack of awareness and appropriate training or guidelines. RR stressed that this was a local issue and ours to manage, noting two paediatric patients in Dorset who had lost eyesight due to vitamin A deficiency. Positively, there was a large group of enthusiastic and knowledgeable colleagues in Dorset supporting patients with ARFID to keep nutritionally safe. Nonetheless the risks relating to ARFID provision in Dorset was high enough to appear on the Corporate Risk Register. Following the escalation of concerns to the ICB an ARFID working group had been developed with colleagues across Dorset County Hospital (DCH), Dorset HealthCare (DHC), and University Hospitals Dorset (UHD) with good progress being made in preventative treatment, but this had been paused due to lack of funding. RV shared her son's story. James was nearly 11. He had a number of diagnoses including autism, learning disabilities, ARFID, pica, insomnia, and cognitive impairment. He was also non-verbal, and experienced substantial sensory disorders and tonic-clonic seizures. By the time James was three years old he would only eat one food item, and this had continued to now. The food item might change on occasion, but the variety never increased. For the last two and a half years James had only eaten beef flavoured Hula Hoops and summer fruit flavoured squash. Despite the extreme limitation of his diet and continuous contact with health professionals James was not diagnosed with ARFID until he was eight; for five years his eating had only been attributed to	

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	his autism. RV wondered what James' life and development might be like if he had received a diagnosis earlier. During those five years James vacillated between seven services, including CAMHS, SALT, Occupational Health, dietetics and others and none were able to meet his needs. RV commended the skills and commitment of the staff involved, but described frustration with fragmented support, navigating across organisational boundaries, understanding different referral criteria and professionals who did not understand why James had been referred to them. Referrals were closed, rerouted and reopened and RV was often sent away with only a leaflet and being told that James was too complex for the service. Over the years James had been described as too complex for social care, nursery, school, the general public, and traditional eating disorder pathways. RV questioned what happened to the people who were too complex. James' diagnosis of ARFID came with a referral to Great Ormond Street Hospital (GOSH). RV waited a year and a half for an initial online assessment which she pinned all hopes to, but when the appointment came, she was told there was no service to support James needs. His case was closed and referred back to Dorset dietetics. During that year and a half James was closed to dietetics and so received no support. RV described that the same pattern continues James is referred to another service who is ultimately not able to meet his needs and his case is closed. James continues to fall through the gaps of the system and continues to be at risk while RV believes the next service will be the one to finally help him. She described this as exhausting and unsafe. RV was acutely aware that James had been through so many services because she advocated strongly for him, but many people did not have the capacity or ability to do the same. RV described that she had challenged the dietetics team who had said James was nutritionally safe; this was dependent on James drinking supplemented squash which RV did not feel was nutritionally safe. The position had been maintained so far and nothing bad had happened, but this was not safety. James already had a lower life expectancy than his peers due to his learning disability and this was further reduced by ARFID. RV understood that setting up a dedicated ARFID came at a cost, but that there was a cost to not setting one up, including the cost of multiple referrals, re-referrals and wasted clinician time which had not results in his eating disorder being treated. James experienced poorer health outcomes and RV described the complicated steps experienced when James had a stomach bug, including a call to 111 who referred him to his GP, then on to A&E, with James ultimately being sent home with a leaflet and advice to call 111 if concerns continued. This used up valuable resources across the system and caused distress to James. RV was clear that she was not criticising the healthcare professionals doing what they could with the resources they had but said that we could ask more of the healthcare system. RV thanked the dietetics teams and the Board for their support and asked for support commissioning an ARFID service. She wanted James to be as safe and healthy as possible and wanted support to be available to the next person who needs it.	

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	Board members thanked RV for sharing James' story, noting the complexity of ARFID and the shortfall in healthcare provision, and the courage and bravery with which RV spoke. CL asked RV if she had felt heard today. RV was grateful to have the opportunity to be heard today, noting that there was nowhere to go when told that a service simply does not exist. She also felt heard by the dietetics team. NP reflected on personal experiences as a parent with a neurodivergent child and recognised the frustration RV voiced. The board frequently considered how to be more inclusive, and person centred, yet the NHS and wider care system continued to create silos which was not always what people needed. NP encouraged RV to continue sharing James' story and offered support in this regard. NB asked what interventions from an ARFID service would be helpful for James. RV reflected on the importance of differentiating between ARFID, autism and other eating disorders. For example, the typical advice to give children the opportunity to explore food could be dangerous for children with ARFID, as they could switch to only eating a less nutritional food. Specialist advice in scenarios such as a stomach bug would also be helpful. SA asked RV how she would know that she had been heard and listened to and further asked RV who supported her. On the first point RV would like to see a change in services available to James and others like him as it was incredibly challenging constantly hearing that James is too challenging for services. On the latter point, RV said it was a lonely life as she had to support James' many conditions. While she had a supportive husband there were not many support groups or spaces for her, particularly as she worked full time. EJ reflected on the basic humanity that was missing when being continuously told James was too complex and considered the importance of the board acting on what it had heard today. Managing low demand/high impact health matters was a challenge but was important. The board should think about how to work across the system to improve the offer available. MBr extended thanks to RV for sharing James' story today, describing it as one of the most powerful stories he had seen at board. MBr noted that it would be wrong to provide a response today in relation to whether an ARFID service could be provided, but that board members would certainly reflect on and learn from James' story. RV had quite rightly described a responsibility that the board has regarding use of resources and MBr reflected on the trusts' advocacy responsibility to advocate for resources being provided in the right places in healthcare. MBr committed to continuing the conversation and to see how the future could be shaped together and thanked RV for reminding the board what was important in healthcare. RV, RR, and KB left the meeting.	

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	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.**	
BoDiC26/110	**Formalities**	
	The Chair declared the meeting open and quorate. Apologies were received from Rachel Small; MM was deputising in her absence. Those observing the meeting were welcomed. DCS extended welcomes to the new Non-Executive Directors (NEDs) who were joining for the first time and had been appointed due to the changing needs of the trusts and to introduce new skills to the boards. This would also support the workload of existing NEDs. DCS introduced each of the new NEDs in turn; NB, JM, KT, AP, LD and CS. DCS further welcomed DD in her new role as Joint Deputy CEO and CS and JoH in their roles as Interim Chief Nursing Officers.	
BoDiC26/111	**Conflicts of Interest**	
	None declared.	
BoDiC26/112	**Minutes of the Meeting held on the 17 June 2026 (Board in Common)**	
	The minutes of the meeting held 17 June 2026 were approved as an accurate record of the meeting.	
	Resolved by the DHC Board: that the Minutes of the Meeting held on the 17 June 2026 be approved. **Resolved by the DCH Board: that the Minutes of the Meeting held on the 17 June 2026 be approved.**	
BoDiC26/113	**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. DD noted the need to change ownership of actions from herself to CS and JoH as appropriate.	
	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.**	
BoDiC26/114	**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.**	
BoDiC26/115	**Chair's Comments – DHC and DCH**	

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	Reflecting on the patient story DCS noted that it was important to remember why the board was here, rather than only processing the governance of agenda items.	
	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.**	
BoDiC26/116	**CEO Report – DHC and DCH**	
	MBr highlighted the following key aspects from the report, noting that much had happened since the last board meeting, including: • A new Prime Minister, Secretary of State and new ministerial team at the Department of Health and Social Care. Messages from the new ministerial team are business as usual with a focus on the 10-year plan and maternity services. • An event is being convened in October to consider the future of maternity services in the southwest and MBr noted the recent, temporary closure of maternity services in Barnstaple which would have big implications for the population in Devon. • National guidance on preventing unlawful access to patient records, following a number of such instances across the NHS. This had recently been addressed this in the CEO Bulletin, stating that patient records should only be accessed to support the provision of care. • The next round of National Oversight Framework (NOF) rankings, and this year's Provider Capability Assessment • As previously discussed in confidential board meetings, DCH has received of a letter from NHS England (NHSE) expressing concerns that elective and emergency performance is off plan for the year in quarter one. The Trust had responded to NHSE with an action plan and description of governance and board oversight of the plan. A response from NHSE indicated they were not fully assured by the Trust's response and sets out the next stages of the process, including a meeting with the regional NHSE team in early October. This is an ongoing topic for the Board and sets the scene for the performance reports to be considered in today's public and confidential Board meetings. • A recently published CQC report had rated DCH's urgent and emergency care and medical care as "good". The CEO report further described the position of DHC's CQC well-led inspection. Generally positive feedback had been received to date but the final report was awaited. • Topping out ceremony of the New Hospital Programme (NHP) at DCH. This was a key part of the strategy, and the ceremony marked the completion of the shell of the building. • Positive recognition for DHC who had received the gold veterans award. EJ raised a number of points and questions: • As Maternity Board Safety Champion EJ noted that maternity safety was everyone's business, and a future Board Development Session would cover this in more detail. The	

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	October meeting would be important for DCH; as a small trust it was difficult to maintain maternity services. • Asked if there had been any data breaches in either trust. • Noted that nursing and quality teams were reviewing the national quality strategy but challenged that quality was everyone's business and asked whether doctors and other senior managers were involved in the work. • Queried whether it would be useful for DHC to complete the Provider Capability Assessment, even if it did not need to. • Reminded the Board of the importance of external assessments being presented to committee prior to external submission. Some assessments to GIRFT and the Human Tissue Authority had been submitted without committee review. • Commended the urgent and emergency care team on the CQC inspection outcome, noting that this was a good report, particularly in light of the winter pressures during the inspection. MBr accepted the challenge regarding external assessments and tasked JeH to review the governance arrangements around these. With regards to the quality strategy, MBr agreed that quality was everyone's business and suggested that the strategy be considered further in a Board Development Session. BB advised that there was increased national focus on unlawful access of patient records, and there had been data breaches in both trusts and that there was a positive reporting culture. These issues were addressed on a case-by-case basis and reported to the Information Commissioner's Officer where appropriate. DD added that there had been cases of individuals intentionally accessing records. In these instances HR processes had been following and appropriate action taken, including dismissal and referrals to the Nursing and Midwifery Council where needed.	**JeH** **JeH**
	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.**	
BoDiC26/117	**Board Assurance Framework – DHC and DCH**	
	JeH outlined that the last Board meeting had approved the revised set of strategic risks; this quarter one update reviewed the controls and assurances against those risks. All risks had been reviewed by the responsible committees, and the full Board Assurance Framework had been reviewed by each trust's Audit Committee. Actions from the previous strategic risks had been incorporate in to this revised Board Assurance Framework. **DHC:** The two highest scoring risks at DHC were SR3 Workforce Capacity and SR8 Digital, each scoring 15 or more. Each risk had an overdue action with a plan in place to address them. There was one amendment	

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following committees, but the strategic risks had all been thoroughly reviewed.

As chair of DHC Audit Committee, NR noted that the committee had discussed that each committees reviewed the risks for which they are responsible and considered the possibility of time in a Board Development Session to review the risks and associated actions more holistically. DCS suggested this be considered initially in the Committee Chairs Group.

DCH:

JeH continued that the highest scoring risks for DCH were SR1 Safety and Quality, SR3 Workforce Capacity, SR4 Capacity and Demand, SR5 Estates, SR6 Finance, and SR8 Digital, each with a score of 15 or more. JeH highlighted that SR4 Capacity and Demand scored higher this time following receipt of a letter from NHSE regarding performance in quarter one and the subsequent rapid self-assessment the Trust had undertaken. There was one overdue action in the DCH Board Assurance Framework and one change following committee regarding the overall assessment of SR1 which would be included in the quarter two report.

As chair of DCH Audit Committee, SP noted for the benefit of new NEDs the extent to which the Board Assurance Framework had developed and improved in recent years, including the ability to see what had changed since the last version. JeH confirmed that changes would continue to be tracked in red in future iterations.

DD questioned whether the workforce risks needed further review, given the impact on DCH operational performance and the number of references to workforce throughout the Board Assurance Framework. JeH noted that this had been discussed recently at Operational Performance Recovery Group and would be reflected in SR3 Workforce Capacity.

CL queried the unmitigated and mitigated scores of SR4 Capacity and Demand, noting that both scored 20, and how best to convey that a number of mitigations had already been put in place, noting the challenging position. AT reflected that she and JeH had debated this very point when updating the Board Assurance Framework and felt that the scoring was appropriate given the challenges faced in quarter one, including the letter from NHSE. In quarter two the impact of the trust's actions was expected to improve the mitigated score.

JM reflected on the Board Assurance Framework as a new member of the Board, noting that it was clear with evidence of good oversight. JM asked what progress was expected to be made by quarter four for highest scoring risks; SR4 Capacity and Demand and SR6 Finance. AT advised that the target score in the Board Assurance Framework (nine for both risks) was the goal, whilst recognising the challenges in that measure.

MBr suggested that it would be helpful to have a final discussion about the Board Assurance Framework at the end of the confidential part of

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	the Board meeting, as there were further agenda items yet to be discussed about operational performance. EJ noted that it was also useful to use the Board Assurance Framework in preparation for DCH's National Escalation Meeting with NHSE regarding performance recovery plans.	
	Resolved by the DHC Board: that the Board Assurance Framework be received for assurance. **Resolved by the DCH Board: that the Board Assurance Framework be received for assurance.**	
BoDiC26/118	**Corporate Risk Register – DHC and DCH**	
	DHC: CS presented the DHC Corporate Risk Register noting that it was a live register and highlighting that: • There where three new risks since the last report to Board and these were outlined in the report. • Risks relating to Child and Adolescent Mental Health Services (CAMHS) were to be consolidated to provide a better understanding of the totality of risk in CAMHS. • Risk 1893 regarding identity fraud by temporary staff had been reopened following the identification of a fraudulent worker on one of the wards. The individual had been prevented from working but the risk was reopened, nonetheless. • There were no overdue risks or actions. The last report had included a significant risk relating to the NHP and sub-contractors, but this had been addressed and the new build handed over, and patients had started to be admitted. As such the risk was entirely mitigated. NB noted that there were a number of risks where the initial (raw) score was the same as the current (residual) risk and sought further understanding about why this was the case. CS reflected that this was due to historic patterns of risk management. A Risk Management Group had been established and was focusing on reviewing long-standing risks on the register. The scores should be improved by education and training for staff, but the difference between the mitigated and unmitigated risks scores would be reviewed. Noting the risks about reduced capacity in two CAMHS teams, DD asked what risk that created for the population as those teams often supported one another during periods of reduced capacity. AHT added that these risks seemed to have escalated quickly and asked if any earlier warning signs had been missed. MM described that the CAMHS risks did not describe the totality of the risk, and that there was ongoing transformation work in CAMHS. Part of the risk related to the changes in the roles as part of the transformation work which remained ongoing. MM added that the service continued to deliver against access targets and the risks were being mitigated and consolidated. **DCH**	**CS**

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	JoH echoed that the risk register was a live document so mitigations or actions may have progressed since the report was written. JoH highlighted: • Five new risks had been added to the risk register since the last report, including risks relating to endoscopy air compressors following the humidity of the first heatwave; achievement of the Maternity Incentive Scheme (MIS); same day emergency care (SDEC) capacity and bedding; insufficient orthopaedic capacity; and a digital risk. • There had been six increased risks in the report period, five of which related to workforce • Six overdue risk reviews. Two risks relating to ophthalmology would be reviewed in light of their inclusion in the single services review with UHD. Asked about the air compressor risk, JoH advised that the humidity, not the temperature, of the first heatwave had been the issue. This had been unprecedented and had been escalated to the region noting the impact on public health and operational challenges. National and regional heatwave plans were being reviewed by Emergency Preparedness, Resilience and Response (EPRR) leads. At DCH, work was ongoing to modernise and upgrade air ventilation systems to meet ongoing climate changes. AT added that further measures had been introduced as part of emergency planning to monitor interventions. In the past environmental controls had been put in to theatres to reduce costs such as preventing some environmental systems turning on unnecessarily, but this may be causing unexpected problems. Steps were now being put in place to ensure those systems were on early enough in the working day. These were unknown consequences previously but were being address with the changing climate. DU noted the potential for future issues with the cooling of servers, which were currently cooled to only as much as was required. With the changing climate they may need to be cooled further. BB confirmed her team were aware of this and a proposal for capital funds had been submitted at DHC; at DCH this was managed centrally by estates. CH noted the developing risk and ongoing conversations regarding heat and aging equipment, describing the strong governance process in place to manage capital funds. Whilst there was a restricted capital enveloped there were mechanisms in place to reprioritise funds when needed, as well as pots of nationally available monies that could be drawn upon. CH cited the endoscopy washers as an example of working with the regional team to access additional available monies. MBr asked CH to review SR5 Estates, in light of the impact of heatwaves, including whether the target score was realistic and how long it would take to reach the target score. CH agreed, noting that the risk in the DCH Board Assurance Framework had been adjusted in light of the six-facet survey. Noting the discussions around target scores in the Board Assurance Framework, JeH clarified that they had been aligned to the previously agreed risk appetites and were now included in the Board Assurance	**CH**

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	Framework for the first time. JeH recognised that further review of the risk appetites and target scores would be required. EJ noted the opportunity to review the art of the possible from a transformation perspective, and whether the trusts were using the estates to the best advantage. CH confirmed this was being considered as part of Advanced Foundation Trust freedoms.	
	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.**	
BoDiC26/119	**Quality Committee Assurance Report - Joint**	
	CL spoke to the previously circulated assurance report, highlighting: • An informal meeting in June for both trusts, with part of that meeting stood up to be a formal meeting for DCH. Topics at the informal meeting included mental health flow, end of life provision, and communication as a complaints theme. • Receipt of the infection prevention and control annual reports, and medicines management reports for both Trusts, with good discussion about anti-microbial resistance stewardship • The challenging MIS compliance at DCH particularly in relation to mandatory training and staffing • At DHC there were staffing issues on Radipole, Herm and St Brelades wards • Evidence of good practice at DHC in their provision of the MenB vaccine • Thorough discussion about the DHC Quality Governance Group decision to close a number of long-standing incidents. On this point CS noted that part of the system where incidents were recorded required a manager to close incidents. There were over 1,000 which required management closure. Quality Governance Group had decided to batch close these, but following concerns from Quality Committee in Common this had not been actioned. Further detail would be returned to committee. CL further advised that she was stepping down from chairing Quality Committee in Common for a period of time due to health issues. EJ would be stepping in to chair for the time being. JoH described the process surrounding mixed-sex accommodation breaches, when asked by JM. She explained the background and criteria and that authorisation for such breaches was required from herself or AT to ensure that all reasonable adjustments had been made before a breach was the only option. Breaches were triangulated with complaints data to understand the patient experience of privacy and dignity.	
	Resolved by the DHC Board: that the Quality Committee Assurance Report be received for assurance.	

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	Resolved by the DCH Board: that the Quality Committee Assurance Report be received for assurance.	
BoDiC26/120	**Maternity Report – DCH**	
	JoH highlighted that training compliance and Saving Babies Lives data was not available to the Quality Committee at the time of reporting and was being brought to the Board in the updated version of the Maternity report. JoH further noted a new risk to MIS compliance due to challenges with release of staff for training as a consequence of current staffing levels. There was still stime to achieve training compliance for MIS; it had not yet breached but was a challenge and so remained an area of high focus. The Trust's internal auditor, BDO, had been asked to undertake an audit of MIS compliance given the increased scrutiny on maternity following publication of national reports including Ockenden and Amos. LD asked what steps were being taken to achieve training compliance. JoH described that days had been set out over the course of the year for training; if clinicians were not able to attend one they were booked on to the next. LD noted there were a lot of abbreviations in the report and requested these be clarified in future reports. Asked about Apgar scores less than seven, JoH noted that this was a special cause variation metric and it was not yet clear what was driving the variation. Work was ongoing to understand this further. As Board maternity safety champion, EJ highlighted recently visits to the maternity unit including one with DD where they had spoken with several preceptee midwives who were on fixed term contracts and were anxious about the future of their roles. EJ described the maternity service as a tale of two halves. Feedback from patients was overwhelmingly positive, with women across the county choosing to birth with the Trust, and positive feedback from MNSI colleagues and no MOSS alerts. However, staffing continued to be a challenge, and c-sections, including elective and unplanned, had increased to 60% of all births. As champion, EJ continued to consider whether the service was safe and being managed as effectively as possible. DCS asked if the trust was prepared for the higher rate of c-sections. JoH described that the high rate reflected the national picture due to patients wanting to plan their births (elective) and increased comorbidity and older age (unplanned). JoH noted that maternity services needed to be responsive and flexible due to the unplannable nature of pregnancy and birth. Conversations were ongoing about how to right size maternity theatres due to the range of staff that were required to safely run a theatre. The Amos 10-point plan has identified the need for a national maternity staffing review including all staff groups in maternity. EJ added that it could be challenging to regularly access a second theatre when needed and CH was aware of the estates element of this. EJ noted that all staffing groups were well represented at maternity safety champion meetings.	

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	MBr commended the work of the maternity service and the focus on providing safe effective care. Looking ahead the ICB would be involved in discussions around the future of maternity, as to address the workforce and estates issue described would take a significant cost, and the high-cost, small-scale with which the Trust provided maternity service was a problem. Previous work by the ICB in to the structural deficit of the trust identified maternity as a significant contributor. The ICB therefore needed to consider how maternity services were commissioned across the ICB cluster in Somerset, Dorset and Wiltshire. NB asked what could realistically be done to address the workforce issues and what mitigations could be taken. JoH described that midwifery was the area of greatest concern. The Trust had submitted an expression of interest for monies to sponsor newly qualified midwives and hoped to substantiate the fixed-term midwives EJ previously mentioned. However, when additional money was not available the trust worked hard to manage safe staffing in the economic climate.	
	Resolved by the DCH Board: that the DCH Maternity Report be received for assurance.	
BoDiC26/121	**Quality Annual Reports (Infection Prevention and Control and Annual Clinical Audit Assurance Report) – DHC and DCH**	
	<u>Infection Prevention and Control (IPC)</u> **<u>DHC</u>** CS outlined that the report had been through IPC Group and Quality Committee in Common and provided assurance of compliance with the Health and Social Care Act and NHSE IPC Board Assurance Framework. DHC performance metrics for the year were broadly positive, with the trust achieving trajectory for C.Diff within the last year. There had also been a reduction of bloodstream infections, and outbreaks of flu and Covid had been contained and managed. The trust was compliant with the majority of IPC Board Assurance Framework standards and good progress had been made to the workplan. There were some areas of non-compliance, and these would be focussed on in 2026/27. Audits demonstrated compliance in inpatient settings with further work to do in community and non-inpatient services where there was reduced organisational assurance. Overall, the report provided assurance that the trust had effective IPC systems in place, with clear plans to reduce risks in the coming year. AHT asked if there were particular community and non-inpatient services that were non-compliant with audits and what the plan was to address this. CS noted that community services did not have the same framework for areas such as hand hygiene and so audits needed to be tailored to meet the needs of the service. Team-based peer audits were being completed, and this was expected to improve compliance. **<u>DCH</u>** JoH highlighted that the report demonstrated that the team and Trust continued to perform well with low rates of infection. While the trust was above trajectory for gram negative bloodstream infections, this was due to the year's trajectory being set as a percentage reduction on the	

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	previous year. When this was applied to already low rates it was difficult to reduce them further, but the trust still performed well in this regard, being the sixth lowest nationally for C.Diff. The team had embedded the Patient Safety Incident Response Framework (PSRIF) with subsequent learning taken in to operational practice, including in winter planning where there were negligible outbreaks last winter. Additionally, the trust had maintained its sterile services accreditation and teams had continued to work with estates and facilities on engineering requirements for water safety. The IPC team has been integral to the NHP Critical Care Unit and Emergency Department (ED), supporting the future proofing requirements and learning from the pandemic and emerging infections. LD commended the team on the successful C.Diff rate, particularly within the context of increasing demand, and asked how this was achieved. JoH credited the teams in ED and SDEC being alert to people presenting with potential infections and promptly testing them. JoH further noted that the local population had been subject to the norovirus and MRNA vaccine trial which might have some benefit to IPC rates. **Clinical Audit** **DHC** LK outlined that the Clinical Effectiveness Committee oversaw the implementation of audits and NICE guidance. In the reporting period 65 clinical audits were undertaken, 18 of which were national audits. All were submitted on time according to the nationally set deadlines. There had been good progress in developing a digital tool to help with the management and completion of audits. However, digital infrastructure continued to be a limiting factor in overseeing audits in the organisation. The draft audit plan had been developed for 2026/27 which met the statutory and mandatory requirements. Good collaboration with DCH was reported. LK confirmed that DHC was delivering the audit requirements and was developing and strengthening the process for national guidance implantation. NR confirmed that this had been reported via Audit Committee, where the number of audits submitted on time was acknowledged. **DCH** The report had been presented to DCH Audit Committee. RW outlined that, in the last year, there had been a steady improvement in oversight of the clinical audit programme, with good compliance with national audits, with in the region of 250 completed. Clinical Effectiveness Committee worked hard to focus on the clinical audit programme, but the NICE programme would need to be a greater focus in the coming year. SP reflected that clinical audit visibility had improved in the last two years with positive progress being made. SP felt assured about the clinical audit function and commended the audit lead for her work; whilst there were further improvements to be made, he felt the right people were in place now to support this.	

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	EJ offered a challenge that clinical effectiveness was more than just audits and NICE programmes, but about how everyone did their job most effectively to meet the needs of the population. Clinical effectiveness should be link to quality improvement (QI) approaches and a part of continuous improvement. She had discussed this recently with AT in relation to using stretch targets for services. It was important to consider learning from other trusts in particular regards and EJ suggested using Clinical Effectiveness Committee as a chance to have discussions and learning from best practice. AT noted the work being done under GIRFT and learning networks for urgent and emergency care and elective care. LK added that she and CS had already had a similar discussion and reflected that the Trust had good focus on safety but could improve on effectiveness and echoed comments about the need for learning from excellence to consider whether the trust was delivering best practice and on the front foot for offering the best quality treatments for patients. DU raised that it would be good to understand the risks and consequences of the overdue NICE actions. RW agreed.	
	Resolved by the DHC Board: that the Quality Annual Reports (Infection Prevention and Control and Annual Clinical Audit Assurance Report) be received for assurance. **Resolved by the DCH Board: that the Quality Annual Reports (Infection Prevention and Control and Annual Clinical Audit Assurance Report) be received for assurance.**	
BoDiC26/122	**Mortuary Oversight Board Assurance Statement - DCH**	
	JoH outlined that, in response to findings from the national Ockenden review, the trust had been set a short timeframe to submit a self-assessment regarding the mortuary and the care of patients after death. The self-assessment was submitted by the 31st July deadline. The DCH board had previously received two assurance reports following the Fuller inquiry into unacceptable care of the deceased, and this self-assessment built on that previous work. The trust was compliant with all but one minor element, with a recommendation regarding swiping out of mortuary. This had been mitigated through swiping in and CCTV on all access points. Due to the short deadline the response had not been through committee or Board, but the self-assessment was submitted based on evidence previously reviewed by Board following the Fuller inquiry. Following the Amos report there was a national 10-point action plan, some of which was for provider to address, and some were national actions. The trust had set up a task and finish group with a 100-day window to work through the actions, which was chaired by JoH. EJ noted that the audit had been completed by the team themselves and asked what oversight there was within the organisation. JoH noted that there had been two meetings about the audit and that the data reviewed was triangulated through Datix reports and HTARI reports.	

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	DD confirmed that there was no mortuary service at DHC; these had previously been closed following the Fuller review.	
	Resolved by the DCH Board: that the Mortuary Oversight Board Assurance Statement be received for assurance.	
BoDiC26/123	**Finance and Performance Committee Assurance Report – Joint**	
	DU highlighted the following key points from the previously circulated report: • The committee met informally in June, jointly, with Strategy, Transformation and Partnership Committee in Common where they received a deep dive in to the neighbourhood programme, and updates on the digital strategy and NHP, followed by a visit to the NHP ED and Critical Care Unit building site. This offered the committees the chance to see infrastructure investments in action. • The formal meeting in July recommended that the DCH and DHC Boards act as the responsible person for Martyn's Law in each Trust. DU provided a precise of Martyn's Law. • The formal meeting was assured by the DCH performance recovery plans for urgent and emergency care, but only partial assurance for the elective care recovery plans which were felt to be under development. • Full discussions around the Board Assurance Framework and Corporate Risk Register, including opportunities to strengthen assurance with deep dives in to risks which impacted multiple committees. • DHC performance report with committee members asking executives to ensure commissioners make the required funding decisions to support operational planning. • DCH performance report noting the interdependencies between committee portfolios and that cross-cutting discussions might be needed. • Consideration of the green strategy and net zero report • A number of approvals as detailed in the assurance report NR thanked colleagues for the better payment policy and the strengthening of controls. With regards to the DHC performance report, NR asked if there was a timeline for when the ICB will decide about commissioning talking therapies and was the Trust prepared to implement a plan if it was commissioned. MM provided assurance that the matter was raised in the ICB contract meeting on 23rd July and continued to be escalated, but a response had not yet been received. Plans submitted to NHSE assumed a sustaining trajectory, but people remained on the waiting list. Changes had been implemented to increase capacity including increasing workforce, but recruitment was expected to take approximately a year. CH added that discussions continued to be had with the ICB, recognising that the issue was more widespread than Dorset and needed to be addressed for the benefit of the population. In terms of operational metrics, there was an impact on the National Oversight Framework (NOF) rating. The funding arrangements would continue to be raised with the ICB and would remain high on the committee's radar until an outcome was achieved. MBr was clear that if the ICB ultimately were not to invest in the service	

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	then discussions would need to take place about ceasing the service. A further update would be provided to the September Board Development Session. EJ urged executives to keep applying pressure to the ICB in this regard, noting the national focus and funding which did not appear to be filtering through.	
	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.**	
BoDiC26/124	**Integrated Performance Report and Finance Report – DHC**	
	<u>Integrated Performance Report</u> CH introduced the report, noting the continued use of the new format and metrics which was closely aligned to the NOF. Updating on quality performance, CS highlighted: • Three cases of C.Diff in the reporting period, with learning captured. Two bloodstream infections and a further five cases which will be in the next report. These appeared to be related to catheter care, as well as the recent heat and hydration. • Medication incidents exceeded the upper limit in May due to increased reporting of patient safety incidents following transfer of care incidents, and incidents linked to the MenB response. There were 25 incidents, all of which had been reviewed with a report to be returned to Medicines Group to capture learning. • An increase in complaints in June and July, including five complaints reopened. Updating on operational performance MM highlighted: • There was no process limit set for length of stay, but there was expected to be one in future. Five people with long length of stays accounted for 64% of the mean length of stay. The team was working with NHSE to look at how to more accurately represent length of stay and was introducing more controls in the peri-hospital programme to improve this metric. • No criteria to reside stood at 36% in the last month • Children and young people access performance remains above target, but this impacted capacity to see patients subsequently. • Children and young people eating disorders performance remains below target for urgent and routine referrals, with a recovery plan was in place. • Challenges continue in achieving 100% recording of patient ethnicity, particularly with GP registration. The importance of this data was noting in addressing health inequalities. • A recovery plan was in place for individual placement support (IPS) and the Trust was on trajectory to meet the target by the end of the year. • The opening of the NHP was supporting improvements in out of area placements. However, a refurbishment of the older adults ward was being delivered at the same time as changes to single sex accommodation within older adults organic ward, which was likely to challenge flow and capacity.	

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	AP noted that many trusts struggled with length of stay metrics and the required metrics were expected to change in the coming year. MBr thanked AP for his insight, noting the importance of the experience of individuals staying too long in hospital and the failing by the trusts and the wider system. While there was work ongoing across the system, MBr was struck by the low numbers of people and found it difficult to believe that collectively with partners it was not possible to do something to make a difference for those patients. This would continue to be a topic of focus and work. NR asked how confident the Trust was that the non-recurrent investment in audiology would address the backlog, and what the position would be if commissioned funding were to stop. MM confirmed this was a key area escalated to the ICB in the July contract meetings. CH added that if commissioned funding was not available, an assessment of the sustainability of the service would be needed. MM further noted the changing model for audiology, with people now able to self-refer to the service. MBr noted that the longest wait for audiology was 16 weeks, against a six-week target. Whilst this still had an impact on the patients affected, it was not the waiting list of most significant concern. The Trust would continue to appeal to the ICB for the service to be commissioned, and consistently across the ICB cluster. With reference to page 160 of 381, SP noted the DHC was operating at or near the upper process limit for no criteria to reside since August 2025 and sought further detail on whether this was budgeted for, or if additional savings could be made by reducing no criteria to reside. MM noted that this could be covered in the future care item to be discussed in part two of the meeting. MBr considered again the experience of the people in those beds, who were in a care setting that was not right for them. Moreover, if those beds were not in use there would be more opportunities to support acute care colleagues. Discussions about the future bed provision in Dorset would remain ongoing. AHT suggested that the report include detail about where solutions were within the Trust's control, or reliant on others. He further noted that audiology had been a topic of concern for some time and performance was not being delivered as planned and therefore needed further understanding. MBr agreed, noting the importance of sustainable services that were properly commissioned and continued to be a discussion with the ICB. Discussions also continued with DCH and UHD with regards to the relationship between audiology and ENT waiting lists which was a short-term issue; longer term was the issue of NHS audiology services across Dorset. The Trust was proud to provide the service, but only if commissioned properly. With regards to workforce, NP considered whether there was enough workforce information included in the dashboard, given the amount of focus on workforce in the meeting so far. The meeting heard that People and Culture Committee in Common received a detailed report with a range of metrics, but there was little specific to escalate to the Board at present. NP noted the completed appraisal rate in DHC was 82.7%, representing a significant improvement in the new appraisal	

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process. People and Culture Committee in Common would be receiving a deep dive in to sickness absence in the September meeting as DHC rates were higher than expected. JeH noted that some appendices were missing from the report and these contained all metrics, including those on track.
Post meeting note: the appendices were circulated to Board members after the meeting.

EJ suggested that the report could be improved by including real outcomes of the services provided, rather than metrics alone. She pointed to the acquired brain injury service as a good example of this.

Finance

CH spoke to the month three finance report:

- The full year financial plan for DHC is a £0.5m surplus and was the same for the remaining years of the medium-term plan. There was a 6.5% cost improvement plan (CIP) requirement for the year, totalling £28m.
- At month three the year-to-date position was a surplus of £773,000 which was broadly in line with plan
- Year-to-date CIP delivery was £4.6m against a plan of £4.8m. CIP was broadly phased flat across the year, and a robust Financial Recovery Board (FRB) was now in place with an advisory internal audit report on FRB had been presented to both trusts' Audit Committees detailing the areas of good practice and areas for improvement.
- Out of area placements were overspent by £405,000 and agency staff costs were above plan by £173,000. This was being tracked through governance routes including Financial Recovery Board. Whilst agency spend was above plan in year, it had reduced compared to the same period last year, indicating positive movements.
- These areas of overspend had been offset by the vacancy rate in the trust, totalling an underspend of £1.3m, and a range of non-pay spend, particularly in Estates and Faculties.
- The Trust ended month three with a cash position of £49.3m; this was largely due to the timing of capital spend which was behind plan, primarily due to the phasing of NHP.

DCs noted that the temporary staffing spend was highest in the medical directorate and asked if more could be done to improve this. LK noted that 14 International Medical Graduates (IMGs) had been recruited to, but there was a six-to-eight-week transition period while they were onboarded during which time locums would still be employed. Two IMGs had left unexpectedly, but recruitment would continue and it was expected that temporary staffing spend would reduce in time. If it did not, plans would be adjusted. CH added that there had historically been overspend in medical temporary staffing. However, he, LK and MBr had discussed how to improve this, and the recruitment LK described was part of the agreed improvement trajectory. Additionally, an action plan was in place to improve CIP performance for the medical directorate and was expected to be resolved over the life of the medium-term plan.

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	EJ asked what the plan was to address the overspent areas and by when. CH described that there were robust budget management processes to identify the overspent areas and plans were in place to mediate them. There was good local governance in individual directorate performance meetings which tracked financial performance. The Financial Recovery Board could be utilised to address the concerns; this had been in place for approximately nine months and offered greater executive oversight of spend. The internal audit of Financial Recovery Board provided a rating of moderate assurance in both domains for both trusts. Moving forward the Trust was looking to address bottom-up costing where appropriate which would address some concerns where there were recurrent issues. EJ further asked why so many of the CIP schemes were rated red. CH noted that these areas were being addressed through the governance processes previously described. The Trust was in a good position with CIP identified with 20% high risk and work was ongoing to reduce these to moderate or low risk. Finally, EJ questioned whether the Trust's staffing model was right, noting the substantial temporary staffing spend. CH noted there had been an improvement in agency spend but recognised that the Trust was not currently meeting the plan. There was a great deal of focus in local groups to address this, with a number of vacancies offsetting the overspend.	
	Resolved by the DHC Board: that the Integrated Performance Report and Finance Report be received for assurance.	
BoDiC26/125	**Integrated Performance Report and Finance Report – DCH**	
	AT noted that the report was being reviewed to take in to account NOF metrics and the DHC template and the updated version would be returned to the next Board meeting. For todays meeting it had been agreed the full report from Finance and Performance Committee in Common would be included in the papers as that covered the full range of performance metrics. This would continue until operational performance had been recovered. With regards to operational performance, AT highlighted: • Pressures in urgent and emergency care performance in quarter one, as previously discussed. By the end of quarter one steady performance was being made and in to quarter two there were improvements in performance. Further detail would be provided in the confidential part of the meeting today. • A deterioration and loss of activity in elective care due to staff absence and the breakdown of equipment. This activity was not reclaimable. • Cancer waiting times performance was a snapshot in time, as performance did not close at the end of the month but took a further six weeks to close. Cancer standards were not met in quarter, with 62-day performance held at 69%, and 28-day performance improved to 77%. Work was ongoing to improve performance but may take some time to materialise.	

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	• Further detail was provided in the full report presented to committee. With regards to quality performance, JoH highlighted: • Sustained performance in IPC • Inspection of pharmacy services by the General Pharmaceutical Council with all standards met, providing strong assurance • A decline in hospital acquired pressure ulcers. This was the third year of concurrent improvement. There had been a spike in orthogeriatrics, with quality improvement work to understand and address this. • Neonatal services achieved UNICEF's Stage one Baby Friendly Imitative Accreditation. Maternity had achieved this last year and would be undergoing the stage two assessment in September. • An increase in the number of complaints received using AI. This was creating lengthy complaints requiring lengthy responses which created further confusion for complainants. In relation to people performance NP noted: • Preparations had started for the staff survey • Slight increase in sickness absence, but the trust continued to be one of the best performing in the region in this regard Returning to operational performance MBr described that the frontline teams in DCH were working incredibly hard in difficult conditions to improve performance. The chart on page 212 of 381 regarding referral to treatment (RTT) metrics, showed that the trust's performance was flat but that this was in the context of increasing demand; the relative position was therefore worsening quickly. At month three the Trust was off plan by 5% in month three against a plan for a 7% improvement or achieving 65% performance. The Trust was significantly off plan; in absolute terms was the 18th worst performance trust in England, and the second or third worst for variation from plan. A number of factors were driving this, including but not limited to referral growth. Referring to page 215 of 381, MBr described that urgent and emergency care was extremely busy throughout the pathway. There had been a 9% increase in attendance at ED, ambulance handovers were running ahead of plan, and there were delays in discharging patients. MBr reframed the graph, describing the orange dots as patients who had waited over 12 hours in ED and that this was a poor experience for patients that should be avoided. Positively, there were signs of improvement in relation to the number of patients with no criteria to reside. AT noted that teams were involved in a great deal of work, not just to reduce the overall number of patients in beds, but to reduce the length of time their discharge is delayed by. The next phase of work would look at discharge to assess for people with very complex needs who fall between commissioning gaps. This was key, alongside rightsizing capacity and working with system colleagues to revisit the urgent and	

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	emergency care approach across Dorset. This work had been ongoing but had lost momentum due to ICB and region restructures. EJ commended the challenge from MBr and noted that the Boards had been receiving reports from the working group. EJ reflected that it would be important to consider how this performance position had been reached and what was in the Trust's ability to address and what needed to be worked on with partners. DD added that the Operational Performance Recovery Group would be sharing weekly assurance reports to the Board, but that detailed discussions would be taking place in the confidential part of Board meetings. NB sought assurance on the level of burden was placed on executives being involved in patients with extended length of stay. AT advised that this allowed executives the opportunity to identify any areas that patients could be referred to and noted that the patients referred to them were often complex with solutions that were not immediately apparent. The Executive Oversight Group allowed health and social care partners to consider complex cases and what solutions would be needed in that space. Discharge to assess was starting to address some of these cases. **Finance** CH spoke to the month three finance report: • The full year financial plan for DCH is a breakeven position, which included £2.6m of deficit support funding. There was a 6.5% cost improvement plan (CIP) requirement for the year, totalling £23.3m • The month three position was a deficit of £3.1m against a plan of £2.9m. The excess deficit solely related to costs relating to industrial action incurred in month one. As previously described the Trust was working with the ICB and NHSE to determine if additional funding was available for this, but at present there was none. This remained a cost that the Trust was not able to cover; this position was comparable to other trusts. • Agency staffing costs totalled £0.6m in month, an increase from recent months but reflective of the operational pressures. Despite this month's increase, there was a general reducing trend over the year. • Bank staffing spend totalled £1.4m in month due to operational pressures; this continued to be a focus of Financial Recovery Board • Overachievement of efficiency delivery in month of £931,000 against a plan of £777,000. Year-to-date performance was in line with plan, with £2m delivered to date. At month three 15% of CIP remained unidentified (£3.4m), and 17% of identified schemes were high-risk. This was a key risk for the reminder of the year and Financial Recovery Board would continue to oversee it. • The Trust's cash position was significantly behind plan in month by £4.5m at £20m, primarily due to the timing of income from the ICB for the sleep service.	

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	• Capital spend was £4.1m behind plan due to the timing of NHP spend and internally funded schemes, but full year compliance was anticipated MBI temporarily left the meeting. SP sought further assurance about the substantive staffing variance year-to-date, noting that the Trust had spent less on substantive staffing than planned, but was spending more than planned on temporary staffing. CH noted that the trust had made investment in to headcount and this was being implemented. JoH provided further detail that the gaps in substantive posts were caused by difficulties in recruiting to specialist roles across all professions, difficulties recruiting to fixed-term contracts to cover periods of maternity leave, and delays in getting successful candidates in to post if they have been recruited from overseas. Additionally suitable vacancies have had to be held for newly qualified nurses who would be starting in September. DD added that she had commissioned a review of workforce particularly for those aeras that supported performance recovery; this would be reported to Operational Performance Recovery Group in due course. Detailed discussions were ongoing with the ICB to consider how to bridge funding gaps for such areas. This could be further discussed in the confidential meeting if required. SP further requested a phased outturn of CIP, including high risk schemes, for the remained of the year. The Trust had a £1m deficit in the first quarter and this needed to be addressed if we were to achieve the breakeven position by year end, while also focusing on performance recovery. CH noted that the CIP submission to NHSE had been robustly challenged and a detailed phased plan for the remainder of the year was in development to understand the overall risk.	
	Resolved by the DCH Board: that the Integrated Performance Report and Finance Report be received for assurance.	
BoDiC26/126	**Green Strategy Annual Report – DHC and DCH**	
	CH noted that the report had undergone detailed discussion at Finance and Performance Committee in Common and was presented to detail the progress made against the Joint Green Plan, recently approved by Board. The sustainability teams continued to work closely with other teams and actions plans, including supporting the social value plan and estates infrastructure strategy to ensure processes were being embedded. The communications plan was currently in development and a plan on page had been drafted. A sustainability day was planned for the autumn which would launch parts of the strategy and the teams continued to work closely with UHD and local authority colleagues to align where appropriate. Finally, a joint travel plan was in development which linked with estates master planning.	
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BoDiC26/127	**Winter Planning (delegating authority to FPC) – DHC and DCH**	
	AT outlined that winter planning requirements had recently been received and set out the need for plans to be approved by Boards by the end of September. AT requested that authority to approve the plans be delegated to Finance and Performance Committee in Common, and the plans to be returned to Board in October for awareness. The quality impacts of winter planning would be considered through Quality Committee in Common. JeH noted that a letter had been received the day before this meeting from the Regional Director for the southwest with additional requirements for confirmation from Board regarding the winter plan assurance statements. An additional Board meeting for this might therefore be required. MBr reflected that the request to delegate authority was fine in principle but considered that a wider discussion by DCH Board might be beneficial, particularly as part of preparations for the meeting in October with the regional team regarding the performance recovery plan. The Board may therefore wish to have the opportunity to endorse the submission and suggested that the winter plan for DCH return to the Board Development Session on 8th September; at that time the Board could consider if an extraordinary Board meeting would be needed at end of September, recognising the importance of the winter plan to DCH's performance recovery. AT confirmed that both DCH and DHC required a winter plan this year. The DHC Board approved the delegation of authority for approving the DHC winter plan to DHC Finance and Performance Committee. The DCH Board agreed that the Board should reserve for itself the approval of the DCH winter plan.	
	Resolved by the DHC Board: that DHC Board approved the delegation of authority for approving the DHC winter plan to DHC Finance and Performance Committee. **Resolved by the DCH Board: that the DCH Board agreed that the Board should reserve for itself the approval of the DCH winter plan.**	
BoDiC26/128	**People and Culture Committee Assurance Report - Joint**	
	EJ highlighted the following key points of the report: • Detailed discussion about the Board Assurance Framework and Corporate Risk Register with consideration to be given in forthcoming meetings in aligning with performance recovery work. • Recommended to medical revalidation report to the Board for approval • Discussion about the Mann Review and the trusts' response to it. NHSE had set clear expectations for trusts, but there was legal representation about the implications of adopting the specific recommended antiracism statement and definition of	

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	antisemitism. It was also important to understand the local community's view. This was a complicated matte and would be further considered by the executive team and returned to People and Culture Committee in Common at a later date. • June's informal meeting received updates on the national transforming people services programme, a presentation on support for locally employed doctors, a presentation on EDS2, and receipt of the People and Culture Committee in Common governance structure. • 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 CS joined the meeting online. SP queried the fact that DHC was on plan for substantive staffing but had a vacancy rate of 7.5%. He further asked whether there was a typographical error in the final bullet point on page 288 of 381; the point referenced DCH data but also DHC services. NP advised that a vacancy rate is always built in to the substantive plan. NP further noted that the figures the report were correct. People and Culture Committee in Common formally reviewed temporary staffing and had discussed in the last meeting the workforce recovery position. CL asked if national guidance had been received from the Equality and Human Right Commission regarding the biological sex ruling by the Supreme Court. NP noted that a position statement was being submitted to Senior Leadership Group meetings in the coming weeks and multidisciplinary discussions remained ongoing at present, but guidance had been published too recently to provide an update at this stage. Further detail would be provided through People and Culture Committee in Common.	
	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.**	
BoDiC26/129	**Medical Appraisal and Revalidation Annual Report (and Statement of Compliance) – DHC and DCH**	
	The reports were taken as read. Board members were invited to ask questions but having been through People and Culture Committee in Common the reports were approved without question or discussion.	
	Resolved by the DHC Board: that the Medical Appraisal and Revalidation Annual Report (and Statement of Compliance) be approved. **Resolved by the DCH Board: that the Medical Appraisal and Revalidation Annual Report (and Statement of Compliance) be approved.**	

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BoDiC26/130	**Strategy, Transformation and Partnership Committee Assurance Report – Joint**	
	MBl returned to the meeting. DCS highlighted the following key points from the report: • Discussions around the emerging Advanced Foundation Trust workstream with agreement that this would be a regular agenda item at the committee • Workforce capacity issues were constraining the delivery of full transformation and improvement agenda • NED engagement at the quality improvement week in September was encouraged. • Recommendation to Board for DHC to join the Dorset Estates Partnership (DEP) subject to legal review • Request for a future update on cyber resilience and recovery arrangements • DCS to step back from chairing the committee, with AHT to take on the role • Receipt of the joint Social Value Plan EJ said that it would be helpful to see the detail of the Advanced Foundation Trust workstream to ensure all Board members were committed to it. DD suggested this be returned to the next informal meeting. DU repeated a question he asked at the committee. Given the significant benefits the One Dorset Provider Collaborative (ODPC) and Vista Health work offered, had the projected numbers been audited. MBr agreed this would be useful but noted the sequencing that needed to be followed. On 2nd September an informal NED tripartite meeting between DCH, DHC and UHD was scheduled which the independent chair of ODPC (TH) had been asked to present at. MBr suggested that the matter be raised there and progressed as needed. MBr agreed with the proposal that ODPC report in to Strategy, Transformation and Partnership Committee in Common, but noted the intention for an ODPC report to be presented to the public Board meeting as well; currently minutes of ODPC board meetings were presented in the confidential part of Board. There was also NED oversight of the governance arrangements for the programme.	**DD**
	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.**	
BoDiC26/131	**Audit Committee Assurance Reports – DHC and DCH**	
	DHC NR noted the committee discussions around the Board Assurance Framework and Corporate Risk Register as well as a thorough discussion about a recently completed internal audit in to ward identity	

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	checks, linked to imposter fraud. The audit had a rating of limited assurance, but it was noted that DHC had been proactive in identifying the issue and in supporting criminal cases, including national cases. Also of note was the reduction in the number of risks scoring 15 or more and commendation for the rapid work to reduce the risks relating to CAMHS and Seastone. In relation to internal audits there were four outstanding actions with a request from the committee for these to be addressed quickly. Finally, a technical update provided by the external auditors had been shared with other committee chairs for consideration. CL sought further detail about the tender waiver report. NR noted that they were not high volume and the majority related to monies received towards the end of the year that needed to be committed before year-end. **DCH** SP echoed previous discussions of the Board Assurance Framework, adding that the publication of national maternity reviews would impact the detail of the quarter two Board Assurance Framework. He further noted: • There were five new high scoring risks on the Corporate Risk Register, with a lack of funding impacting on the trust's ability to replace end of life equipment. • MIS had been added to the internal audit programme given the risk to achieving the scheme. The audit in to outpatient follow up had been delayed to support this. • Moderate assurance had been provided by the audit in to Financial Recovery Board • Verbal update received on the ward identity checks audit, with limited assurance provided. The audit would be returned to the committee in full at the next meeting. • Receipt of the counter fraud annual report, noting a 40% increase in reported fraud • 0 procurement breaches in the tender waiver report • Material improvement made in Freedom of Information (FOI) compliance, but this was still not in line with the Information Commissioner Office (ICO) target of 95% • Improvements in clinical audit work	
	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.**	
BoDiC26/132	**Mental Health Legislation Committee in Common Assurance Report – Joint**	
Setchell,Ryan 09/10/2026 11:05:42	AHT highlighted the following key points from the report: • Positive CQC reports following inspections on Alumhurst Ward with the committee commending the ward team on their work. The report contained no recommendations for improvement. • Discussions around the reformed Mental Health Act, considering the impact and risks for the Trust. In the short term there were	

	none identified and the publication of a code of practice was awaited. • Deep dive in to section 136 providing assurance that DHC was performing well in this regard • Update on the Supreme Court ruling regarding the change in Deprivation of Liberty Safeguards (DOLS), with fewer people expected to be subject to DOLS in the future • Work to continue to try to reduce the length of reports including reporting by exception in the mental health dashboard • DCH committee was not quorate. This has been a challenge in recent meetings, but membership is being addressed.	
	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.**	
	CONSENT SECTION	
	The following items were taken without discussion:	
BoDiC26/133	**Charitable Funds Committee Assurance Report – DCH**	
	Resolved by the DCH Board: that the Charitable Funds Committee Assurance Report be received for assurance.	
BoDiC26/134	**Charitable Funds Legacy Variation - DHC**	
	Resolved by the DHC Board: that the Charitable Funds Legacy Variation be approved.	
BoDiC26/135	**Cost Collection Exercise – DHC and DCH**	
	Resolved by the DCH Board: that the Cost Collection Exercise be approved. **Resolved by the DHC Board: that the Cost Collection Exercise be approved.**	
BoDiC26/136	**Questions from the Public**	
Setchell,Ryan 09/10/2026 11:05:42	JPL asked, related to the operational recovery, how are we addressing the DCH structural challenges caused by our scale in a rural catchment area and the rapidly increasing demand due to our aging demographics? Specifically, what advocacy avenues are we pursuing to adjust funding allocation formulas and what progress has been made? MBr noted the breadth of the question and suggested that the topic be returned to a future Council of Governors meeting for a fuller discussion. In the meantime, MBr described that the context was difficult and particularly challenging for a small, standalone district general hospital and this was the case across the NHS. Work was being done at a national level to look at the small, rural, district general	**JeH**

	hospital model and DCH was involved in this. MBr described that there was acknowledgement of the problems, but that it was difficult to achieve movement on adjusting the funding formula and would need to continue to be advocated for. When doing this, it was important to place the needs of the local population at the forefront.	
BoDiC26/137	**Any Other Business**	
	DCS noted that this was JoH's last board meeting and extended thanks to her for her contribution to DCH and the Board during her time at the Trust and wished her every luck in her new role at Salisbury NHS Foundation Trust.	
BoDiC26/138	**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 13 October 2026 at Board Room, DHC Headquarters, 2 Nuffield Road, Poole**	
BoDiC26/139	**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	Included in OctoberDHC Learning from Deaths report. Recommend close	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~~ ~~JeH~~ POS	08.12.2026	The Trust has commenced monthly Risk Management Group. The aim of the group is to ensure enhanced operational review of all significant risks by the group on a monthly basis, alongside work reviewing all risks that are over two years of age. With the implementation of a new local risk management system, the group considers that there will be delivery of greater governance and oversight of all risks within the organisation. This alongside enhanced risk training, the new Joint Risk Strategy and forthcoming update risk policy should support in-depth reflective review of risk improving the Trusts delivery plans and strategies and increasing the Trusts risk maturity. Recommend close	Complete
External assessments governance arrangements	BoDiC26/116 / CEO Report – DHC and DCH	11.08.2026	Governance arrangements around external assessments to be reviewed	JeH	13.10.2026	Submissions will be presented via Committees and Board where approval at this level is required. The timing of all external submissions does not always allow for Committee or Board review in advance of submission. Where this is the case we will notify the Committees of external submissions through routine reporting. Recommend close	Complete
Quality strategy Board Development Session	BoDiC26/116 / CEO Report – DHC and DCH	11.08.2026	Quality strategy to be considered in a future Board Development Session	JeH	13.03.2027	Included in Board Development Session schedule	Open - Not yet due
Review of mitigated and unmitigated risk scores	BoDiC26/118 / Corporate Risk Register – DHC	11.08.2026	The difference between mitigated and unmitigated risks scores would be reviewed	CS	08.12.2026	Not yet due	Open - Not yet due
Review of SR5 Estates	BoDiC26/118 / Corporate Risk Register – DHC abd DCG	11.08.2026	SR5 Estates to be reviewed in light of the impact of heatwaves, including whether the target score was realistic and how long it would take to reach the target score.	CH	08.12.2026	Not yet due	Open - Not yet due
Item for COG meeting	BoDiC26/136 / Questions from the Public	11.08.2026	A future COG meeting to consider JPL's question in more detail	JeH	13.10.2026	The question was discussed and answered in the DCH Council of Governors meeting held 21/09/2026. Recommend close	Complete

Actions to other Committees								
Topic	**Minute Reference & Name**	**Date of Meeting**	**Action**	**Lead**	**Deadline**	**Response**	**Status**	**Committee referred to**
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~~ ~~JeH~~ POS	13.10.2026	QCIC received the following update at the 29/09/26 meeting: A ward establishment review was completed with NHS England in September, with the final report pending. Early feedback includes consideration of staff unavailability and workforce deployment, providing additional context to Care Hours Per Patient Day (CHPPD) and productivity measures. Further work is being undertaken to triangulate CHPPD with quality and operational outcomes to demonstrate the impact of workforce investment on patient care. A fuller analysis will be presented in the November Quality Report. Recommend close	Complete	QCiC
Advanced Foundation Trust workstream update	BoDiC26/130 / Strategy, Transformation and Partnership Committee Assurance Report – Joint	11.08.2026	Deatil of the Advanced Foundation Trust workstream to be returned to an informal meeting.	DD	08.12.2026	Not yet due	Open - Not yet due	STPCIC

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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	Deferred to Dec. Work ongoing	X	X		**Annual**				~~X~~	X		Chief Nursing Officer
Nutrition Strategy Update	Assurance	Deferred to Dec. Work ongoing	X	X		**Annual**			~~X~~	~~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~~	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
ODPC assurance report	Assurance	Starting Dec 2026			X	**Bi-monthly**					X	X	Deputy Chief Executive Officer
Audit and Governance													

Public Board of Directors

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 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	Approval	At a meeting of the Charitable Trustees	X	X		Annual				X			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	Scheduled for discussion at November Mental Health Legislation Committee in Common		X		Annual			~~X~~	~~X~~	X		Chief Medical Officer
Approval of Associate Hospital Managers	Approval			X		Annual					X		Chief Medical Officer

Setchell Ryan
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Dorset County Hospital
Dorset HealthCare

Report to	Board of Directors in Common – DHC and DCH	
Date of Meeting	13 October 2026	
Report Title	Chief Executive Officers Report	
Prepared By	Jonquil Williams, Joint Business Manager to the Deputy CEO	
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

- Thirlwall Inquiry
- Martha's Rule
- Unauthorised access to patient records

Federation

- National Oversight Framework Q1 2026/27
- Provider Capability Assessment
- Dorset County Hospital Performance
- Winter Planning
- Stroke services
- Winton Healthcare hub
- Annual Members' Meeting

Recommendation

Members are requested to receive the report for information.

Rachel Ryan
09/10/2026 11:05:42

Chief Executive Officer's Report – October 2026

1. National/regional

1.1 Thirlwall Inquiry - Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018

The Thirlwall Inquiry was established to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital. Full details of the Inquiry can be found at: The Thirlwall Inquiry | Examining the events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital. The Thirlwall Inquiry Report was published on 15 September 2026 and on 21 September 2026 NHS England wrote to all Trusts making it clear that: *This is not just a matter for Trusts with neonatal services. It is a matter for every single Trust and ICB Board to consider, and for every member of staff across the NHS.* The letter is located at: NHS England » Thirlwall Inquiry report and recommendations

As a board we recognise that the publication of the Thirlwall Inquiry report must be a moment of great reflection and learning, which should lead to action in every trust across the country, including our own. It sets out a series of failures and missed opportunities, including of board leadership, that contributed to a set of tragic events.

At a national level, in response, on Tuesday 22 September, the Secretary of State delivered a statement in Parliament that committed to commencing a series of actions recommended in the final report:

Specifically:

- *Urgently work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Taking learning from places where this is already used, a national approach will be developed to support neonatal units to implement this.*
- *Go further on new guidance on the safe use and storage of insulin and strengthened guidance for medical examiners reviewing neonatal death.*
- *Undertake a review of Working Together to Safeguard Children (April 2026) and safeguarding training nationally.*
- *Work through plans to regulate NHS managers through a barring scheme for senior leaders who fail in their responsibilities.*
- *Continue rollout of the National Bereavement Care Pathway for families experiencing neonatal loss.*

The letter outlined actions that Trusts should immediately progress a series of actions in response to the Inquiry's findings. In addition, trusts are reminded that the Insightful provider board guide is intended to help boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

Setchell Ryan
09/10/2026 11:05:42

Due to the importance of the inquiry and its findings we have a standalone agenda item as part of the board meeting today, but recognise this is the beginning of a process of more detailed and considered reflection, and we will also create time in future board meetings and development sessions to ensure we do this fully, and in a way that continues to revisit the learning and the themes of the inquiry.

1.2 Implementation of Martha's Rule in emergency departments

On 21 September 2026, we received a letter from NHSE regarding the implementation of Martha's Rule in Emergency Departments (ED).
Every trust is now encouraged to begin implementation of Martha's Rule into ED services by:

- building on existing local escalation processes and governance structures
- aligning with existing outreach or equivalent escalation processes, including those supporting delivery of Martha's Rule in adult and/or paediatric inpatient settings across the organisation
- working across multidisciplinary teams to test and adapt approaches that support local context while maintaining the Martha's Rule core standards

Implementation is expected to be completed by the end of March 2028.
For EDs, implementation includes the following: adults and paediatrics, majors (including 'chairs'), resus, reception and waiting rooms, and temporary escalation spaces (TES) including corridors. While Martha's Rule may offer value in other settings, such as same day emergency care facilities (SDECs), urgent treatment centres (UTCs) and minor injury units (MIUs), these are currently out of scope.

DCH became a Phase 1 pilot in mid-2024 for Martha's Rule, with components two and three fully running in all adult inpatient areas, Paediatrics and Maternity since Dec 2024. Our service is called 'Call for Concern' and we receive between 6-14 calls per month, the majority of which are not in scope, i.e. not a true deterioration and largely relate to concerns with communication, treatment and care. We have developed successful pathways across various specialities, which have been celebrated and shared at regional and national groups.

Component one, Patient Wellness Question (PWQ), has proved more challenging. However, we have substantially rolled out a paper PWQ assessment across all adult inpatient areas.
An update on Martha's Rule is reported to each Deteriorating Patient Group which is then reported to the Patient Safety Committee and then to Quality committee via our routine reporting.

1.3 Unauthorised access to patient records

Over recent months there have been a number of high-profile incidents across the NHS involving staff accessing confidential patient information without a legitimate reason. Such actions are wholly unacceptable. Patients entrust us with some of their most personal and sensitive information, and any unauthorised access represents a serious breach of that trust, as well as our legal and professional obligations to protect confidentiality. Sir Jim Mackey, Chief Executive of NHS England, recently wrote to all NHS organisations reinforcing a zero-tolerance approach, making clear that unauthorised, inappropriate or unjustifiable access to patient information is unlawful, damages public confidence and should, in almost all circumstances, be regarded as gross misconduct.

Attached 09/01/2026 11:05:42

Where concerns have arisen we have acted decisively, including dismissal where warranted. The position set out by NHS England is therefore consistent with the approach already taken within our organisations.

In response to the recent national communications, our Chief Nursing Officers have written to all staff reiterating their responsibilities and our zero-tolerance approach. A professional cascade has also been undertaken through our Chief Medical Officers to reinforce these expectations with medical colleagues. Recognising that these requirements apply to all staff, not just registered professionals, we will also be launching a wider communications campaign alongside our ongoing information governance programme.

To provide further assurance, the Chief Digital Information Officer and SIRO is leading a programme of work across both Trusts to review and strengthen our arrangements. This includes reviewing training and induction, ensuring our new integrated electronic healthcare record supports robust audit and monitoring processes, and proactive audits of access to records are undertaken. Protecting patient confidentiality is fundamental to maintaining public trust in our services. We will continue to take the strongest possible action where inappropriate access is identified and ensure that our systems, controls and culture support the highest standards of information governance.

The letter to all NHS Trusts can be found here: NHS England » Unauthorised, inappropriate and unjustifiable access to confidential patient information

2. Federation

2.1 National Oversight Framework

The National Oversight Framework (NOF) for Quarter 1 April – June 2026 segmentation and league table performance was published in September 2026.

This is the first set of published performance metrics for 2026/2027. There are several new and some revised metrics. This was agreed following NHSE led consultation and working groups to review and agree the performance metrics.

Dorset County Hospital
In there were 23 scoring metrics for DCH, this has now increased to 35 in 2026/2027, several of the remaining metrics have also been revised to match existing national reporting/datasets such as operational planning.

At Q1 2026/27 (April – June) the trust has remained in segment 3 (no change from Q4 25/26) and is ranked joint 107/134 trusts, which is a decline from Q4's position (86/134), in addition the average metric score decreased from 2.44 in Q4 to 2.72 in Q1.

Dorset HealthCare
In 2025/26 there were 13 scoring metrics for DHC, which has increased to 29 for 2026/27, several of the remaining metrics have also been revised to match existing national reporting/datasets such as operational planning.

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In early September 2026, the NOF National Programme lead confirmed that the NHS talking therapies recovery rate for trusts has been changed to a contextual rather than scoring metric due to concerns raised about comparability, therefore this is no longer a NOF metric for DHC but remains a metric in operational planning.

At Q1 2026/27 (April – June) the trust has remained in segment 2 (no change from Q4 25/26) and is ranked joint 32/58 trusts, which is a decline from Q4's position (24/61), in addition the average metric score decreased from 2.21 in Q4 to 2.31 in Q1, however this is based on an increased number of metrics across performance, finance, workforce and quality metrics, some of which are new and not previously reported on.

As a board we are always aware that when we discuss performance what this really means is patient experience – and each number we discuss represents a patient or family experience. We are very focused on these areas of performance, and taking steps to improve, and this will be discussed in our board meeting today as we review the performance position for each trust.

2.2 Dorset County Hospital performance

Following receipt of the letter from NHSE on 26 June that raised concerns about levels of performance through quarter one, the team at DCH have developed recovery plans for our Urgent and Emergency, Referral to Treat and Cancer Pathways which were signed off by the Board on 08 September 2026. We presented these to the NHSE Regional Team on 02 October 2026. The regional team were supportive of the work that has gone into creating the plans and the actions outlined, though these actions now clearly need to be delivered and improvements in performance sustained and achieved across all areas. and they will recommend an outcome to the national team. I want to thank the hard work of the team at DCH at developing these plans.

2.3 Provider Capability Assessment

Dorset County Hospital is required to submit a Provider Capability Assessment as per the guidance issued on 26 July 2026. This will be the second submission for the Trust. Dorset HealthCare is exempt from the 2026 self-assessment as it has recently been through the Advanced Foundation Trust (AFT) process.

The focus is on provider boards' awareness of the challenges facing their organisations, and what is needed to address them. It is intended to promote board self-awareness as well as transparency with oversight teams, providing a framework for NHSE engagement with providers. For Dorset County Hospital a robust and consistent process for the self-assessment has been followed to develop the overall conclusions, aligned with the approach used in 2025/26, leading to Board approval of the self-assessment on 30 September 2026.

The approved self-assessment ratings are included in the table below. This has been submitted to NHS England who will now triangulate this with their view and other sources of information and arrive at an overall Trust rating.

Domain	2026 - Proposed Domain Rating
Strategy, Leadership and Planning	Green
Quality of Care	Green

Domain	2026 - Proposed Domain Rating
People and Culture	Green
Access and Delivery of Service	Amber-Green
Productivity and Value for Money	Amber-Green
Financial Performance and Oversight	Amber-Green

2.4 Winter Planning

A letter outlining the expectations and assurance requirements for NHSE Winter Planning 2026/27 was sent to all NHS Trusts 17 July 26. The letter outlined that winter plans should be completed by the end of August (developed jointly by all local partners), in readiness for testing via the System wide winter readiness exercise 16 September and signed off by Trust Boards using the Board Assurance Statements (BAS) to NHSE by 30 September 26.

The proposed Winter Plans for DCH and DHC were discussed at the Board in Common on 8 September 2026. However they could not be approved as they were still subject to the NHSE regional assurance testing exercise to be held on 16 September 2026. Final approval was therefore delegated to the Finance and Performance Committee, which met on 30 September 2026 and approved the plans for submission to NHSE on the same day.

There were no changes to the plans or assessment ratings between the stages of review described above and the conclusions of the Self-Assessment Board Assurance Rating were an overall assessment of '5 – Full Assurance' for both Trusts.

The ICB Cluster Winter Plan 2026/27 has been included in the reading room for information.

2.5 Stroke Services at Dorset County Hospital

Our new stroke service designed to help patients access specialist emergency hyperacute stroke care more quickly, 24 hours a day, seven days a week, across Dorset and Somerset is now live.

The new service launched on Wednesday 9 September, following significant work by NHS partners across Somerset and Dorset to develop, test and prepare for the new services to open for patients.

Investment has been made in workforce, facilities and clinical pathways, including refurbishment of our stroke unit at DCH, recruitment of additional nursing and medical staff, development of a new standard operating procedure and simulation testing to support implementation.

This is a significant step forward for our local population and for the stroke service at DCH – and I want to give a huge thank you to all colleagues involved who have worked so hard to get to this point. We will now monitor patient outcomes and experience closely to ensure that the benefits planned are delivered and that we continue to learn and improve the service going forward.

2.6 Winton Neighbourhood Health Centre

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We are really pleased to be partners in a new health centre in Bournemouth that has officially opened, bringing new and up to date healthcare facilities into the heart of the Winton community. Thanks to a £1.9 million NHS investment, Banks and Bearwood Medical Practice, Dorset HealthCare and NHS Dorset have worked together with other partners to transform the

Bournemouth, Christchurch and Poole (BCP) Council-owned building on Alma Road into a new Neighbourhood Health Centre.

The building is the former Winton Health Centre, which has been unused since July 2023 following its closure. It will now be home to Banks and Bearwood GP practice and a range of community health services run by Dorset HealthCare, including:

- paediatric services
- children's speech and language therapy
- podiatry
- leg ulcer clinics
- community oncology
- heart failure clinics
- health visiting, school nursing and district nursing
- NHS talking therapies for mental health.

This is a real step forward in terms of co-location of local neighbourhood services and is a visible sign of our commitment to transform community care in line with our trust strategy and the national move to a “left shift” towards stronger neighbourhood based care. It sits alongside the Neighbourhood and Wellbeing programme which we are co-leading with the Dorset GP Alliance, and is working with partners, including UHD, local GPs our two local authorities, and representatives of the VCSE to design and implement a new model of local neighbourhood care.

2.7 Annual Members Meeting

On Tuesday 29 and Wednesday 30 September, Dorset County Hospital and Dorset Healthcare held their Annual members meetings. Both meetings were well attended by our staff and members and were a fantastic opportunity to share the great achievements from both trusts. We had a presentation from our Stroke team at DCH following the change of service in Somerset and we were able to celebrate the early success we have seen and at DHC we had a presentation from our Children and Young people mental health team which championed incredible system working and co-production in Dorset to ensure the best outcomes for our Children and Young people in Dorset.

I want to thank those who attended and those who represented the trusts at each meeting.

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Dorset County Hospital
Dorset HealthCare

Quality Committee in Common Assurance Report for the meetings held on Tuesday 29 September 2026

Chair	Eiri Jones, Non-Executive Director
Executive Lead	Cara Southgate, Interim Chief Nursing Officer (DHC) Pam O'Shea, Interim Chief Nursing Officer (DCH) 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	A number of recurring themes were identified throughout the meeting: • Training – the ability for people to be released to attend or access to specific training. • Welfare of staff in order to be able to deliver high-quality care • Limited BI and digital capacity to support with a number of matters covered in the meeting • Positively, reports continued to evidence the quality care provided to patients • For DHC positive CQC outcomes, including 'Good' ratings for Blandford and Wimborne MIUs and Learning Disability Services, with several areas rated Outstanding.
Key issues / matters discussed at the meeting	**Executive Triumvirate Current and Emerging Issues** (DHC/DCH) DHC: • The Trust had been notified of a serious incident involving a patient known to the Trust. The Committee was assured that the Trust was working with the necessary authorities in relation to this. • Three wards remained in safer staffing measures: St Brelades, Radipole, and Waterstone. Newly registered staff were expected to join the wards soon; staffing pressures would remain while those staff were onboarded but would improve soon. • Twynham ward remains under enhanced surveillance by the provider collaborative. A recent visit was broadly positive, with some actions identified. • Positively, Tarrant ward attended the GSF awards where they received the gold standard for end-of-life care and platinum accreditation. • 12 International Medical Graduates (IMG) had arrived and started working at the Trust. Reductions in agency spend has already been seen.

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- Work was beginning on the OPMH transformation programme, with good engagement from clinical teams anticipated. Additionally, LK and CS were working to improve the governance of Quality Committee sub-groups, with a focus on embedding effectiveness, horizon scanning, and new treatments.

DCH:

- Verbal update on the job planning audit which would be presented to the next Audit Committee. The report had recently been published and identified limited assurance. There were a number of quality aspects for Quality Committee's attention, and Joint Executive meetings had discussed the resource gap with a plan to establish a programme of work to improve the position.
- Operational pressures increasing, Escalation areas may need to be used; if this does happen, daily walkarounds of those areas would be enacted.
- Reducing temporary continued to be a focus and NHS England had undertaken an establishment review at the Trust. High-level feedback identified healthcare support worker recruitment and retention and unavailability of staff as having an impact on quality of care.
- There were several high-profile inquests ongoing this month. Any learning identified would be acted upon and reported to committee as appropriate.
- Commendations to Purbeck Ward and DHC colleagues for their collaborative working to support the discharge of a patient with a particularly long stay in the hospital.

Progress Report: Joint Strategy Enabling Plan – Clinical and Quality Plan (Joint) updating on the key priority programmes. Key developments included the transition of the Future Care Programme into business as usual, continued progress with the mental health crisis pathway, Single Electronic Health Record, neighbourhood teams, and strengthened co-production through a new engagement group focused on increasing representation from seldom-heard communities.

Members welcomed progress but requested future reports provide stronger evidence of impact on patient outcomes, experience and quality of care, including relevant outcome measures and quality indicators to support assurance.

Quality Reports (including PSIRP Progress and Quality Governance Group Assurance Reports) (DHC/DCH) updating on core quality metrics for each Trust. Of note

DHC:

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- An increase in bloodstream infections was reviewed, with catheter management identified as a key theme and improvement work underway.
- Complaints remained stable, with communication and documentation continuing as the main areas for learning.
- An increase in AI-generated complaints was creating additional complexities to the complaints process, and a pilot approach is being developed to address this.
- Pressure ulcer cases were reviewed, with most acquired prior to admission and ongoing work underway to strengthen reporting and learning.
- Positive CQC outcomes, including 'Good' ratings for Blandford and Wimborne MIUs and Learning Disability Services, with several areas rated Outstanding.
- Workforce pressures were discussed, with assurance provided that there is no significant impact on Mental Health/Community pressures impacting on DCH patient flow.

DCH:

- Infection prevention and control performance remained strong, with low MRSA rates, improved Gram-negative bloodstream infection performance and no outbreaks reported during the quarter.
- Continued improvement in pressure ulcer performance was noted, supported by the rollout of specialist mattresses, although completion of the programme remains dependent on available funding.
- No safe staffing red flags were reported.
- Progress with Martha's Rule implementation was noted, although rollout remains slower than planned due to IT-related challenges.
- An increase in complaints relating to AI-generated correspondence and requests regarding access to patient records was highlighted, with appropriate monitoring and staff awareness measures in place.
- A reduction in mixed-sex accommodation breaches
- Obstetrics and Gynaecology Team have been highly commended for overall performance, professional development and obstetrics and gynaecology training.
- The Committee discussed risks relating to workforce capacity, audit completion, and training compliance, seeking assurance that these are being actively managed and that the impact on quality and patient safety continues to be monitored. Training capacity and staff access to mandatory training were identified as areas for ongoing oversight.
- Assurance was provided regarding the end of life care provision, which was no longer available on weekends. The committee noted the importance of care planning prior to the end of the week, and that end of life care was part of training for all clinicians.

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Safeguarding Children and Adults Annual Report (DHC/DCH)

DHC:

- Safeguarding arrangements remain effective and compliant with statutory requirements. Strong multi-agency engagement continues across safeguarding adults and children process.
- Key achievements included strengthened safeguarding support for community services, enhanced Mental Capacity Act practice, progress in implementing sexual safety standards, and continued development of training focused on domestic abuse, self-neglect and safeguarding practice.
- Priorities for 2026/27 include improving safeguarding and Prevent training compliance, further embedding Mental Capacity Act practice, extending sexual safety standards across all care settings, strengthening responses to domestic abuse and exploitation, and ensuring learning from safeguarding reviews is embedded across services. The Committee noted the report and received assurance regarding the effectiveness of safeguarding arrangements.

DCH:

- Safeguarding arrangements remain effective, with strong multi-agency working and positive progress in workforce capability, including safeguarding training and support for vulnerable groups. Increasing safeguarding demand and case complexity, particularly relating to mental health, abuse, exploitation and Deprivation of Liberty Safeguards, was noted.
- Key areas for improvement include safeguarding training compliance and digital solutions to strengthen child protection information sharing and recording. Members highlighted the importance of maintaining staff resilience, raising organisational awareness of safeguarding responsibilities, and ensuring safeguarding considerations are embedded across all aspects of quality and patient safety. Overall, the Committee received strong assurance regarding safeguarding performance and governance.

National Patient Experience Survey Results (DHC/DCH)

DHC:

Mental Health Survey:

- Results demonstrated performance broadly in line with comparator organisations, with no significant areas of concern identified. Positive improvement was noted in older people's mental health services.
- Areas for further focus included service users' experience of accessing crisis care, support for wider wellbeing needs such as physical health, social connection and financial wellbeing, and ensuring equitable experiences for younger people, autistic people, disabled people and those accessing care primarily by telephone.

DCH:

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Cancer Survey:

- Results were above the expected range across most domains and demonstrated continued positive patient experience.
- Areas for improvement included communication with primary care following discharge and patients' awareness that family members or carers could attend appointments with them. Further work is underway to understand and address these findings.
- A refreshed Cancer Board is strengthening oversight of quality, patient experience and survey learning.

National Inpatient Survey:

- Results showed the Trust performing above the national average and ranked within the top 20% of participating organisations. Strengths included patient feedback relating to kindness, compassion, dignity and respect.
- Areas identified for improvement included admission and discharge processes and patients' experience of noise at night. Divisions are developing action plans to address survey findings, with progress to be monitored the Quality Governance Group.
- Members welcomed the positive results and emphasised the importance of sharing learning across services while maintaining focus on continuous improvement.

Learning from Deaths Report (Q1) (DHC/DCH)

DHC:

- 29 unexpected deaths were reported during Quarter 1, including one inpatient death following a choking incident. A Patient Safety Incident investigation and wider thematic review of choking incidents are underway to inform organisational learning.
- Thirty-five inquests were held during the period, with no Prevention of Future Deaths notices received. Learning from reviews and inquests continues to reinforce the importance of physical health monitoring, particularly within mental health services.
- LeDeR reviews had still not resumed, but internal trust processes reviewed deaths, with no systemic or clinical failings identified. The Committee noted ongoing work to strengthen learning processes and welcomed evidence that findings continue to support and reinforce good practice across the organisation.

DCH:

- Summary Hospital-level Mortality Indicator (SHMI) remains within expected ranges, with no significant concerns identified. Learning from Structured Judgement Reviews (SJRs) continues to highlight themes relating to escalation of care and communication, informing improvement work including implementation of a new Dorset Treatment Escalation Plan and standardisation of mortality and morbidity reviews.

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- Risks relating to clinical coding and delays in review completion within one division, both of which are being closely monitored. Members were assured that processes for identifying and learning from mortality themes continue to be strengthened, with additional oversight and speciality-level assurance arrangements being developed.

For both trusts the incoming risk management system (Healthcare Guardian) would include a mortality module which will include Learning from Deaths. Improvements and alignments in process were expected.

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

- Updated report structure in line with national recommendations
- Maternity outcomes remain stable, with no Maternity Outcomes Signal System (MOSS) alerts received and successful testing of escalation arrangements through a recent simulation exercise. Positive developments included improved recruitment, progress towards achieving Birthrate Plus staffing requirements, sustained reduction in third- and fourth-degree tears, improved complaint response times and active delivery of the 10-point plan following the Ockenden/Amos recommendations.
- It was confirmed that the 10-point plan was submitted as required the by 22nd September deadline.
- Training compliance has improved and the Maternity Incentive Scheme (MIS) remains a key area of focus, although associated risks continue to be closely monitored.
- Ongoing concerns relating to maternity staffing (which was a potential barrier to achieving MIS compliance), access to second theatre and completion of the formal evacuation plan, all of which remain on the risk register.
- Training compliance was highlighted as a wider organisational theme requiring ongoing Board oversight.

Policy Status Report (DHC/DCH) Bi-annual update on the policies in the scope of the committee. 15 overdue policies for DHC; with some being >12 months overdue and needed attention. Four overdue policies for DCH Verbal updates on the progress of those policies. Discussions around the long-overdue policies, with concerns about the quality impact of out-of-date policies. Healthcare Guardian would include a policy module which will support with managing policies in the longer term.

Walkarounds Output Report (DCH) noting that much feedback is about practical solutions, but it would be helpful to hear more patient solutions. Consideration was being given to how to engage patients in the walkarounds and get their feedback.

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Seasonal Surge (Winter) Plan – Quality Aspects (DHC/DCH) presented to the committee to consider the quality implications ahead of formal sign-off at Finance and Performance Committee in Common.

DHC: Plan was developed in line with requirements, ahead of a readiness exercise on 16th September. There was no additional resourcing associated with the plan and no negative quality impacts identified by the equality quality impact assessment.

DCH: Focus is on reducing overcrowding in ED, eliminating corridor care, and improving inpatient vaccination. A Winter Assurance Group would meet weekly to monitors data and gather soft intelligence throughout the winter period. The plan was build around reducing risk as much as possible; it was not without risk but teams would proactively respond to any risks.

Committee was assured that the impact on quality has been considered Updates would be provided to committee throughout winter, and a retrospective review of the plans would happen in spring.

Joint Heath Inequalities Plan Update (Joint) The Committee received assurance that governance arrangements and reporting processes for health inequalities continue to develop. Progress has been made in establishing dashboards and adopting a Core20PLUS5 approach, although data quality and BI capacity remain key challenges.

Members noted that future reporting should focus on identifying specific local health inequalities and demonstrating the impact of actions taken to reduce inequalities in access, experience and outcomes. Continued alignment with system-wide health inequalities work was also highlighted.

Patient Carer Race Equality Framework (PCREF) (DHC) noting strong governance and process in place, with work on track for quarter one milestones. Concerns remained regarding BI capacity for data quality and reporting, particularly in relation to recording ethnicity data.

Antimicrobial Resistance (AMR) Update (DHC/DCH)
DHC has joined the national Point Prevalence Survey, supporting AMR benchmarking and learning across providers, and progress has been made with implementation of national antimicrobial stewardship priorities.
There were plans to enhance antimicrobial monitoring through electronic prescribing systems, although delivery may be impacted by digital workforce pressures associated with the HealthSet programme.
A key risk remains workforce and digital capacity to sustain and develop AMR initiatives as antimicrobial use increases across community and hospital-at-home services.

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DCH: Members noted new national targets requiring a reduction in overall antibiotic use and an increase in prescribing from the 'Access' group of narrow-spectrum antibiotics. Work is underway to align prescribing practices and deliver improvements against these targets. Progress was also noted on initiatives to reduce inappropriate urine dipstick use and improve the timely switch from intravenous to oral antibiotics. The Committee was assured that there is clear oversight of the programme, with improvement work underway to support delivery of national expectations.

The Committee received a briefing on emerging **SEND reforms** and their implications for health and care services. Dorset HealthCare is working with Dorset and BCP Councils to support local implementation, including the development of integrated pathways and expert support models. Potential impacts on neurodevelopmental services, particularly ADHD and autism pathways, were noted. The Committee agreed that any future service, commissioning or quality implications should be brought back through the appropriate governance routes for assurance.

Provider Capability Assessment – Quality of Care (DCH) The assessment covered six domains, each of which was assigned to a committee; for this committee the domain was "Quality of Care". The self-assessment asks trusts to consider whether they are capable of managing it's challenges in relation to each domain. The proposed rating from the review process for "Quality of Care" is 'green'. The committee discussed the extent to which the trust could rate itself green given elective performance, but it was agreed that on balance it could do. The committee recommended the outcome to the DCH board for approval.

Decisions made at the meeting

- Recommendation to Board to approve the DCH Provider Capability Assessment (Quality of Care) submission

Issues / actions referred to other committees / groups

- Nil

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	Y			
Eiri Jones	Y	Y	Y	Y			
Claire Lehman	Y	Y	Y	A			
Suresh Ariaratnam (to Aug 2026)	Y	n/a	Y				

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Dawn Dawson (to Aug 2026)	A	A	A				
Louise Dickinson (from Aug 2026)				Y			
Jo Howarth (to Sept 2026)	n/a	n/a	Y	A			
Lucy Knight	Y	n/a	Y	Y			
Pam O'Shea (from Sept 2026)				Y			
Stuart Parsons	Y	Y	Y	Y			
Alex Priest (from Aug 2026)				Y			
Rachel Small	A	n/a	A	A			
Cara Southgate	n/a	n/a	Y	Y			
Anita Thomas	Y	A	Y	Y			
Rachel Wharton	Y	Y	A	Y			

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Report to	Board in Common (DHC)	
Date of Meeting	13th October 2026	
Report Title	Learning from Deaths Report – Quarter 1 2026-27	
Prepared By	Ellie Lindop, Deputy Director of Nursing, Therapies and Quality	
Approved by Accountable Executive	Lucy Knight, Chief Medical Officer	
Previously Considered By	Mortality Governance Group, 25th August 2026 Quality Governance Group 7th September 2026 Quality Committee in Common, 29th September 2026	
Action Required	**Approval**	No
	Assurance	Yes
	Information	No

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

Executive Summary

The following report provides the Trust Quarter 1 update relating to compliance with the National Quality Board Framework (2017) and the Patient Safety Incident Response Framework (2022).
In summary:

- A total of 29 unexpected deaths were reported (of which one was an inpatient death). Of these, 25 were in the Mental Health, Learning Disabilities, and Children & Family Services Directorate and four within the Integrated Community Services Directorate.
- A total of 35 inquests were listed by the Coroner in relation to the Trust, and no Regulation 28 report's were received.
- There were no Learning and Disability deaths reviewed under the LeDeR process. The Learning Disability Service continued to complete internal reviews of all deaths.
- In total, 30 expected deaths were reported, 29 of which were in the Integrated Community Services (ICS).

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

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Recommendation

Receive the report for **assurance.**

LEARNING FROM DEATHS REPORT (QUARTER 1 2026-27)

1.0 INTRODUCTION

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

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

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

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

2.0 SUMMARY TRUST REVIEW PROCESS

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

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

3.0 OVERVIEW OF UNEXPECTED DEATHS REPORTED

3.1 In Q1 2026-27, a total of 29 trust wide unexpected deaths were recorded on the Trust's incident reporting system, comprising one inpatient death and 28 community deaths. This metric continues to report around the long-term average (10.0), indicating no significant change.

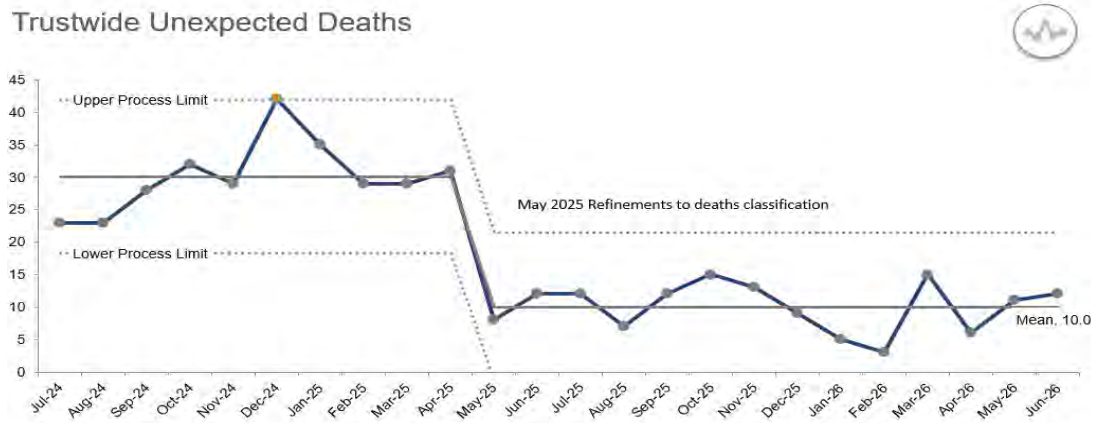

Figure 1 Trustwide Unexpected Deaths

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3.2 Of the 29 deaths reported, 25 occurred within the Mental Health, Learning Disabilities, and Children & Family Services Directorate and four within the Integrated Community Services Directorate. The distribution is illustrated in **Figure 2**.

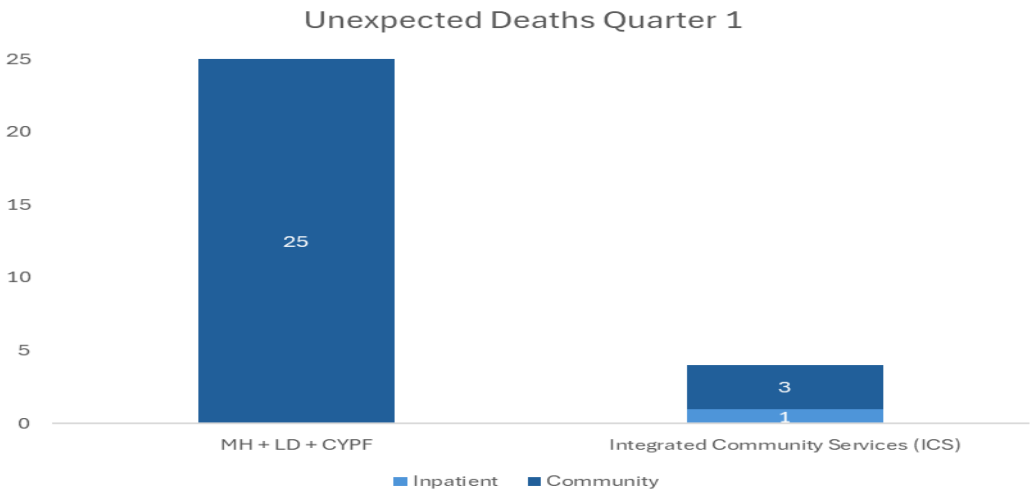

Figure 2 Unexpected Deaths by Service Setting

3.3 One unexpected inpatient death was reported within the Integrated Community Services Directorate.

3.4 Of the 28 deaths reported in the community, 25 were within the Mental Health, Learning Disabilities, and Children & Family Services Directorate and three within the ICS Directorate. This metric indicates natural (common cause) variation; see figure 3.

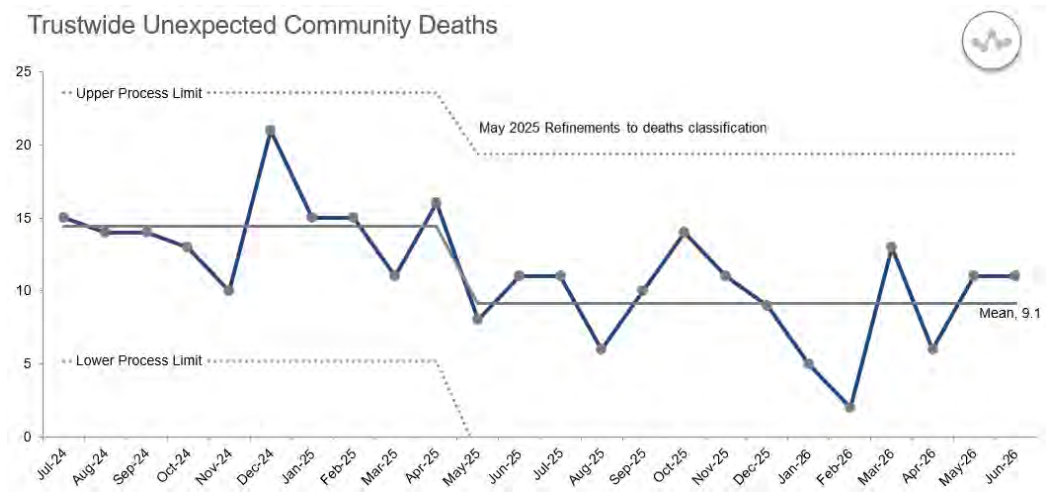

Figure 3 Trustwide Unexpected Community Deaths

3.5 Analysis of the number of unexpected community and inpatient deaths by directorate shows natural (common cause) variation, with no evidence of significant change.

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

4.1. In Q1 Dorset Health Care received No Regulation 28 reports.

4.2. In Q1 a total of 35 inquests were listed.

- Six were Pre Inquest Review Hearings (PIRH).
- Six were documentary Inquests (a documentary inquest (or "inquest in writing") is a UK coroner's process for investigating deaths that relies only on written evidence, without witnesses attending court)
- One inquests was adjourned until 2027
- Six inquests required no Dorset HealthCare witnesses to attend and were held as a documentary inquest.
- This left 16 inquests that concluded within the quarter.

Of these 16 inquests, one inquest was heard in the presence of a jury. The remaining 15 were heard in front of a coroner solely.
Two of the 16 inquests lasted for more than five days and of the remaining 14, three lasted for two days and 11 for one day.
The outcomes of the 16 concluded inquests were as follows:

- None returned an open conclusion,
- Two concluded natural causes,
- Six had a conclusion of suicide,
- Two recorded a conclusion of a drug-related death,
- Six returned a narrative conclusion.

4.3. The following learning is noted: -

- Mental health continuity and interagency coordination and the need for physical health monitoring and tracking in a mental health setting. It was felt that such monitoring helps rule out underlying organic causes of psychiatric symptoms and manages the metabolic side effects of psychiatric medications.
- The need for improved communication between sectors, such as HMP Winchester, community mental health teams, GPs, and NHS 111, to ensure continuity of care and medication upon release was highlighted.
- Specific learning was to also ensure Police and Healthcare Liaison is embedded along with the Right Care Right Person approach.

5.0. PSIRF Learning

5.1. This section of the report brings together organisational learning from reviews of the unexpected deaths occurring during the latter part of Quarter 4 25/26 (this was not available at the time of previous reporting) and the early part of Quarter 1 26/27, aligned with PSIRF and Learning from Deaths requirements. While the majority of deaths were assessed as non-preventable/ avoidable and care was generally deemed appropriate, where learning was identified this was on a local level and did not involve any systematic failures that caused or contributed to deaths during this time period.

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5.2. Overall findings across all periods reviewed, no cases demonstrated evidence of clinical failings. Though some local learning was identified, the overall picture is positive, particularly with regards to communication, collaborative working, and recording and access of information.

5.3. **Quarter 4 (March 2026): Key Themes**
Death reviewed in March 2026 predominantly involved individuals with complex health and social needs, that solely occurred in community settings. While baseline standards of care were largely met, there was a single case where care planning was not reviewed, however this was an isolated case and not representative of wider system learning.

Quarter 1 (April 2026): Key Themes cases involved multifactorial deaths including medical cause deaths of combined toxicity, completed suicide, however, the majority are unascertained, pending inquest. Themes from learning highlight a period of transition with new a consultant, that impacted on communication. There were also themes of sustained substance abuse along with reduced engagement from service users. However, there were no concerns regarding care delivery for this month.

5.4. **Quarter 1 (May 2026): Key Themes**
Themes of medical cause of death throughout May range from hanging, unascertained and physical health related reasons. The majority of learning was positive, showcasing collaborative working, communication and information sharing between services, both internally and externally. It is also noted that that for a particular service user, interventions provided by the team vastly improved the person's quality of life prior to their passing. It was also noted the clinical documentation was accessible by all services.

5.5. **Cross-Cutting Learning and System Implications:**
Across all periods reviewed, consistent themes emerged which highlight strengths in service delivery, while also identifying areas for continued focus and improvement:

- The overall standard of care was assessed as appropriate, with no evidence of clinical failings or systemic factors that caused or contributed to deaths reviewed during this period.
- Effective communication, collaborative working, and information sharing between services were recurring strengths, supporting coordinated care across organisational boundaries.
- Accessible and comprehensive clinical documentation enabled continuity of care and supported informed decision-making across multidisciplinary teams.
- Positive examples of person-centred interventions demonstrated the value of proactive engagement and ongoing support in improving quality of life, particularly for individuals with complex health and social care needs.
- Reduced engagement from some service users and the impact of long-term substance misuse continued to present challenges to care delivery, highlighting the importance of persistent outreach, risk monitoring, and multi-agency collaboration.
- Service transitions and changes in clinical leadership can create communication challenges; however, learning identified the importance of maintaining robust handover arrangements and clear information sharing processes to minimise disruption to care.
- Learning identified during this period was isolated to individual cases and did not indicate recurrent themes requiring organisation-wide corrective action.
- The predominance of positive findings across reviews provides assurance regarding the effectiveness of existing governance processes, multidisciplinary working, and the delivery of safe and responsive care.

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Overall, the findings from this reporting period indicate a positive picture of care delivery, with learning primarily focused on reinforcing existing good practice rather than addressing systemic concerns.

5.6. In summary, overall, reviews of unexpected deaths between March and May 2026 identified no evidence of clinical failings or systemic issues that caused or contributed to death. The findings provide assurance regarding the quality of care delivered, with strengths consistently demonstrated in communication, multidisciplinary working, information sharing, and clinical documentation. Where learning was identified, this was limited to individual circumstances, including considerations around care plan review, service transitions, substance misuse, and service user engagement. The overall picture is one of safe and effective care, with learning focused on reinforcing existing good practice and maintaining high standards across services.

6.0. LEARNING DISABILITY DEATHS (LeDeR)

6.1. In Q1, no LeDeR reviews were completed for people with a learning disability known to Dorset Healthcare at the time of their passing.

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

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

- Full involvement of family and care team in DNAR and End of Life decisions.
- Familiar carers remaining in place throughout hospital admission reduces distress and enables the persons specific needs to be accommodated.
- Rapid liaison between community staff enabled prompt removal of patient equipment after a patient’s death in line with the family’s request for such.
- Community team making follow-up calls to family over several weeks to ensure their wellbeing following death of a loved one.

6.4. Learning identified included:

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

7.0. END OF LIFE CARE (Expected Deaths)

7.1. In total, 30 expected deaths were reported. Twenty-nine occurred within the Integrated Community Services (ICS) Directorate and one occurred within the Mental Health, Learning Disabilities and Children & Family Services Directorate.

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7.2. Reviews identified a number of examples of good practice and opportunities for continued improvement in end-of-life care delivery.

7.3. Areas of Good Practice Identified

- Consistent use of the Gold Standards Framework (GSF) to recognise patients approaching the end of life and support timely care planning.
- Good medication reviews and symptom management, with evidence of compassionate, person-centred care.
- Positive communication and decision-making with patients and families, including discussions regarding Treatment Escalation Plans (TEPs) and care preferences.
- Many reviews described peaceful and well-supported deaths, with families feeling involved, informed and supported throughout the patient's end of life journey.
- Evidence of staff responding sensitively to individual needs, including supporting faith and spiritual practices where identified.

7.4. Areas identified for continued improvement

- Improve completion of the Last Days of Life Care Plan (LDLCP), particularly Part 1 assessment template.
- Ensure clearer documentation of discussions with patients and families regarding hydration, psychological, social, spiritual and religious needs.
- Strengthen Advance Care Planning (ACP) documentation, including recording patient wishes, preferences and discussions with families where patients lack capacity.
- Improve recording of faith, religious, spiritual and cultural needs to support personalised care and inform after-death care requirements.
- Continue to address delays in discharge and transfer arrangements for patients approaching the end of life, recognising the impact that difficulties accessing community support and care packages can have on achieving a patient's preferred place of care and on their psychological, emotional and spiritual wellbeing.

7.5. Overall, the reviews demonstrated high-quality, compassionate end of life care, with many examples of dignified deaths and excellent support provided to families. Learning was predominantly focused on strengthening documentation, advance care planning and system challenges associated with achieving preferred place of care, with no significant concerns identified regarding the standard of care provided.

8.0. MEDICAL EXAMINER CONTACT

8.1. No feedback was received from the Medical Examiner during Q1.

9.0. SUMMARY

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

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

APPENDIX 1 REVIEW PROCESS

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

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Dorset County Hospital
NHS Foundation Trust

Report to	Board in Common (DCH)	
Date of Meeting	13th October 2026	
Report Title	Learning from Deaths Q1 2026/27	
Prepared By	Dr Adam Nicholls, Interim Deputy Chief Medical Officer	
Approved by Accountable Executive	Dr Rachel Wharton, Chief Medical Officer	
Previously Considered By	Quality Governance Group 16.09.26 Quality Committee in Common 29.09.26	
Action Required	**Approval**	-
	Assurance	Y
	Information	-

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

Executive Summary

Mortality indicators reviewed during Quarter 1 2026/27 continue to provide assurance that there is no evidence of excess or avoidable mortality at Dorset County Hospital. The Trust's Summary Hospital-level Mortality Indicator (SHMI) remains within the expected range, critical care mortality remains as expected, and no deaths reviewed through the Structured Judgement Review process were judged avoidable. Additional assurance has been provided through specialty mortality review processes, including the Perinatal Mortality Review Tool, national audits and Coroner activity.

Learning identified during the quarter centred on communication, documentation and care planning particularly around escalation, and referral for specialist advice. There is a theme around frailty and care of older adults including discharge safety and care transitions. In response, improvement work has focused on implementation of the Dorset Treatment Escalation Plan programme, review of escalation guidance, including nasal high flow therapy, and strengthening mortality governance arrangements. The Hospital Mortality Group will continue to monitor clinical coding resilience, timely completion of mortality reviews and any learning from coronial proceedings with relation to heat wave deaths as key priorities for Quarter 2.

Recommendation

Members are requested to:

- Receive the report for **assurance**

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Learning from Deaths Q1 2026/27

1.1 Mortality Assurance

Table 1. Mortality Assurance Dashboard Q1 2026/27

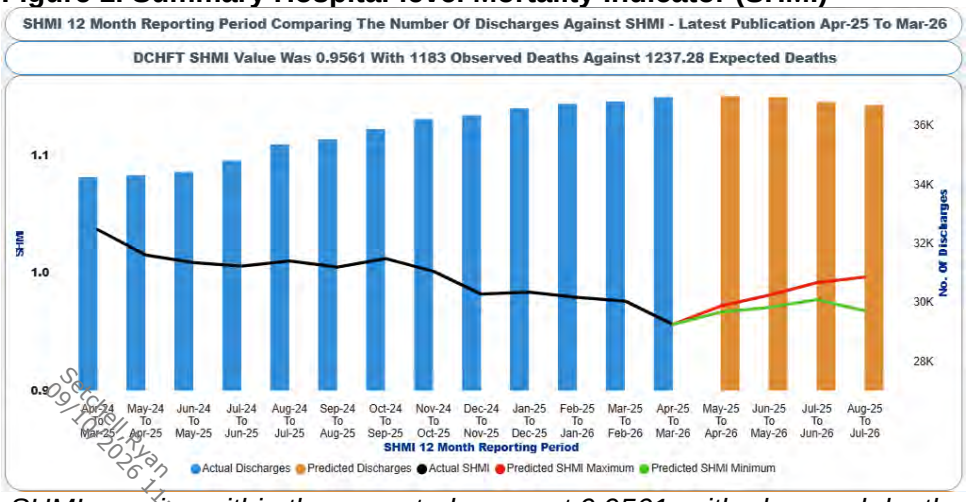
Indicator	Position	Assessment
SHMI	0.9561	Within expected range
ICNARC Risk-Adjusted Mortality	15.7%	Within expected range
National Hip Fracture Database (NHFD) Mortality	6.4%	Within expected limits, improving trend, remains above national average
Structured Judgement Reviews Completed	60 completed	Mortality review programme active
Deaths Judged Avoidable Through SJR	0	Assurance
Regulation 28 Notices	0	Assurance

Mortality review activity undertaken during Quarter 1 continues to provide assurance that there is no evidence of excess or avoidable mortality at Dorset County Hospital.
The Trust's most recent Summary Hospital-level Mortality Indicator (SHMI), covering the period to March 2026, is 0.9561, remaining within the expected range. During the reporting period there were 1,185 observed deaths compared with 1,235 expected deaths, indicating mortality remains below the level predicted for a Trust with a similar case mix.

Alongside Trust-wide mortality indicators, specialist mortality review processes continue to provide additional assurance. During Quarter 1, two perinatal deaths were reported through the Perinatal Mortality Review Tool (PMRT) process. Both families were informed of the review process and offered the opportunity to contribute. Reviews continue to be undertaken in accordance with national PMRT and MBRRACE-UK requirements, with learning overseen through established maternity governance arrangements. No themes requiring escalation through the Learning from Deaths process were identified during Quarter 1. No learning has been escalated from child death outcome panels.

The most recent Intensive Care National Audit and Research Centre (ICNARC) data demonstrates a risk-adjusted mortality rate of 15.7%, which remains within the expected range.

Figure 1. Summary Hospital-level Mortality Indicator (SHMI)



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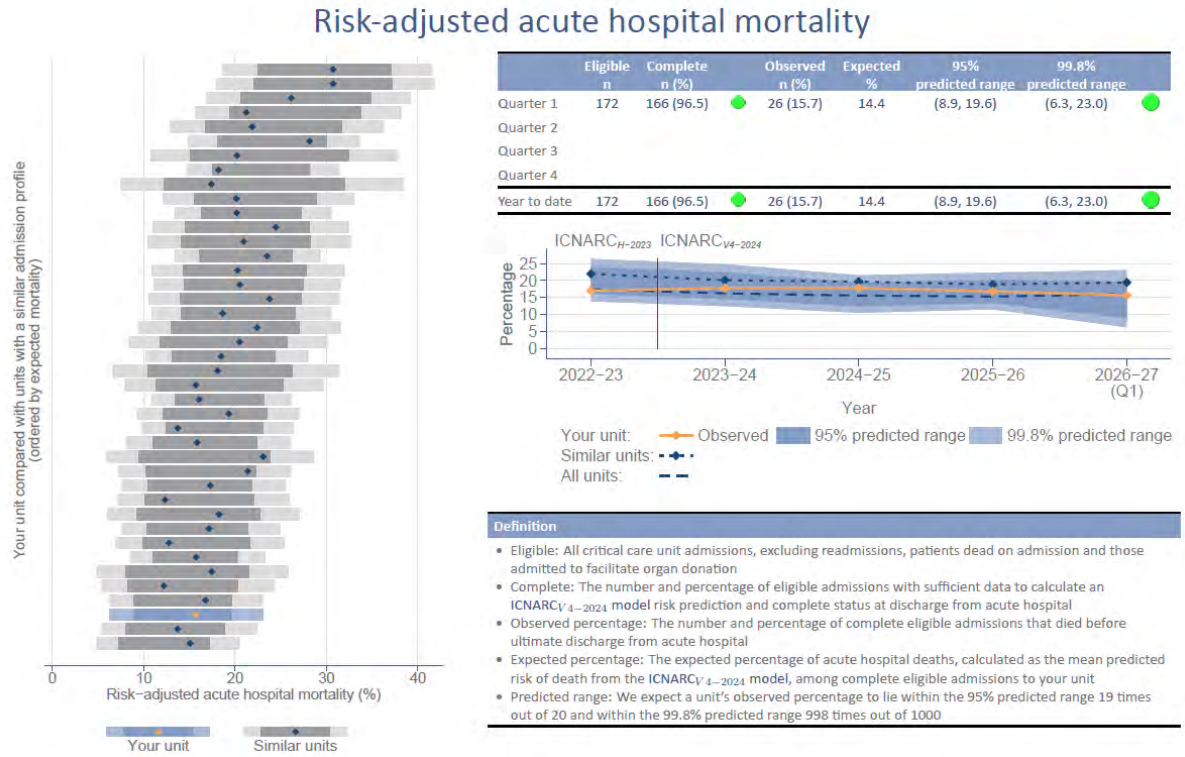
SHMI remains within the expected range at 0.9561, with observed deaths (1,185) remaining below expected deaths (1,235).

Figure 2. ICNARC Risk-Adjusted Mortality



Risk-adjusted critical care mortality remains within the expected range (15.7%).

Structured Judgement Review Activity

Structured Judgement Reviews (SJRs) continue to be undertaken across both clinical divisions in accordance with the Trust's Learning from Deaths Policy. During Quarter 1, a total of 60 SJRs were completed, including reviews from previous quarters undertaken as part of ongoing backlog reduction activity. No deaths reviewed through the SJR process were judged avoidable. Learning identified through review most commonly related to escalation processes, communication, documentation and care planning

Table 2. Structured Judgement Review Activity Q1 2026/27

Division	Deaths Requiring SJR	SJRs Completed During Quarter
Family Services & Surgery	32	43
Urgent & Integrated Care	29	17
Trust Total	61	**60**

Assurance from Review Findings

SJR findings continue to demonstrate that patients received generally good standards of care. Reviewers consistently identified examples of timely senior decision making, multidisciplinary working, appropriate escalation, and compassionate end of life care. Learning identified through the review process has informed the themes and improvement activity described in the following sections.

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2. Learning Themes and Quality Improvement

Learning from deaths is informed through triangulation of Structured Judgement Reviews (SJRs), Morbidity and Mortality meetings (M&Ms), Coroner activity, national audits and discussion through

Hospital Mortality Group. During Quarter 1, recurring themes were identified across multiple sources of intelligence. Alongside opportunities for improvement, mortality reviews also highlighted examples of excellent practice which continue to provide assurance regarding the quality of care provided to patients and families.

✅ What We Do Well	🔍 What We Learned	🔧 What We Are Improving
Compassionate communication with patients and families	Communication, documentation and care planning	**Dorset TEP Programme**
High quality end of life care	Escalation, referrals and specialist advice	**Nasal High Flow Guidance**
Early senior clinical review	Frailty and complex older adult care	**Standardisation of M&M Meetings**
Multidisciplinary working	Discharge safety and care transitions	
Patient-centred decision making		

2.1 Learning from Excellence
Mortality reviews continued to identify many examples of high-quality care across both divisions. Positive themes included compassionate communication with patients and families, timely involvement of specialist palliative care services, strong multidisciplinary working, early senior clinical review and patient-centred decision making. Reviews also highlighted examples of excellent care in complex surgical, trauma and critical care patients. National Audit of Care at the End of Life (NACEL) findings provide further assurance regarding the quality of end of life care delivered by the Trust.

2.2 Learning for Improvement (themes from Quarter 1)

2.2.1 Communication, Documentation and Care Planning
Communication, documentation and care planning remained recurring themes across SJRs, M&M meetings, Coroner learning and Hospital Mortality Group discussions. Most findings related to opportunities to improve the consistency and clarity of documentation rather than concerns regarding clinical care. Learning centred on documentation of referral discussions, communication of patient-specific risks, recording of significant clinical events and ensuring effective communication with patients, families and clinical teams during periods of deterioration. Coroner learning also reinforced the importance of reliable handover processes during transitions of care.

2.2.2 Escalation, Referral and Access to Specialist Advice
Mortality reviews demonstrated that timely specialist review and multidisciplinary decision making are frequently strengths within patient care. Where learning was identified, it most commonly related to the processes supporting escalation and referral rather than the quality of specialist input itself. Themes included documentation of specialist advice, clarity regarding treatment ceilings and escalation decisions, and occasional delays in specialty review. Learning reinforced the importance of contemporaneous documentation when specialist advice has been sought and where alternative management plans have been agreed.

2.2.3 Frailty, Orthogeriatric and Complex Older Adult Care
Learning from mortality reviews, specialty governance meetings and national audit data identified recurring themes relating to the care of frail older adults and patients with multiple comorbidities. Themes included appropriate location of care, access to specialist review, treatment escalation planning and medication optimisation. Several reviews highlighted the interface between orthopaedic and medical services, particularly for older patients presenting with trauma, head injury or hip fracture. These findings

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are consistent with ongoing review of National Hip Fracture Database outcomes and continue to support focused review of frailty and orthogeriatric pathways.

2.2.4 Emerging Learning: Discharge Safety and Care Transitions
A case reviewed through Hospital Mortality Group identified learning relating to discharge planning and communication across healthcare interfaces. The review highlighted the importance of ensuring discharge information reaches the correct healthcare provider, that medication arrangements are robust, and that patients can access prescribed treatment following discharge. Although identified through a discharge to a custodial setting, the learning has wider relevance and reinforces the importance of communication, coordination and continuity of care during transitions between healthcare providers.

2.3 Quality Improvement Arising from Learning from Deaths
Learning identified through Structured Judgement Reviews, Morbidity and Mortality meetings, Coroner learning and Hospital Mortality Group discussions has informed a number of improvement opportunities. Whilst learning themes are broad and often multifactorial, the Trust has focused improvement effort on three areas where recurring themes have been identified across multiple sources and where changes are anticipated to have the greatest impact on patient care and organisational learning.

Table 3: Improvement Priorities

Improvement Priority	Learning Identified	Current Position
Dorset TEP Programme	Recurring themes relating to escalation planning, treatment ceilings and communication of patient wishes.	Ongoing implementation and review of future DNACPR/TEP arrangements.
Nasal High Flow Guidance	Learning regarding escalation decisions and appropriate use of advanced respiratory support in deteriorating patients.	Guidance under review and due to return through Hospital Mortality Group.
Standardisation of M&M Meetings	Need for consistent identification, sharing and escalation of learning across specialties.	SOP development and implementation of minimum standards underway.

The impact of these initiatives will continue to be monitored through future mortality reviews, speciality governance arrangements and Hospital Mortality Group to determine whether identified learning themes reduce over time and whether improvements in care processes can be demonstrated.

3. Emerging Issues, Risks and Priorities for Quarter 2

Whilst mortality indicators and mortality review findings continue to provide assurance regarding the quality of care delivered by the Trust, Hospital Mortality Group has identified several emerging issues and risks that may influence the effectiveness of the Learning from Deaths programme and the reliability of mortality intelligence. These represent priorities for Quarter 2 and will continue to be monitored through established governance arrangements.

3.1 Clinical Coding and Mortality Intelligence
Reliable mortality intelligence is dependent upon accurate and timely clinical coding. The Hospital Mortality Group continues to monitor coding performance following a significant increase in the clinical coding backlog, which currently exceeds the Trust's stated manageable threshold. Whilst mortality indicators continue to provide assurance, delayed or incomplete coding may affect the recording of diagnoses, comorbidities and palliative care activity and therefore influence externally reported mortality measures, including SHMI.
The issue remains subject to ongoing organisational oversight and has been escalated through established governance arrangements. A programme of recovery and sustainability actions is underway,

Document Ref: 2026-1-106-v2

including workforce development, backlog reduction activity, targeted validation of coded data and longer-term work to strengthen coding resilience and improve documentation quality.

3.2 Timely Completion of Mortality Reviews
Structured Judgement Reviews remain the Trust's principal mechanism for identifying learning following patient deaths. Maintaining timely completion of reviews is therefore essential to ensuring that learning is identified, shared and acted upon promptly.
Whilst review activity improved during Quarter 1, including continued backlog reduction work, maintaining review timeliness remains an area of focus, particularly where previous operational pressures have affected review activity. This remains an area of concern in division and will continue to be monitored at HMG. Progress on the recovery plan will be reported in quarter 2.

3.3 Strengthening Mortality Governance
Work has continued during Quarter 1 to strengthen the governance processes that support organisational learning from deaths. This includes the development of minimum standards for Morbidity and Mortality meetings, refinement of mortality review processes and improvements in the consistency of thematic learning capture across specialties.
These developments build upon previous governance review recommendations and are intended to provide greater assurance that learning is consistently identified, shared and translated into measurable quality improvement activity. The development of a dedicated mortality module within the Trust's new incident management system is also expected to strengthen future learning capture, thematic analysis and organisational oversight.

3.4 Emerging Learning from Coroner Activity
Coroner learning continues to provide valuable intelligence regarding emerging risks and areas for improvement. During Quarter 1, learning from inquests reinforced themes relating to discharge communication, continuity of care, access to medication for vulnerable patients and effective communication across organisational boundaries.
The coroner has highlighted increasing scrutiny of heat-related deaths, particularly amongst frail and vulnerable individuals cared for in non-ventilated environments. Whilst this does not currently represent an established mortality theme within the Trust, it is recognised as an emerging area of risk and learning and will continue to be monitored through Hospital Mortality Group and wider patient safety governance arrangements.

3.5 Priorities for Quarter 2
The hospital mortality group will continue to focus on:

- Improving the timeliness and completion of Structured Judgement Reviews.
- Supporting improvements in clinical coding quality and mortality intelligence.
- Embedding standardised approaches to Morbidity and Mortality meetings and mortality governance.
- Progressing priority improvement programmes arising from learning themes, including the Dorset TEP programme, review of nasal high flow guidance and strengthening of mortality governance processes.
- Monitoring emerging learning from Coroner activity and national mortality reviews.

Collectively, these actions will help ensure that learning from deaths remains timely, reliable and effective in supporting improvements in patient care and organisational learning.

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Report to	Board in Common (DCH)	
Date of Meeting	13 October 2026	
Report Title	Maternity and Neonatal Quality and Safety Report (July & August data)	
Prepared By	Jo Hartley Director of the Midwifery and Neonatal Service	
Approved by Accountable Executive	Pam O' Shea – Interim Chief Nursing Officer	
Previously Considered By	Quality Committee in Common 29.09.2026 Quality Governance Group 16.09.26	
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 July and August 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 MOSS alerts received
- Average of 82 days between stillbirths and 305 days between neonatal deaths, and no significant change in overall mortality measures.
- Increase in unexpected neonatal admissions (ATAIN) to 7.8% in August, requiring further review and action. However, all cases are reviewed and any learning is used to improve services.
- Increase in term babies with an Apgar score below 7 at five minutes.
- 6.4 WTE Midwives approved for substantive positions.
- Training compliance improved in several areas though risk remains to Maternity Incentive Scheme (MIS) Yr 8 for Practice Obstetric Multi-Professional Training (PROMPT).

Caring

- Good engagement in the Perinatal Cultural Improvement plan.

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- Eight early resolution complaints and one closer look complaint received during July & August 2026. Learning from complaints, Duty of Candour processes, birth reflections and PMRT reviews and patient experience reviews themes are routinely triangulated through governance forums to inform service

Effective

- Improvement work has contributed to a reduction in third and fourth degree tears, reaching 1.0% in August 2026.
- Currently reviewing the guideline for homebirth and coproducing an information leaflet with a family who have used the service

Responsive

- Response times to complaints has improved. Learning incorporated into quarterly report as well as monthly report into Governance Meeting
- Work underway with BI around health inequalities to enable a drill down into key clinical quality metrics (CQIMs) to identify any disproportionately affected women in relation to perinatal outcomes.

Well led

- A Maternity Outcome Signalling System (MOSS) Drill activated 08.09.26. Eight day completion deadline met. Further details to be included in next report.
- 10 Point Plan & Maternity Triage signed off by Trust Board 08.09.26. Submission deadline 25.09.26.
- Actively recruiting obstetric workforce

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 for assurance of maternity and neonatal quality and safety performance for July and August 2026

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Maternity & Neonatal Trust Board Safety Report

September 2026

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Presented by Perinatal Leadership team

July/August data

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Dorset County Hospital
NHS Foundation Trust

Executive summary

Safety	Quality and learning	Workforce	Risks and mitigations

	RAG	Key Message
Safety	green	No Moss alerts received. Average days between stillbirths 82, NNDs 305.
Quality & Learning	green	Good engagement and progress with the Perinatal Cultural Improvement Plan.
Workforce	amber	Significant gaps in the midwifery workforce due to LTS & maternity leave. Currently recruiting fixed term into gaps. Awaiting confirmation from NHSE around funding for NQM.
Equity	amber	PMRT review notes EDI data in reviews. Further work with bi team to improve triangulation of EDI data within monthly reporting
Governance & oversight	green	Monthly Safety Champions meeting well attended. Regular Safety Champions walkabout on the ward. CNO chairing Amos - 10 Point Plan

What is going well: Reduction in the occurrence of 3rd and 4th degree tears to a rate of 1% in Aug 2026. Successful MOSS simulation completed

What is of concern: ATAIN increased in Aug to 7.8%. Elements 3 and 4 in the Maternity Care Bundle noncompliant on benchmarking. MNVP resignation has led to reduced engagement and service user feedback. Recruitment underway through third party employer, Evolving Communities

Emerging risks: the MOSS simulation concluded that the lack of an elective pathway for planned caesareans (LSCSs) was impacting safety in relation to start/finish times for emergency LSCSs and delays for elective LSCSs

Improving/deteriorating trends: following an improvement, noted increase in term babies with an Apgar score <7 at 5 minutes. Actions to be agreed

Key system actions underway: Focus on improving intermittent auscultation

Board assurance statement:

The Board can be partially assured that all perinatal safety systems are in place. Outcome measures are overall stable
However, concerns remain regarding maternity staffing, ATAIN figures and compliance around the Maternity Care Bundle. Work is continuing with agreed action plans and timescales

Actions required from Board:

☐ Decision / approval

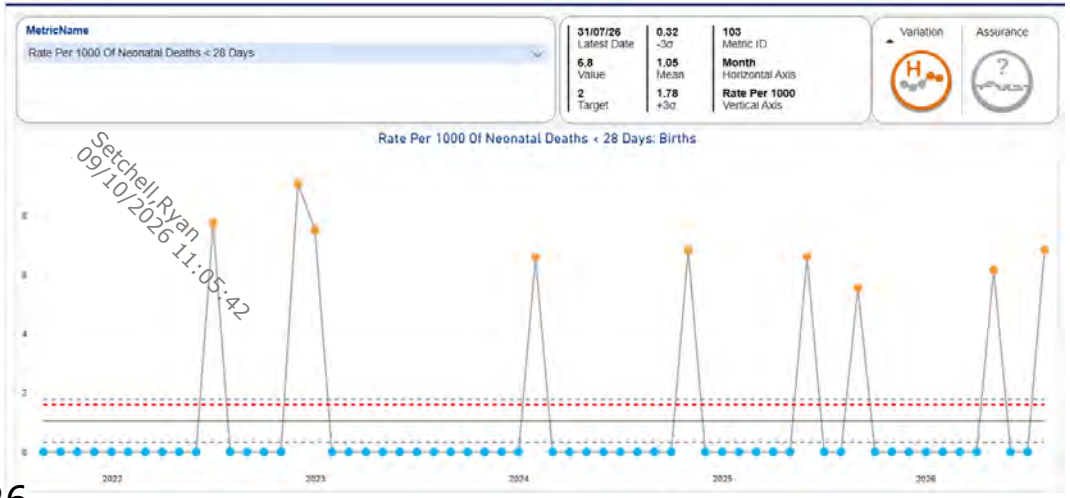
Trust Performance Against National Safety Ambitions

Dorset County Hospital
NHS Foundation Trust

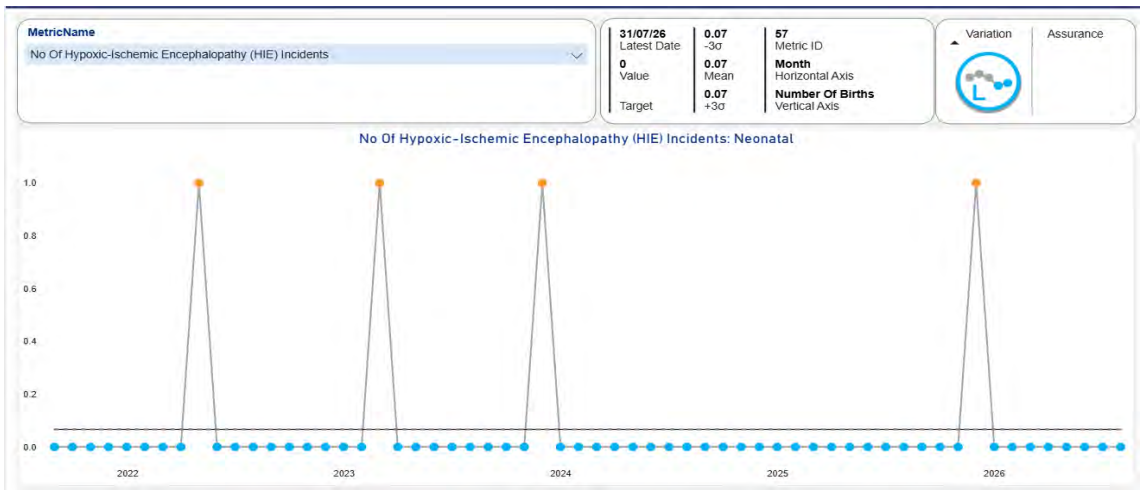
number of births 150 in July

Rates per 1000 stillbirth

Rates per 1000 neonatal death



No of HIE incidents



Trust Performance Against National Safety Ambitions

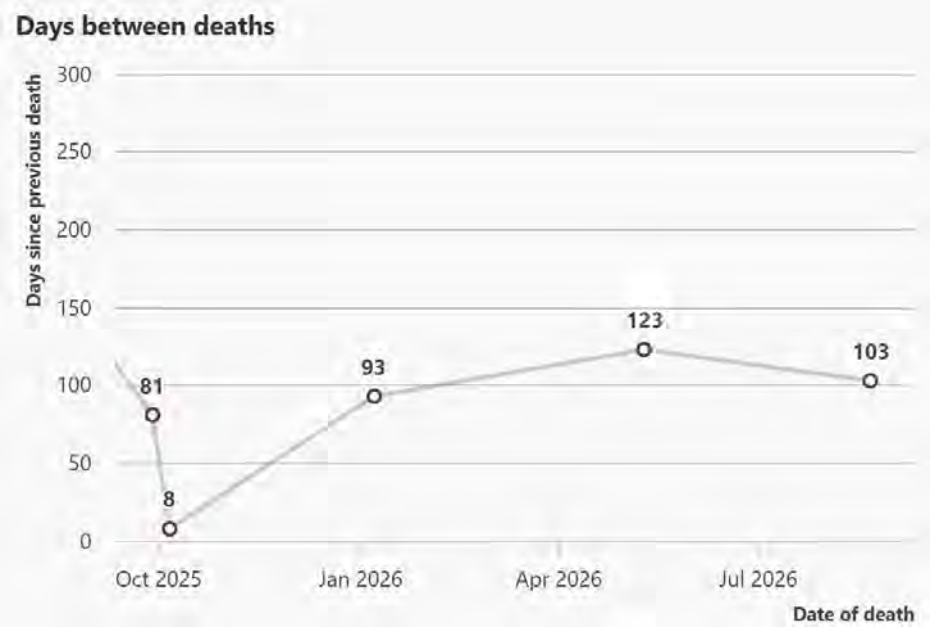
Dorset County Hospital NHS Foundation Trust

Date of last stillbirth

21.08.26

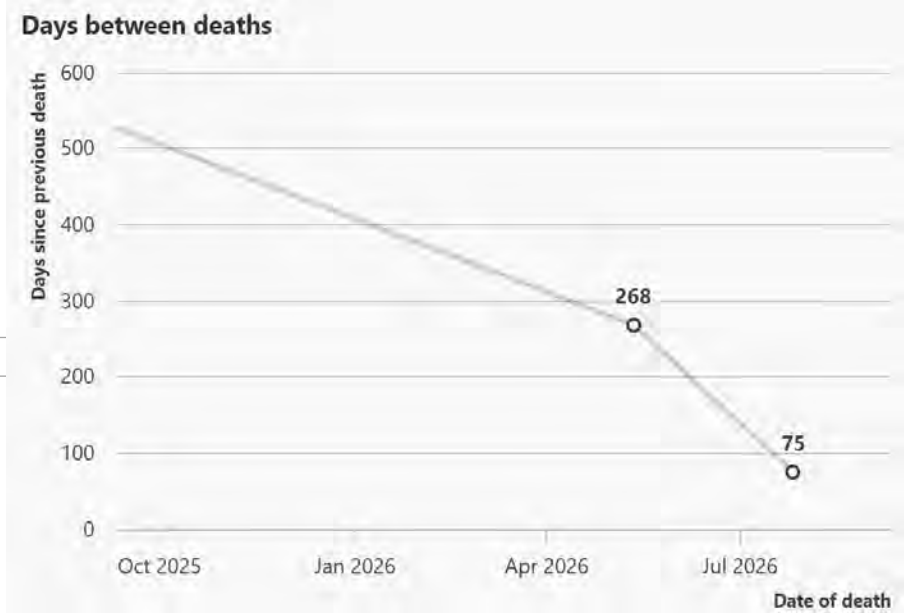
Average days between stillbirths 81.6

No significant change



Date of last neonatal death 26.07.26
Average days between deaths 305.5

No significant change



Date of last HIE 17.11.26

Average days between HIE

No significant change

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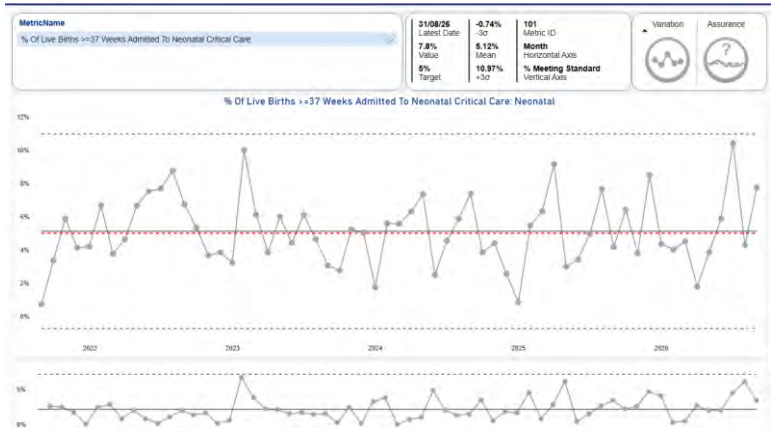
July 4.3%
Latest month August
Unexpected admissions to NNU **7.8%**

Significant change



Risk Register

True, Sarah - Governance Lead, SCBU							
2260	Family Services (B4)	Sarah True	04/12/2025	Evacuation Plan for the Neonatal Unit	24/10/2026	Quarterly review	Moderate Risk
Hollingsworth, Clare - Paediatric consultant							
2356	Family Services (B4)	Clare Hollingsworth	02/07/2026	Lack of Second Paediatric Team to cover use of a second theatre in Maternity	02/10/2026	Quarterly review	Moderate Risk
Hartley, Jo - Director of Midwifery & Neonatal Services							
876	Family Services (B4)	Jo Hartley	21/09/2021	Maternity Staffing	30/10/2026	Monthly review	High Risk
1689	Family Services (B4)	Jo Hartley	29/06/2023	Opening a Second Theatre for a Maternity Case in an Emergency Situation & The Elective Pathway	17/11/2026	Quarterly review	Moderate Risk
1980	Family Services (B4)	Jo Hartley	20/09/2024	EPAC restricted service	16/11/2026	Quarterly review	Moderate Risk
2044	Family Services (B4)	Jo Hartley	14/01/2025	Risk to Sustainability of Maternity & Neonatal Digital Service	17/11/2026	Quarterly review	Low Risk
2139	Family Services (B4)	Jo Hartley	07/04/2025	Risk to the Maternity Advice Line Provided by UHD for all of Dorset	17/11/2026	Quarterly review	Moderate Risk
2359	Family Services (B4)	Jo Hartley	09/07/2026	Failure to Achieve the Standards for the Maternity Incentive Scheme	30/10/2026	Monthly review	Moderate Risk
2360	Family Services (B4)	Jo Hartley	09/07/2026	Clinical Safety Case for Badgernet - Management of Actions	09/10/2026	Quarterly review	Moderate Risk
2382	Family Services (B4)	Jo Hartley	01/09/2026	Second Oncall Obstetric Consultant Rota Gaps	01/12/2026	Quarterly review	Moderate Risk
1881	Family Services (B4)	Debora Pascoal Horta	01/05/2024	Neonatal Nursing & Medical Staffing	16/10/2026	Monthly review	Moderate Risk

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Risk Register – please note some risk rating will have changed since the previous slide due to current updates

876	Maternity Staffing	**Update** Risk reduced.6.4 fixed term midwives now substantive. Currently 8.64wte vacancies due to maternity leave and LTS. Recruitment of 2.88wte fixed term midwives successful backfilling maternity leave and secondment. They will start work towards the end of the year. Ongoing reliance on agency midwives, particularly at night. MSW workforce significantly carrying a 17% vacancy rate due to apprenticeship offset and NQM offset. Ongoing reliance on incentivised shifts. Sickness managed following Trust policy.	21/09/2021 monthly reviews	High 16	Corporate
1689	Opening a second theatre in an emergency &the elective pathway	**Update** There is a demand and capacity reviewed each week and escalation when required.. Of note, review of second theatre use in an emergency has highlighted the need for an additional Neonatal team due to needing to attend in Main Theatre if required. Splitting the team to provide support for both maternity and main theatre increases risk particularly with complex cases. The caesarean rate is now approx. 50% of births which impacts daily on theatre capacity	29/06/2023 quarterly review	moderate 12	Division
1881	Neonatal Nursing	**Update** Four new starters in post and planning new roster with new starters as part of the numbers (rather than supernumerary) which will see the risk reduced.	01/05/2024 monthly review	Moderate 9	Division
2359	Failure to achieve the safety standards for the maternity incentive scheme	**Update** Multi professional training on the 25th September met the threshold for compliance. Currently the 1.3wte midwives required to meet compliance with BR Plus remains outstanding. Risk rating has reduced	30/06/2026, monthly review	Moderate 12	division

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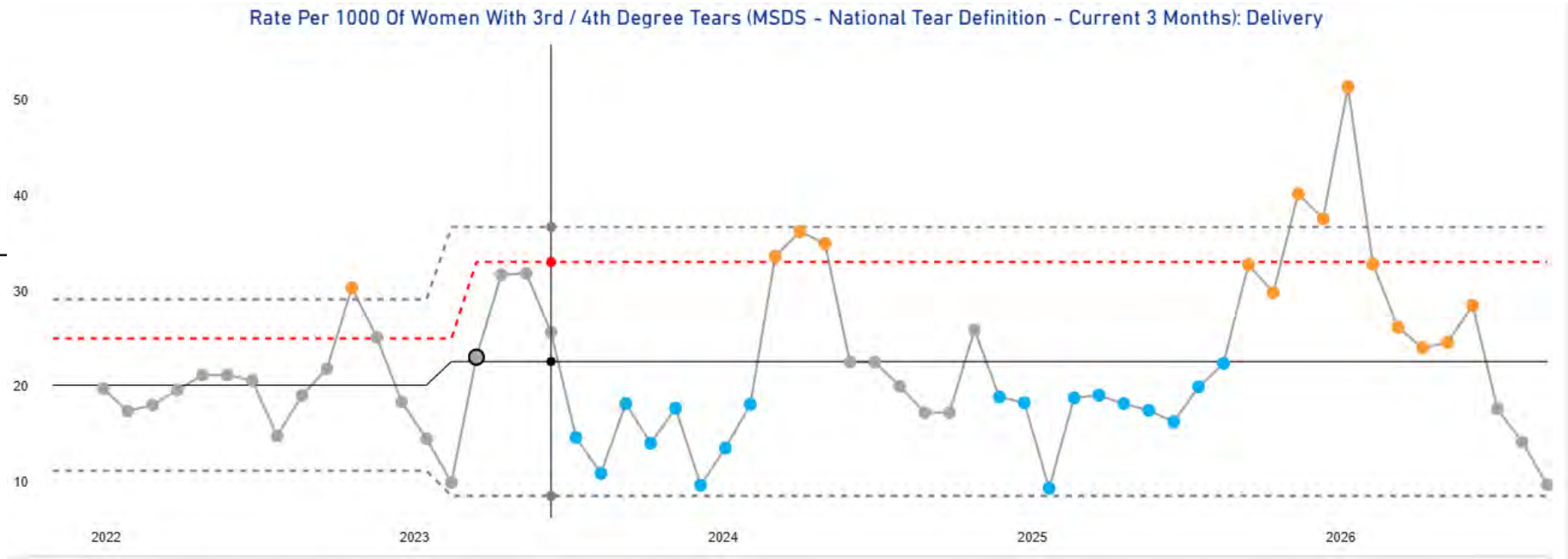
Third & Fourth Degree Tear QI

OASI Care Bundle QI project
National rate per 1000

The OASI (Obstetric Anal Sphincter Injury) Care Bundle was introduced at DCH in January 2024 through a dedicated awareness and training week, during which 28 staff members were trained. Training was subsequently embedded within mandatory midwifery training, supported by a training video, and included in Foundation Year Doctor induction programmes. By the end of 2024, all substantive midwifery staff had received OASI training.

The SPC chart demonstrates a period of improved performance following implementation, with rates of third and fourth degree tears remaining below the long-term mean throughout much of 2024 and 2025. Between June 2025 and April 2026, a significant number of midwives from Yeovil District Hospital joined the workforce following the temporary closure of Yeovil maternity services. These staff had not received OASI training, and this period coincided with increased variation and a rise in tear rates. Although several factors may have contributed to this deterioration, the arrival of a substantial number of staff who had not undertaken OASI training may have been a contributory factor alongside the wider challenges associated with workforce transition and integration. Following the return of these staff to Yeovil after service reopening in April 2026, rates improved, reaching 1.0% by August 2026.

To support sustainability, OASI training is embedded within local induction and education programmes. In line with the Core Competency Framework, OASI training is mandated every three years, with refresher training scheduled for 2027. Ongoing monitoring of this metric is undertaken through the governance framework.



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10 Point Plan for Maternity & Neonatal Services

Dorset County Hospital
NHS Foundation Trust

Action required	Progress	Action	Action Holder	By when
1. Listening to women and their families by rolling out Martha's Rule	Partially compliant	Further work required to improve delivery of components 2 + 3, as well as patient wellness question within Neonates	DPH ES	Dec 26
2. Listen to women and their families using real time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level	Partially compliant on 2.1, 2.3	Low return rate for FFT. Trust to explore use of DrDr platform	LB	Dec 26
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care	Partially compliant on 3.2	Newly appointed clinical director to be core member or reproductive health clinical governance and divisional governance	JoH	Nov 26
4. 'Amos into action' staff listening exercise				
5. Addressing inequalities in maternity and neonatal outcomes	Non-compliant	Dashboard under development. To roll out the Perinatal Equity & Antidiscrimination programme when available.	LB	Dec 26
6. Ensuring 24/7 safety and responsiveness of maternity and neonatal services	4 out of 7 sections compliant – 3 partially	Action plans in place as detailed on 10 Point Plan baseline assessment submitted to Board 08.09.26	JoH	Dec 26
7.Trusts to review their homebirth services	Compliant			
8. Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach	Compliant			
9. Deliver safe and effective triage in maternity services (already committed by Government)	Partially compliant 9.2, 9.3	Triage benchmarking completed. Cost implications need to be reviewed	NC	Dec 26
10. Post death care (already committed by Government)	Partially compliant	Once Bereavement Clinical Room completed, installation of CCTV and swipe access required	JoH	Nov26

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Dorset County Hospital NHS Foundation Trust

Reported incidents and thematic learning from investigations

Reported incidents from SPEN,PMRT/ MNSI/ MOSS/ PSIRF findings / National reports

Incident type	Notifiable Incidents July/August 2026	What actions have been implemented	Family view / DoC	External Reviewer
PMRT	Antenatal Stillbirth 39+1 August 2026	Initial local review has not identified any significant learning or action however await for joint PMRT with external review.	Parents aware of process	Await review
MBRRACE	NND 21+2 July 2026	Initial local review has not identified any significant learning or action. PMRT not supported due to gestation, for MDT M&M review	Parents aware of process	N/A

Learning From incidents Summary of learning and actions from MNSI and NHS EN reports, local PMRT and Patient Safety Incident Response Framework (PSIRF) reviews, Maternity Outcomes Signal System (MOSS) critical safety checks, NHSR claims scorecards and relevant national reports

Theme *No Final MNSI Reports in July/August	What learning and actions have been prioritised	Outcome / Learning /Actions/ Improvements	What impact have earlier actions had	What support do you need from executive board
Fetal monitoring using IA	Thematic review • Compliance with IA guidance • Identifying 2nd stage	Recent MNSI reports and local review have highlighted some gaps in training compliance and outcomes for low-risk labour & birth • Safety pin for all staff – update guidance • Thematic review on-going • Hourly per review & risk assessment • Second midwife to be present for second stage and birth • Monthly audits • Low risk labour care and IA incorporated into mandatory training day • 'pushing purple pen' to alert staff that a women is fully dilated on the labour ward board • 1:1 staff case review and discussion to support practice • Local cases discussed and fetal monitoring sessions	IA audit has shown improvement since implementation of actions	

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Coroners' reports

Dorset County Hospital NHS Foundation Trust

Outstanding report due

Date listed	Summary
No Coroner reports in this period.	

Regulation 28 report issued

Action required	Progress	Responsible (role)	By when
No Regulation 28 reports in this period.			

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Perinatal Improvement Plan

Progress updates from National reports / MNIST action plans / CQC / Thematic review action plans as required.

Include actions relating to a local improvement plan utilising the patient safety incident response framework (PSIRF) and ensure they are reflected in the minutes of Board, ICB, Local and regional learning systems.

Escalations/Actions	Support required	Progress from previous escalations
Action plan from MNSI safety recommendations • Homebirth guideline • Homebirth Leaflet • IA/low risk study day • IA thematic review		Low risk labour care update day started Thematic review in progress, Audits or all IA in progress.

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Case ID	Action	Lead	Status	Due Date	Progress/Notes
DCH109284	Action plan from MNSI recommendations	Jo Hartley	Ongoing	Sept 2026	Homebirth guideline and leaflet in progress. IA training and QI work in progress.

Performance Metrics

Dorset County Hospital NHS Foundation Trust

Service Suspensions

Number of times services were suspended

	Month											
	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Obstetric unit	0	1	0	1	3							
Midwifery led unit	0	1	0	1	3							
Homebirth service	4	4	1	5	3							
Neonatal unit (internal)	0	0	0	0	0							
Neonatal unit (external)	0	0	0	0	0							

Women experiencing delays to induction >6hrs

Number of women whose commencement of induction of labour (IOL) is delayed >6 hours from point of admission for induction (from home or ward)

	Month											
	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Delays to induction >6hrs	0	8	2	8	6							

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Women experiencing delays to elective caesarean section >24hrs

Number of women scheduled for an elective caesarean section who had this delayed by more than 24hrs

	Month											
	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Delays to caesarean >24hrs	0	0	4	4	2							

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Home Births in July & August

No. home births / Born Before Arrival (BBA)	No. birthing at home against medical advice	No. of births at home where there is a multi-disciplinary plan in place	No. transferred into acute unit	No. of transfers with a delay
9 homebirths 3 BBAs	5	2	2 2	1 0

Learning and action taken from incident review and audits

Learning	Action	Progress on actions / impact
Parents are unable to decline neonatal resuscitation due to the legal rights of the neonate	1. Homebirth leaflet to include information on neonatal resuscitation. 36-week risk assessment 2. Care outside guidance discussion plans to include information on neonatal resuscitation.	HoMN to oversee leaflet development. Care outside guidance discussions now incorporate neonatal resuscitation information.
Homebirth team compliance with intermittent auscultation (IA) 83% first stage, 46% second stage	Facilitate second midwife attendance early to support IA and documentation improvement	Monitoring underway via monthly snapshot and quarterly re-audit

Guidelines	Approved by	Date approved
Operational guideline inclusive of midwifery, obstetrics, neonates and ED	In progress	
Guideline on birthing against medical advice	RHCG	22.11.2022

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Triage

Dorset County Hospital NHS Foundation Trust

Metric	June 2026	July 26
1. Proportion of women for whom expected timeframes are met for initial assessment and for clinical review, based on their category of urgency.	91%	90%
2. a) Proportion of women who experience a delay in assessment, review or onward care b) proportion of these where there is an outcome recorded.	9% delay in assessment 0% delay in onward care 100% of a) had outcome recorded	10% delay in assessment 7% delay in onward care 100% of a) had outcome recorded
3. Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback	3	3
4. Frequency of staff being redeployed to other maternity care areas within the unit from maternity triage: % of shifts affected by re-deployment	0%	0%

Improvement actions	Progress	Impact	Responsible
Introduced direct assessment within Maternity Triage for women from 16 weeks' gestation following complaints	• Clear referral and access pathways were established between ED and Maternity Services.	• Enhanced patient experience and reduced unnecessary attendance and waiting within the ED environment	Triage /Maton
Increased midwifery staffing to improve capacity to achieve (BSOTS) assessment timelines.	• Workforce requirements reviewed against activity and demand	• Improved compliance with BSOTS assessment timeframes.	Matron
Reviewed the triage waiting environment following patient feedback. Relocated seating within the clinical area to improve visibility and oversight by staff.	• Chairs moved into an area allowing direct observation by clinical staff.	• Improved patient safety through enhanced observation.	Triage lead

Sarah Rowan 09/06/2026 11:05:42

Training Compliance

Dorset County Hospital NHS Foundation Trust

Training compliance for all staff groups related to the **Maternity Incentive Scheme**. *Please note, this does not include Sept data*

Midwives

	July-26	Aug-26
Prompt	91%	92%
Fetal Monitoring	84%	96%
Newborn BLS	92%	92%

Obstetricians

(split by consultant and SAS doctors/other Obstetricians as per MIS Yr 8 from July/August 2026)

	July-26	Aug-26
Prompt Cons & SAS drs	50%	58%
Prompt other Obst drs	87.5%	87%
Fetal monitoring Cons % SAS drs	92%	83%
Fetal monitoring other Obst drs	100%	100%

MSWs

	July-26	Aug-26
Prompt	85%	90%

Anaesthetists

	July-26	August-26
Prompt	81%	83%

Paediatric medics

(split by consultant and SAS doctors/other Paediatricians as per MIS Yr 8 August 2026

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	July-26	Aug-26
NBLS Cons and SAS drs	100%	100%
NBLS other Paediatric drs	100%	100%
RCUK NLS certification	100%	100%

Neonatal nurses + ANNP

	July-26	Aug-26
NBLS Neonatal Nurses	100%	94%
NBLS ANNP	100%	100%
RCUK NLS Nurses	87%	87%
RCUK NLS ANNP	100%	100%

1st MIS Checkpoint: 30th Sept 2026
met/not met/pending

2nd MIS checkpoint: 30th Nov 2026
met/not met/pending

Training Compliance

Dorset County Hospital NHS Foundation Trust

Training compliance for all staff groups in maternity related to the CCFv2 and Trust mandated training. *Refer to training report for additional information (*note due to nhs.net migration some data not accessible July ** data pending on esr)*

Midwives

	July-26	Aug-26
Adult BLS	*	77%
Level 3 safeguarding children	89%	90%

Obstetricians

	July-26	Aug-26
Adult BLS Cons	*	60%
Adult BLS Regs	*	70%
Adult BLS drs on obs rota	*	75%

Maternity Support Workers

	July-26	Aug-26
Adult BLS	*	94%
Level 3 safeguarding children	85%	85%

Paediatric medics

(split by consultant and SAS doctors/other Paediatricians as per MIS Yr 8 August 2026)

	July-26	Aug-26
Adult BLS Cons and SAS drs	76%	69%
Adult BLS drs on paed SHO rota	85%	**

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Neonatal Nurses and ANNP

%QIS: 74% (minimum as per BLISS=70%)

	July-26	Aug-26
Adult BLS	88%	88%

Saving Babies Lives v3.2 Care Bundle

	July -26	Aug-26
All maternity staff VBA	89%	93%
Midwives and MSWs Co training	90%	92%
Midwives and Obst practical sfh training	92%	92%

Dorset County Hospital
NHS Foundation Trust

Staffing Vacancy rates

Staff group	Vacancy rate (%)
Midwifery	band 7: 11% due to LTS, secondment and mat leave Band 5/6: 15% due to mat leave, secondment, LTS
Maternity Support workers	17% vacancy rate (.4wte) 2wte held against apprenticeships
Obstetric consultants Resident doctors	0 4 registrar vacancies – 2 deanery posts will rotate in Oct. One appointed, one out to advert
Neonatal Nurses	0
ANNP	0
Neonatology consultants Resident doctors	1 0
Obstetric anaesthetists	0

Risks	Mitigations	Escalations
Maternity staffing 876	See previous slides	

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Safety Champions feedback - July & August 26

Feedback raised by staff	Action and progress
General Wellbeing & support for staff. Noted unit busy with c-sections Opportunities to consider staffing models and handover to postnatal, especially for c-sections. Staff positive and response to workload and demands.	Trial of new handover format in progress.

Feedback raised by service users	Action and progress
Women felt well cared for.	

Additional safety champions intelligence	Action and progress
July Safety Champions Meeting dedicated to MNSI regional team to share relevant trust regional and national level information in addition to MNSI news and updates.	Themes and safety recommendations discussed. Length of coroners postmortems raised and noted by MNSI colleagues who have also raised as a concern.

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Escalations	Support required	Progress from previous escalations

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Themes and Progress with Perinatal Cultural Improvement Plan

Aim: To develop and sustain a psychologically safe, compassionate and learning-focused perinatal culture where women, families and staff are listened to, concerns are acted upon, and multidisciplinary teams work together to deliver safe, personalised and equitable care.

Theme	Progress	Support requirements
Listening to Women and Families (Three-Year Delivery Plan, Ockenden, Amos)	MNVP engagement and embedded in governance forums, Birth debrief themes monthly review and dissemination, patient voice incorporated into governance via Duty of candour, PMRT feedback, FFT, complaints and debriefs. Quarterly Experience of Care presented at Maternity Governance and Board. Service-user representation included in quality improvement projects	Recruitment of permanent MNVP Lead
Psychological Safety and Speaking Up (Three-Year Delivery Plan, CQC)	Safety Champions feedback mechanism established, anonymous culture pulse survey, NHS staff survey results analysed, FTSU posters displayed across unit	Dedicated FTSU engagement sessions within maternity
Learning and Improvement Culture (CQC, Ockenden)	PSIRF learning reviews and thematic incident learning underway, Safety huddles undertaken, Learning from Excellence (LfE) submitted, Quarterly safety newsletter shared (Maternity and Neonatal), Safety bulletins shared across teams, National QI initiatives adopted, Local QI identified and undertaken through governance forums using triangulated data – Audit, Incidents, Feedback, Outcomes	Protected learning time for staff
Compassionate and Inclusive Leadership (PSIRF, MIS, Ockenden)	Walkarounds by Manager on Call (MoC) daily mon-fri, Staff listening events undertaken with future events planned, Organisational leadership training offers disseminated, Black Maternity Matters training incorporated into mandatory training	Continued Executive sponsorship and organisational development support
MDT Working and Civility (Ockenden, CQC, Amos)	Joint simulation training – (Obstetric, Anaesthetic, Neonatal, Midwifery, SWAST), MDT PROMPT training, MDT governance reviews continuing, MDT safety huddles,	Further multidisciplinary training opportunities
Staff Wellbeing and Retention (Three-Year Delivery Plan, Amos)	Preceptorship package, Labour ward Co-Ordinator package, PMA support, Hot debriefs undertaken, Tea trolley rounds, Positive feedback shared with staff – from patients and incidents/reviews	Organisational Development support Retention and wellbeing plan development

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Insights from service users and Maternity & Neonatal Voices Partnership Co-production

Insights

None received from MNVP lead during July or August

MNVP specific feedback cards and post boxes installed on the unit

Co-Production

Birth Reflections patient leaflet co-designed

Joint Anaesthetic/Obstetric Simulation Training – MNVP lead played the role of the patient

Milk Kitchen relocation and design reviewed by MNVP lead from service user perspective – also advised regards patient facing information on feeding

Update

MNVP lead resigned in August and role vacant. Recruitment underway for replacement via third party employers Evolving Communities. Interim solution to mitigate vacancy: MNVP lead at UHD or SW MNVP lead will attend governance meetings at DCH.

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Additional Service User feedback

Debriefs / Birth Afterthoughts	Action and progress
Consultant Postnatal Debrief Clinic -12 women seen	Patient letters used to capture themes discussed. Themes fed into wider feedback thematic analysis.
Birth Reflections Midwife Debriefs – 26 undertaken 13 face to face 13 via telephone	Thematic analysis undertaken and posters created to capture improvement key messages and celebrations
Friends and Family test	**Action and progress**
MAT AN 0.0% **MAT Birth 0.0%**	ANDAU process devised for collecting feedback for triage New processes for collecting responses underway
MAT PNW 0.0% **MAT PNC 0.0%**	HoMN met with PALS to discuss FFT return rate and QI required New processes for collecting responses underway
Complaints and Compliments	**Action and progress**
8 ERCs 1 Closer look	7 closed 2 remains open

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Neonatal Pulse Oximetry Testing

Dorset County Hospital
NHS Foundation Trust

MIS year 8 Safety Action E.

Neonatal pulse oximetry testing

- Trusts must develop a standardised, equitable, and governance approved guideline for neonatal pulse oximetry testing, aligned to the BAPM framework.
- The guideline must describe the required clinical processes, data entry standards, and pathways for all birth settings (including homebirths) to ensure that every baby receives pulse oximetry screening between 2 and 24 hours of age, with clear escalation processes for babies in the amber and red pathways.

What good might look like	Current trust position
A single Trust-wide guideline, or an adopted regional guideline adapted locally if needed, describing consistent screening and escalation processes across all birth settings.	2090 v1 Pulse Oximetry Screening in Newborns. Published 07/10/2021 Current version 2090 v2 (reviewed and updated 2025) available on DCH Trust Intranet
Clear inclusion of when testing should occur (2–24 hours of age), how results should be documented and how amber/red pathways should be escalated.	Available in guidance 2090 v2 as Quick Reference Guide flow chart, page 3, 4 & 8
Evidence that the guideline has been approved through maternity/neonatal governance, with a plan in place for implementation and staff awareness.	Approved March 2021 through *Paediatric and Neonatal Clinical Governance* as Expert Group. Implemented 2021, now standard practice for all newborns.
Routine review through governance to ensure the guideline remains aligned with BAPM expectations and that progress towards implementation continues.	Implemented 2021. 2090 v2, reviewed and updated 2025. Next scheduled review 2028. August 2026: Confirmed DCH guidance 2090 v2 Pulse Oximetry Screening in Newborns aligns with BAPM expectations.

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Maternity Care Bundle

Dorset County Hospital
NHS Foundation Trust

All NHS trusts providing maternity services and ICBs are responsible for fully implementing the MCB by March 2027.

We are benchmarking current compliance and developing an improvement plan with timeline for sign off by the trust board

providing regular reports, escalating to ICB, where we are unable to meet standards. A plan for Implementing MCB is a MIS 8 requirement.

Element 1 Venous thromboembolism	• Reducing thrombotic events in early pregnancy by risk assessing all pregnant women at the earliest opportunity before antenatal booking and providing rapid access to thromboprophylaxis for those identified at high risk. https://thrombosisuk.org/earlypregnancy/ • Maternity VTE in EPAC, shared with ED, critical care and through divisions. Medication provision in place. Pathway required.
Element 2 Pre-hospital and acute care	• focuses on Pre-hospital and acute care in pregnancy • ensuring unwell pregnant women receive the right care at the right time through improving access to urgent obstetric and maternal medicine care; and implementing a common approach to the monitoring, identification and management of maternal deterioration across all care settings. • BSOTS in place, MEWS, maternal medicine pathway in place
Element 3 Epilepsy in pregnancy	• improving control of seizures by ensuring timely access to specialist multidisciplinary epilepsy care during and after pregnancy. • Referral pathway in place
Element 4 Maternal mental health	• improving the identification and response to perinatal mental health concerns through the consistent use of National Institute for Health and Care Excellence (NICE) recommended screening tools and timely referral to appropriate specialist support.
Element 5 Obstetric haemorrhage	• improving the management of haemorrhage through standardised approaches to timely identification, escalation and response to obstetric bleeding, along with ongoing multidisciplinary review and learning. • Teg funded and purchased, training to commence in June 26, scales in use, emergency kit in place • Multidisciplinary team (MDT) case review should be undertaken for all women with significant bleeds (>2L) and all cases of cryoprecipitate and fibrinogen concentrate use within a month.

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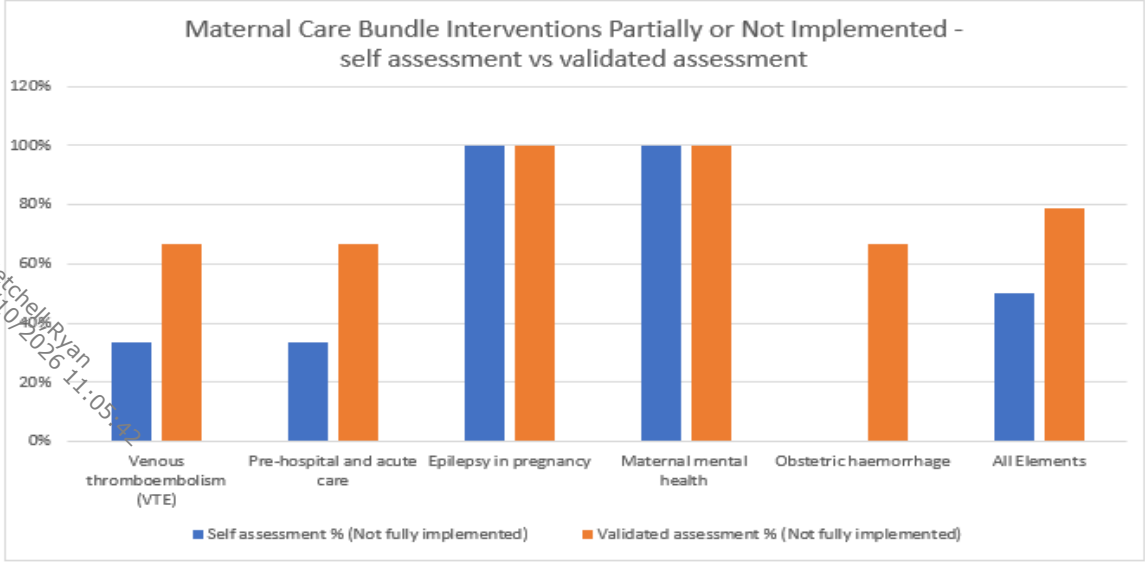
NHS Foundation Trust

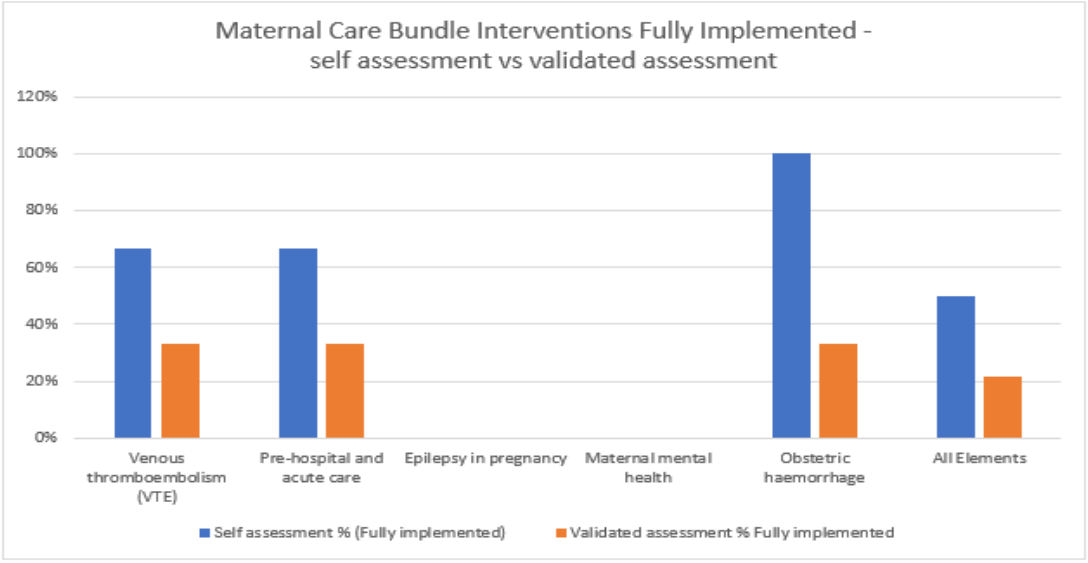
Board report summary: Implementation of the Maternal Care Bundle

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (Trust Board Validated)	% of Interventions Fully Implemented (Trust Board Validated)	Escalation required for board review*
Element 1	Venous thromboembolism (VTE)	Partially implemented	67%	Partially implemented	33%	Yes
Element 2	Pre-hospital and acute care	Partially implemented	67%	Partially implemented	33%	Yes
Element 3	Epilepsy in pregnancy	Not implemented	0%	Not implemented	0%	Yes
Element 4	Maternal mental health	Not implemented	0%	Not implemented	0%	Yes
Element 5	Obstetric haemorrhage	Fully implemented	100%	Partially implemented	33%	Yes
All Elements	TOTAL	Partially implemented	50%	Partially implemented	21%	

*If yes, please refer to 'Board summary - action plans' worksheet for details.





Dorset County Hospital
NHS Foundation Trust

Progress to achieve NHS Resolution, Maternity Incentive Scheme Year 8, 6 safety actions

	Assessment of compliance (met/partially met/not met)	Is there clear evidence to support compliance	Gaps requiring action
A – Workforce and Capacity	In progress & on track	partial	A2 –Locum certification needed A4 – Midwifery workforce update A5 – Anaesthetic workforce rotas needed
B - Training	Compliance risk	partial	B1 – Obstetric emergency training Both compliance points have staffing planned to meet, but no margin at all for slippage
C - Learning from reviews and investigations	In progress & on track	partial	
D - Service User Voice and Equity	In progress & on track	partial	
E - Care Bundles	In progress & on track	partial	
F - Board Oversight, Governance, Culture and Leadership	In progress & on track	Partial	F4 – Perinatal culture improvement plan

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Dorset County Hospital
Dorset HealthCare

Report to	Board of Directors in Common	
Date of Meeting	13/10/2026	
Report Title	Joint Health Inequalities Workstream Update	
Prepared By	Dr Helena Posnett, Trust Lead for Health Inequalities (DHC) Adam Nicholls, Deputy Chief Medical Officer (DCH)	
Approved by Accountable Executive	Dr Lucy Knight, Chief Medical Officer (DHC) Dr Rachel Wharton, Chief Medical Officer (DCH)	
Previously Considered By	Quality Committee in Common, 29/09/2026	
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 – - Risk Controls and Plans: Joint Health Inequalities Plan - Actions to Improve Controls and Assurance (DHC): Review of reporting of health inequalities metrics with clearer focus on outcomes (CFWD) - In progress SR7: Partnerships and Transformation	
Financial	Nil	
Statutory & Regulatory	NHS Trusts have legal and contractual requirements in relation to health inequalities – which relate to service provision and the delivery of wider activities which impact on the health and wellbeing of people e.g. the Trust's role as an employer.	
Equality, Diversity & Inclusion		
Co-production & Partnership	Tackling health inequalities requires partnership working within and between Trusts and with lived experience, community, statutory and voluntary partners.	

Executive Summary

High-performing NHS Foundation Trusts can demonstrate, through robust evidence, a systematic approach to identifying, addressing, and reducing health inequalities (HI). Tackling HI is a critical enabler of Trust priorities, including Quality and Patient Safety, the Neighbourhood Programme, Elective Recovery, and the Patient Care Race Equality Framework. It aligns with Value-Based Healthcare and the ambitions of Integrated Health Organisations, supporting the delivery of improved outcomes within a financially constrained environment. It is core to realising the full population health benefits from implementation of HealthSet.

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During 2025/26, the scale and complexity of the HI agenda highlighted the need for a strategic reset. March's Quality Committee in Common flagged an urgent need for data and Board reporting, and visibility and alignment of inclusion-related activity and resource across the Trusts. A gap analysis was

undertaken against legal and contractual HI requirements and relevant guidance. Social value, and equality and public involvement legal duties, though inter-dependent, are out of scope.

Our focus for 2026/27 is on strengthening our organisational foundations to enable the routine identification of HI priorities and action to be taken, and compliance.

Key Messages are:

- Both Trusts have measures partially or fully in place to support compliance.; however, significant gaps remain, particularly in the collection, analysis, reporting, and publication of HI data, and in the consistency of practice across services. DCH is currently more mature, with HI dashboards available for operational and strategic use.
- Both Trusts must develop a 2026/27 HI Plan in Q1, in line with NHS Standard Contract Schedule 2N (which aligns to legal duties). Suggested areas have been reviewed alongside wider HI guidance for prioritisation. Existing commissioned services and the Joint Strategy Breakthrough Objectives already align with the national CORE20PLUS5 framework.
- The Joint 3-Year HI Plan responds to the gap analysis and focuses on meeting HI legal duties though (i) a clear strategic vision, (ii) use of HI data and insights to drive improvement and measure impact; and (iii) ensuring HI is considered in everything we do – building organisational ownership.
- The 2026/27 Joint HI Action Plan includes specific reference to CORE20PLUS5 and elective recovery and will take a watching brief on all other areas.
- All Quarter 1 activities have been completed, and most Quarter 2 actions are on schedule. Business Intelligence (BI) constraints have delayed the development of the DHC HI dashboard. BI resource has been identified to support the work with delivery expected in year. As a result, there remains a risk to the timely delivery of interdependent activities required to strengthen compliance and inform priority setting and improvement action in year. Progress is being closely monitored and subject to regular Executive review. Other risks being managed, relate to the routine use of patient and community insights to drive improvement and measure impact, uncertainty arising from ICB and NHSE change, and organisational capacity to deliver the 2026/27 Joint HI Action Plan. The Board Assurance Framework (BAF) recognises the importance of strengthening HI data and reporting.

Recommendation

The Board is asked to note:

- full assurance that the Joint 3 Year HI Plan and Joint 2026/27 HI Action Plan have been developed in response to a gap analysis against legal, contractual, and wider HI requirements.
- partial assurance regarding delivery of the Joint 2026/27 HI Action Plan due to BI constraints with residual risk to compliance and delivery; under close monitoring and Executive review, including BAF implications.

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Joint Health Inequalities Workstream: Update

1. Purpose of Paper and Scope

1.1 High-performing NHS Foundation Trusts can demonstrate, through robust evidence, a systematic approach to identifying, addressing, and reducing health inequalities (HI).

1.2 Tackling HI is a critical enabler of Trust priorities, including Quality and Patient Safety, the Neighbourhood Programme, Elective Recovery, and the Patient Care Race Equality Framework. It aligns with Value-Based Healthcare and the ambitions of Integrated Health Organisations, supporting the delivery of improved outcomes within a financially constrained environment. It is core to realising the full population health benefits from implementation of HealthSet.

1.3 To date, NHS Dorset has coordinated the system-wide approach to reducing HI, with provider trusts supporting workstreams and delivering plans aligned to the NHS Standard Contract Schedule 2N (Health Inequalities).

1.4 In 2025/26, the breadth and interdependencies of the HI agenda highlighted the need for a strategic reset; March's Quality Committee in Common flagged an urgent need for data and Board reporting, and visibility and alignment of inclusion-related activity and resource across the Trusts. For 2026/27, NHS restructuring increases expectations for Trust-led ownership of the HI agenda, amid uncertainty around Cluster capacity and the future assurance role of NHSE SW.

1.5 To inform next steps, a gap analysis was completed in relation to legal and contractual requirements alongside other available HI guidance. This is available on request. Our focus for 2026/27 is on strengthening our organisational foundations to enable the routine identification of HI priorities and action to be taken, and compliance.

1.6

1.7 **This paper presents**:

- Key findings from the gap analysis
- Overview of Joint 3-Year HI Plan and Joint 2026/27 HI Action Plan – in response
- Progress against the Joint 2026/27 HI Action Plan
- Summary of current governance arrangements and risks being managed
- Ask to Group

1.8 Social value, and equality and public involvement legal duties, though inter-dependent, are out of scope.

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2. Key findings from the gap analysis

2.1 Health Inequalities Legal Duties:

- Both Trusts have measures partially or fully in place to support compliance. This includes Executive leadership, Board development, equality impact assessments, national HI indicator development, and service improvement and transformation examples drawing on data and patient and community insights.
- However, gaps are noted – significantly in relation to the collection, analysis and publication of Trust HI data, and consistency of practice across services. DCH is currently more mature with HI dashboards ready for operational and strategic use.

2.2 Contractual Duties including CORE20+5 – and wider national guidance:

- Both Trusts must develop a 2026/27 HI Plan in Quarter 1, in line with NHS Standard Contract Schedule 2N (aligned to legal duties). Considerations range from the Five-Year Commissioning Plan to specific topics e.g. CORE20PLUS5[1], digital inclusion, prevention, elective recovery. Wider HI guidance is also available e.g. patient safety, health literacy.
- This has been reviewed to enable prioritisation for 2026/27. Of note, commissioned services and the Joint Strategy Breakthrough Objectives already align with the national and system CORE20PLUS5 framework. Moving forwards Health and Wellbeing Boards will confirm PLUS groups; these are expected to include inclusion health groups for example those who are homeless.

3. Overview of Joint 3-Year HI Plan and Joint 2026/27 HI Action Plan

3.1 The Joint 3-Year Joint HI Plan (see Appendix 1) responds to the gap analysis and focuses on meeting legal duties though:

- a clear strategic vision,
- use of HI data and insights to drive improvement and measure impact; and
- ensuring HI is considered in everything we do – building organisational ownership.

3.2 For 2026/27, the following topic areas are in scope:

- CORE20PLUS5 clinical services for adults[2] and children[3]
- Delivery of the HI aspects of guidance on reforming elective care[4]

3.3 For 2026/27, the HI Workstream will take a watching brief on all other topic areas. Plans will be iterative – to respond to emerging PLUS groups, new Trust data and guidance, and alignment opportunities e.g. Neighbourhood Programme.

4. Progress against Joint 2026/27 HI Action Plan (Appendix 2)

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[1] The national and System HI framework
[2] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities
[3] NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people
[4] NHS England » Reforming elective care for patients

4.1 All Quarter 1 activities have been completed, and most Quarter 2 actions are on schedule. Business Intelligence (BI) constraints have delayed the development of the DHC HI dashboard. BI resource has been identified to support the work with delivery expected in year. As a result, there remains a risk to the timely delivery of interdependent activities required to strengthen compliance and inform priority setting and improvement action in year. Progress is being closely monitored alongside live BI work planning to ensure milestones remain realistic and achievable, and is subject to regular Executive review.

5. Summary of current governance arrangements and risks being managed

5.1 The Joint HI Steering Group meets quarterly, chaired by DCH's Deputy Chief Medical Officer. The governance route to Board is via Trust Quality Governance Groups and upwards to Quality Committee in Common. Bi-annual updates include progress against the Annual Joint HI Plan. The Terms of Reference are available on request.

5.2 In addition to that described in (4.1), other risks being managed relate to the routine use of patient and community insights to drive improvement and measure impact, uncertainty arising from ICB and NHSE changes, and organisational capacity to deliver the 2026/27 Joint HI Action Plan. The Board Assurance Framework (BAF) recognises the importance of strengthening HI data and reporting.

5.3 ICB and NHSE restructuring is expected to affect future governance arrangements.

6. Recommendation

6.1 The Board is asked to note:

- *full* assurance that the Joint 3 Year HI Plan and Joint 2026/27 HI Action Plan have been developed in response to a gap analysis against legal, contractual, and wider HI requirements.
- *partial* assurance regarding delivery of the Joint 2026/27 HI Action Plan due to BI constraints with residual risk to compliance and delivery; under close monitoring and Executive review, including BAF implications.

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Appendix 1: Joint 3 Year HI Plan

Primary Driver	Year 1 - outputs	Year 2 - outputs	Year 3 - outputs	Impact
Clear Strategic Vision	✓ CORE20PLUS5 and HI elective recovery mapped and surfaced within HI workstream ✓ Joint Strategy HI metrics reviewed and refreshed ✓ HI embedded in priority emerging programmes ✓ Communications Plan developed and delivered, to enable good practice to be shared routinely ✓ Annual Report produced to inform Year 2	✓ Priority focus areas agreed ✓ Strategy HI metric targets agreed and tracked ✓ Communications Plan delivered ✓ Good practice routinely shared ✓ Annual Report produced to guide future planning	✓ Priority focus areas agreed ✓ Strategy HI metric targets agreed and tracked ✓ Communications Plan delivered ✓ Good practice routinely shared Annual Report produced to guide future planning	• Strong Board oversight • Staff, patients, and communities understand the priorities • HI reduce over time
Using HI data and insights to drive action and measure impact	✓ Optimised patient ethnicity data collection ✓ HI access dashboards live, reported to Board and setting priorities ✓ EPIC implementation optimised to enable a focus on tackling HI e.g. data quality, flags ✓ Refreshed National HI measurement framework published with Trust indicators ✓ HI information in Directorate reporting – incl CORE20+5 services, DNAs and waiting lists ✓ Patient and community insight gaps identified	✓ Optimised data collection (focus tba) ✓ HI experience dashboards live, reported to Board and setting priorities ✓ EPIC implementation optimised to enable a focus on tackling HI ✓ HI data, patient and community insights shaping priorities at strategic and operational levels	✓ Optimised data collection (focus tba) ✓ HI outcomes dashboards live, reported to Board and setting priorities ✓ EPIC implementation optimised to enable a focus on tackling HI ✓ HI data, patient and community insights shaping priorities at strategic and operational levels	• Communities understand why personal information is collected • Board can set and monitor priorities using reliable HI data and insights • Directorates routinely use HI data and insights to improve services • Staff trust the HI data and insights available to them
HI being considered in everything we do	✓ Board development delivered ✓ EDS2 Inclusive Leadership actions delivered ✓ Assurance impact assessments cover HI ✓ HI woven through communications activities throughout the year where possible ✓ Equity embedded in the Improving Together Programme ✓ Staff support needs identified to turn data/ insights into action	✓ Planning and testing solutions to support staff ✓ Further actions to enable embedding, based on learning	✓ Planning and testing solutions to support staff ✓ Further actions to enable embedding, based on learning	• Board and wider staff have the skills and confidence to tackle HI • Organisational Culture supporting HI

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Appendix 2: Joint 2026/27 HI Action Plan

	Objective	Q1	Q2	Q3	Q4	Impact
Delivered						
On schedule						
Behind schedule						
Clear Strategic Vision	*CORE20PLUS5 and HI elective recovery mapped and surfaced through HI workstream*		• EDS2 Domain 1 case studies agreed • Mapping complete against guidance	• EDS2 Domain 1 case studies developed • Implementation of actions identified; escalation of unmitigated risk	• EDS2 published and learning shared • Implementation of actions identified; escalation of unmitigated risk	✓ Strong Board oversight ✓ Staff, patients, and communities understand the priorities ✓ HI reduce over time
	Joint Strategy HI metrics reviewed and refreshed		• Proposal scoped	• Proposal refined	• Metrics live	
	HI embedded in priority emerging programmes			• Opportunities explored e.g. Neighbourhood Programme, IHO development	• Opportunities explored and implemented	
	Communications Plan developed and delivered, to enable good practice to be shared routinely		• Agree approach • Review other Trust webpages	• Establish HI intranet page to share resources incl case studies with staff • Publish HI Plan (priorities); communicate	• Establish external webpage; publish annual report incl progress and communicate to key stakeholders	
	Annual Report produced to inform Year 2			• Planning in line with legal duties	• Report delivered • Consider repeat gap analysis	
Using HI data and insights to drive action and measure impact	*Optimised patient ethnicity data collection*	• Data quality and completeness baseline complete (DHC)	• Scoping coproduced ethnicity recording improvement plans[5]	• Implementation	• Implementation	✓ Communities understand why personal information is collected ✓ Board can set and monitor priorities using reliable HI data and insights ✓ Directorates routinely use HI data and insights to improve services ✓ Staff trust the HI data and insights available to them
	HI access dashboards live, reported to Board and setting priorities		• Dashboard live (DNAs, waiting lists) - DHC	• Insights shaping strategic and operational priorities	• Implementation; insights shaping strategic and operational priorities	
	EPIC implementation optimised to enable a focus on tackling HI e.g. data quality, flags		• Framework for public heath considerations shared	• Opportunities identified; implementation	• Opportunities identified; implementation	
	Refreshed National HI measurement framework published with Trust indicators				• DiiS publish indicators, in partnership with Provider Trusts	
	HI information in Directorate reporting – incl CORE20+5 services, DNAs and waiting lists				✓ Routine directorate reporting live	
	Patient and community insight gaps identified	• Scoping via Engagement and Coproduction Development Group	• Mapping of involvement approaches	• Mapping extended to consider equity of representation and gaps identified	• Implementation of actions identified; escalation of unmitigated risk	
HI being considered in	*Board development delivered*				• Session delivered	

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[5] NHS England » Ethnicity Recording Improvement Plan

everything we do	*EDS2 Inclusive Leadership actions delivered*		• Scoping aligned to patient and public facing We All Belong Campaign	• Scoping aligned to patient and public facing We All Belong Campaign	• Implementation of actions identified, with escalation of unmitigated risk	✓ Board and wider staff have the skills and confidence to tackle HI ✓ Organisational Culture supporting HI
	Assurance impact assessments cover HI		• Scoping aligned to EDI review of EIA processes	• Scoping aligned to EDI review of EIA processes	• Implementation of actions identified, with escalation of unmitigated risk	
	HI woven through Patient Safety			• Approach agreed	• Implementation	
	HI woven through Patient Experience			• Approach agreed	• Implementation	
	HI woven through communications activities throughout the year where possible		• Scoping approach with Comms	• Comms forward plan process established, with link to HI Workstream	• Routine comms includes HI as appropriate	
	HI embedded in the Improving Together Programme			• Refreshed stakeholder membership at the Improving Together Programme Board to provide focus on equity and prevention	• Teams supported to identify HI projects for prioritisation, as HI data becomes available	
	Staff support needs identified to turn data/ insights into action				• Teams supported to identify HI projects for prioritisation, as HI data becomes available	

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Dorset HealthCare University
NHS Foundation Trust

Report to	Board of Directors in Common (DHC)	
Date of Meeting	13/10/2026	
Report Title	Implementing the Patient Carer Race Equality Framework: Bi-annual Update	
Prepared By	Dr Helena Posnett, Consultant in Public Health and Trust Lead for Health Inequalities Sarah Rose, Director of Operations, Dorset Mental Health Forum	
Approved by Accountable Executive	Dr Lucy Knight, Chief Medical Officer (Executive Lead for Health Inequalities)	
Previously Considered By	Quality Committee in Common, 29/09/2026	
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		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1: Safety and Quality – SR7: Partnerships and Transformation	
Financial	No direct implication	
Statutory & Regulatory	This report provides an update on Dorset Healthcare's moral duty and contractual requirement to implement the Patient Carer, Race Equality Framework (PCREF). This supports the Trust to evidence how it is meeting legal and regulatory duties.	
Equality, Diversity & Inclusion	PCREF speaks to equality, diversity and inclusion, with respect to the patients and communities we serve and our workforce	
Co-production & Partnership	Co-production and partnership are core to PCREF specifically with racialised and ethnic minority communities in Dorset (those with lived experience, their carers, our staff, and communities); and between organisational functions.	

Executive Summary

- Significant inequalities persist in relation to mental health services for racialised communities. The Patient and Carer Race Equality Framework (PCREF) is part of the Joint Anti-Racism and Inclusion Framework and enables compliance with legal, regulatory and contractual obligations.
- PCREF is interdependent with the Joint Health Inequalities (HI) Workstream, reported separately. During 2025/26, the scale and complexity of the HI agenda highlighted the need for a strategic reset. March's Quality Committee in Common flagged an urgent need for HI data and Board reporting, and visibility and alignment of inclusion-related activity and resource across the Trusts.
- The 2026/27 PCREF Plan focuses on addressing gaps identified through a refreshed self-assessment against guidance. In 2026/27 we will continue our focus on: developing the

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organisational foundations which shape day to day practice practise and will enable data and patient, carer and community insights to set priorities for action taken, supporting service-led improvement, and compliance.It covers:

1. Leadership and Governance: *agreeing interdependency reporting, reviewing legal and regulatory compliance, improving ethnicity data recording; developing routine Board reporting; increasing organisational awareness of responsibilities*
2. Organisational Competencies: *strengthening co-production and community leadership arrangements; developing a culturally competent education offer; embedding learning within high-acuity services, extending improvement activity to community mental health, perinatal, and children and young people's services.*
3. Patient and Carer Feedback: *enhancing mechanisms to capture, act on and report patient and carer experiences.*

- PCREF delivery is interdependent on a wider range of programmes and services reported through established governance arrangements. These include activities focused on workforce anti-racism, and delivering culturally competent care (food, translation services) and Transformation Programmes with significant coproduction expectations e.g. Neighbourhood Programme. Related Physical Health projects are overseen by the Quality Priority Programme.
- All Quarter 1 activities have been completed, and most Quarter 2 actions are on schedule. Business Intelligence (BI) constraints have delayed the development of the DHC HI dashboard (with a focus on access). BI resource has been identified to support the work with delivery expected in year. As a result, there remains a risk to the timely delivery of interdependent activities required to strengthen compliance including Board reporting of quality metrics reviewed by ethnicity, including restrictive practice and Mental Health Act detentions and patient and carer feedback. Progress is being closely monitored and subject to regular Executive review. Other risks being managed relate to (i) the routine use of patient, carer and community insights to drive improvement and measure impact, with budget to enable participation (ii) a lack of programme support e.g. to enable interdependency reporting, (iii) a lack of evaluation support to better evidence impact and (iv) organisational capacity constraints to take forwards actions particularly those to be identified through planned reviews of legislative and regulatory requirements, and coproduction in interdependent transformation programmes. The Board Assurance Framework (BAF) recognises the importance of strengthening health inequalities data and reporting (including ethnicity).

Recommendation

The Board is asked to note:

- *full* assurance that the 2026/27 PCREF Plan has been developed in response to a refreshed self-assessment against guidance
- *partial* assurance regarding delivery of the Joint 2026/27 HI Action Plan due to BI constraints with residual risk to compliance and delivery; under close monitoring and Executive review, including BAF implications.

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Implementing the Patient Carer Race Equality Framework: Bi-annual Update

1. Background and Purpose of paper

1.1 Significant inequalities persist in relation to mental health services for racialised communities. The Patient and Carer Race Equality Framework (PCREF), forms part of the Joint Anti-Racism and Inclusion Framework and supports compliance with legal, regulatory and contractual obligations.

1.2 PCREF has a clear interdependency with the Joint Health Inequalities (HI) Workstream, reported separately. In 2025/26, the breadth and interdependencies of the HI agenda highlighted the need for a strategic reset; March's Quality Committee in Common flagged an urgent need for data and Board reporting, and visibility and alignment of inclusion-related activity and resource across the Trusts

1.3 A refreshed self-assessment (June 2026) based on guidance[1], has informed the 2026/27 PCREF Plan. In 2026/27 we will continue our focus on: developing the organisational foundations which shape day to day practice practise and will enable data and patient, carer and community insights to set priorities for action taken, supporting service-led improvement, and compliance.

1.4 This paper presents:

- Findings from the self-assessment, and required action
- The 2026/27 PCREF Plan – in response, and progress
- Governance arrangements and key programme risks
- Ask to the Group

1.5 PCREF delivery is interdependent on a wider range of programmes and services reported through established governance arrangements. These include activities focused on workforce anti-racism, equality impact assessments, our approach to engagement and coproduction, translation and interpretation, food and nutrition, chaplaincy and faith services and communication (including the Accessible Information Standard). Transformation Programmes also have significant coproduction expectations.

1.6 Related Physical Health projects are overseen through the Quality Priority Programme.

2. Self-assessment and Required Action

2.1 The full self-assessment is available on request and highlights the breadth and complexity of PCREF. Key points are provided below.

2.2 Core Measure: Leadership and Governance (Legislative & Regulatory Obligations)[2]

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[1] NHS England » Patient and carer race equality framework

[2] Nominate an executive board lead and establish governance structures, accountability and leadership across the organisation. Co-develop, implement and review local PCREF plans with racialised communities and your workforce. Identify

- Executive leadership and governance arrangements are established. The Trust needs to strengthen the collection, analysis and use of data and insights to inform decision-making, drive improvement and demonstrate impact. Board reporting should routinely include performance and quality metrics reviewed by ethnicity, including restrictive practice and Mental Health Act detentions and patient and carer feedback.
- Equality Impact Assessments are in place. The Trust needs to review legislative and regulatory requirements to evidence compliance and identify action required.

2.3 Core Measure: National Organisational Competencies[3]

- PCREF is a key delivery framework within the Joint Anti-Racism and Inclusion Framework. The We All Belong campaign should be used to increase awareness of Trust responsibilities and the PCREF Plan for staff, patients, carers and communities.
- Activity is underway or planned through existing programmes, to strengthen organisational competencies including:
    - *Workforce* – ensuring ethnic minority and racialised staff are supported, represented and able to influence decision-making across the Trust
    - *Coproduction* – a core component of priority transformation programmes
    - *Cultural competence* – equipping staff to provide culturally responsive care e.g. through improvements to food and nutrition, translation and interpretation

  Interdependency reporting needs discussion and agreement.
- The inpatient Culture of Care Programme has successfully supported quality improvement activity focused on *cultural competence*, and *staff knowledge and awareness*. The Trust needs to embed learning in inpatients and extend projects to wider settings to build the evidence base, drive consistency of practice, and improve access, experience and outcomes
- Co-production infrastructure is being established. Initial work has focused on relationship-building (pre-production) with Gypsy, Roma and Traveller, Nigerian, Afghan and asylum-seeking communities. The Staff Multi-Cultural network enables staff and community voice to be heard and supports service improvement.
    - Meaningful co-production will require new mechanisms for community influence and change to existing structures and ways of working. This is a significant

priorities for improvement in meeting the specific legislative and regulatory requirements relating to equalities to include in local PCREF plans. Monitor core measures at Trust Board level on a regular basis and publish PCREF plans

[3] Engage with racialised communities to identify and agree core organisational competencies. Agree on measurable and practical actions to co- develop in local PCREF plans. Ensure the whole organisation is aware of its responsibilities in implementing local PCREF plans.

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programme of long-term transformational change with many interdependencies including Neighbourhood Health, Therapeutic Admissions.

- Maintaining clear priorities and organisational focus will be critical. Further detail is available on request.

- A Trust-wide education offer is required to support the long-term behavioural and cultural change needed to deliver equitable and culturally responsive care.

2.4 Core Measure: Patient and carer feedback mechanism[4]

- The Trust needs to establish robust mechanisms to ensure the experiences of racialised and ethnic minority patients and carers are captured and acted upon. This should be a core element of Board reporting (see 2.2) with transparent feedback loops.
- Awaited National guidance on experience measures will inform future action.

3. 2026/27 PCREF Plan and Progress

3.1 The 2026/27 PCREF Plan (Appendix 1) translates the self-assessment findings into a focused programme of work across the three PCREF core measures. This balances the need for immediate improvement with longer-term transformational change required:

- Leadership and Governance: agreeing interdependency reporting, reviewing legal and regulatory compliance, improving ethnicity data recording; developing routine Board reporting; increasing organisational awareness of responsibilities
- Organisational Competencies: strengthening co-production and community leadership arrangements; developing a culturally competent education offer; embedding learning within high-acuity services, extending improvement activity to community mental health, perinatal, and children and young people's services.
- Patient and Carer Feedback: enhancing mechanisms to capture, act on and report patient and carer experiences.
- All Quarter 1 activities have been completed, and most Quarter 2 actions are on schedule. Business Intelligence (BI) constraints associated with EPIC and wider priorities have delayed the development of the DHC HI dashboard, with a focus on access. BI resource has been identified to support the work with delivery expected in year. As a result, there remains a risk to the timely delivery of interdependent activities required to strengthen compliance including Board reporting of quality metrics reviewed by ethnicity, including restrictive practice and Mental Health Act detentions and patient and carer feedback. Progress is being closely monitored

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[4] *Ensure patient experience data is used, monitored and flowed to national datasets to enable bench- marking, lesson-sharing and service improvement. Ensure outcome measures are routinely used and monitored locally, and flowed to national datasets to enable benchmarking, lesson-sharing and improvement of services. Agree approaches for implementing a 'real time' and transparent feedback loop for racialised and ethnically and culturally diverse communities*

alongside live BI work planning to ensure milestones remain realistic and achievable, and is subject to regular Executive review.

4. Programme Governance and Risk

4.1 A multidisciplinary PCREF Working Group meets every six weeks and includes representation from the Staff Multi-Cultural Network, Dorset Mental Health Forum (bringing lived experience and community perspectives), and local authority Public Health. The group's Terms of Reference is scheduled for review in Q2.

4.2 Governance and assurance are provided through the Joint Quality Committee in Common, with onward reporting to the Board. Dr Lucy Knight, Chief Medical Officer and Executive Lead for Health Inequalities, is the Executive Sponsor for the programme.

4.3 The Board receives bi-annual assurance reports on progress against the PCREF Plan and the three core measures.

4.4 The Dorset Race Equality Council (DREC) has recently relaunched in partnership with Dorset Community Action Network, with a renewed focus on community engagement and amplifying the voices of ethnic minority communities. Initial contact has been established and opportunities for partnership working are being explored.

4.5 In addition to that described in (3.3), other risks being managed relate to (i) the routine use of patient, carer and community insights to drive improvement and measure impact, with budget to enable participation (ii) a lack of programme support e.g. to enable interdependency reporting, (iii) a lack of evaluation support to better evidence impact and (iv) organisational capacity constraints to take forwards actions particularly those to be identified through planned reviews of legislative and regulatory requirements, and coproduction in interdependent transformation programmes. The Board Assurance Framework (BAF) recognises the importance of strengthening health inequalities data and reporting (including ethnicity).

4.6 Contractual reporting to NHS Dorset continues. ICB and NHSE restructuring is expected to affect future governance arrangements.

6. Recommendation

6.1 The Board is asked to note:

- ***full* assurance** that the 2026/27 PCREF Plan has been developed in response to a refreshed self-assessment against guidance
- **partial assurance** regarding delivery of the Joint 2026/27 HI Action Plan due to BI constraints with residual risk to compliance and delivery; under close monitoring and Executive review, including BAF implications..

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APPENDIX 1: PCREF Implementation Plan 2026/27:

Part 1: Legislative and regulatory obligations (Leadership and governance)		Q1	Q2	Delivered Q3	On schedule Q4	Behind schedule Impact
Governance and assurance	Maintain robust arrangements incl. Board reporting and oversight of interdependencies incl coproduction	• Repeat self-assessment • Develop 26/27 Plan	• Refresh TOR • Biannual reporting to Board • Interdependency reporting agreed	• Collaboration opportunities agreed with DREC	• Biannual reporting to Board • Consider repeat self-assessment to shape 2027/28 planning	• Strong Board oversight and assurance • Health inequalities reduce over time
Legislatory and Regulatory requirements	Undertake gap analysis and implement any actions required		• Review self-assessment through focused on legislative and regulatory requirements	• Implementation of actions; escalation of unmitigated risk	• Implementation of actions; escalation of unmitigated risk	• Improved compliance with legislative and regulatory requirements.
Comm-unications	Embed PCREF within the We All Belong campaign to increase awareness of Trust responsibilities and priorities internally and externally.		• Review other Trust webpages re PCREF • Establish PCREF intranet page to share resources incl case studies with staff	• Sharing content with Comms to promote • Establish external PCREF webpage to communicate key updates • Publish PCREF Plan and communicate	• Sharing content with Comms to promote • Learning from 2026/27 shapes public facing messages based on what matters to communities and what can be expected	• Increased awareness of PCREF across staff, patients and communities.
Ethnicity data	Improve ethnicity data quality and completeness from baseline	• Data quality and completeness baseline complete	• Scoping coproduced ethnicity recording improvement plans[5]	• Implementation	• Implementation	• More complete and reliable ethnicity data.
Board and service reporting	Strengthening Board reporting through the inclusion of key ethnicity-related performance and quality indicators and patient and carer feedback to support service improvement and decision-making	• Review of reporting guidance	• Board Reporting Plan agreed with BI and Patient Experience teams • Resource identified to deliver Board Reporting requirements • Health Inequalities Dashboard live (DNAs, waiting lists)	• Implementation; insights shaping strategic and operational priorities	• Implementation; insights shaping strategic and operational priorities • Carer feedback summary available; complaints reporting available using ethnicity	✓ Board can set and monitor priorities using reliable HI data and insights ✓ Directorates routinely use HI data and insights to improve services ✓ Staff trust the HI data and insights available ✓ Data and insights available and setting priorities for 2027/28 ✓ A stronger evidence base to support future benchmarking, evaluation and PCREF delivery.

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[5] NHS England » Ethnicity Recording Improvement Plan

Part 2: Organisational Competencies				Delivered	On schedule	Behind schedule
Objective		**Q1**	**Q2**	**Q3**	**Q4**	**Impact**
Coproduct-ion Infrastruc-ture	Develop co-production infrastructure, building on relationships established and strengthening community leadership in service design and improvement.		• Agree scope for capture and oversight of activity in interdependent programmes, representatives, and gaps	• Implementation of actions identified, with escalation of unmitigated risk • Reassess coproduction approach acknowledging interdependencies		✓ Increased representation in PCREF Working Group and within system meetings of community leaders ✓ Regular activity updates in PCREF Working Group ✓ Stories, quotes, feedback to add to Insights Bank ✓ Increased opportunities for engagement with community reps at all levels ✓ Pilot and proof of concept coproduction activities ✓ Investment in community infrastructure and feedback loops ✓ Non-tokenistic, sustained involvement and equity in delivery ✓ Accessible communication tools including infographics, plain language, and visual storytelling
		• Relationship Building and identification of community representatives	• Relationship Building and identification of community representatives	• Relationship Building and identification of community representatives	• Relationship Building and identification of community representatives	
			• Finalise My Recovery Stories Booklet • One World Festival, promoting engagement and membership	• Finalise My Recovery Stories Booklet		
			• First Multiagency Health Inequalities Coproduction network for Dorset partners (tracked through **MH LD Steering Group**)	• Coproduction session, orientating new partner organisations		
			• Development of opportunities for lived experience voices (ICN)	• Development of Lived Experience Reference Group Poverty Truth Commission		
				• ICN GP Pilot • Further sessions alongside GRT Communities		
Education offer	Develop education offer, to improve staff knowledge and confidence to deliver culturally responsive care.	• Options explored incl Global Black Thrive	• Testing elfh offer to consider suitability to promote		• Coproduced cultural competency education offer with community partners	✓ Available education offer for 2027/28
High Acuity	Sharing and embedding learning (tracked through **Reducing Restrictive Practice governance)**	• Review approach to EDI champion roll out	• EDI champions in place on Herm and St Brelades • Comms approach agreed to support EDI champions • Shared approach to training and development through EDI champions	• Roll out EDI champions to other wards	• Roll out EDI champions to other wards	✓ EDI champion network established and sharing learning
			• Ensure incidents of racism are routinely reported	• Review My Wellbeing Plan audit for consideration of cultural needs	• Sharing of good and poor practice through peer and advocacy channels established and reported • Update Welcome packs for patients and supporters	✓ Improved staff experience ✓ Improved staff knowledge, cultural competence and confidence. ✓ More culturally responsive services.

Phase
1.Set-up and shared ownership (Preproduction)
2. Listening and view-seeking
3. Sense-making
4. Co-design improvements
5. Test and learn
6. Embed and scale

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Part 2: Organisational Competencies				Delivered	On schedule	Behind schedule
					that include expectations around cultural needs	✓ A stronger evidence base to support PCREF delivery and evaluation.
		• Project scoping and focus agreed: PICU (patient experience), Alumhurst and Herm and St Brelades (staff experience)	• Project plans developed • PDSA cycles	• PDSA cycles	• PDSA cycles • Develop approach to debriefs	
					• Mechanisms developed to involve communities and enable cultural needs of inpatients to be met and support admission avoidance	
Community mental health	**Extending improvement activity across wider services**	• Project scoping and pilot site consensus (tracked through **Access Wellbeing Steering Group**)	• Boscombe test of concept: mapping under-represented groups in services • Methodology captured	• Relationship building with under-represented groups • Methodology captured	• Relationship building with under-represented groups • Coproduce projects to improve access • Roll out methodology to second pilot site	✓ Improved staff experience ✓ Improved staff knowledge, cultural competence and confidence. ✓ More culturally responsive services. ✓ A stronger evidence base to support PCREF delivery and evaluation.
Perinatal focus		• Project scoping incl perinatal and maternal mental health services, and Steps2Wellbeing	• Project plan developed • Data deep dive to understand un-met need for care	• Relationship building with under-represented groups	• Relationship building with under-represented groups • Coproduce projects to improve access	
Children & Young People's Services		• Project scoping	• Project plan developed to understand un-met need for care aligned to Transformation benefits workstream	• Data analysis • Relationship building with under-represented groups	• Relationship building with under-represented groups • Coproduce projects to improve access	
			• Project plan to enable diversity of voice aligned to Transformation engagement workstream	• Relationship building with under-represented groups • Diversity of engagement in activities, learning shared	• Relationship building with under-represented groups • Diversity of engagement in activities, learning shared	

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Part 3: Patient and carers feedback mechanisms				Delivered	On schedule	Behind schedule
Objective		**Q1**	**Q2**	**Q3**	**Q4**	**Impact**
Board and service reporting	Establish robust mechanisms that ensure the experiences of racialised communities are systematically captured, inform decision-making, and can be evidenced through service improvement and Board reporting.	Activities to strengthen patient and carer feedback mechanisms are incorporated within Part 1: Leadership and Governance. This reflects the Trust's current position, where foundational work is required to improve the routine collection, analysis, and reporting of ethnic minority and racialised patients, carer and community insight alongside quality and performance data.				✓ Improved capture and use of patient, carer, and community insight. ✓ Greater assurance that the voices of racialised communities influence service development and decision-making. ✓ More transparent feedback loops demonstrating how engagement informs action and improvement. ✓ A stronger evidence base to support future benchmarking, evaluation, and PCREF delivery.

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Dorset HealthCare University
NHS Foundation Trust

Report to	Board in Common (DHC)	
Date of Meeting	13th October 2026	
Report Title	Safeguarding Service Annual Report 2025/26	
Prepared By	Head of Safeguarding – Alison Clark	
Approved by Accountable Executive	Interim Chief Nursing Officer – Cara Southgate	
Previously Considered By	Quality Governance Group 02 June 2026 Quality Committee in Common, 29th September 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 Safety and Quality	
Financial	No implication	
Statutory & Regulatory	Children Act 2004, Working Together to Safeguard Children (2018/2023/2026) and the Care Act 2014.	
Equality, Diversity & Inclusion	No implication	
Co-production & Partnership	No implication	

Executive Summary

This Annual Safeguarding Report provides assurance on the effectiveness of safeguarding arrangements within Dorset Healthcare University NHS Foundation Trust (DHC) for the period April 2025 to March 2026.

DHC continues to meet its statutory responsibilities to safeguard and promote the welfare of children and adults at risk. Safeguarding remains embedded across the organisation, supported by strong governance structures, clear leadership, and active engagement across multi-agency partnerships.

Key Achievements

- Continued delivery of safeguarding priorities aligned with Dorset Safeguarding Adults Board and Children's Partnerships.
- Strong multi-agency engagement, including representation across MASH, MARAC, MAPPA, and safeguarding partnerships in both BCP and Dorset Council areas.
- Progress in embedding a 'Think Family' approach across services.
- Enhanced safeguarding support to community services, including 32 targeted visits to district nursing teams, improving confidence and practice.
- Completion and implementation of action plans relating to the Mental Capacity Act (MCA) following independent audit, with demonstrable improvements in compliance.
- Progress in sexual safety standards across inpatient mental health settings, with further work planned for community services.
- Continued development of safeguarding training, including domestic abuse and self-neglect, supported by a train-the-trainer approach.

Key Activity and Demand

- Safeguarding demand remains high, particularly within the Multi-Agency Safeguarding Hub (MASH), with over 10,800 cases reviewed during the year.

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- Increased activity observed in DoLS applications, reflecting improved awareness and appropriate use of legislation.
- 40 allegations against staff were managed during the reporting period, a significant increase from previous years, though not all were substantiated.

Areas of Risk and Challenge

- Training compliance remains below the Trust target of 95% across several safeguarding areas, particularly MCA/DoLS and Level 3 training.
- Prevent Level 3 compliance remains static at 73%.
- Variable multi-agency presence within MASH has at times impacted collaborative working.
- Continued need to strengthen staff confidence and application of the Mental Capacity Act in practice.

Assurance and Governance

Robust governance arrangements are in place, with safeguarding performance reported regularly through the Safeguarding Group, Directorate Management Groups, and Quality Governance structures. This ensures appropriate oversight, accountability, and escalation of risk.
There are no outstanding statutory compliance issues identified for safeguarding children or adults.

Priorities for 2026–2027

Key areas of focus include:

- Improving safeguarding and Prevent training compliance.
- Strengthening practice and confidence in the Mental Capacity Act.
- Enhancing sexual safety across all care settings.
- Embedding learning from safeguarding reviews and audits.
- Supporting system-wide changes, including Multi-Agency Child Protection Teams (MACPTs) and implementation of CP-IS.
- Continuing to develop responses to domestic abuse and exploitation.

Conclusion

The Trust can provide assurance that safeguarding arrangements are effective and continue to develop in response to emerging risks, learning, and national priorities. DHC remains committed to continuous improvement to ensure the safety and wellbeing of all those in its care.

Recommendation

Members are requested to:

Receive the report for **assurance**.

Appendices

1. **Dorset HealthCare Safeguarding Service Annual Report 2025-26**– This report is available in the Board in Common document folder on AdminControl, for the October 2026 meeting – titled '*5.6ai DHC Safeguarding Service Annual Report 2025-26*'.

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Report to	Board in Common (DCH)	
Date of Meeting	13 October 2026	
Report Title	DCH Safeguarding Annual Report	
Prepared By	Sarah Cake - Head of Safeguarding	
Approved by Accountable Executive	Pam O'Shea– Interim Chief Nursing Officer	
Previously Considered By	Quality Committee in Common 29.09.26 Quality Governance Group 15.07.26 Safeguarding Committee quarterly meetings 2025-2026	
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		No
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality and Safety	
Financial	No implication.	
Statutory & Regulatory	• Female Genital Mutilation Act 2003 • Mental Capacity Act 2005 • UN Convention on the Rights of Persons with Disabilities 2006 • Mental Health Act 2007 • Children and Families Act 2014 • Modern Slavery Act 2015 • Serious Crime Act 2015 • NHS Constitution and Values (updated Jan 2021) • Domestic Abuse Act 2021 • Serious Violence Duty 2023 • Prevent Duty 2023 • United Nations Convention on the Rights of the Child 1989 • Children Act 1989 and Children Act 2004 • Working Together to Safeguarding Children 2023 • European Convention on Human Rights • The Care Act 2014 Regulation 13 NHS Safeguarding Accountability and Assurance Framework July 2024 **Providers:** Must demonstrate that safeguarding is embedded at every level, including identifying named nurses/doctors and submitting an annual safeguarding report to their board. **The 11 Indicators:** The Safeguarding Commissioning Assurance Toolkit (Safeguarding-CAT) uses 11 key indicators—	

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	such as leadership, training, and safer recruitment—to provide a structured approach to assurance
Equality, Diversity & Inclusion	As above
Co-production & Partnership	Dorset Safeguarding Children Partnership, DBCP Safeguarding Adults Board

Executive Summary

Adult Safeguarding

- Over the last 12 months, Dorset County Hospital (DCH) submitted 130 safeguarding concerns for consideration under Care Act Section 42 criteria. Much of the safeguarding team's work focused on prevention, advice and signposting where statutory investigations were not required.
- The highest number of concerns related to adults aged over 75 years, with the main issues being:
  - Neglect and omission of care
  - Carer fatigue
  - Financial abuse
- For adults aged 18-60 years, self-neglect and substance misuse were the predominant concerns, while adults aged 60-75 years were more likely to present with domestic abuse and alcohol-related self-neglect.
- Six safeguarding enquiries involved DCH services, primarily relating to communication and discharge planning issues. These were managed through nominated enquiry processes, and learning was shared with relevant departments.
- No referrals relating to modern slavery were made.
- Transitional safeguarding activity for young people at risk of exploitation, addictions and extra-familial harm increased during the year.
- One Prevent enquiry was undertaken, with no formal referrals.

Children's Safeguarding

- Children's safeguarding activity continued to increase, with 9,207 Emergency Department attendances for 0-17 year olds, representing a 13.8% increase on the previous year.
- Weekly Integrated Liaison Meetings reviewed children and young people with safeguarding concerns, mental health issues, self-harm presentations or frequent attendances.
- Emerging themes included:
  - Increased ketamine use among young people
  - Child exploitation risks
  - Peer-on-peer assaults
  - Safeguarding implications of parental mental health and substance misuse.
- Referrals concerning children showed a sustained upward trend throughout 2025-26, indicating increasing safeguarding pressures.
- There was a notable rise in safeguarding concerns arising from adult presentations where children may be affected by:
  - Drug and alcohol misuse
  - Domestic abuse
  - Mental health crises
  - Impaired parenting capacity

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Extra Familial Harm Risks (EFHR)

- DCH remained an active partner in Dorset's multi-agency response to child exploitation and extra-familial harm.
- Staff participated in weekly and quarterly EFHR panels, ensuring children at risk were identified, information shared and safeguarding plans coordinated across agencies.
- DCH raised awareness during National Child Exploitation Day and strengthened links with youth workers and community partners.

Multi-Agency Working and Governance

- DCH met its safeguarding responsibilities under both the Children Act and Care Act and received no concerns regarding safeguarding governance or practice during 2025-26.
- The Trust contributed to safeguarding reviews, domestic homicide reviews, child death reviews and safeguarding adult reviews, ensuring learning informed practice and quality improvement.
- Collaborative work across Dorset safeguarding partners continued to strengthen system-wide learning and improvement.

Training and Supervision

- Safeguarding training compliance generally remained between 84%-95%, although some programmes fell below the Trust target of 85-90%.
- New Level 3 safeguarding training for both adults and children was introduced, receiving positive feedback.
- Children's safeguarding supervision remained well established, with staff reporting increased confidence, improved safeguarding knowledge and greater participation in multi-agency decision-making.

Maternity Safeguarding

- Maternity services managed:
  - 15 referrals for concealed, denied or late-presenting pregnancies
  - 6 Female Genital Mutilation (FGM) referrals
- Following a CQC assessment, maternity processes were strengthened to improve Child Protection Information Sharing (CP-IS) checks and safeguarding oversight.
- A complex case involving a late-presenting pregnancy demonstrated effective multi-agency working and the use of professional escalation procedures where safeguarding concerns differed between agencies.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- Ongoing staff support, coaching and bespoke MCA training continued throughout the year.
- 1,074 DoLS applications were submitted, representing an increase from 1,010 in 2024-25.
- DCH continued to work regionally to improve MCA application, share learning and strengthen assurance arrangements.

Domestic Abuse

- Domestic abuse referrals increased significantly, particularly involving:
  - Older adults
  - Pregnant women
  - Children affected by domestic abuse
- Recognition and reporting of non-fatal strangulation improved, supported by robust clinical pathways and close working with specialist services.

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Learning Disability and Autism

- The Trust continued to strengthen care for people with learning disabilities and autism through:
  - Oliver McGowan mandatory training
  - Updated reasonable adjustment care plans
  - Learning Disability benchmarking participation
  - Enhanced patient engagement activities
- Feedback highlighted strengths in staff compassion and communication, while also identifying opportunities to improve signage, waiting-time information, accessibility and parking.

Safeguarding Concerns Involving Staff

- The safeguarding team worked closely with HR, Local Authority Designated Officers (LADO) and partner agencies when concerns arose involving employees.
- Processes were strengthened to improve timeliness, risk assessment and senior oversight.
- The team supported implementation of new sexual safety policies and procedures.

Audit, Quality Assurance and Risk

Key areas of assurance work included:

- Child Protection Medical peer reviews
- Section 11 safeguarding audit
- Safeguarding assurance audits
- Prevent reporting
- Learning disability audits
- Research and publication demonstrating improved safeguarding documentation in the Emergency Department.

Key ongoing risks include:

- Recording of carers and parental responsibility on electronic systems.
- Level 3 Children's Safeguarding training compliance.

Key Achievements and Future Focus

Notable achievements during 2025-26 included:

- Introduction of new safeguarding training programmes.
- Refresh of safeguarding intranet resources.
- Improved domestic abuse pathways.
- Active involvement in Families First for Children reforms.
- Increased multi-agency working across safeguarding partnerships.

Overall, the report demonstrates a continued rise in safeguarding demand across adults, children, maternity and domestic abuse services, while evidencing strong multi-agency partnerships, robust governance arrangements, ongoing quality improvement and a proactive approach to supporting vulnerable people across Dorset County Hospital.

Recommendation

Members are requested to:

- Receive the report for **assurance**

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Appendices

1. **Dorset County Hospital Safeguarding Annual Report and Quality Improvement Plan 2025-2027** – This report is available in the Board in Common (public) document folder on AdminControl, for the October 2026 meeting – titled '*05.6bii DCH Safeguarding Annual report 2025- 2026 and QI Plan*'.

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Report to	Board of Directors in Common – DCH and DHC	
Date of Meeting	13 October 2026	
Report Title	Thirlwall Inquiry - Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018	
Prepared By	Jenny Horrabin, Joint Executive Director of Corporate Affairs	
Approved by Accountable Executive	Matthew Bryant, Chief Executive Officer	
Previously Considered By	N/A	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Quality, SR2 Empowerment	
Financial	No implication in this report, although likely implementations arising from recommendations of Inquiry	
Statutory & Regulatory	Response to national inquiry	
Equality, Diversity & Inclusion	No implication in this report, although likely implementations arising from recommendations of Inquiry	
Co-production & Partnership	No implication in this report, although likely implementations arising from recommendations of Inquiry	

Executive Summary

The Thirlwall Inquiry was established to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital. Full details of the Inquiry can be found at: The Thirlwall Inquiry | Examining the events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital.

The Thirlwall Inquiry Report was published on 15 September 2026. The Reports can be found at the links below and copies are also included in the Reading Room that sits alongside these papers:

- **Summary Report**: Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018 – Summary report
- **Full Report (Volumes I, II, III):** The Report | The Thirlwall Inquiry
- **Recommendations:** Recommendations from the Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018 and included at Appendix A.

On 21 September 2026 NHS England wrote to all NHS Trusts (attached at Appendix B). This letter makes it clear that: *This is not just a matter for Trusts with neonatal services. It is a matter for every single Trust and ICB Board to consider, and for every member of staff across the NHS.*

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On 22 September the Secretary of State for Health and Social Care delivered a statement in parliament that committed to commencing a series of actions recommended in the final report, while the Government considers the Inquiry's recommendations in full and these are detailed in the appended letter.

As part of this all NHS Trusts are required to review the Thirlwall Report and consider its findings at the next available board meeting and specifically:

"Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team."

There are key messages for all NHS Trusts in respect of organisational culture, leadership, escalation, patient safety, safeguarding and accountability. Thirlwall found profound failures in governance and culture, including concerns not being acted upon, reputational considerations outweighing safety concerns, weak escalation processes, and staff feeling unable to challenge decisions.

As a board we believe we have had a strong focus on encouraging a culture of speaking up and curiosity in both trusts, supported by a clear governance framework.

However, to ensure we are reflecting fully and ensuring all the recommendations from the Thirlwall report are considered, we will be having reflective conversations with each senior leadership team and identifying time for the whole board to have a discussion in our next board development session before coming back to board in December. The particular recommendations that relate to arrangements of care in a maternity setting will be taken to the Quality Committee in November.

In the meantime, we have provided below a brief overview of the arrangements in place at each Trust and where that has been reported to date, to support initial reflection, but in doing this we want to identify opportunities for further learning rather than to provide assurance at this stage:

- **Insightful board guidance:** The Provider Capability Assessment was completed in 2025 for Dorset County and Dorset HealthCare. Dorset County Hospital was assessed as 'Amber Green' and Dorset Healthcare was assessed at 'Green in 2025. In 2026 Dorset healthcare is not required to undergo this process as they have been subject to NHSE review as part of the Advanced Foundation Trust (AFT) process. Dorset County has self-assessed for 2026, and this was approved by the Board on 30 September 2026. Both the AFT and Provider Capability Assessment are aligned to the six domains of the Insightful Board guidance
- **Safeguarding reporting:** Safeguarding is reported through the Quality Committee, with the Safeguarding Annual Reports presented to the Quality Committee in September 2026 (and are included as a separate agenda item for the Board today)
- **Freedom to speak up guardians:** We have a designated Speak Up Guardian in place on each Trust. The Speak Up Guardians are both supported by an Associate Guardian as well as a network of champions. There is a clear line of reporting to the People and Culture Committee. An

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independent review was undertaken in Dorset Healthcare in 2025 and this provided positive assurance on the arrangements in place. The recommendations were subsequently implemented across both Dorset County Hospital and Dorset Healthcare

- **Implementation of the NHS Leadership and Management Framework:** the new NHS Leadership and Management Framework consists of a code of practice. Standards and competencies for leaders and managers at 5 levels were launched internally at the joint leadership forum. During 2026/27, we will begin to embed the Framework into development, appraisal, recruitment and talent processes, and to support leaders and managers to use the self-assessment tool as part of their normal appraisal and development conversations.
- **Culture of curiosity and challenge at board:** we have in place a comprehensive Board Development Plan. Dedicated time has been spent on maternity, children and young people and safety and organisational culture. We have dedicated time in November 2026 with an externally facilitated session on 'Effective Challenge' and we plan to link this to the findings and recommendations from the Thirlwall Inquiry. The aim of this is to ensure we create the right culture through effective challenge and create a safe space for effective challenge and questioning.
- **Maternity oversight at board:** at Dorset County Hospital we received regular reports at both Quality Committee and Board and Maternity Services. Our most recent report (on the Board agenda today) has been updated to reflect best practice and facilitates more effective oversight of the key issues and challenges with improved tri-angulation. In September 2026 the Board approved the baseline assessment to the 'Maternity and Neonatal 10 Point Plan Action Plan'. We will continue to review our reporting, and the interim Chief Nursing Officer will be undertaking a focussed review in this area during October 2026.

The Thirlwall Inquiry emphasises that patient safety must be the ultimate priority for NHS Boards requiring collective responsibility for creating an open culture where concerns are acted upon rather than being dismissed. Boards must also embrace a culture of continuous learning maintaining agility to respond decisively to safeguard our patients, and we are committed to working in this way.

A more detailed report will be presented to the Quality Committee in November 2026 and to Board in December 2026. Informal briefings will be provided to ensure that the Board receives the ongoing assurance in advance of the formal reporting.

Recommendation

Members are requested to:

- Receive the recommendations of the Thirlwall Report and a briefing on the arrangements in place and plans for a detailed review and reporting timeframes

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Recommendations

My recommendations are set out below. The reasons for each are explained in the relevant chapters of this report.

The long-standing underfunding of hospital services for babies and children is well recognised and requires action. The drive to increase the provision of health services in the community should not obscure or undermine the urgent need for adequate and enduring funding for hospital services for babies and children. I trust that the government will give this issue the urgent attention it requires.

CCTV and monitoring

Recommendation 1

All cots and incubators in all neonatal units should be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. The funding for this should be centrally managed and ring-fenced, to ensure consistency and implementation across all neonatal units at speed. By 31 March 2027, NHS England should set out a roadmap for how this will be implemented.

Chapter 33

Insulin

Recommendation 2

i. Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units. I acknowledge that steps are being taken to achieve this. By 31 March 2027, all neonatal units must meet the expected requirements for access control and storage of insulin set out in the NHS England Getting It Right First Time guide, *GIRFT Neonatology: Guide to safe insulin use*.

ii. Until access to insulin requires the provision of biometric data, each Trust should install CCTV cameras focused on storage fridges, cupboards or units. The cameras should store recordings for at least 28 days.

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iii. The GIRFT *Laboratory Handling of Insulin Requests in the Investigation of Hypoglycaemia* guidance for the testing and reporting of insulin and C-peptide results, issued in October 2025, must be made mandatory and of national application.

Chapter 34

Bereavement care

Recommendation 3

The National Bereavement Care Pathway for neonatal death should be implemented nationally and in all Trusts by 31 August 2027.

Chapter 29

Safeguarding and contracts of employment

Recommendation 4

i. All Trusts must provide safeguarding training to all staff (appropriate to their role and expertise) and Board members, including Non-Executive Directors. This training should include how to deal with concerns and suspicions about deliberate harm caused by staff.

ii. By March 2027, every existing contract of employment for work in an NHS hospital must be amended to include an obligation on the employee to follow all relevant safeguarding guidance, including the Suspicion of Deliberate Harm Protocol (at Recommendation 9), for dealing with concerns and suspicions about deliberate harm. Agency and bank staff contracts and all new contracts of employment must include the same obligation.

Chapter 41

Operating systems (interoperability)

Recommendation 5

NHS England must provide, by 31 March 2027, a clear and timed route to ensuring that computer systems are harmonised across the NHS by December 2028. Work on the development of a mandatory information standard with requirements for interoperability between systems should be taken forward and implemented as soon as possible. This should mean that data relating to babies and neonates in hospital may be entered on a single occasion, be reviewed in a timely manner and facilitate continuous monitoring.[1]

Chapter 35

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Monitoring deaths in hospitals

Recommendation 6

i. By 31 March 2027, all hospital Trusts must have in place effective mechanisms for Board-level monitoring of all deaths of children and babies.

ii. By 31 March 2027, all hospital Trusts must have in place a clear and predetermined route to senior management for the escalation of concerning data trends or patterns.

Chapter 35

Data reporting

Recommendation 7

i. All hospitals with a neonatal unit should name a 'lead reporter' with responsibility for inputting data regularly (at least weekly) and reviewing real-time data viewers on neonatal and maternity units in the MBRRACE system. Whilst the lead reporter does not necessarily need to be a clinician, they must be trained to understand and interpret the available data and able to explain and discuss it with clinicians.

ii. Save where data requires immediate action, in which case a report should be made to the Medical Director and the Board immediately, the lead reporter should report to Trust Boards at least every six months and advise:

   a. whether any alerts or a need for investigation have arisen

   b. the investigation or action plan in place.

Chapter 35

Sudden Unexpected Death in Infancy and Childhood (SUDIC)

Recommendation 8

i. NHS England must:

   a. Immediately inform all Trusts with a neonatal unit that the SUDIC process applies to the sudden and unexpected deaths of babies who have never left hospital.

   b. Direct all Trusts that they must, within seven days, draw this information to the attention of all relevant staff and the Board.

ii. DHSC must complete its review and revision of the SUDIC guidelines and ensure the revised guidelines are distributed to all Trusts by no later than 31 March 2027. The guidelines must include a clear statement that SUDIC applies to sudden and unexpected deaths of babies who have never left hospital.

iii. SUDIC forms must be redesigned and shortened to keep bureaucracy to a minimum. The focus should be on what it is essential to know.

Chapters 12 and 28

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Suspicion of Deliberate Harm Protocol and guidance

Recommendation 9

Protocol

i. By 31 March 2027, NHS England must produce and distribute a one-page protocol setting out the steps to be taken by managers when concerns or suspicions are raised that a healthcare professional may have deliberately harmed a patient. The Suspicion of Deliberate Harm Protocol must make explicit that:

   a. It is irrelevant whether the person to whom the concerns have been expressed does or does not believe they are true, as is the fact that the person raising the concern is not sure.

   b. Where concerns or suspicions of deliberate harm are being raised in good faith, they must be acted upon immediately.

   c. Only in cases where the concerns are obviously irrational or malicious (which assessment must be recorded) will no further action be justified.

   d. Pending investigation of a member of staff, action to protect patients by moving the person suspected of causing harm is likely to be the first step.

   e. The moving of a person suspected of causing harm and the investigation into suspicions and concerns about a member of staff is a neutral act.

   f. Safeguarding steps must be followed, as a result of which the police will become involved.

Guidance

ii. Guidance of no more than two pages should accompany the protocol. It must set out the factors to be considered when assessing the nature of the concerns and suspicions. The reader should be directed to guard against their own biases, loyalties and prejudices. The guidance should explain what should be said and when to those who are or who may be involved with any investigation (such as patients, parents and staff). This must include that patient safety comes first, and investigation is required. The guidance should also explain that failure to follow the protocol will be a breach of contract by an employee, as well as a breach of the relevant code of conduct.

Implementation

iii. Trusts must embed the Suspicion of Deliberate Harm Protocol and guidance within their hospital.

Chapter 41

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Panel of experts

Recommendation 10

Serious consideration should be given by DHSC to the setting up of a panel of independent experts from all specialties to be called upon in situations where there are emerging concerns about an individual and harm to a patient or patients. A team from any specialty or combination of specialties would be drawn from the panel to conduct a swift, technical investigation into the concerns raised. This may most often be necessary where there are concerns that harm is being or has been caused inadvertently.

The precise make-up of the panel should be determined by DHSC but could include, for example:

a. two doctors and two nurses from each clinical specialty

b. four senior managers

c. four pathologists including paediatric and perinatal pathologists

d. other experts as decided by DHSC.

Where necessary, a small team (always including clinicians from the relevant specialty/ specialties) would be drawn from the panel to carry out an independent investigation into clinical concerns. Such investigations should always include safeguarding considerations (including contacting the police). In addition to reporting their findings to the Trust and DHSC, the experts would be available to be called as witnesses in any proceedings that may follow.[2]

Chapter 41

Medical examiners

Recommendation 11

i. The National Medical Examiner should, by 31 March 2027, prepare and distribute a one-page document setting out all the steps to be taken by a medical examiner when dealing with the death of a neonate.

ii. The revised SUDIC guidelines (see Recommendation 8 above) should be set out within the good practice guidelines for medical examiners, not merely signposted.

iii. Medical examiners should ask direct questions of the attending practitioner as to whether there is a concern that a child has been harmed or some other safeguarding concern. Where there may be such a concern, the medical examiner should ensure that there is a record made that day of the contact details of every doctor or nurse who attended to the baby during life.

iv. There should be a pool of neonatologists who can assist medical examiners with their work until such time as it is possible to appoint the appropriate number of regional neonatologist medical examiners. Ring-fenced funding should be provided for this purpose.

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v. The medical examiner system should be reviewed again in 2027 by DHSC. The review should include the adequacy of funding for medical examiners and their support staff and offices. In particular, the question of whether the funding should be ring-fenced must be addressed. Thereafter, reviews should be as directed by DHSC and NHS England.

Chapter 32

Paediatric and perinatal pathologists

Recommendation 12

DHSC and NHS England must ensure that, by June 2033, there are 37 doctors in training posts as paediatric and perinatal pathologists, in line with the workforce requirement set out by the Royal College of Pathologists in the November 2025 *Paediatric and Perinatal Pathology Workforce Report*. The incentive scheme should remain in place and funded until at least 37 doctors are in training posts as paediatric and perinatal pathologists.

Chapter 28

Accountability and regulation of managers

Recommendation 13

i. DHSC and NHS England must develop and put in place a barring system for all managers (clinical and non-clinical) by September 2027. It should be reviewed in 2030 with a view to moving to a full statutory regulation system by September 2032.

ii. NHS England must require any Trust seeking approval for the movement of a senior manager to another Trust to demonstrate that:

    a. The move is not proposed because of the manager's lack of capability or misconduct.

    b. The manager meets the fit and proper person test.

    NHS England must not grant approval, and Trusts must not seek approval, unless they are able to demonstrate the matters at a. and b. above.

iii. In addition to the statutory duty for organisations, all managers must be subject to an individual duty of candour to all patients and colleagues. This should be included in the code of conduct and in the contract of employment for all managers.

iv. The NHS Leadership and Management Framework Code, a code of conduct for NHS managers published in July 2026, must be amended urgently to set out, at the beginning, the uncontroversial duty of every manager to put patients first. I suggest the following wording, with thanks to Mr Jarrold: 'I will make the care and safety of patients my first concern and act to protect them from risk.' What matters is that patients come first.

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v. In the Leadership and Management Framework Standards, the competency 'delivering across healthcare' should be first (it is currently third). The first and fundamental competency under this heading is, rightly: "*I put patients first and report safety concerns and incidents.*"

Chapter 37

Care Quality Commission (CQC)

Recommendation 14

i. CQC should conduct without-notice inspections of hospital departments. Inspection teams should include at least two current practising experts in the relevant field (in this case paediatrics/neonatology).

ii. Inspectors should investigate what is happening in hospital departments and not accept what they are told at face value. Where processes are being inspected, questions must be asked to elicit the effectiveness of those processes.[3]

iii. Training should make explicit that CQC is responsible for ensuring the safety of patients in hospitals and not just for checking there are processes in place which, if implemented, should ensure patient safety. Inspectors and team leaders must always approach an inspection of neonatal services not as a box-ticking exercise but as a way to determine that babies in hospital are safe.

Chapter 42

Assessment of the performance of CQC

Recommendation 15

There must be a rigorous and consistent review and assessment of the performance of CQC by the Health and Social Care Committee, initially once a year and, once the committee is satisfied, once every three years, or such other frequency to be determined by the select committee.

Chapter 42

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Parliamentary and Health Service Ombudsman

Recommendation 16

The functions of the National Guardian's Office should be taken over by the Parliamentary and Health Service Ombudsman in England. The Ombudsman's powers must be increased to include:

a. investigating complaints that whistleblowing in the NHS has not been dealt with adequately

b. assisting whistleblowers by referring their concerns to the relevant NHS bodies and overseeing the response.

Chapter 31

Implementation of recommendations

Recommendation 17

A new responsibility for auditing the implementation of the recommendations of statutory inquiries into NHS bodies should be given to the National Audit Office. Funding for appropriate additional staffing should be made available so that it may begin its work by September 2027.

Chapter 31

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Endnotes

1 Baroness Amos's final report from the National Maternity and Neonatal Investigation recommends DHSC/NHSE must deliver estates and digital systems that are fit for modern maternity and neonatal care with 12-month, 5-year and 10-year investment commitments and implementation deadlines. The importance of interoperable digital systems is a common theme in both our reports and should be treated as a priority. The Rt Hon. the Baroness Valerie Amos LG CH, *Independent Investigation into Maternity and Neonatal Services in England: Final report and recommendations*, June 2026 (**https://www.matneoinv.org.uk/wp-content/uploads/2026/08/NMNI-Final-Report-and-Recommendations.pdf**)

2 Baroness Amos's final report recommends that NHS England, DHSC and CQC "*put in place a specialist regulatory unit, with a sufficiently sensitive methodology, to provide regulatory assessment for maternity and neonatal services*" within nine months. This must include clinicians so that "*the most recent clinical perspectives are fully integrated into the regulatory function*". This recommendation aligns with my recommendation and should be taken forward with urgency. The Rt Hon. the Baroness Valerie Amos LG CH, *Independent Investigation into Maternity and Neonatal Services in England: Final report and recommendations*, June 2026, page 20 (**https://www.matneoinv.org.uk/wp-content/uploads/2026/08/NMNI-Final-Report-and-Recommendations.pdf #page=20**)

3 Baroness Amos's final report recommends that DHSC, NHS England and CQC must drive improvement within 12 months in the quality, transparency, oversight and accountability of their investigations, and ensure that learning is captured and acted upon when things go wrong. Our recommendations regarding CQC should be taken forward with urgency. The Rt Hon. the Baroness Valerie Amos LG CH, *Independent Investigation into Maternity and Neonatal Services in England: Final report and recommendations*, June 2026, page 16 (**https://www.matneoinv.org.uk/wp-content/uploads/2026/08/NMNI-Final-Report-and-Recommendations.pdf#page=16**)

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To: NHS trusts and integrated care boards:

- chief executives
- chief operating officers
- chief nursing officers
- chairs
- medical directors

cc. NHSE regional teams:

- regional directors
- chief nursing officers
- medical directors

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

21 September 2026

Thirlwall Inquiry report and recommendations

Dear colleagues,

Lady Justice Thirlwall's report is a sobering moment for all of us working in the NHS. From the devasting failure, both of individuals and the system, to act quickly enough to safeguard babies, to the questions it poses about the NHS culture that prevented this – the need for change goes beyond the walls of a single hospital ward. We must address these together now.

Our thoughts remain very much with the families affected who have experienced unimaginable loss and pain, and the NHS repeatedly failed them. The care, safety, and safeguarding of all patients is the principal duty of all of us, and this is why we must all act with the urgency, curiosity, and openness to ensure that the learning from this Inquiry is translated into clear action.

Secretary of State
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This is not just a matter for Trusts with neonatal services. It is a matter for every single Trust and ICB Board to consider, and for every member of staff across the NHS.

Recommendations

On Tuesday, the Secretary of State delivered a statement in Parliament that committed to commencing a series of actions recommended in the final report, while the Government considers the Inquiry's recommendations in full.

Specifically:

- Urgently work to develop plans for all cots and incubators in all neonatal units to be fitted with baby monitors (in-cot cameras with livestreaming video), so that parents can observe their baby remotely at any time. Taking learning from places where this is already used, we will develop a national approach to support neonatal units to implement this;
- Go further on new guidance on the safe use and storage of insulin and strengthened guidance for medical examiners reviewing neonatal death;
- Undertake a review of the 'Working Together to Safeguard Children' (April 2026) and safeguarding training nationally;
- Work through plans to regulate NHS managers through a barring scheme for senior leaders who fail in their responsibilities;
- Continue rollout of the National Bereavement Care Pathway for families experiencing neonatal loss.

Actions needed now

Trusts should immediately progress the following actions in response to the Inquiry's findings:

- **Every Trust and ICB Board to review the Thirlwall report and to consider its findings at the next available public Board meeting:** Boards should reflect on whether it would have been possible for similar events to occur at their own organisation and seek assurance that sufficient measures are in place to keep the babies and children in their care safe, no matter what setting. Central to this is a culture of professional curiosity, where both Board members and staff feel empowered, supported, and confident to speak up, challenge concerns, and raise issues without fear. Any risks to this must be urgently discussed with the regional team.
- **Sudden and Unexpected Death In Children** (SUDIC): The Inquiry rightly made clear that no member of staff should ever assert that they did not know what to do in response to a sudden and unexplained death. The SUDIC protocol is applicable for every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably

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expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death**.** This includes sudden and unexpected deaths within neonatal units. **All Trusts with a neonatal unit must urgently communicate to all relevant staff and the Board that the SUDIC process applies as set out above. This must be completed by no later than Monday 28 September 2026.** It is important to note that SUDIC reporting runs alongside your own internal reporting processes.

- **National Bereavement Care Pathway for stillbirth and neonatal death:** ICBs and providers should take immediate action to improve care of the bereaved as has already been set out in the NHS Medium Term Planning Framework (October 2025).

- **Insulin**: By 31st March 2027, all neonatal units must meet requirements for access control and storage of insulin as set out in the GIRFT neonatology Guide to safe insulin use. Until access to insulin requires the provision of biometric data, each Trust should urgently install CCTV cameras in neonatal units focused on storage fridges, cupboards or units by 30 November 2026 at the latest. The cameras should store recordings for at least 28 days.

- **Safeguarding:** Trusts and ICBs should ensure that all staff and Board members are compliant with safeguarding training requirements at the appropriate level and confirm that staff know who to raise and escalate concerns to. Boards must assure themselves that the safeguarding of babies and children is given the level of prominence required.

In addition, Trusts are reminded that the Insightful Provider Board guide is intended to help Boards identify the information they need and the cultures, behaviours and governance required to ensure that information is used effectively.

Health and wellbeing

We are mindful that the findings of this Inquiry may impact the confidence of parents and families whose babies are currently receiving neonatal care. We would urge you to consider what steps can be taken locally to provide parents with assurance of the care being given and support that is required during the care of their baby.

We also recognise that caring for very sick babies can be psychologically difficult for staff and this is an opportunity to review the support mechanisms in place for staff working in these services.

Next steps

The report firmly underlines why the urgent work we are doing through the Maternity and Neonatal Care 10-Point Plan must be a top priority for the NHS. As the Secretary of State has clearly set out, the safety, safeguarding and wellbeing of mothers and babies must never be treated as a side issue and must be a central priority for NHS boards.

Secretary of State
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The findings of this crucial report will be a key focus of our next CEO leadership event tomorrow**.** It is important that we challenge each other when we meet on whether we are all doing enough to ensure that babies and children are protected, no staff member is ignored when they raise concerns, and that we are consistently acting to the highest standards of governance and leadership.

Yours sincerely,

Duncan Burton

Chief Nursing Officer for England

Sarah-Jane Marsh

NHS England Chief Operating Officer

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Dorset County Hospital
Dorset HealthCare

Finance and Performance Committee in Common Assurance Report for the meeting held on Wednesday 30 September 2026

Chair	Dave Underwood – Non-Executive Director
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	• Additional funding requested from NHP to support the refurbishment of St Anne's. A verbal updated on the outcome would be provided to Board • Positive progress with the recruitment of International Medical Graduates which was helping to improve longstanding psychiatrist vacancies in mental health services and reduce spend on locums. • Approval of the DCH and DHC Winter Plans • Recommended to Board the approval of the DHC Charitable Funds year end accounts • The committee endorsed the Provider Capability Assessment ahead of Board approval.
Key issues / matters discussed at the meeting	**DHC Performance Report** • National Oversight Framework (NOF) metrics had recently changed for community and mental health trusts, increasing from 10 to 29 metrics; this may have an impact on how the trust performs in NOF. • The Trust remains in Segment 2 of the NOF, although its relative position has deteriorated. Improvement work is underway to address data quality issues and targeted areas of underperformance. • A number of operational plan metrics were off track with key performance challenges relate to talking therapies, length of stay, out-of-area placements, diagnostics and individual placement support, with recovery plans in place. • Nationally there is a focus on reducing out-of-area placements, improving access to children's mental health services and reducing mental health-related emergency department breaches. • The committee was assured by the report. **DCH Performance Report incl. Operational Performance Recovery Group Update** noting • A focus on recovery with a full assurance process in place including weekly meetings chaired by Matthew Bryant regarding urgent and emergency care, RTT and cancer metrics. Performance remains

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challenged in these domains, but strong assurance that diagnostic performance continues to improve.

- In urgent and emergency care, the focus remains on improving patient flow, reducing ambulance handover delays and supporting hospital discharge through system-wide initiatives, such as Discharge to Assess. There was ongoing work arising from an external flow review and the implementation of bed reconfiguration and discharge improvement programmes.
- On elective recovery, RTT performance remains challenged but recovery plans are progressing, including additional validation, locum recruitment and increased capacity in key specialties. Cancer performance remains volatile, with particular pressures in colorectal services, although recovery actions are being implemented. The Committee was assured that clear recovery plans are in place and performance continues to be closely monitored through established governance arrangements.
- A decline in August four-hour performance was largely due to workforce disruption associated with the annual resident doctor changeover. Staffing has since stabilised, supported by new consultant appointments.
- The Committee discussed ongoing work to improve patient flow, reduce length of stay and strengthen discharge processes. Ambulance handover performance has improved, although achieving the new national 30-minute standard will require continued improvements in flow, discharge planning and reduced avoidable conveyances.
- The committee recognised the challenges but was assured by the plans and responses in place.

Seasonal Surge (Winter) Plan

DHC:

- The draft plan was reviewed by the Board on 8th September, pending the regional test exercise on 16th September. The exercise found that plan met the standards required and was presented to committee for approval.
- The plan was compliant with all elements required by a mental health and community provider.
- As outlined at Board, the risks to the plan included a reliance on partners achieving system standards for discharge over the winter period, which was not currently being met. Work continued with local authority patterns to improve P1 capacity.
- Quality Committee considered the quality implications of the plan at yesterdays' meeting and raised no concerns.
- The plan was approved.

DCH:

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- The full plan was presented to committee for approval. The equality quality impact assessment had been reviewed at Quality Committee yesterday.
- This was a consistent plan, but there were residual risks owing to the dependence on system partners. Mechanisms, such as weekly system meetings, were in place to escalate any issues throughout the lifetime of the plan.
- Despite these risks the paper recommended 100% assurance on the plans with supporting narrative included.
- The cluster ICB winter plan would be included alongside the winter plans in the upcoming board papers.
- The plan was approved by committee.

Maternity Workforce Business Case (DCH)
The paper was withdrawn at the start of the meeting. A comprehensive review of staffing, skills and resource is being undertaken at present, with this being a high-priority area nationally with several national reviews in to maternity services. This was an area of focus for Pam O'Shea as interim Chief Nursing Officer over the next eight weeks. In the meantime, members of staff on fixed term posts have been made permanent. The business case would be returned to committee in future once the review had been completed.

DHC Finance Report incl. Financial Recovery Board Update at month 5

- On plan with a surplus of £1.1m , achieved through releasing items from the balance sheet; this is not usually done until month 12 so might be a concern in the coming months.
- Temporary staffing spend was still above plan but was £1m less than this time last year. A great deal of work continues to reduce spend.
- 100% CIP had been identified, but £5m of that was high risk. The trust was £630,000 behind plan in relation to CIP. Internal forecasting suggests a potential deficit against plan at year end of £5.3m due to high-risk CIP schemes. Continued scrutiny of the plan through Financial Recovery Board was working to mitigate this risk. The two main high-risk areas are system transformation programmes and estates disposals.
- A low allocation of internal capital this year, but success in securing external bids. Prioritisation work for 2027/28 capital planning was already beginning.
- The committee was assured by the report and the responses to their questions.

DCH Finance Report incl. Financial Recovery Board Update at month 5

- £4.7m deficit against a plan of £4.5m. The deviation from plan relates to industrial action costs incurred earlier in the year.

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- Temporary staffing was causing pressures on pay spend and was a driver to improve substantive recruitment. Improvements in agency and bank spend in month, but further work to do.
- Of the total £23.3m CIP required, £3.4m (14%) was unidentified. Schemes to address this were being drawn up at pace. 15% (£3.5m) of identified schemes were high risk, with work ongoing to de-risk them. Plans delivered were ahead of year-to-date target at 44%.
- Q1 and Q2 deficit support funding had been confirmed by NHS England, with approval processes for Q3 ongoing.
- Cash balance was healthy but continued to be a high risk as in recent year. Daily monitoring continued with a focus on cost controls and discretionary spend.
- Capital was £7.8m behind plan due to new hospital programme (NHP) external works. Internal capital also behind plan due to timing with no particular concerns raised.
- Internal forecasts were being developed at pace and would be included in the next report.
- Committee members recognised the challenging position and the unidentified gap in plans but were assured that the trust understood its financial position and still planned for a break-even year end position.

NHP Funding Request (DHC) outlining that due to a change in regulations a different roof structure is required for the St Anne's refurbishment which was more expensive than originally planned for. As such the committee was informed that an additional £5.5m was being requested from the New Hospitals Programme, with the proposal being presented to their investment committee today. Advice from NHP was positive and a verbal updated on the outcome would be provided to Board.

DHC Charitable Funds Year End Accounts reporting a closing fund balance of £746,000, slightly lower than the previous year, with funds held across both restricted and unrestricted categories. Ongoing work to strengthen the use of charitable funds across DHC, including closer collaboration with DCH and improved oversight of restricted funds to maximise benefits for patients and staff. The Committee also noted actions taken to improve investment returns through higher-interest accounts and welcomed efforts to increase fundraising activity and engagement with donors, patients and local communities. The importance of maintaining flexibility in charitable funding, while recognising the valuable contribution of local League of Friends organisations, was also highlighted. The committee recommended the accounts for approval by the Board.

Green Strategy/Net Zero Progress Report noting:

- Recent approval of the five-year strategy and the establishment of joint governance arrangements across both trusts

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- Progress has been made in delivering carbon reduction initiatives, including LED lighting upgrades, solar photovoltaic installations and the rollout of electric vehicle charging points.
- The trusts remain committed to achieving an 80% reduction in Scope 1 and 2 emissions by 2032. The importance of developing a more detailed carbon reduction roadmap to demonstrate how targets will be achieved as also noted.
- Key challenges remain around estate decarbonisation and securing the capital investment required to deliver future reductions.
- The Committee was assured by the progress made to date and ongoing plans.

Emergency Planning, Response and Resilience Self-Assessment
Both trusts had self-assessed as 100% compliant with core standards. Commendations were extended to the DHC EPRR team for their work in this assessment at the same time as leading on the MenB outbreak response. The ICB had indicated support of the trust's self-assessment. Thanks were extended to the DCH EPRR lead for the assessment. For DCH there was a focus on securing premises under Matyn's law requirements with assurance provided that the necessary processes were in place.
The committee was assured by the reports.

Premises Assurance Model for both Trusts, noting significant changes to the assessment methodology. Performance was generally positive across both organisations with no major safety concerns identified; most gaps relating to policies, documentation and governance processes. Action plans are in place to address these areas, with most expected to be completed by year-end. The Committee also noted progress in aligning estates and facilities services across both trusts through the federated model and received assurance that compliance improvements continue to be monitored through established governance arrangements. The committee was assured by the report.

Update on International Medical Recruitment Progress. The programme had been introduced to address longstanding consultant psychiatrist vacancies within mental health services. Through GMC sponsorship arrangements, DHC has recruited to 12 consultant vacancies. The programme is delivering early benefits through reduced reliance on locum doctors, improved workforce stability and a more sustainable long-term staffing model. While there is an initial investment in induction, supervision and mentoring, the programme is expected to generate financial and operational benefits over the next two to three years.
The Committee welcomed the programme as a significant step towards reducing locum dependency, strengthening the substantive medical workforce and supporting improvements in service quality, productivity and performance.

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Policies: Bi-annual update on the policies in the scope of the committee. Ten polices overdue for DHC; this was an increase from previous reports due to the recent request to include operational policies. Six policies overdue for DCH. Some of these were quite long overdue, with verbal updates provided in this regard and discussion about the importance of timely policy updates to ensure best practice and safety.

DCH SubCo Ltd Assurance and Performance Report noting progress in service expansion plans following the pharmacy refurbishment. While workforce recruitment has been slower than anticipated, staffing levels are improving and additional governance arrangements are in place to support delivery. Members noted ongoing monitoring of dispensing error rates and were assured that management oversight and staff support measures are driving improvement. The Committee welcomed the positive impact of the service on patient experience and noted plans for further growth.

Provider Capability Assessment: Access and Delivery of Services, Productivity and Value for Money, Financial Performance and Oversight for DCH only. The assessment covered six domains, each of which was assigned to a committee; for this committee three domain were assigned: access and delivery of services, productivity and value for money, financial performance and oversight. The self-assessment asks trusts to consider whether they are capable of managing it's challenges in relation to each domain. The proposed rating from the review process for each of these domains is 'amber-green'. The committee discussed whether the rating for 'financial performance an oversight domain' given the financial challenges the trust faced but felt on balance it was appropriate.

The committee endorsed the Provider Capability Assessment ahead of Board approval.

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
  Heath and Safety Group
- DCH:
  Operational Performance Recovery Group
  Capital Planning and Space Utilisation Group
  Emergency Planning & Resilience Group
  Health & Safety Group

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	Value Delivery Board Under AOB the committee agreed that a DCH only Finance and Performance Committee meeting would be held for one hour in the time allotted for the informal meetings, to provide focused time on DCH performance. This would be in place until the end of the financial year at which point it would be reviewed to determine if it was still required.
Decisions made at the meeting	Approvals and Ratifications by DCH and DHC committees: • DHC Winter Plan • DCH Winter Plan • Recommended to Board the approval of the DHC Charitable Funds year end accounts • The committee endorsed the Provider Capability Assessment ahead of Board approval.
Issues / actions referred to other committees / groups	• Nil

Quoracy and Attendance						
	27/05/26	**29/07/26**	**30/09/26**	**25/11/26**	**27/01/27**	**24/03/27**
Quorate?	**Y**	**Y**	Y			
Dave Underwood	Y	Y	Y			
Andreas Haimbock-Tichy (to August 2026)	N	Y (first 2 hours)				
Chris Hearn	Y	Y	Y			
Lucy Knight	Y	Y	Y			
Claire Lehman	Y	Y	A			
Jonty McNuff (from August 2026)			Y			
Nikki Rowland (from August 2026)			A			
Rachel Small	N	N	Y			
Anita Thomas	Y	Y	Y			
Rachel Wharton	Y	N	Y			
Nick Braisby			Y (until 12.00)			

Setchell,Ryan
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NHS
Dorset HealthCare University
NHS Foundation Trust

Report to	Board in Common (DHC)	
Date of Meeting	13 October 2026	
Report Title	Integrated Corporate Dashboard – August 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	SLG 17 September 2026 (Draft)	
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

The enclosed Integrated Corporate Dashboard sets out the key metrics and exceptions for the Board to consider. An expanded update is included on three key areas this report (Length of Stay, Audiology and Talking Therapies), following a request from August Board for additional information on these.

Length of Stay – The Peri-Hospital Admissions Programme has been set up to review and identify operational and system level issues impacting on patient flow and timely discharge across mental health inpatient services. The programme has Executive leadership (led by the Chief Operating Officer) and multi-disciplinary (and for system level multi-agency) workstreams which have been set up in four key areas (meeting every 2 weeks) to review the challenges/barriers, identify and implement potential solutions using a QI approach and Plan, Do, Study, Act (PDSA) cycles. The operational workstreams are; Inpatient Processes (internal), Admissions (system), Discharges (system) and Data flow (internal).

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The Inpatient Processes workstream has identified some administrative processes that are impacting on the average length of stay (ALoS) which are being addressed via a time limited task and finish group to work through and implement a viable solution. This has been trialled during July and August with a very positive impact on the 3-month rolling ALoS reducing it below the required operational trajectory in August (local data) and is reporting as compliant for the first time this financial year at 71.7 days/73-day target for adults and PICU. Work is underway to finalise and roll out the process as one of the agreed methodologies to address LOS which will be overseen by the 45-Day Panel established as part of the Peri-Hospital Admissions Programme.

A number of actions from the other workstreams have been implemented and are running concurrently. All Acute and PICU patients are being reviewed to with an aim to facilitate discharges to increase capacity and generate better flow. Out of Area patients have their plans reviewed regularly with the intention of repatriation or direct discharge to a community option and an additional bed was opened on Haven Ward (PICU) in July 26 and two additional beds opened on Chine Ward (Female). The Patient Flow Team have set up a "45-day panel"; this meets monthly and reviews all patients with a LOS over 45 days across adult and PICU beds with the aim to identify any immediate areas of support required either clinically or to facilitate more rapid discharge.

In the longer term, additional bed capacity will be opened as the current building and refurbishment work under the New Hospital Programme (NHP) comes online. Shore Ward is due to come online from Summer 2028 and will provide an additional 8 adult acute beds reducing the need to use the block booked beds at the Priory Southampton and reducing the need to send people out of area.

The transformation programme reports into the Strategy, Transformation and Partnerships Committee in Common who receive a milestone update report as a standing item. Progress with performance trajectories are overseen by the Finance and Performance Committee in Common.

Diagnostic Waiting Times (6-week standard)
Audiology performance remains below both the 6-week Referral to Assessment (DM01) standard and above the Medium Term Plan (MTP) forecast for numbers waiting over 6 weeks for a diagnostic test. Audiology accounts for the majority of Dorset HealthCare's diagnostic waiting list position (DM01). Maintaining compliance remains challenging due to sustained demand growth and national workforce shortages affecting the availability of qualified Audiologists.

Capacity pressures increased during 25/26, while demand for hearing services continued to grow, service investment remained limited, with only a modest increase in capacity through Community Diagnostic Centre (CDC) funding in West Dorset. Workforce pressures experienced in late 2025 and early 2026 are now largely resolved.

Demand has increased significantly following the introduction of the nationally mandated self-referral pathway for age-related hearing loss in September 25. This has generated approximately 100 additional referrals per month. The service has also seen a substantial increase in patients requiring re-assessment (approximately 300 additional patients per month), driven by the repatriation of patients previously managed through outsourced arrangements, the transition to next generation hearing aid technology, and a growing underlying patient population. In addition, both acute trust ENT services have increased the demand on audiology assessments through insourcing additional ENT activity due to waiting list pressures. Funded surge work in ENT does not provide corresponding funded surge capacity in audiology.

As a consequence of the sustained imbalance between demand and capacity, the DM01 Diagnostic waiting list has increased from 1,226 waiting at the end of Aug 25 to 2346 waiting at the end of Aug 26.

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A recovery paper went to the Senior Leadership Group (SLG) on 10 June 26 to highlight performance challenges and identify options for improvement. The report concluded that: previous data quality issues had resulted in demand pressures being modelled too low in the operational plan submission; these issues have now been addressed. The service is experiencing an additional c.400–450 referrals per month associated with self-referral and re-assessment activity. A range of productivity and efficiency measures have already been implemented, including workforce skill-mix changes, benchmarking and optimisation of appointment durations, and reductions in follow-up activity where clinically appropriate. Short-term recovery options were identified, including additional weekend clinics and insourcing arrangements to increase capacity and support waiting list reduction were approved with £114k non-recurrent recovery investment approved internally. Implementation of this recovery is underway, however trajectories for the recovery are currently under due to the data quality issues previously referenced.

There remains a longer-term structural gap between demand and capacity which will require further recurrent investment to achieve sustainable performance improvement and reduce reliance on temporary staffing. Recurrent investment of £220k is recommended to enable the Service required to regain and maintain performance.

The findings and recommendations from the Audiology Recovery Plan are to be discussed with Dorset ICB through the routine Contract Review Meeting (CRM) process to explore potential commissioning and investment options and a paper has been submitted to the ICB ahead of the CRM scheduled for Sept 26.

NHS Talking Therapies –Reliable Recovery (RR) and Reliable Improvement (RI). There are four measures associated with the two metrics in the operational planning (number and percentage for each).

In August 26, all four measures remain, as expected, off track and with minimal recovery at this stage in the plan. The number of people completing a course of treatment (CCOT, not a MTP target but is used to calculate the denominator for the metrics) dropped below threshold for the first time this financial year as anticipated (661/871 threshold). August is a month where year on year, consistently there is a lower number of patients discharged from the service due to both staff and patient availability to complete treatments. A short-term deterioration on all measures was also anticipated due to a higher proportion of patients moving off waiting lists because of outsourcing to external providers. This is because a proportion of patients do not engage in treatment and are discharged, impacting both CCOT and potentially RI and RR, and this will be at higher numbers than usual in Q2-3 26/27. RI and RR performance is expected to improve following a 4–6-month lag as treatment is completed both in service and with external providers.

There is an ongoing discussion about the level of investment versus deliverable activity with NHSE (region and national). The operational plan submitted by the ICB has not been signed off by NHSE as it does not meet the revised access figure of 12,235. The Dorset ICB submitted plan is based on 9,839 as per the 'fair share' allocation of the MTP. In the Regional Performance meeting held in September the ICB confirmed that the position remains as submitted in the operating plan 26/27 (as it is consistent with the investment).

The service has had a significantly increasing waiting list (over 3000 patients in June 2026 waiting for treatment and over 2000 waiting for assessment). Consistently high waiting times negatively impacts outcomes, as the longer a patient waits for access to therapy, the less likely they are to achieve RR and RI (those who naturally recover form part of the metric and remove themselves from the waiting list).

A non-recurrent investment of £2m was agreed internally to outsource activity to external providers. The outsourcing commenced in July 2026, however due to various factors (mainly related to staff availability over summer holidays both with Xyla the provider and in service), the reduction in waiting lists is expected

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to increase from September. To date, treatment waiting lists have reduced by 839 patients, with a further reduction of 2,552 expected by end of Q3 (Dec 26) and 2,811 by end of Q4 (Mar 27).

The allocated expansion funding and non-recurrent funding to outsource treatment is anticipated to meet the proposed access figure of 12,235 by the end of the financial year and meet the RR & RI trajectories, specific actions have been identified in the plan to meet this by the end of March and there is caution this can be achieved in year with the non-recurrent monies, however this is not a sustainable position within the current recurrent investment and discussions are ongoing with the ICB to agree a way forward for investment from 27/28.

In addition to the specific update requested by Board on the above metrics, the following metrics within the MTP were flagging as off track in August 2026, with further details on the exception reasons included in the report:

Off Track Metrics	MTP Target	DHC M5 Compliance
1. Number of Patients that achieved reliable recovery	395	259
2. % of patients that achieved reliable recovery	51%	39.2%
3. Number of patients that achieved reliable improvement	566	442
4. % of patients that achieved reliable improvement	69%	66.9%
5. Mean LOS for patients discharged from OPMH	123	127
6. Number of patients accessing IPS	714	532
7. Number of patients waiting over 6 weeks for diagnostic test	70	920
8. % of patients waiting over 6 weeks for diagnostic test	4%	34.3%
9. Out of Area Placements	3	8
10. Virtual Ward Occupancy	80%	66.9%

Recommendation

Members are requested to:

- Receive the report for **assurance**
- Note the areas where recovery plans are underway and the timescales associated with recovery.

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Dorset HealthCare University
NHS Foundation Trust

Integrated Corporate Dashboard

August 2026

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Introduction

Dorset HealthCare University
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Celebrating Progress across Dorset Healthcare

July and August saw continued progress across the Trust, with national recognition, investment in community services and positive developments in access and patient flow.

Bringing care closer to home

The new **£1.9 million Winton Neighbourhood Health Centre** opened in August, bringing GP and Dorset HealthCare community services together in a modern facility at the heart of the local community.

National recognition

Dorset HealthCare received the **Defence Employer Recognition Scheme Gold Award** – the Ministry of Defence's highest level of recognition for organisations demonstrating exceptional support for the Armed Forces community.

Supporting better patient flow

Adult Acute and PICU **length of stay reduced to 71.7 days, below the 73.3-day threshold**. A new **45-Day Panel** was also introduced in August to identify and address barriers affecting patients with extended stays.

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Understanding SPC Charts

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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

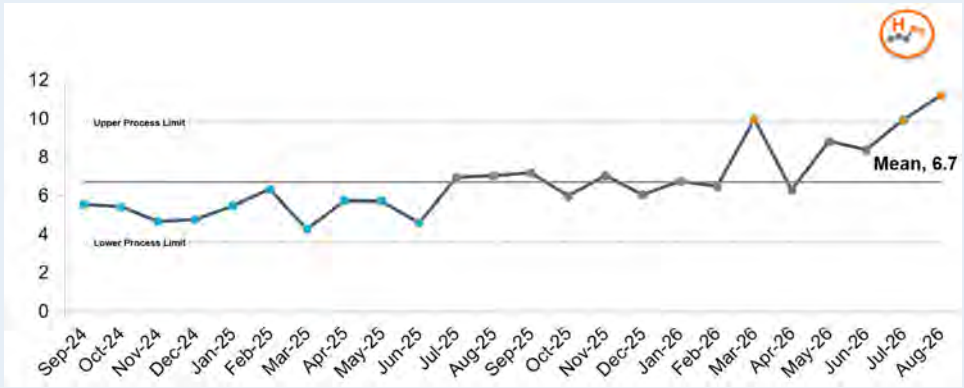
Blue dots	Improvement or better-than-expected performance.
Orange dots	Potential concern or worse-than-expected performance.
Assurance icon	Whether the current process is capable of achieving the required standard consistently.

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**

Secretary 09/10/2026 11:05:42

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

Falls On Inpatient Wards Per 1,000 OBD



Description of metric

The rate is calculated from the number of incidents of falls reported on Ulysses in the month in hospitals as a proportion of occupied bed days (multiplied by 1,000) in the month.

In Month: 11.2 **Threshold:** none

In August 2026, 121 falls were reported, an increase from the previous month. The highest reporting area was St Brelade's Ward, accounting for 46 falls (38%), followed by Radipole Ward with 14 falls (11.6%). Importantly, all falls resulted in no or minor harm, with the three incidents initially recorded as moderate harm within ICS subsequently reviewed and downgraded to minor harm. The increase was fundamentally driven by a large cohort of repeat fallers, with 11 patients on St Brelade's Ward experiencing multiple falls during the month. In addition, and unusually, Seaview Ward reported five falls, reflecting an increasingly complex patient cohort with significant physical health needs alongside severe mental illness. Review of these incidents identified no common environmental or system factors, with falls largely associated with individual patients' physical frailty, deterioration, cognitive impairment, mobility difficulties or behavioural presentations. In all cases, staff responded appropriately through enhanced observations, multidisciplinary review, medication optimisation where required, and timely escalation, providing assurance that patient harm was minimised despite the increased falls activity. Recent falls reviews of falls with harm have identified variation in compliance with lying & standing blood pressure measurements and multifactorial falls risk assessments being completed. The Falls Steering Group is currently devising a trust falls improvement plan following a thematic review of falls in the organisation.

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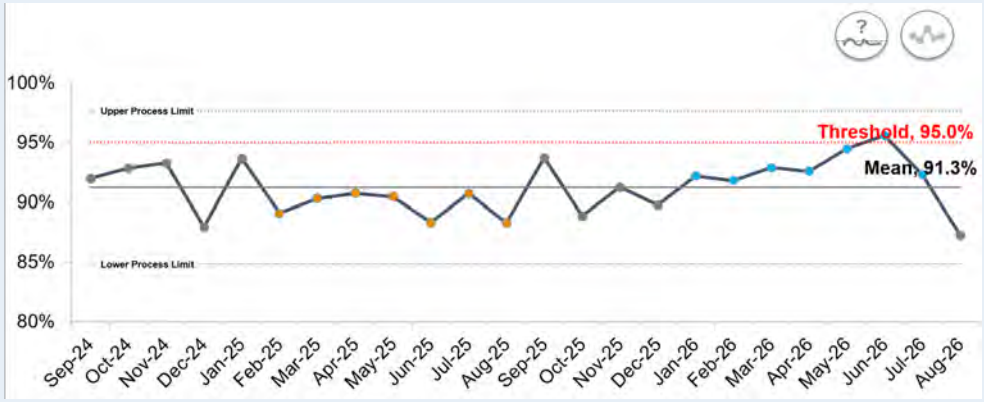
Venous Thromboembolism (VTE) risk assessment within 24 hours



Description of metric

Percentage of applicable patients who receive a VTE within 24hours of admission to hospital. All Community hospital patients and mental health patients. Contractual target.

In Month: 87.3% **Threshold:** 95%

Trustwide VTE risk assessment within 24 hours reduced to 87.3% in August, below the 95% target and the process mean of 91.3%; current variation indicates the target is not being achieved reliably. There were 20 breaches across 157 admissions, comprising six in Mental Health and 14 in Integrated Community Services. Sixteen breaches related to assessments completed outside the 24-hour timeframe, two assessments were not recorded as completed, and two Mental Health assessments were completed on time but were not accurately reflected in the electronic record. Ward managers have reinforced completion requirements through supervision and team meetings, with additional oversight from the Head of High Acuity. Within Integrated Community Services, a centrally held action plan has been shared with Matrons to support improvement. Continued non-compliance presents a risk that VTE risk is not identified promptly, with ongoing focus on timely completion, accurate recording and recurrent breaches.

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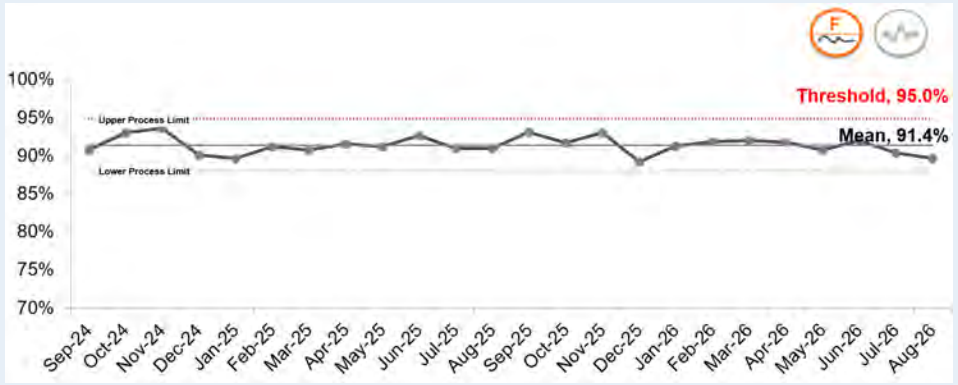
Friends & Family Test – Positive Experience Feedback



Description of metric

Those responding 'very good' plus those responding 'good' as a percentage of all responses in the month.

In Month: 89.7% **Threshold:** 95%

Analysis of poor and very poor feedback identified recurring themes relating to communication, responsiveness, access to services, and service users feeling listened to and supported. Also highlighted were concerns regarding support during periods of distress and whether services were able to meet the needs of individuals with more complex mental health needs. Additional themes related to continuity of support and responsiveness, whilst urgent access pathways highlighted issues relating to access and timeliness of contact. Support by the Patient Experience team will be provided to services to ensure improvement actions are developed and implemented in response to identified feedback themes.

You Said We Did

ICS (Swanage Physiotherapy): Patient feedback highlighted the need for stronger therapeutic relationships and engagement during appointments. In response, additional communication and patient engagement training was provided to physiotherapy staff.

CYPS (Health Visiting): Patient feedback highlighted an opportunity to improve the consistency and confidence of session delivery. In response, rota arrangements have been enhanced to ensure less experienced staff are supported alongside experienced colleagues when delivering sessions, helping to provide parents with a more consistent experience and information.

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Complaints

Description of metrics (in month figure)

National Oversight Framework metric

Number of complaints received, both written and verbal, including any themes identified (72**)**

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 decreased to 72 in August, down from 86 in July, although demand remained highest within Mental Health Community Services, ICS Specialist Services, Integrated Urgent Care Service (IUCS) and CAMHS. The most common themes were communication, patient care, clinical treatment, values and behaviours, appointments and access to services.

Learning from complaints focused on improving communication, documentation, discharge planning, continuity of care and professional standards. Key examples included strengthening explanations around information sharing and confidentiality, improving discharge coordination and patient information, reinforcing compassionate engagement with people in crisis, and enhancing communication about referral pathways and access arrangements.

Despite ongoing pressures, 100% of complaints were acknowledged within the mandatory timescale of three working days, and 77% of closed complaints received a response within agreed timescales. Five complaints were reopened, all relating to Mental Health Services, with four originating from previous reporting periods. No new Ombudsman cases were received, although 22 investigations remained open. The Trust continues to embed learning from complaints, monitor trends in reopened cases and support service improvements to enhance patient experience.

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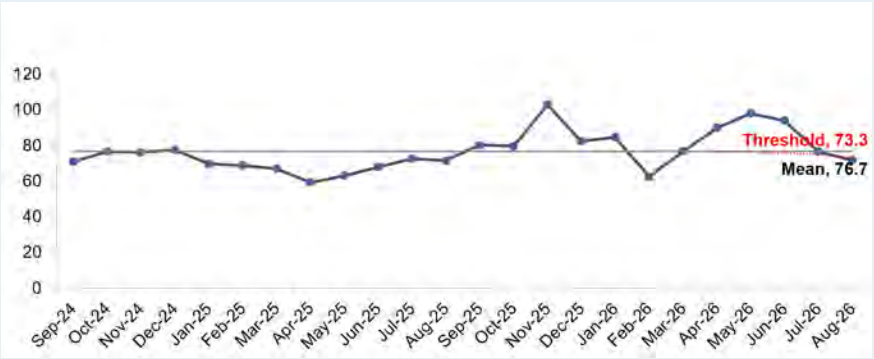
Length of Stay – Adult Acute & PICU



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

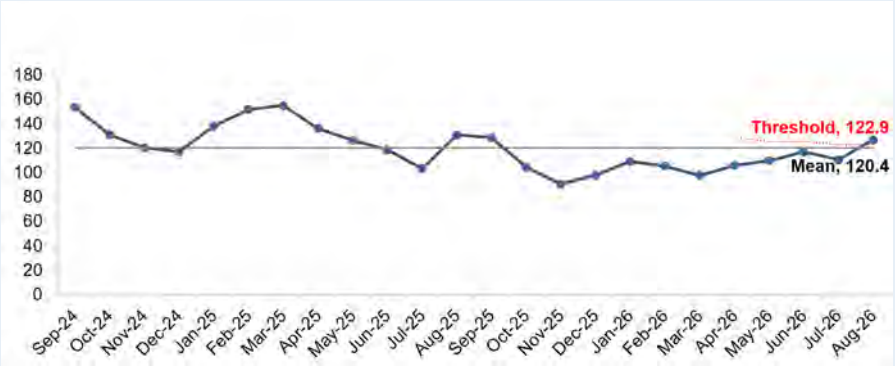
Description of Metric

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

Rolling Three Months: 71.7 **Threshold:** 73.3

Adult Acute and the Psychiatric Intensive Care Unit (PICU) wards average length of stay has experienced a reduction and is below target. Work continues through the Peri-Hospital Admissions Programme one of the Trust's key transformation projects this year and the four workstreams. It has been identified that the length of stay metric is predominantly impacted by a small number of individuals who have an extraordinarily long length of stay. Extended length of stay is clinically appropriate for a small number of patients and it has been identified that patients with an extended length of stay are 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. The 45 Day Panel was stood up in August and completed a review of patients with a length of stay of 45 days within Acute and PICU beds, identifying issues that may extend their length of stay and discussing appropriate actions, aiming for them to be discharged before 60 days. This is being undertaken as part of the Inpatient Processes workstream. The metric may potentially fluctuate between being on and off track whilst the Peri-Hospital Admissions workstreams embed further processes. 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. Patients that are identified as clinically ready for discharge are reviewed weekly at a system-wide Operational Flow group and patients awaiting admission are reviewed daily and least restrictive options are prioritised wherever possible with the support of community teams.

Length of Stay – Older Adult



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.

3-Month Rolling: 127.1 **Threshold:** 122.9

The 3-month rolling average length of stay for Older Adult Acute Mental Health beds increased to 127.1 days in August, 4.2 days above the 122.9-day threshold.
Patient flow remained constrained throughout the summer, with delays particularly pronounced on St Brelade's and Herm Wards. During August, difficulties obtaining funding approval for packages of care, especially from BCP Council due to additional approval measures implemented, contributed to delays in discharging patients who were otherwise ready to leave hospital.
The Discharge Coordinator Team met three times each week with Older People Mental Inpatient Service to identify and escalate barriers to discharge and review patient flow across the wards. This was supported by the Mental Health Peri-Hospital Admissions programme and wider system working with local authority partners to progress packages of care and expedite discharge.
Delays in agreeing and implementing packages of care remain a key risk to timely discharge and length of stay. Projected September performance indicates improvement, suggesting some recovery in patient flow, although this will need to be sustained to return the metric within the 122.9-day threshold.

Healthier lives Empowered citizens Thriving communities

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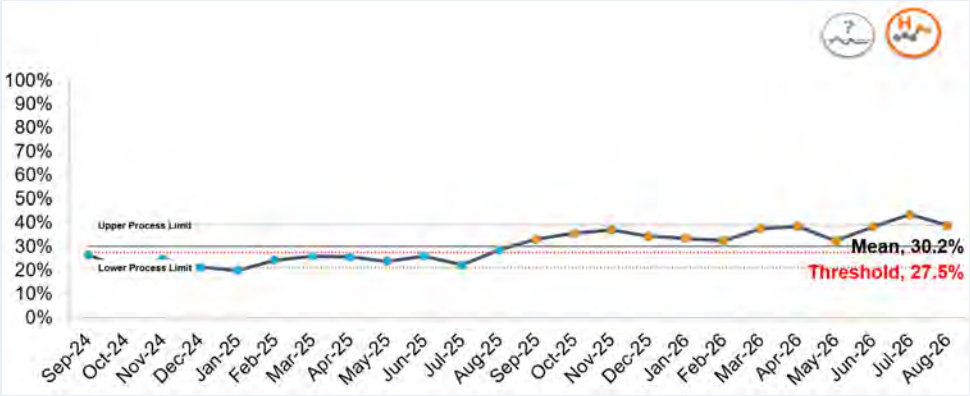
Intermediate Care Beds Occupied By People With No Criteria To Reside



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: 39% **Threshold:** 27.5%

During August, the percentage of Occupied Beds where there was No Criteria to Reside (NCTR) in Community Hospitals was 39% with 62 inpatients having no criteria to reside at the end of the month.

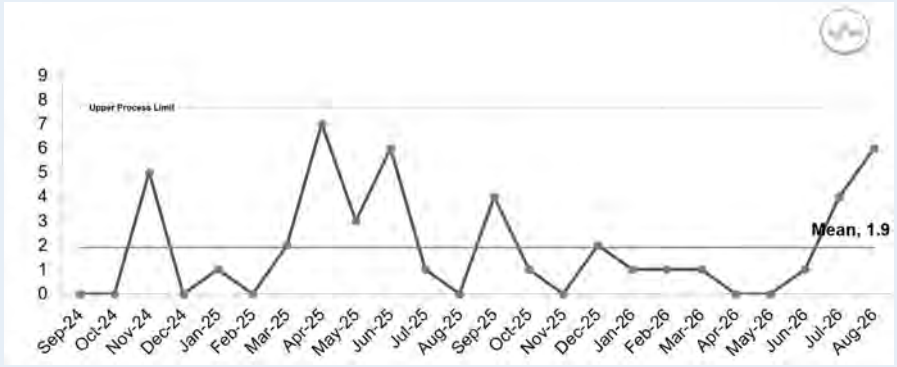
System Escalation processes are established to address inpatients with long NCTR, with all partners recognising the current position is unsustainable. Transfer Of Care (TOC) Hubs in the East and West are fully established supporting and working with Social Care partners. East and West Weekly System Improvement Groups are in place monitoring and implementing actions. Community Hospitals Service Manager and TOC lead have twice weekly meetings with discharge team and ward leads to ensure all actions have taken place. In addition there are weekly escalation meeting with Service Director and fortnightly Chief Operating Officer escalation meetings that reviews cases identified by the TOC lead.

One of the main barriers remains waits for allocation of a social worker, and the COO is meeting with LA Directors in October 2026 to escalate this issue to agree alternative solutions.

A new partnership agreement is now in place with £1.8m of funding identified by ICB to support Discharge to assess for complex discharges commencing from late August 2026. In late September four of our Community Hospitals will be visited by Dr Ian Sturgess, a national rehabilitation expert, who will independently advise on opportunities to improve flow and patient pathways.

Service Delivery 01/10/2026 11:05:12

Under 18 Restrictive Interventions

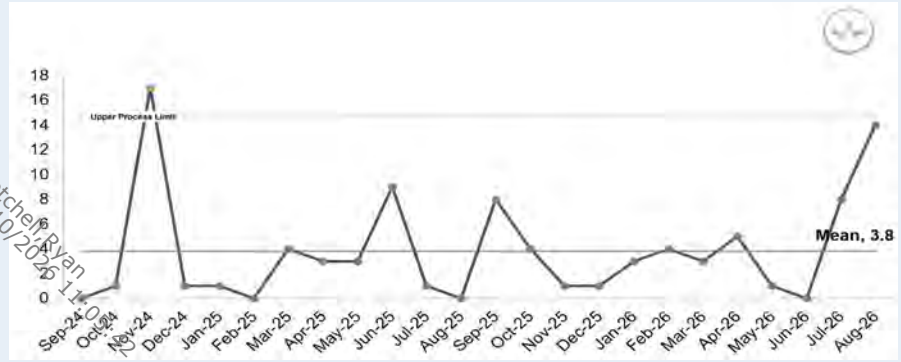


Prone Restraint

Description of Metric

Number of prone restraint incidents reported on Ulysses for patients under the age of 18 years.

In Month: 6 **Threshold:** None



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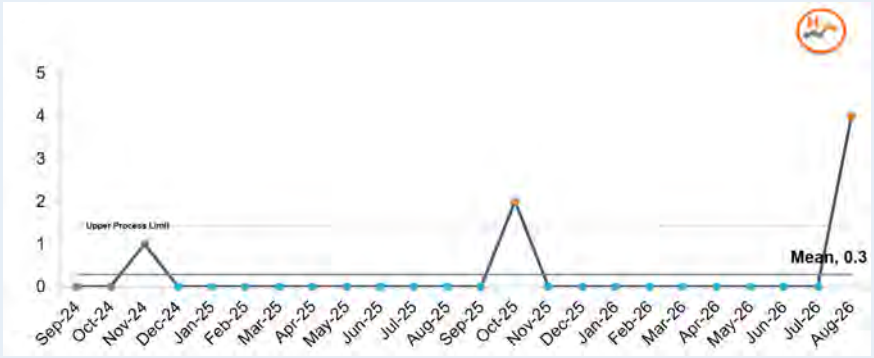
Supine Restraint

Description of Metric

Number of supine restraint incidents reported on Ulysses for patients under the age of 18 years.

In Month: 14 **Threshold:** None

Under 18 Restrictive Interventions

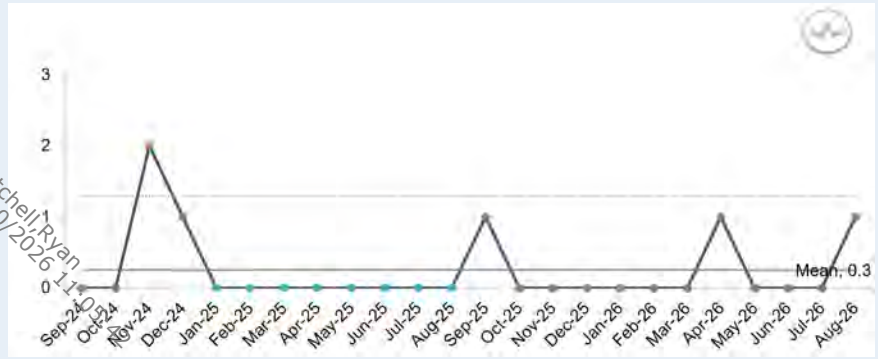


Seclusion

Description of Metric

Number of seclusion incidents reported on Ulysses for patients under the age of 18 years.

In Month: 4 **Threshold:** None



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Rapid Tranquilisation

Description of Metric

Number of rapid tranquilisation incidents reported on Ulysses for patients under the age of 18 years .

In Month: 1 **Threshold:** None

Under 18 Restrictive Interventions

Narrative

In August, the use of restrictive interventions increased due to the complexity and acuity of three young people.

Two young people were on Seastone Ward, our new CAMHS Psychiatric Intensive Care Unit which opened on 1 June 2026.

One young person was a patient on Pebble Ward.

Two young people accounted for 12 and 11 reported incidents respectively, with the third young person involved in two. This indicates that the increase was concentrated within a small number of particularly complex cases rather than reflecting a wider increase across services.

Clinical teams continue to focus on prevention through trauma-informed care, positive behaviour support plans, sensory regulation strategies and personalised interventions based on individual triggers and warning signs. Incidents are reviewed through multidisciplinary debriefs to identify learning, while staff receive ongoing training in de-escalation and therapeutic engagement. Restrictive interventions remain subject to routine governance oversight, with trends monitored to identify themes, challenge practice where appropriate and support continued reduction.

There remains a risk of physical and psychological harm associated with restrictive interventions, particularly where repeated intervention is required during periods of acute distress. To mitigate this, incidents are reviewed for clinical appropriateness, care plans are updated following episodes of restraint or seclusion, and young people receive post-incident support and debrief where appropriate. Governance processes provide assurance that restrictive interventions remain a measure of last resort and that emerging risks are identified, escalated and managed appropriately.

Sekhelli Kyan
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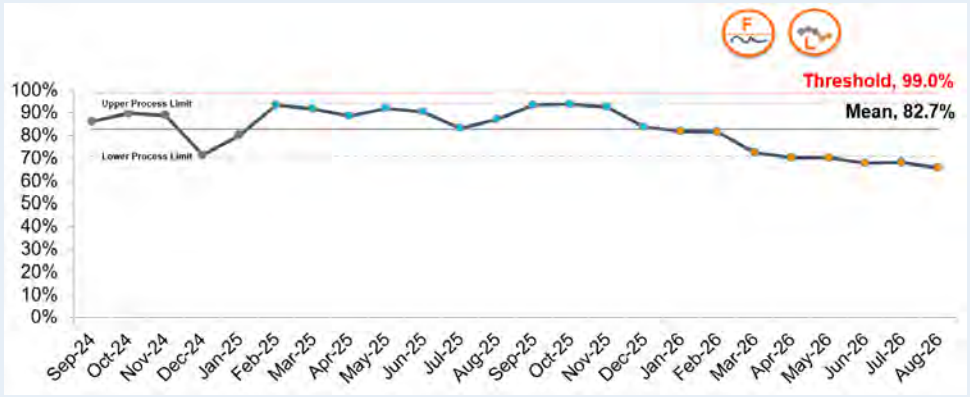
Maximum 6 week wait for diagnostic procedures



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: 65.7% **Threshold:** 99%

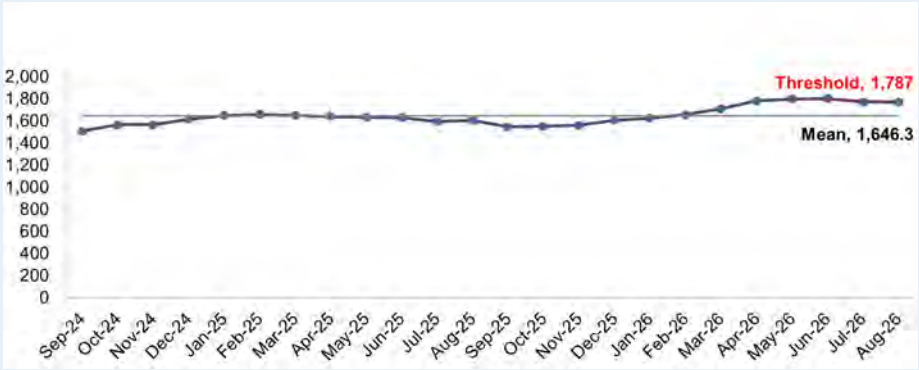
Performance against DM01 target has continued to decline: Audiology Compliance: 60.8%, 919/2,346 breaches (July 63.9%, 854/2,366 breaches). The Longest Waiter was 14 weeks (July longest waiter 33 weeks). Thirty-one (31) waiting 13+ weeks (July 15 waiting 13+ weeks).

Despite the performance decline, total numbers on the diagnostic waiting list have dropped and the resulting change in denominator has in part impacted compliance. Recovery action plan has been developed proposing costed options for recovery and £116k funds identified to support the service. Fortnightly recovery meetings are in place to plan improvements to increase capacity including DNA management, clinic utilisation. Data quality concerns remain, and work continues to ensure data validity and accurately forecast a recovery trajectory. Initial data indicated pressure from self referral however there are also increasing demands from re-assessment self referrals and secondary care ENT demand. The workforce position has improved. Additional recovery funds are being utilised for both locums, bank hours and substantive staff on additional hours.

Clinical risk is minimised through triage processes. There remains a risk to delays in patient care but no evidence of harm. Patient information from assessment to hearing aid fitting is available. Waiting list waits are being published on the Trust website to keep patients informed.

Scotchen, Ryan
09/10/2026 11:05:42

Children & Young People Access



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

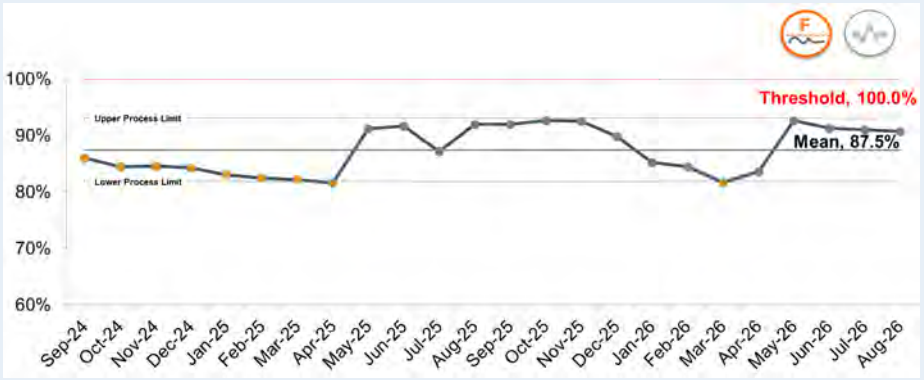
Description of Metric
Number of CYP aged 0-17 supported through NHS funded mental health services receiving at least one contact with an MHST. 12 month rolling period.

In Month: 1,771 **Threshold:** 1,787

The CYP Aged 0-17 Supported Through NHS Funded Mental Health Services Receiving At Least One Contact with a Mental Health Support Team metric is reporting (-16) below the threshold for August, the metric is included in the October 2025 recovery plan and monitored via the MTP trajectories.
It is anticipated that the metric will underperform against the threshold until October, due to schools being closed for the summer holidays, which reduces the number of referrals during this period.

Sekwell Ryan
09/10/2026 11:05:42

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: 90.8% **Threshold:** 100%

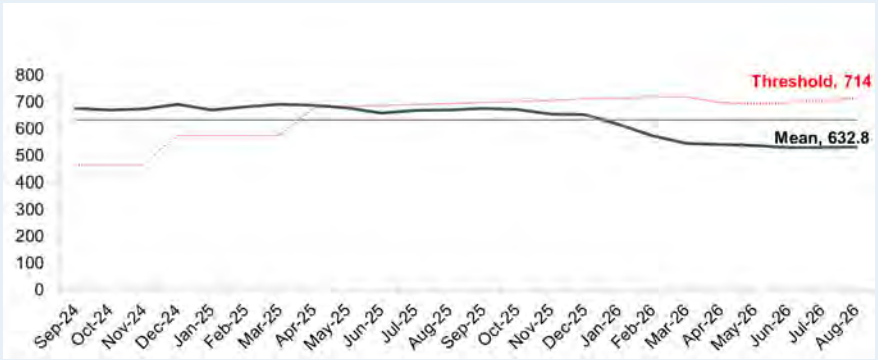
Completeness of patient ethnicity data remains below the local target of 100%, creating a data quality risk and limiting full analysis of performance, access, experience and outcomes by ethnicity. The recent improvement in this metric relates to the re-establishment of a broken data link between DHC 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. Exclusions 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.

Setchell,Ryan
09/10/2026 11:05:42

Meet the existing commitments to expand 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

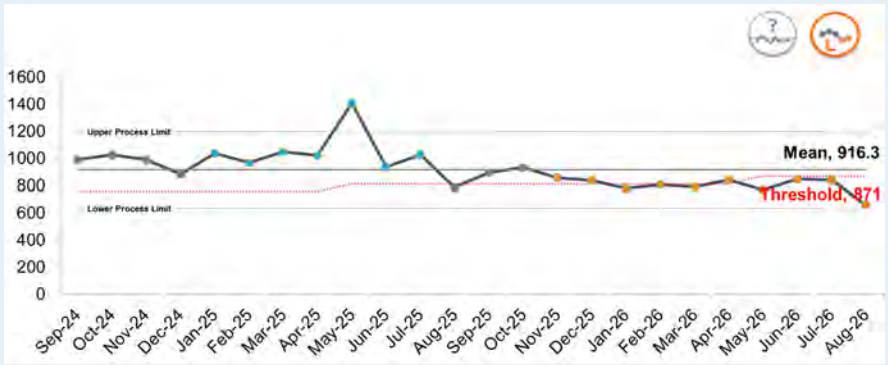
In Month Position: 532
In month Trajectory: 714 **Year End Target:** 776

Dorset Work Matters (DWM) is the Individual Placement Support (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 2025/26 expansion funding was delayed, impacting on the services ability to achieve the target set in line with expansion. The 2026/27 Medium Term Plan trajectories have been set to achieve an access rate of 776 by March 2027. Expansion recruitment has been successful, and the service continues to actively recruit to an additional three posts, new starters are undertaking the three-month induction and onboarding process required for all new Employment Specialists. In addition demand and capacity modelling has identified opportunities for improved productivity within the service which is being implemented. The service anticipates that an improved access rate trajectory will be evident from October 2026.

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 good fidelity score and a quality mark with the IPS Grow review in 2025/26. Whist the in month performance is not at threshold, the projected performance based on current activity is to be compliant by the end of 26/27 as per the recovery plan.

Setchell Ryan
09/10/2026 11:35:42

Talking Therapies



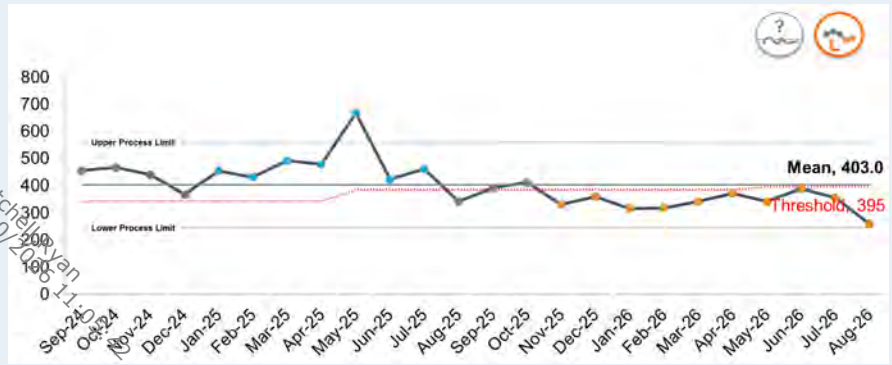
Courses of Completed Treatment

Long & Medium Term Operational Planning metric

Description of Metric

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

In Month: 661 **Threshold:** 2026/27 871 TBC (2025/26 812)



Reliable Recovery

Long & Medium Term Operational Planning & National Oversight Framework metric

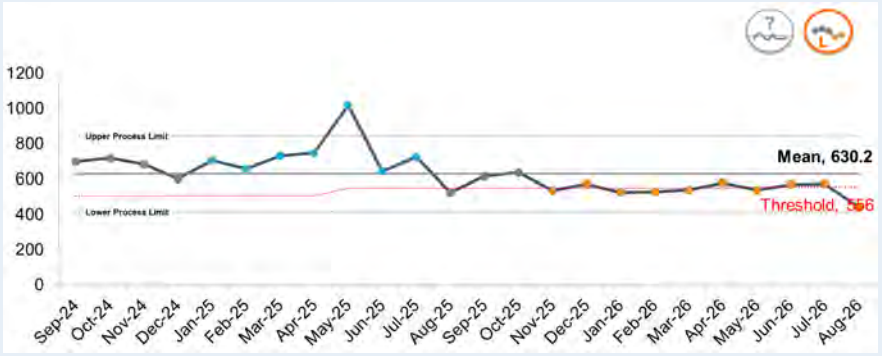
Description of Metric

Number of patients that achieved reliable recovery.

In Month: 259 **Threshold:** 2026/27 395 TBC (2025/26 384)

Setchell Ryan
09/10/2026 11:01

Talking Therapies



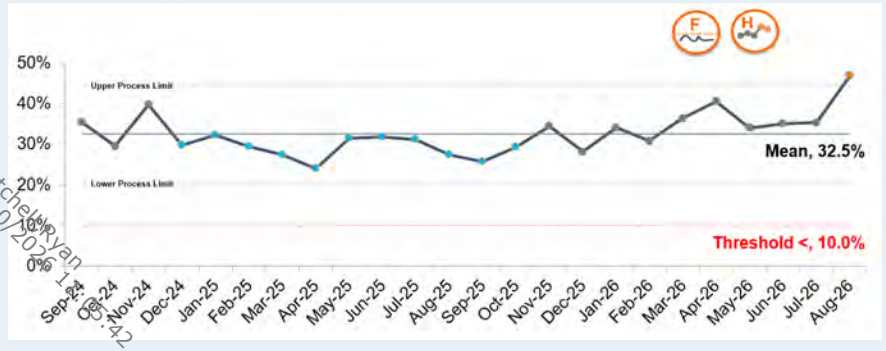
Reliable Improvement

Long & Medium Term Operational Planning & National Oversight Framework metric

Description of Metric

Number of patients that achieved reliable improvement.

In Month: 442 **Threshold:** 2026/27 556 TBC (2025/26 552)



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Talking Therapies 1st to 2nd Treatment

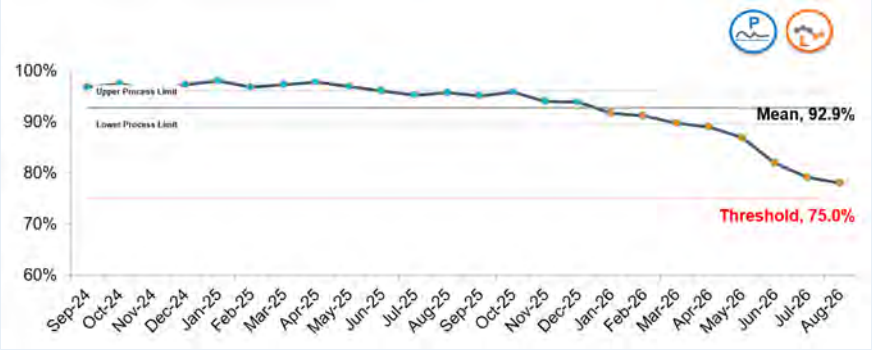
Long Term Operational Planning metric

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: 47.0% **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: 78.0% **Threshold:** 75%

Narrative

Courses Of Completed Treatment

The courses of treatment metric has started to dip below the threshold and is showing special cause variation due to sustained below mean performance over the last twelve months and therefore future compliance is at risk. The service requested that this target be brought into line with national fair share expectations for 2026/27 however the NHSE position remains that ongoing expansion is required beyond this. 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 recent non-recurrent investment received should have a significant impact on this from Q3, when the courses delivered by the external supplier (Xyla*) is reflected in the data, however this remains a long-term risk as this investment is non-recurrent.

*Xyla is a private external provider of NHS Talking Therapies. Steps2Wellbeing has been provided non-recurrent investment to significantly increase the number of courses of treatment outsourced to Xyla over coming months.

Setchel, Ryan
09/10/2026 11:05:42

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 twelve months. This indicates a deteriorating position. The impact of the lack of expansion investment for 2025/26 has previously been outlined through the Board report and quality impact assessment. The key issue is the interaction between current waiting lists, investment and the known relationship between longer waits and outcome measures.
The recent non-recurrent investment received should have a significant impact on this metric from Q3, as those patients who wait less time for treatment start to be discharged (due to the previously outlined interaction between waiting lists and impact on outcomes). In addition, the service has now moved its focus onto recovery metrics improvement, rather than primarily focusing on wait list reduction. However, as previously outlined, whilst there will be a temporary reprieve, the waiting lists would be expected to increase in 2027/28 without ongoing investment, and this metric would deteriorate again.

Reliable Improvement

Reliable Improvement has also dipped below the required of 69%. This should be treated as an emerging risk but should be mitigated in 2026/27 due to the non-recurrent investment, however, will be a risk in 2027/28. The factors that influence Reliable Recovery outlined above also impact Reliable Improvement.

Setchell,Ryan
09/10/2026 11:05:42

Talking Therapies

1st to 2nd Treatment

This indicator remains above the 10% target and is likely to continue to increase over the next two months approximately. This is due to the investment received to support waiting lists, which is being used to move patients into therapy with Xyla. A higher proportion of patients who have been waiting more than 90 days for therapy have started treatment than usual, inflating this figure. However, this is a data anomaly for a positive improvement for patient care.

There are still a proportion of patients waiting for more than 90 days for remote appointments for some interventions, however these will all be offered an appointment within the next 4-6 weeks. Wait list sizes have already dropped since the investment. The focus thus far has primarily been High Intensity Cognitive Behavioural Therapy (HI CBT) (wait list size reduction of 35% since 4 June 2026) and HI counselling (wait list reduction of 42%). The rest of the longer waiters are those waiting specifically for face to face (F2F) appointments. Provision of F2F appointments remains a challenge for the service due to a combination of staffing levels and accommodation issues in some areas. The business team and service managers are scoping further accommodation possibilities to mitigate the latter.

The service is maintaining its focus on offering least intrusive interventions first to reduce pressure on more intensive waiting lists and adherence to the attendance policy, however the service remains significantly under-invested in terms of workforce for the metrics requested. Without ongoing investment this remains a risk for 2027/28.

6 week wait

The 6 week wait target continues to be achieved; however, with performance still 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 aforementioned investment will have a positive impact on this metric in coming months, however as the data is only reported once a patient completes treatment, it is expected to be Q3 before this is visible in the reports. Patients started to be sent to Xyla mid to end July, and the initial focus was on those waiting for more intrusive interventions, which are between 12 and 20 weekly sessions, therefore it will be October before the first of these start to flow to the data. This does however remain a longer-term risk moving into 2027/28 as the investment is non-recurrent.

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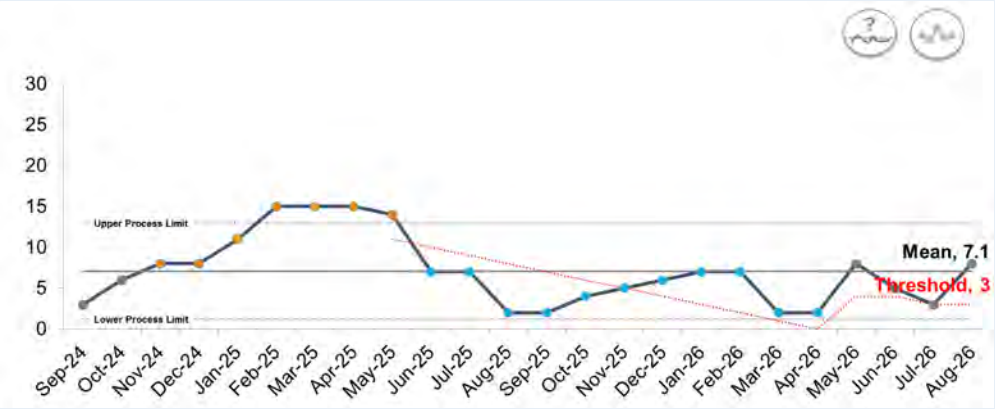
09/10/2026 11:05:42

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: 8 **Threshold:** 3

The use of out of area placements increased in August this is reflective of the lack of patients transferred back to a local bed in August and a lower number of patients discharged in the month. All patients in an adult acute or Psychiatric Intensive Care Unit (PICU) bed have been reviewed to identify those who may be able to be discharged and unblock some barriers to increase capacity. All patients in an Out of Area (OOA) bed are closely monitored by the OOA Coordinator to ensure regular reviews for repatriation or direct discharge.

The Patient Flow team have now stood up the “45 day panel” to review those patients who have been admitted for longer than 45 days in an adult acute or PICU bed to identify immediate areas of support either clinically or to facilitate more rapid discharge. It is recognised that patients should receive care as close to home as possible, ensuring they retain access to their support networks, and communities. To support this, whilst work is ongoing through the New Hospital Programme to increase local bed capacity, a block booking with Southampton Priory remains in place to support Dorset Healthcare’s inpatient footprint and we remain diligent in sustaining further reduction in OOA bed use in line with our Medium-Term Plan trajectory.

Secretary 09/10/2025 11:05:

Finance

Finance

Metrics (£000s)	In Month	YTD	YTD Threshold
Cash Balance	-4,938 Decrease	42,100	53,100
Capital Expenditure	1,359	7,604	11,600
Financial efficiency : variance from efficiency plan	510 Adverse	629 Adverse	10471
Financial stability : variance from NHSE plan	-2 Favourable	-5 Favourable	-1120 Surplus
Better payment practice code		96.6%	95.0%

National Oversight Framework metrics

The cash balance is down by £4.9m this month due to the increase in debtors, reduction in prepayments and capital creditors.
Cash levels are below plan due to increased internally funded capital spend in M12 leading to a £4.5m variance in year- end balance compared with the forecast year- end position and increased capital spend at St Leonards.

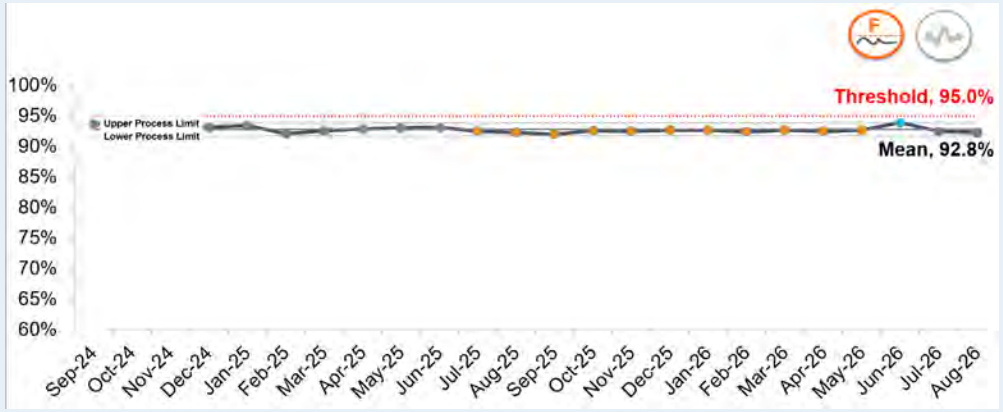
The capital expenditure is below plan by £4.0m due to slippage of the New Hospital Programme new builds, but these are now complete. However, this has delayed the start on the St Ann's refurbishment. All risks are managed at programme level and the programme remains on financial target.

The capital programme for 2026/27 has been reforecast to £23.1m. This increase is due to the recognition of brokerage within the Dorset system of £1.3m towards the Healthset project.

Efficiency savings are behind plan by £629k. All red schemes are being reviewed with an assessment required as to whether they will deliver this financial year, stating what actions are being taken to deliver them or to find alternative savings. The full savings target of £28.8m has been identified with only 17% being high risk.

Scotchell, Dean
09/10/2026 11:05:42

Mandatory Training Completed



Description of metric

Percentage of staff at month end having completed the Mandatory training requirements, as set nationally by the UK Core Skills Training Framework (2013). The required level of training is dependant on profession and workplace, and staff group requirements are decided locally.

In Month: 92.3% **Threshold:** 95%

Mandatory Training compliance saw a minimal decrease this month to 92.3%.This remains beneath the current compliance target of 95% but the same figure as this time last year.

The potential contributing factors for this include session capacity recovery following trainer absence for Basic Life Support (BLS) /Emergency Life Support (ELS), annual leave and annual leave cover during the holiday period. Both BLS and ELS saw slight increases this month.

The Trust's overall compliance rate of 92.3% when compared against national benchmarking is still an exceptional achievement considering the challenges facing frontline staff meaning risk to patients and staff remains low.

Learning and Development continue to provide reminders to individuals, reports to managers and ongoing support to ensure training can be completed.

Sergiu Ryan
09/10/2026 11:05:42

Quality

Metrics	In Month	Target	Assurance	Variation
Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infections (blood stream infection)	0			
Clostridioides difficile infections	0			
E. coli bloodstream infections	2			
Other significant HCAI – number of patients affected	0			
NHS England Patient Safety Alerts Outstanding	0	0		
Patient Safety Events (excludes falls & all no/low harm)	52			
Falls on inpatient wards per 1,000 OBD	11.2			
Medication incidents	84			
Violent incidents - patient on patient in hospital	22			
Falls Assessment within 24 hours	88.3%	95.0%		
Venous Thromboembolism (VTE) risk assessment within 24 hours	87.3%	95.0%		
Pressure ulcer risk assessments (Purpose T) within 6 hours	94.9%	95.0%		
MUST risk assessment within 24 hours	96.4%	95.0%		
ICS in-patients not feeling safe	0.0%			
MH in-patients not feeling safe	6.5%			
Friends & Family Test - positive experience feedback	89.7%	95.0%		
Number of complaints	72			
Number of complaints with Ombudsman involvement	0			
Reopened complaints	5			
Duty of Candour	N/A			
Patients reporting being involved in their care	93.2%			
Category 4 pressure ulcers acquired in our care (DHC)	0			
Admissions to adult facilities of patients who are under 16 years old	0			
Average length of stay for patients in Adult Acute and PICU Mental Health Beds	71.7	73.3		
Average Length of Stay for Patients in Older Adult Acute Mental Health Beds	127.1	122.9		
Right to reside (CHS)	39.0%	27.5%		
Prone Restraint (Adult)	2			
Supine Restraint (Adult)	17			
Seclusion (Adult)	1			
Rapid Tranquilisation (Adult)	0			
Prone Restraint (<18 y.o.)	6			
Supine Restraint (<18 y.o.)	14			
Seclusion (<18 y.o.)	4			
Rapid Tranquilisation (<18 y.o.)	1			

Setchell,Ryan
09/10/2026 11:05:42

Access and Targets (performance)

Metrics	In Month	Target	Assurance	Variation
IUCS Proportion of Clinical Call backs within agreed timeframe	46.4%	90.0%		
Community Waiting List sitrep - numbers waiting over 52 weeks	0	0		
Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	78.5%	70.0%		
Maximum 6-week wait for diagnostic procedures	65.7%	99.0%		
Children & Young People (CYP) Access 1+ Contact, DHC Under 18s rolling 12 months	8,033	6,628		
Number of CYP aged 0-17 supported throu ental health services receiving at least one contact with an MHST	1,771	1,787		
Children and Young People with community mental health related waits - over 104 weeks	N/A	671		
Children & Young People Eating Disorders (CYPED) Urgent - 1 week rolling 3 month	67.0%	95.0%		
Children & Young People Eating Disorders (CYPED) Routine - 4 weeks rolling 3 months	72.0%	95.0%		
Completeness of Patient Ethnicity Data	90.8%	100.0%		
Dementia Diagnosis Rate	57.8%	66.7%		
Serious Mental Illness (SMI) Physical Health Checks	70.1%	75.0%		
Number of women accessing (1+ contact) specialist community PMH and MMHS services in the previous 12 months	746	699		
Meet the existing commitments to expand Individual Placement Support	532	714		
Health Visiting - 6 to 8 Weeks visit	97.1%	95.0%		
Health Visiting - 10 to 12 Months Visit	95.5%	95.0%		
Health Visiting - 24 to 28 Months Visit	92.1%	95.0%		
Health Visiting - Antenatal Visits	93.0%	95.0%		
Health Visiting - New Birth Visits within 14 Days	91.1%	95.0%		
Health Visiting - New Birth Visits within 30 Days	98.7%	98.0%		
CiC Review Health Assessments	84.5%	90.0%		
CYP SALT - 18 Week RTT	93.6%	95.0%		
Health Visiting - Data quality percentage of infants feeding status at 6-8wks	64.3%	50.0%		
Percentage of children who received a 2-2½ year review using Ages and Stages Questionnaire (ASQ-3) who were at or above the expected level of development in all five domains	72.6%	95.0%		
Talking Therapies Courses of Treatment	661	871		
Talking Therapies Reliable Recovery	259	395		
Talking Therapies Reliable Improvement	442	556		
Talking Therapies 1st to 2nd treatment	47.0%	10.0%		
Talking Therapies Waiting Times - 6 weeks	78.0%	75.0%		
Virtual wards bed occupancy rate	67.1%	80.0%		
Community Mental Health (CMH) 2+ Contacts, Local Provider Data rolling 12 months	8,891	9,526		
Southampton Priory Placements - Appropriate Out of Area Placements (number of active placements at end of month)	8			
Out of Area Placements - Inappropriate Placements (active placements at end of month)	8			

Chart Area

Setchell,Ryan
09/10/2026 11:05:42

Finance

Metrics (£000s)	In Month	YTD	YTD Threshold
Cash Balance	-4,938 Decrease	42,100	53,100
Capital Expenditure	1,359	7,604	11,600
Financial efficiency : variance from efficiency plan	510 Adverse	629 Adverse	10471
Financial stability : variance from NHSE plan	-2 Favourable	-5 Favourable	-1120 Surplus
Better payment practice code		96.6%	95.0%

People

Metrics	In Month	Target	Assurance	Variation
Mandatory training completed	92.3%	95.0%		
Completed Appraisals last year	82.5%			
Employee Relations cases (current live cases)	60			
Staff turnover (monthly)	0.7%			
Leaver rate	6.4%			
Vacancy rate	7.2%			
Sickness absence rate (monthly)	5.5%			

Strategy - Overall Delivery

Metrics	In Month	Target	Assurance	Variation
NHSE System Oversight Framework - Segment	2			
Overall CQC Rating	Outstanding			
CQC Well Led rating	Outstanding			

Please note that workforce survey results are reported to the Board separately through dedicated reports. The Staff Pulse Survey is undertaken three times each year, with the annual NHS Staff Survey taking place in the remaining quarter. These results are therefore not included within this appendix.

Temporary workforce reporting and clinical supervision rates reporting is currently in development and will be incorporated in a future iteration once available.

For any metrics that do not currently have a commissioned, contractual, national or local target, an internal review is underway to consider whether identifying a specific target would add value to the board assurance process for metrics in question.

Setchell,Ryan
09/10/2026 11:05:42

Appendix B - Inpatient Nursing Staffing – National Return for August 2026

Safer Staffing Summary

This information is reported to the monthly Safer Staffing Forum and Quality Governance Group, with escalation to the Quality Committee in Common, as required. Detailed staffing data is provided in the monthly *Right Staffing Report.*

Community Hospital and Mental Health In-Patient dashboard overviews are included within the report

Fill Rate Analysis

Hospital Site Details		Ward Name	Specialty 1	Day				Night			
Site code	Hospital Site name			Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nursing associates (%)	Average fill rate - non-registered nursing associates (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nursing associates (%)	Average fill rate - non-registered nursing associates (%)
RDYEY	WESTMINSTER MEMORIAL HOSPITAL	Ashmore/Shaston Ward	314 - REHABILITATION	100.7%	91.7%	N/A	N/A	98.7%	100.0%	-	-
RDYFC	YEATMAN HOSPITAL	Beech Ward	314 - REHABILITATION	91.3%	89.4%	N/A	-	95.2%	96.8%	-	-
RDYEJ	BRIDPORT COMMUNITY HOSPITAL	Colmers Ward	314 - REHABILITATION	99.9%	81.8%	-	N/A	102.0%	63.5%	-	-
RDY22	ALDERNEY HOSPITAL	Guernsey Ward	314 - REHABILITATION	87.9%	80.6%	-	N/A	100.0%	95.2%	-	-
RDYFE	VICTORIA HOSPITAL W'BORNE	Hanham Ward	314 - REHABILITATION	96.4%	89.3%	N/A	N/A	100.0%	100.0%	-	-
RDY22	ALDERNEY HOSPITAL	Jersey Ward	314 - REHABILITATION	85.7%	63.0%	N/A	N/A	96.8%	96.8%	-	-
RDYEG	WESTHAVEN HOSPITAL	Radipole Ward	314 - REHABILITATION	91.1%	78.1%	-	N/A	83.0%	89.2%	-	-
RDYFC	YEATMAN HOSPITAL	Rowan Ward	314 - REHABILITATION	90.2%	94.4%	N/A	N/A	93.3%	90.1%	-	-
RDYFF	SWANAGE COMMUNTIY HOSPITAL	Stanley Purser Ward	314 - REHABILITATION	97.6%	95.9%	-	N/A	100.5%	90.3%	-	-
RDYFF	BLANDFORD COMMUNITY HOSPITAL	Tarrant Ward	314 - REHABILITATION	97.8%	95.1%	-	-	102.5%	86.1%	-	-
RDYFC	ST ANN'S HOSPITAL	AAU Seaview	710 - ADULT MENTAL ILLNESS	86.1%	100.4%	-	N/A	84.6%	110.5%	-	-
RDY10	ST ANN'S HOSPITAL	Alumhurst Ward	710 - ADULT MENTAL ILLNESS	68.0%	109.9%	-	N/A	71.0%	158.1%	-	-
RDY10	ST ANN'S HOSPITAL	Chine Ward	710 - ADULT MENTAL ILLNESS	86.6%	86.5%	-	N/A	66.1%	140.3%	-	-
RDY10	ST ANN'S HOSPITAL	Coral Ward	710 - ADULT MENTAL ILLNESS	63.9%	112.0%	-	N/A	59.8%	138.6%	-	-
RDYFX	NIGHTINGALE HOUSE	Florence House	710 - ADULT MENTAL ILLNESS	72.9%	227.1%	-	-	101.0%	213.9%	-	-
RDYFT	MAIDEN CASTLE HOUSE	Glendinning Unit	710 - ADULT MENTAL ILLNESS	107.6%	118.5%	-	-	113.4%	107.0%	-	-
RDYFT	ST ANN'S HOSPITAL	Harbour Ward	710 - ADULT MENTAL ILLNESS	78.0%	121.8%	-	N/A	84.8%	183.6%	-	-
RDY10	ST ANN'S HOSPITAL	Haven Ward Female	928 - MENTAL HEALTH REHABILITATION	60.5%	109.2%	-	N/A	85.4%	102.2%	-	-
RDY10	ST ANN'S HOSPITAL	Haven Ward Male	928 - MENTAL HEALTH REHABILITATION	94.3%	102.9%	-	N/A	79.9%	115.1%	-	-
RDY22	ALDERNEY HOSPITAL	Herm Ward	715 - OLD AGE PSYCHIATRY	104.1%	88.9%	-	N/A	100.2%	99.6%	-	-
RDY32	KIMMERIDGE COURT	Kimmeridge Court	710 - ADULT MENTAL ILLNESS	73.1%	75.5%	-	N/A	60.2%	157.7%	-	-
RDYEW	FORSTON CLINIC	Melstock House	710 - ADULT MENTAL ILLNESS	95.5%	111.7%	-	N/A	178.0%	100.2%	-	-
RDYFX	NIGHTINGALE HOUSE	Nightingale House	710 - ADULT MENTAL ILLNESS	88.0%	98.4%	-	-	96.8%	121.2%	-	-
RDYMR	PEBBLE LODGE	Pebble Lodge	711 - CHILD AND ADOLESCENT PSYCHIATRY	68.4%	98.5%	-	N/A	91.9%	104.0%	-	-
RDYMR	PEBBLE LODGE	Seastone House	711 - CHILD AND ADOLESCENT PSYCHIATRY	62.5%	84.7%	-	N/A	68.0%	111.2%	-	
RDYMR	ALDERNEY HOSPITAL	St Brelades Ward	715 - OLD AGE PSYCHIATRY	80.5%	96.7%	-	N/A	75.9%	111.8%	-	-
RDY22	ST ANN'S HOSPITAL	Twynham Ward	712 - FORENSIC PSYCHIATRY	72.2%	96.1%	-	N/A	80.6%	116.1%	-	-
RDY10	FORSTON CLINIC	Waterston AAU	710 - ADULT MENTAL ILLNESS	92.3%	81.3%	-	-	87.2%	113.1%	-	-

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Overall Position

Community Hospitals: Average Registered Nurse (RN) fill rates remained within the KPI threshold of 90% to 120% for both day and night duties across July and August. Healthcare Support Worker (HCSW) fill rates were below the KPI on day duties in both months, while night duty fill rates remained within KPI parameters. Staffing levels continued to be affected by the temporary closure of beds to admissions at Radipole due to staffing availability, staff deployment across Community Hospital services to mitigate gaps, sickness absence (consistent with previous months), vacancies, and limited availability of substantive

and temporary staff to cover additional shifts. Recruitment activity remains ongoing, including substantive recruitment and a targeted Trust Bank campaign across East, North and West Dorset to strengthen workforce capacity and support sustainable staffing levels

Mental Health: Average RN fill rates remained below the KPI threshold for both day and night duties throughout July and August, declining from 83% and 89% in July to 81% for both shifts in August. RN fill rates continued to be impacted in Haven F, Haven M, Seastone, Coral and Alumhurst, where recruitment to enhanced establishments has increased required workforce levels and affected achievement of planned fill rates while recruitment progresses. Additional factors affecting fill rates included increased staff unavailability due to the school holidays, sickness absence, annual leave and flexible working arrangements, particularly limitations on night-duty working.

Mental Health Support Worker (MHSW) fill rates remained within KPI parameters for day duties but exceeded the upper threshold for night duties (122% in July and 128% in August), reflecting the continued use of MHSWs to support and backfill duties where RN shifts could not be filled.

Falls data for Radipole and St Brelades is currently under review with the clinical team as part of wider thematic falls review work across inpatient services. The Falls Steering Group will consider emerging themes and agree initial improvement actions, with a falls improvement plan expected to be presented to PSOP in October 2026.

Waterston Ward, St Brelades and Radipole remain under Safest Staffing Support, with enhanced monitoring, review and support arrangements in place. Wards identified as staffing exceptions undergo further analysis and review through the monthly Right Staffing Report.

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Appendix B - Inpatient Nursing Staffing – National Return for August 2026

Hospital Site Details		Ward Name	Specialty 1	CHPPD				
Site code	Hospital Site name			Registered nurses/midwives	Care Staff	Registered nursing associates	Non-registered nursing associates	Overall
RDYEY	WESTMINSTER MEMORIAL HOSPITAL	Ashmore/Shaston Ward	314 - REHABILITATION	3.5	3.1	0.5	0.2	7.3
RDYFC	YEATMAN HOSPITAL	Beech Ward	314 - REHABILITATION	3.8	2.9	1.7	0.0	8.4
RDYEJ	BRIDPORT COMMUNITY HOSPITAL	Colmers Ward	314 - REHABILITATION	2.8	2.7	0.0	0.4	5.9
RDY22	ALDERNEY HOSPITAL	Guernsey Ward	314 - REHABILITATION	3.3	3.5	0.0	0.3	7.0
RDYFE	VICTORIA HOSPITAL W'BORNE	Hanham Ward	314 - REHABILITATION	2.8	3.0	0.0	0.1	5.9
RDY22	ALDERNEY HOSPITAL	Jersey Ward	314 - REHABILITATION	3.3	3.1	0.3	0.2	6.9
RDYEG	WESTHAVEN HOSPITAL	Radipole Ward	314 - REHABILITATION	2.7	3.2	0.0	0.3	6.2
RDYFC	YEATMAN HOSPITAL	Rowan Ward	314 - REHABILITATION	4.0	4.0	0.5	0.2	8.7
RDYFF	SWANAGE COMMUNTIY HOSPITAL	Stanley Purser Ward	314 - REHABILITATION	3.5	3.1	0.0	0.2	6.8
RDYFF	BLANDFORD COMMUNITY HOSPITAL	Tarrant Ward	314 - REHABILITATION	2.4	2.9	0.0	0.0	5.3
RDYFC	ST ANN'S HOSPITAL	AAU Seaview	710 - ADULT MENTAL ILLNESS	4.6	7.8	0.0	0.0	12.5
RDY10	ST ANN'S HOSPITAL	Alumhurst Ward	710 - ADULT MENTAL ILLNESS	6.2	7.6	0.0	0.3	14.1
RDY10	ST ANN'S HOSPITAL	Chine Ward	710 - ADULT MENTAL ILLNESS	4.0	6.1	0.0	0.2	10.3
RDY10	ST ANN'S HOSPITAL	Coral Ward	710 - ADULT MENTAL ILLNESS	N/A	N/A	N/A	N/A	N/A
RDYFX	NIGHTINGALE HOUSE	Florence House	710 - ADULT MENTAL ILLNESS	8.7	14.9	0.0	0.0	23.6
RDYFT	MAIDEN CASTLE HOUSE	Glendinning Unit	710 - ADULT MENTAL ILLNESS	3.2	3.3	0.0	0.0	6.5
RDYFT	ST ANN'S HOSPITAL	Harbour Ward	710 - ADULT MENTAL ILLNESS	3.4	6.0	0.0	0.3	9.7
RDY10	ST ANN'S HOSPITAL	Haven Ward Female	928 - MENTAL HEALTH REHABILITATION	8.6	18.4	0.0	0.3	27.4
RDY10	ST ANN'S HOSPITAL	Haven Ward Male	928 - MENTAL HEALTH REHABILITATION	7.2	14.0	0.0	0.0	21.3
RDY22	ALDERNEY HOSPITAL	Herm Ward	715 - OLD AGE PSYCHIATRY	4.0	9.1	0.0	0.2	13.2
RDY32	KIMMERIDGE COURT	Kimmeridge Court	710 - ADULT MENTAL ILLNESS	8.1	9.3	0.0	0.3	17.6
RDYEW	FORSTON CLINIC	Melstock House	710 - ADULT MENTAL ILLNESS	3.7	4.9	0.0	0.1	8.6
RDYFX	NIGHTINGALE HOUSE	Nightingale House	710 - ADULT MENTAL ILLNESS	3.0	5.6	0.0	0.0	8.6
RDYMR	PEBBLE LODGE	Pebble Lodge	711 - CHILD AND ADOLESCENT PSYCHIATRY	5.6	12.1	0.0	0.2	17.9
RDYMR	PEBBLE LODGE	Seastone House	711 - CHILD AND ADOLESCENT PSYCHIATRY	21.1	59.7	0.0	0.1	80.9
RDYMR	ALDERNEY HOSPITAL	St Brelades Ward	715 - OLD AGE PSYCHIATRY	3.6	10.4	0.0	0.2	14.2
RDY22	ST ANN'S HOSPITAL	Twynham Ward	712 - FORENSIC PSYCHIATRY	4.2	6.8	0.0	0.2	11.2
RDY10	FORSTON CLINIC	Waterston AAU	710 - ADULT MENTAL ILLNESS	3.1	4.6	0.0	0.0	7.7

The above table show care hours per patient day (CHPPD). This is calculated by dividing actual staff hours by number of patients on the ward at 23.59.

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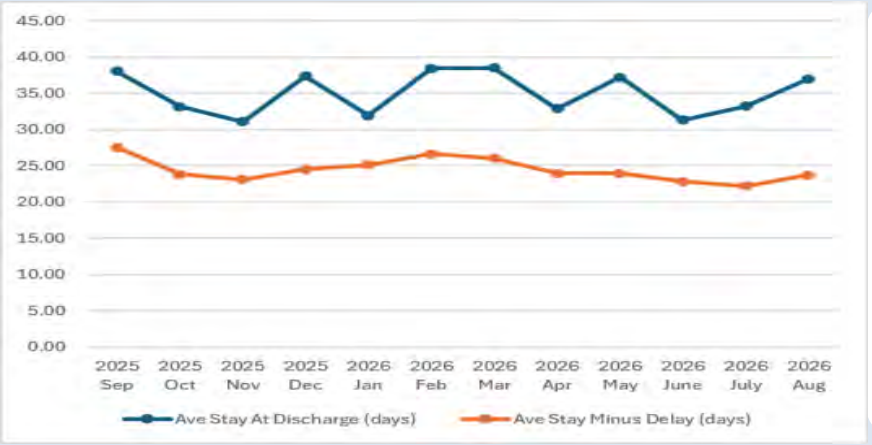
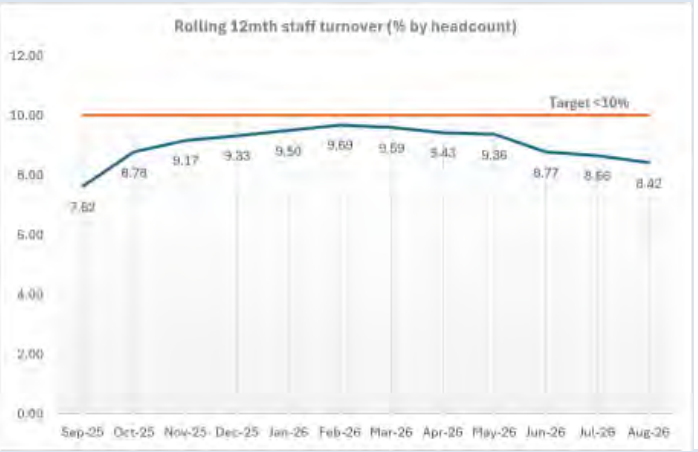
Integrated Community Services–Operational Performance Board Summary – August 2026 (5)

Community Hospitals Average Length of Stay



In August '26 average LoS at discharge was 36.94 days. If average delays of 13.24 days had not occurred, average LoS would have been 23.7 days.

Staff Turnover Rate



The 12 month turnover rate (headcount) for Community Services was 8.42% in August '26 against a Trust total of 8.63%. This is within the target of <10%.

Highlight on a Service

Gold Standard Framework (GSF) Hospital Ward of the Year 2025

The Willows (Rowan and Beech) first achieved Gold Standards Framework (GSF) accreditation in 2016. This milestone was followed by successful reaccreditation in 2019, when the ward received the prestigious title of **GSF Hospital Ward of the Year**, the first ward to achieve this recognition. The award reflected the team's commitment to providing outstanding, holistic end-of-life care, supporting patients and families with compassion, dignity and respect.

Building on this success, The Willows achieved its third GSF reaccreditation and Platinum Status in 2022. The team was honoured to be nominated once again for Ward of the Year. Despite the challenges faced during this period, staff demonstrated exceptional resilience, supporting one another and consistently delivering high-quality care through strong teamwork and dedication.

In 2025, The Willows proudly achieved further GSF reaccreditation and was once again nominated for Ward of the Year. At the GSF Awards Ceremony in September 2025, the team was delighted to learn that they had won the **GSF Ward of the Year Award**.

Winning Ward of the Year and maintaining GSF accreditation is a remarkable achievement and a source of immense pride for the team. Every day, staff go above and beyond to provide comfort, dignity and compassion to patients and families during some of life's most difficult moments. Their unwavering dedication, kindness and professionalism ensure that care at The Willows leaves a lasting impact on those they support. This award is a testament to the team's heart, spirit and commitment to delivering exceptional person-centred care.

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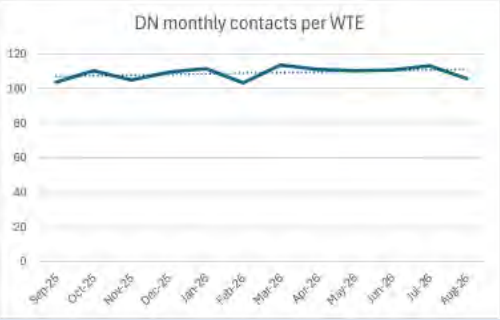
Contacts FTE in community nursing



In Aug 26 there was an average of 106 contacts per WTE for District Nursing Staff, compared to 105 in Aug 25. There has been an overall increase in contacts per wte over the last year although there has been a drop in Aug due to seasonal factors. Factors contributing to the increase in contacts including the move towards more community-centred care, earlier discharges and patients requiring administration of medication at home with an increasing number of patients requiring insulin

Service Director Commentary

DHC performance against the diagnostic standard has remained challenged with ongoing work to ensure accurate demand and capacity figures, with regular performance meetings of the service and B&P. An in-year recovery plan has been approved via SLG and additional capacity is in place with further planned through insourcing. Commissioners have been made aware that additional funds will be required to deliver a sustainable service through contracting meetings.

Total number of patients waiting for a community appointment reduced this month with reductions in MSK and Physio total wait lists. 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. There are zero over 52 weeks

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 AUGUST 2026 (M5)

NHS Dorset HealthCare University NHS Foundation Trust

Key Highlights

Metrics	
No Target	61
Targeted	69
Total	130

Pass	10
Fail	13
Hit or Miss	46

EXCELLENT Improving	GOOD Improving or On Target
15	3

CONCERN Deteriorating	VERY CONCERNING Deteriorating or Off track
20	5

There are 130 local & contractual metrics across All Age MH&LD, CYP and NHSTT Services as shown above.
There are 28 National metrics (MTP & NOF) of which 18 have reportable targets. In July 2026 (M4) 44% of the National metrics were on track. The local and contractual metrics are monitored monthly as agreed operational priorities by the DMG/ICB. These are a mixture of activity based and non-targeted metrics.

Caseload & Activity Summary

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

DIRECTORATE COMBINED CASELOAD	25/26 YTD	26/27 YTD	# Growth	% Growth
	182,555	168,534	-14,021	-8%

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

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Workforce

12 Month Turnover	Jul-26
152 CYPSER	6.39%
152 MENSER	7.39%
Directorate total	7.26%

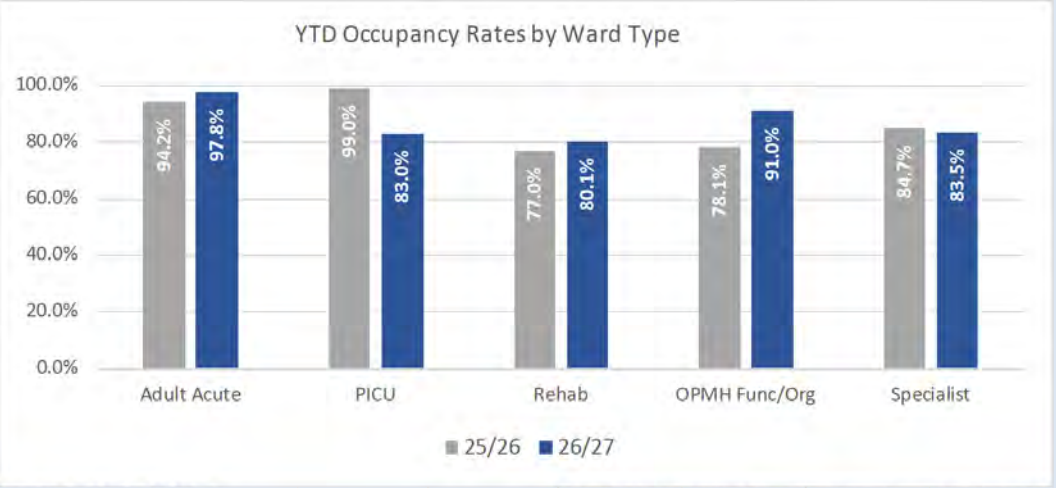
Finance: (Brackets) = favourable variance

	Annual Budget	YTD Actual	FOT Variance
CYP	14.6	6.1	(2.6)
MHS	120.6	49.2	0.6
Directorate total	135.2	55.3	(2.0)

Service Director Commentary

- There has been (as per seasonality) a reduction in caseload and referrals against community functions (at M5).
- Performance 44% of national metrics on track (of 28) with strong delivery in CYP access, & Perinatal. Whilst there is improvement needed in IPS, OOA, LOS and NHS TT – recovery plans are in place (with IPS & LoS on track).
- Inpatient Flow - High occupancy (94.5%; Adult Acute 98.6%) driving pressure. LOS has improved to below target for Adult Acute/PICU; discharge flow remains a constraint.
- Out of Area Placements – are increasing linked to seasonal challenges and acute hospital pressures. Thus, the reduction trajectory was off track; block beds fully utilised.
- Workforce & Finance – turnover remains stable with increased focus on recruitment. Financial position is stable at M4 with an increased pressure from OOA use. The CYP variance is linked to income from Local Authorities and expected to deliver in line with expectation (~£1m overspent due to 0-19 contract)
- Key Priorities – included improving flow and reduce LOS further. Continue to recover access standards (NHS-TT, IPS, Perinatal). Sustain OAP reduction and continue to improve community offers through the peri-hospital programme.

Inpatient Summary



OCCUPANCY RATES All wards	25/26 YTD	26/27 YTD	Growth	% Growth
	86.6%	87.1%	0.5%	0.6%

AVERAGE LoS (in days)	Target	Actual
Adult Acute & PICU	73.0	71.7
Older Adult Acute	123.0	127.1

OUT OF AREA PLACEMENTS	
APPROPRIATE	2
INAPPROPRIATE	8

Dorset HealthCare University
NHS Foundation Trust

Report to	Board in Common (DHC)	
Date of Meeting	13 October 2026	
Report Title	Trust Finance Report for Month 5, August 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 30/09/2026	
Action Required	**Approval**	
	Assurance	Yes
	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	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 five months ended August 2026 are as follows:

- The Trust delivered an adjusted year-to-date surplus of £1,125k at month 5 which equates to a surplus of £5k against the plan submitted to NHSE for 2026/27.
- The year-to-date position includes a prior year benefit of £2.9m due to the release of some balance sheet items.
- With the exception of Medical Staffing, People and Culture, and Strategy, Transformation and Partnerships, all areas are underspent at month 5.
- As at month 5 savings of £9.84m have been delivered against a plan of £10.47m leading to a deficit against target of £0.63m. 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 5.
- 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 5 2025/26 – August Summary

1. Summary

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

KPI	RAG
Current Month Break Even	
Year to Date Variance to Plan.	
Forecast Outturn (assuming minimal 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 £1,125k at month 5 which equates to a surplus of £5k against the plan submitted to NHSE for 2026/27.
- The ytd position includes a prior year benefit of £2.9m due to the release of some balance sheet items.
- With the exception of Medical Staffing, People and Culture, and Strategy, Transformation and Partnerships, all areas are underspent at month 5.
- As at month 5 savings of £9.84m have been delivered against a plan of £10.47m leading to a deficit against target of £0.63m. The Trust's full year efficiency target is £28.8m.

2. Year to date performance

2.1 Summary

- The graph below shows that the Trust delivered an adjusted year-to-date surplus of £1,125k at month 5. This equates to a surplus of £5k (£3k surplus at month 4) against the plan submitted to NHSE for 2026/27.
- Appendix 1 includes the full detail of the Trust's financial performance.

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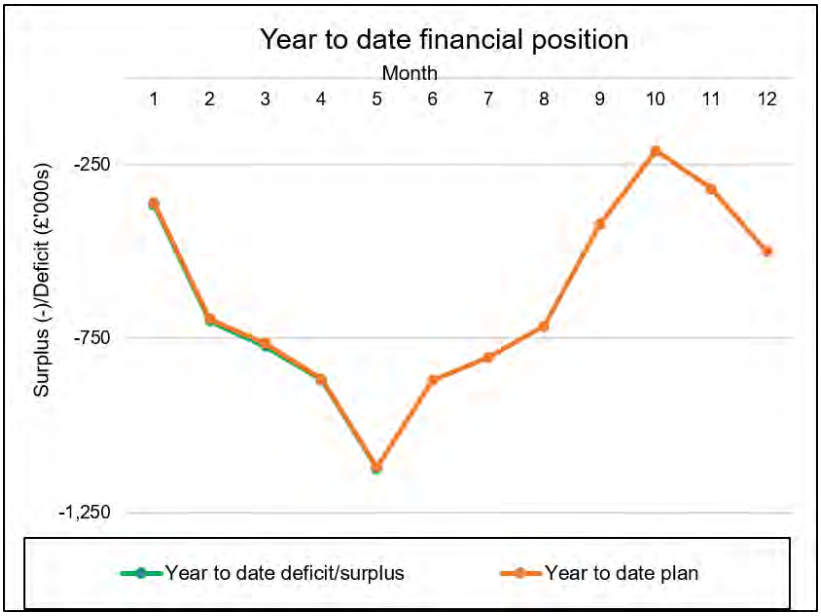

- The key drivers of the Trust's position are set out in the table below.

Drivers of Financial Performance	£'000s
Out of area placements	684
Efficiency savings	629
Depreciation/amortisation	200
Premises costs	(575)
Pay slippage	(943)
Surplus against NHSE plan	**(5)**

2.2 Temporary staffing

- Temporary staffing costs increase by £491k in month 5, which is a 5-week month.
- Agency costs increased by £45k, from £483k to £528k, bank increased by £437k and overtime increased by £9k.
- Agency expenditure is £897k lower than the same period last year, bank £208k lower and overtime costs £88k lower.
- The largest area of agency spend is currently in the Medical directorate, which is £705k lower than the same period in 25/26.
- The month 3 increase in Medical agency costs is linked to VAT treatment rather than usage.
- With effect from July, HMRC have confirmed that the supplies of GMC registered locum doctors may be VAT exempt where the doctor performs medical services in that professional capacity.

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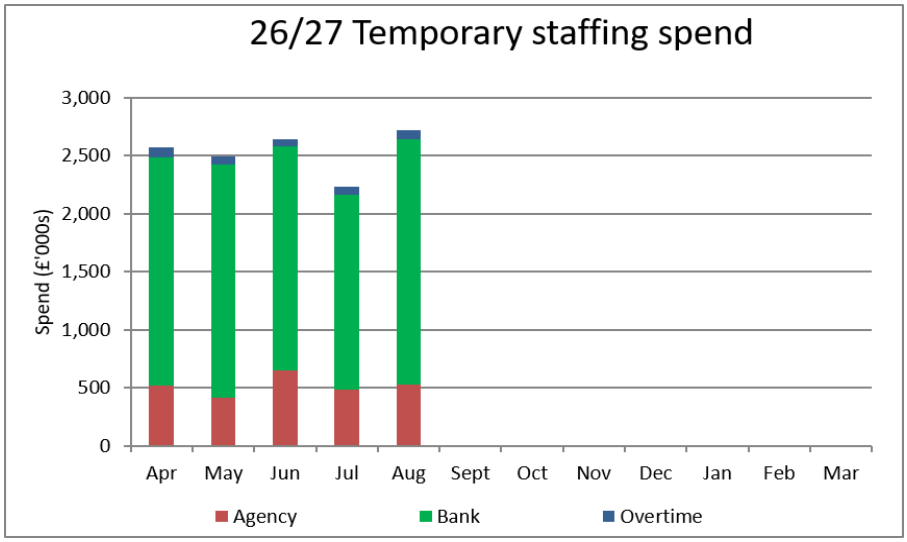
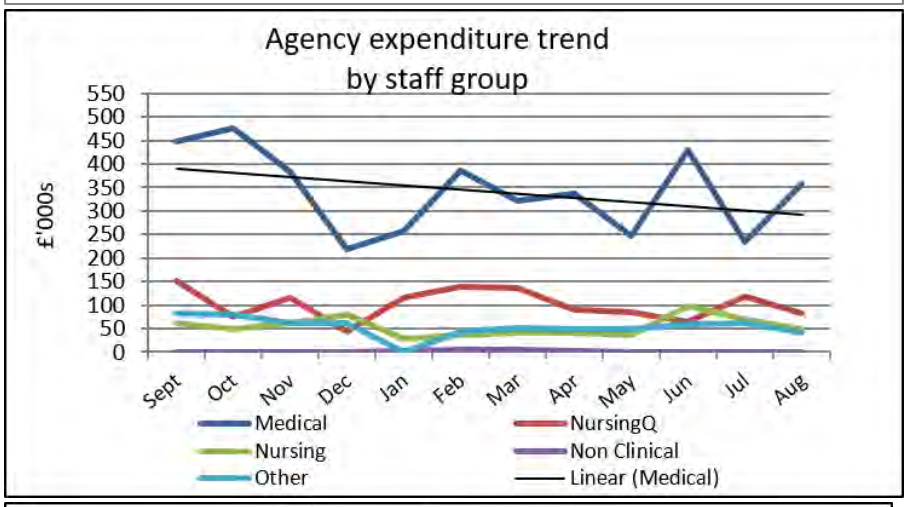
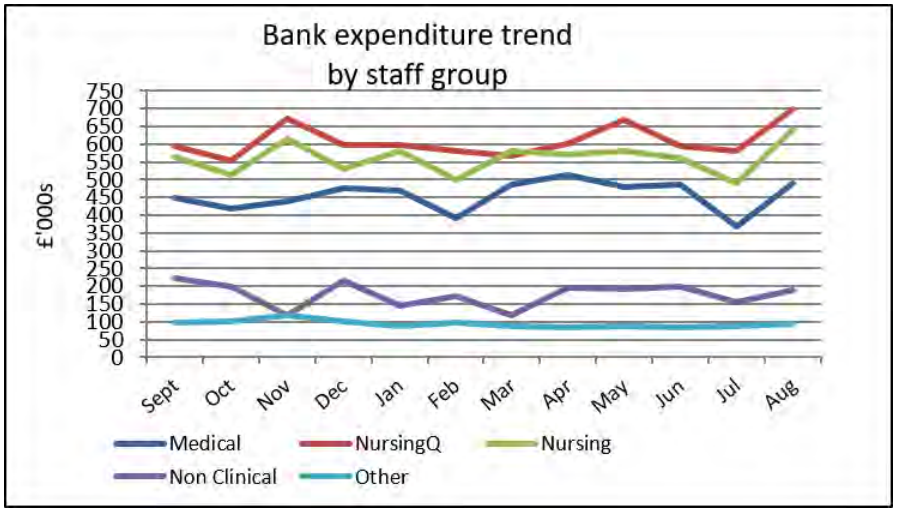
- Agency expenditure is above plan by £328k and 1.85% of total pay costs.
- Bank expenditure is above plan by £1,346k and is 6.91% of total pay costs.







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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 tables below show the position as at the end of August.
- As at month 5, savings of £9.84m have been delivered against a plan of £10.47m leading to a deficit against target of £0.63m (£0.12m at month 4).

Division	Core Target Allocations £'000	Temporary Workforce Allocation £'000	Core Identified £'000	Core (Unidentified) / over £'000	Core % identified	Of identified (Current Month) Risk Level Low £'000	Medium £'000	High £'000	R/NR Recurrent	Non Recurrent
Core - 5%										
MH & CYP	3,549	4,102	4,584	1,035	129%	3,434	900	250	17%	83%
ICS	2,713	2,295	2,713	(0)	100%	1,795	669	249	38%	62%
Medical	0	2,360	0	0		0	0	0		100%
Estates	2,437	96	2,474	37	102%	1,294	180	1,000	53%	47%
Finance	254	19	349	96	138%	254	95	0	27%	73%
Digital	1,083	26	1,083	(0)	100%	244	553	287	70%	30%
Business & Performance	362	0	362	1	100%	362	0	0	47%	53%
Transformation & QI	14	0	14	0	100%	14	0	0	100%	0%
Nursing & Quality	503	34	492	(11)	98%	440	32	20	48%	52%
People & Culture	831	19	831	(0)	100%	362	144	324	97%	3%
Corporate	63	1	79	16	125%	79	0	0	100%	0%
Central	1,392		1,343	(49)	96%	1,254	67	0	81%	19%
Temporary Workforce Reduction	8,953	(8,953)	6,772	(2,181)	76%	1,913	4,123	736	100%	0%
Subtotal	**22,154**	**0**	**21,096**	**(1,058)**	**95%**	**11,447**	**6,762**	**2,865**	**57%**	**43%**
Central Stretch - 1.5%	6,646		7,704	1,058	116%	5,726	0	2,000	44%	56%
Total	**28,800**		**28,800**	**0**	**100%**	**17,173**	**6,762**	**4,865**	**52%**	**48%**

- 100% of efficiency schemes have been identified with 52% being recurrent.

- Of these:
  - £17.17m (60%) is low risk.
  - £6.76m (23%) is medium risk
  - £4.87m (17%) is high risk.

CIP Banked as at Month 5

Division	Core Target Allocations £'000	Temporary Workforce Allocation £'000	Core Identified £'000	Achieved (Banked) £'000	Achieved against Target %	Achieved Recurrently %	To be Banked £'000	Of identified not yet banked: Low £'000	Medium £'000	High £'000	Low %	Medium %	High %
Core - 5%													
MH & CYP	3,549	4,102	4,584	2,588	73%	*31%*	**1,996**	846	900	250	42%	45%	13%
ICS	2,713	2,295	2,713	1,795	66%	*52%*	**918**	-	669	249	0%	73%	27%
Medical		2,360	-	-	0%	*0%*	**-**	-	-	-			
Estates	2,437	96	2,474	874	36%	*81%*	**1,600**	420	180	1,000	26%	11%	63%
Finance	254	19	349	254	100%	*0%*	**95**	-	95	-	0%	100%	0%
Digital	1,083	26	1,083	107	10%	*100%*	**976**	137	553	287	14%	57%	29%
Business & Performance	362	-	362	257	71%	*66%*	**105**	52	-	-	50%	0%	0%
Transformation & QI	14	-	14	14	100%	*100%*	**-**	-	-	-			
Nursing & Quality	503	34	492	302	60%	*51%*	**190**	139	32	20	73%	17%	11%
People & Culture	831	19	831	290	35%	*95%*	**541**	72	144	324	13%	27%	60%
Corporate	63	1	79	79	125%	*100%*	**-**	-	-	-			
Central	1392		1,321	535	38%	*74%*	**786**	772	67	-	98%	8%	0%
Temporary Workforce Reduction	8,953	(8,953)	6,772	469	5%	*100%*	**6,303**	1,444	4,123	736	23%	65%	12%
							-						
Subtotal	**22,154**	**-**	**21,074**	**7,564**	**36%**	**1**	**13,510**	**3,883**	**6,762**	**2,865**	**29%**	**50%**	**21%**
Central Stretch - 1.5%	6,646		7,726	5,235	79%	*19%*	**2,491**	491	-	2,000	20%	0%	80%
Total	**28,800**		**28,800**	**12,799**	**44%**	**67%**	**16,001**	**4,374**	**6,762**	**4,865**	**27%**	**42%**	**30%**

- Of these:
  - £4.37m (27%) is low risk.
  - £6.76m (42%) is medium risk
  - £4.87m (31%) is high risk.

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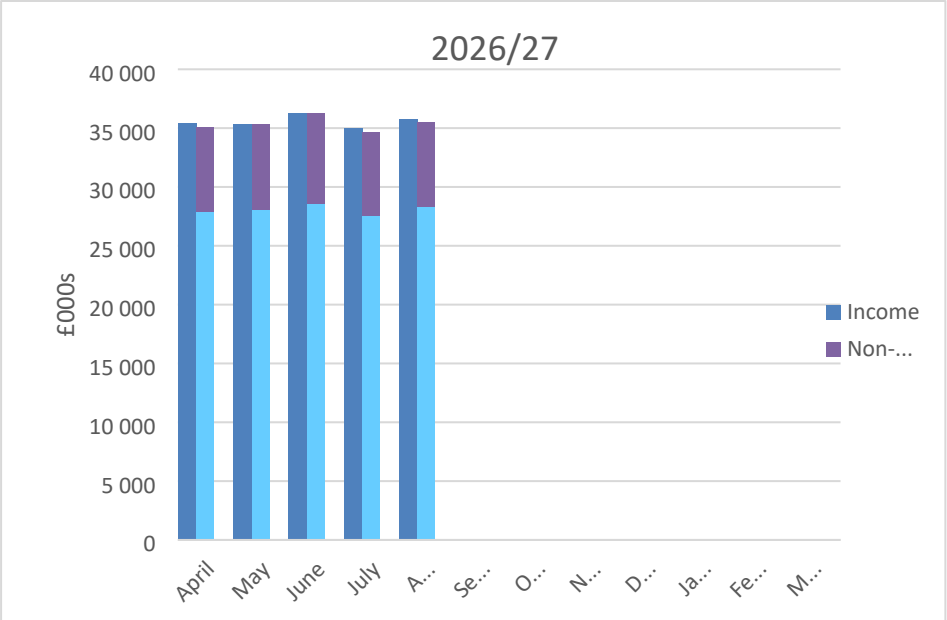
2.4 Out of area placements

- The mental health bed capacity in Dorset is currently below the modelled requirements, meaning that out of area placements will continue to be necessary until the new St Ann's hospital 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 9 patients remaining in a non-block booked bed at the end of August, the budget is overspent by £684k.

3. Performance in month

- During the month of August, the Trust's income exceeded expenditure by £240k. This is before technical adjustments and impairments. The run rate is shown in the graph below.



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.

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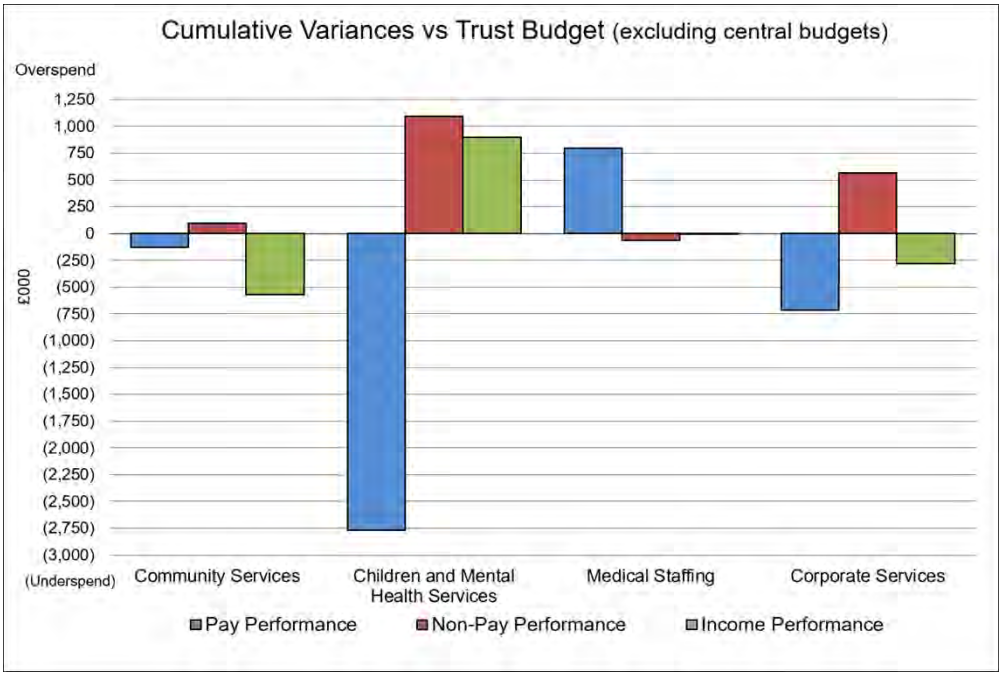
	Full year budget	Month 5 spend	YTD spend	Variance to budget at Month 5
	£'000s	£'000s	£'000s	£'000s
Trust Wide Income	(356,075)	(29,231)	(146,002)	1,250
Central budgets	38,543	(64)	(1,064)	(242)
Integrated Community Services	114,887	9,185	47,039	(600)
Mental Health & Children's Service	135,216	11,069	55,337	(777)
Medical Staffing	29,351	2,690	13,107	738
Nurse Executive and Quality	9,839	767	3,867	(203)
Finance and Strategic Development	43,283	3,536	17,177	(429)
People & Culture	5,181	227	1,639	130
Strategy, Transformation & Partnerships	14,653	1,197	6,188	103
Corporate Services	4,159	384	1,795	(28)
Total	39,037	(240)	(917)	(57)
Capital donations/grants/peppercorn lease	(39,537)	(152)	(208)	
Adjusted total	(500)	(393)	(1,125)	

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



4.1 Integrated Community Services

	Full year budget	Month 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(19,579)	(1,939)	(8,871)	(20,312)	(733)
Pay	111,631	9,252	46,334	111,190	(441)
Non-pay	22,835	1,872	9,577	23,093	258
Total	114,887	9,185	47,039	113,971	(916)

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Drivers of year-to-date performance

- Unachieved savings of £166k.
- Vacancies in the Pain, Podiatry, Musculoskeletal, Integrated Community Rehabilitation services and Community Hospitals, partly offset by vacancy factor, MIU costs due to service demand and high hearing aid expenditure.
- High MIU income.

Key Factors in outturn forecast position

- Assumed unachieved efficiency savings of £850k, which includes the achievement of a further £50k above those that have already been banked and 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	2,713	100%	1,795	669	249	38%	62%

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.

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4.2 Mental Health and Children's Services

	Full year budget	Month 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(32,963)	(2,747)	(12,367)	(31,304)	1,660
Pay	150,775	12,052	59,519	144,263	(6,512)
Non-pay	17,403	1,764	8,185	20,237	2,833
Total	135,216	11,069	55,337	133,196	(2,019)

Drivers of year-to-date performance

- With 9 patients remaining in a non-block booked bed at the end of August, the OOA budget is overspent by £684k.
- Unachieved savings of £42k.
- 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.

Key factors in outturn forecast position

- Assumed unachieved savings of £961k – only savings that have already been banked are included in the forecast.
- Savings yet to be banked are unlikely to result in a further reduction in spend.
- Vacancies across most areas.
- High out of area placement expenditure.

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**.**

			Of identified:				
			Risk level			R/NR	
Core Target Allocations £'000	Core Identified £'000	Core % identified	Low £'000	Medium £'000	High £'000	Recurrent	Non Recurrent
3,549	4,584	129%	3,434	900	250	17%	83%

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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 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(3,139)	(267)	(1,371)	(3,141)	(2)
Pay	30,845	2,819	13,778	32,447	1,602
Non-pay	1,645	137	700	1,568	(77)
Total	29,351	2,690	13,107	30,874	1,523

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 £705k.

Drivers of outturn forecast position

- High, but decreasing, agency expenditure.

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 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(1,620)	(161)	(768)	(1,892)	(272)
Pay	10,028	809	4,057	9,763	(266)
Non-pay	1,430	119	579	1,407	(23)
Total	9,839	767	3,867	9,278	(560)

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Drivers of year-to-date performance

- Unachieved CIP savings of £7K.
- Pharmacy, R&D and participation income ahead of target.
- Vacancies partly offset by vacancy factor.

Drivers of forecast outturn position

- Assumed unachieved savings of £95k which includes the achievement of a further £107k above those already banked.
  - 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.

			Of identified:				
			Risk level			R/NR	
Core Target Allocations £'000	Core Identified £'000	Core % identified	Low £'000	Medium £'000	High £'000	Recurrent	Non Recurrent
503	492	98%	440	32	20	48%	52%

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 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(9,346)	(427)	(3,861)	(9,446)	(100)
Pay	18,201	1,376	6,963	16,731	(1,469)
Non-pay	34,428	2,587	14,075	35,232	804
Total	43,283	3,536	17,177	42,517	(766)

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Drivers of year-to-date performance

- Unachieved CIP savings of £385k.
- Facilities and finance vacancies.
- Low electricity costs and estates related costs.

Drivers of outturn forecast position

- Assumed unachieved savings of £1,424k – only savings that have already been banked are included in the forecast.
- Facilities vacancies.
- Low electricity costs.
- Low estates and facilities 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 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
Estates	2,437	2,474	102%	1,294	180	1,000	53%	47%
Finance	254	349	138%	254	95	0	27%	73%

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 5 spend £'000s	Year to date spend £'000s	Forecast Outturn £'000s	Forecast variance to budget £'000s
Income	(51)	(8)	(36)	(85)	(34)
Pay	10,319	895	4,392	10,311	(8)
Non-pay	4,385	309	1,831	4,655	270
Total	14,653	1,197	6,188	14,882	229

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Drivers of year-to-date performance

- Unachieved CIP savings of £420k.
- IM&T vacancies.
- Low IT related expenditure.

Drivers of outturn forecast position

- Assumed unachieved savings of £1,002k – only savings that have already been banked are included in the forecast.
- IM&T vacancies.
- Low IT non-pay expenditure**.**

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	362	100%	362	0	0	47%	53%
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 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(6,745)	(734)	(3,194)	(6,694)	51
Pay	9,346	799	3,961	9,510	164
Non-pay	2,580	162	872	2,628	48
Total	5,181	227	1,639	5,444	263

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Drivers of year-to-date performance

- Unachieved CIP savings of £213k.
- Payroll and Learning and Development vacancies.

Drivers of outturn forecast position

- Assumed unachieved efficiency savings of £541k – only savings that have already been banked are included in the forecast.
- Vacancies.

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%	362	144	324	97%	3%

4.8 Corporate Services

	Full year budget	Month 5 spend	Year to date spend	Forecast Outturn	Forecast variance to budget
	£'000s	£'000s	£'000s	£'000s	£'000s
Income	(642)	(61)	(276)	(663)	(20)
Pay	3,464	293	1,419	3,339	(125)
Non-pay	1,338	152	652	1,342	4
Total	4,159	384	1,795	4,018	(141)

Drivers of year-to-date performance.

- Vacancy slippage.
- Achievement of the efficiency savings target.

Drivers of forecast outturn position

- Vacancies.

Performance against efficiency target

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- 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.

			Of identified:				
			Risk level			R/NR	
Core Target Allocations £'000	Core Identified £'000	Core % identified	Low £'000	Medium £'000	High £'000	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 £5.3m against the planned £0.5m surplus.
- Current projections assume only minimal efficiency savings, in addition to 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.
- It should be noted that, of the £16m CIP savings yet to be banked (highlighted in section 2.3) many of the identified low risk schemes relate to vacancy slippage which is already included within the forecast below. This means that it is imperative that the savings linked to the medium and high risk schemes are realised, in order to achieve the Trust's planned year end position.

Forecast Outturn	Variance to budget at Month 5	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	(600)	(1,439)	523	(916)	
Mental Health & Childrens Services	(777)	(1,865)	(155)	(2,019)	
Medical Staffing	738	1,771	(248)	1,523	(1,523)
Nurse Executive & Quality	(203)	(487)	(74)	(560)	
Finance & Strategic Development	(429)	(1,030)	264	(766)	
People & Culture	130	312	(49)	263	(263)
Strategy, Transformation & Partnerships	103	247	(19)	229	(229)
Corporate Services	(28)	(68)	(74)	(141)	
Trust Wide Income	1,250	2,999	(616)	2,383	(2,383)
Central budgets	(242)	(580)	4,704	4,124	(4,124)
Total	(57)	(137)	4,257	4,120	(8,522)
Capital donations/grants/peppercorn lease				1,181	
Adjusted forecast - Variance to Plan				5,300	

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6. Provider Collaborative Financial Position

6.1 Dorset HealthCare as Provider

Dorset HealthCare provides a number of services through various provider collaboratives. The month 5 position is shown below.

Service	Provider Collaborative	Lead	Risk share	Expenditure variance to budget at month 4 £000s	Forecast expenditure variance to budget £000s
Adult secure (low and medium) - For Me PC	Thames Valley and Wessex	Oxford Health	15.44%	(300)	(568)
Children & adolescent mental health services (CAMHS) Tier 4	South West	Devon Partnership	19%	(152)	(196)
Perinatal mental health	South West	Devon Partnership	14%	7	3
Adult eating disorders	Hampshire and Isle of Wight.	Dorset HealthCare	100%	235	197

Drivers of year-to-date performance

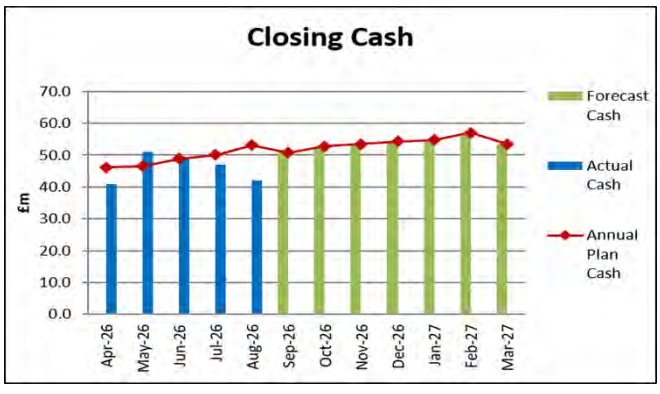
- Adult low and medium secure – vacancies.
- CAMHS Tier 4 – Vacancies.
- Adult eating disorders – reduced income due to low activity.

Drivers of outturn forecast position

- As above.

7. Cashflow and Payments

- The cash balance at M5 was £42.1m (£47.0m at month 4), a reduction of £4.9m which is due to the increase in debtors, reduction in prepayments and capital creditors.
- Cash levels are below plan (£11.0m) due to repayment of year end NHSE funding not included in the plan due to timing; £4.5m variance in year end balance compared with forecast year end position, and increased capital spend at St Leonards.
- Overall debtors remain high with £11.26m of LA and NHS debt which is over 90 days old. DCH represents 99.8% of this balance.



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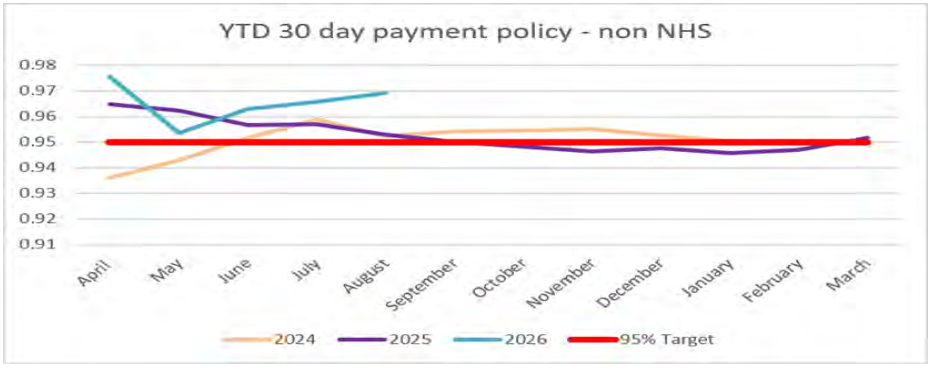
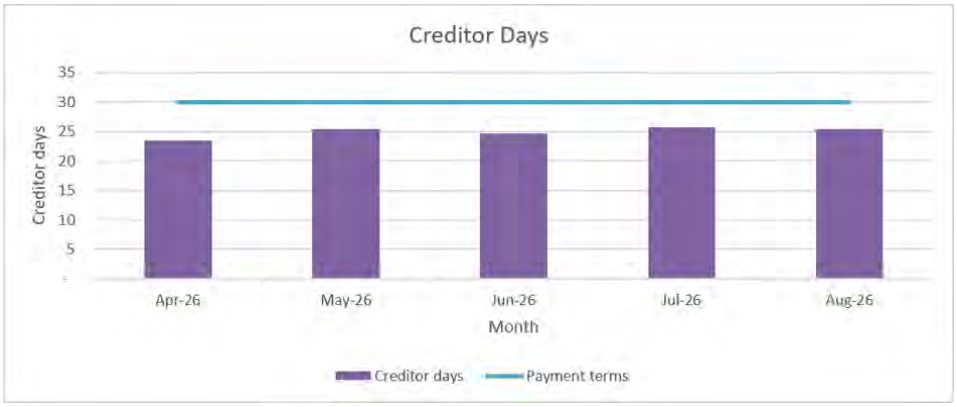
- The YTD Better Payment Practice Code performance is shown below. The target is 95% which has been achieved again this month; 96.91% for non-NHS invoices.

Better Payment Practice Code	YTD M5	26/27
Non-NHS Invoices	No.	£000
Total bills paid	13,668	32,235
Total bills paid within target	13,245	31,192
Percentage of bills paid within target	**96.91%**	**96.76%**
NHS Invoices		
Total bills paid	332	41,620
Total bills paid within target	282	40,128
Percentage of bills paid within target	**84.94%**	**96.41%**
Total		
Total bills paid	14,000	73,855
Total bills paid within target	13,527	71,320
Percentage of bills paid within target	**96.62%**	**96.57%**



- 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.

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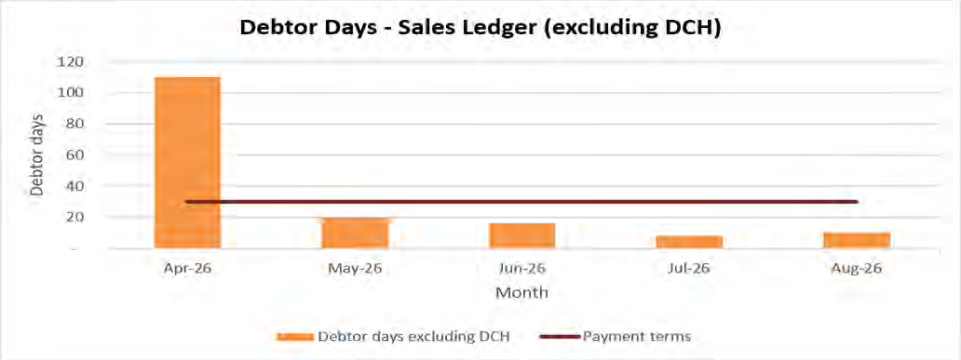
- The cash days graph below shows the number of days that the Trust could sustain its current level of expenditure without any further income, giving a snapshot of our current cash position.

- 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.



8. Capital programme.

- The capital expenditure target for 2026/27 is £23.1m. This is an increase in month due to the recognition of agreed brokerage from UHD of £1.4m for the Healthset project.
- Total year to date spend was £7.6m against a year-to-date plan of £11.6m. Internally funded capital CDEL spend was £4.04m and externally funded capital spend was £3.56m.
- Forecast 2026/27 New Hospital Programme spend is £10.20m a reduction of £6.04m as a result of slippage on the new builds delaying the further refurbishment works to be undertaken at St Ann's.
- Work is being undertaken to see if the underspend from zero rated VAT can be used for additional opportunities in line with the business case objectives. St Ann's NHP is under review for scope enhancements.
- Slippage on the NHP new builds has moved planned month 1 to month 5 spend to 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.

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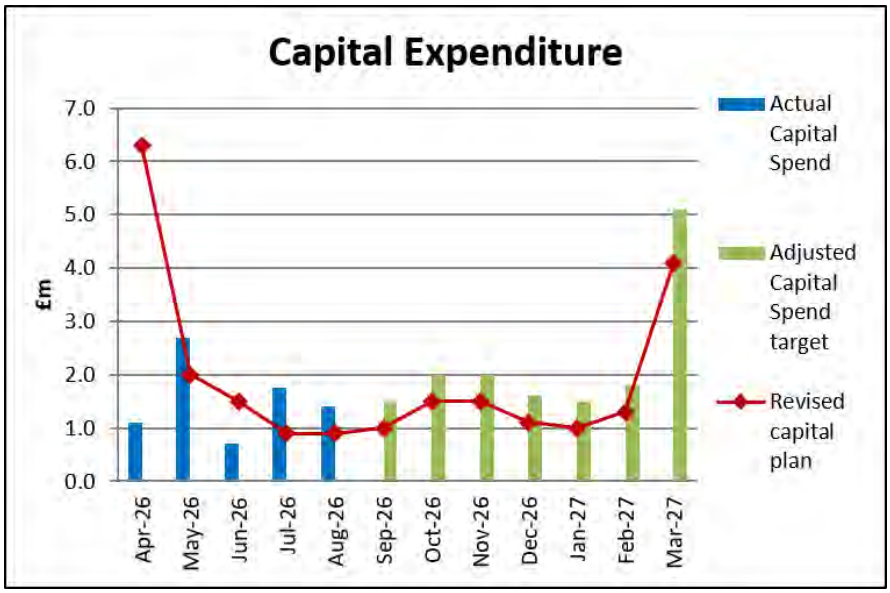
- The accurate accruing to completion at the quarter months.
- The identification of internally funded capital slippage, and the reallocation to additional spends in year brought forward from future years.
- Regular monthly meetings of the Capital Investment Meetings (CIM), where progress is reported, 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 – £10.2m (externally funded)
  - Backlog maintenance - £2.4m (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 £5.99m (plan £5.79m) at month 5, £200k 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.



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.

Setchell,Ryan
09/10/2026 11:05:42

Appendix 1 – Trust financial performance

INCOME & EXPENDITURE SUMMARY								
Month 5 2026/27		YTD			IN MONTH			
August	ANNUAL BUDGET	YTD Budget	YTD Actuals	YTD Variance	Budget	Actual	Variance	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
INCOME								
Baseline Income	(354,160)	(146,225)	(144,975)	1,250	(29,266)	(29,016)	250	R
Integrated Community Services	(19,579)	(8,304)	(8,871)	(567)	(1,635)	(1,939)	(304)	G
Children, Y.P. & Family Services, All Age Mental Health & L.D. Services	(32,963)	(13,262)	(12,367)	895	(2,812)	(2,747)	65	R
Medical Staffing	(3,139)	(1,370)	(1,371)	(1)	(277)	(267)	9	G
Nurse Executive & Quality	(1,620)	(683)	(768)	(85)	(136)	(161)	(25)	G
Finance & Strategic Development	(9,346)	(3,661)	(3,861)	(200)	(437)	(427)	10	G
People & Culture	(6,745)	(3,224)	(3,194)	30	(727)	(734)	(7)	R
Strategy, Transformation & Partnerships	(51)	(21)	(36)	(14)	(4)	(8)	(3)	G
Corporate	(642)	(268)	(276)	(9)	(54)	(61)	(8)	G
Interest Received	(1,915)	(1,027)	(1,027)	(0)	(215)	(215)	0	G
Central Budgets	(1,970)	(777)	(934)	(157)	(104)	(139)	(36)	G
Total Trust Income	**(432,130)**	**(178,821)**	**(177,679)**	**1,142**	**(35,667)**	**(35,715)**	**(48)**	R
EXPENDITURE								
Integrated Community Services	134,466	55,943	55,911	(32)	11,147	11,124	(23)	G
Children, Y.P. & Family Services, All Age Mental Health & L.D. Services	168,179	69,375	67,703	(1,672)	14,004	13,815	(189)	G
Medical Staffing	32,489	13,739	14,478	739	2,733	2,957	224	R
Nurse Executive & Quality	11,459	4,753	4,635	(118)	951	928	(23)	G
Finance & Strategic Development	52,629	21,267	21,038	(229)	4,067	3,964	(103)	G
People & Culture	11,926	4,732	4,832	100	927	961	34	R
Strategy, Transformation & Partnerships	14,704	6,106	6,223	117	1,221	1,204	(17)	R
Corporate	4,802	2,090	2,071	(20)	434	446	12	G
Central Budgets	(4,392)	(2,531)	(2,615)	(84)	(1,062)	(421)	640	G
Impairments	38,942	0	0	0	0	0	0	G
Total Trust Expenditure	**465,203**	**175,476**	**174,277**	**(1,199)**	**34,421**	**34,977**	**556**	G
NET INCOME & EXPENDITURE	**33,073**	**(3,345)**	**(3,402)**	**(57)**	**(1,245)**	**(737)**	**508**	
PDCD	5,964	2,485	2,485	0	497	497	0	G
RETAINED (SURPLUS)/DEFICIT	**39,037**	**(860)**	**(917)**	**(57)**	**(748)**	**(240)**	**508**	G
EBITDA			**4.7%**					
Technical adjustments								
Capital donations/grants/peppercorn lease/PPE	(39,537)		(208)					
ADJUSTED (SURPLUS)/DEFICIT	**(500)**		**(1,125)**					

Setchell,Ryan
09/10/2026 11:05:42

Report to	Board of Directors	
Date of Meeting	13 October 2026	
Report Title	Operational Performance Report (July and August 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	Yes
	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

Performance during August 2026 demonstrates continued progress across several strategic priorities despite sustained operational pressures, workforce challenges and financial constraints. Significant achievements include improvements in urgent and emergency care performance, progress against revised elective recovery trajectories, stable quality indicators, and continued development of major capital infrastructure. Areas requiring continued focus include emergency flow, ambulance handovers, cancer pathways, workforce productivity, appraisal compliance and financial recovery. We have put in place arrangements to strengthen weekly reporting and board oversight of our recovery programme, with metrics and an update report now being shared weekly with NEDs.

Quality, Safety and Patient Experience

The Trust continues to maintain a strong safety profile. There was one fall resulting in severe harm during August, with a full investigation identifying no gaps in care and demonstrating good compliance with falls prevention processes. Medication safety performance improved, with incidents reducing from 70 in July to 48 in August, and no moderate or severe harm medication incidents reported.

Pressure ulcer performance remains positive and the Trust is on track to achieve its objective of reducing hospital-acquired pressure ulcers by 30% by March 2027. The sustained absence of acquired pressure ulcers within Critical Care is a notable achievement and reflects the successful implementation of preventative interventions.

Healthcare-associated infection performance remains under close surveillance. Whilst numbers remain relatively low, ongoing focus is required on C. difficile and gram-negative bloodstream infections. SHMI

Secretary to
09/10/2026 11:05:42

remains within expected limits, providing assurance that there is no evidence of excess mortality within the organisation.

In terms of patient experience, whilst complaint volumes reduced slightly from 82 to 74, resolution times for early resolution complaints deteriorated, with only 24% resolved within 10 working days in August compared with 50% in July. Communication, consent, access and discharge processes remain recurring themes.

Performance

Urgent and Emergency Care

Emergency demand remains above historical levels but is showing signs of stabilisation. Attendances in August were 5,558, broadly unchanged from July. Year-to-date demand remains 5.3% higher than the previous year.

Performance against the 4-hour standard remains below national expectations and medium-term plan trajectories but has achieved the revised NHS England recovery trajectory for both July and August. Twelve-hour waits have reduced for three consecutive months, with the August position achieving the agreed recovery target.

Ambulance handover performance remains a challenge, although encouraging improvement was seen during August. Handover delays exceeding 45 minutes reduced sufficiently to achieve the recovery trajectory, while delays over 15 minutes remain above plan. Flow and discharge improvement initiatives, including bed reconfiguration, frailty pathway redesign and strengthened front-door decision making, are central to the Trust's recovery plans.

Bed occupancy remains above planned levels, driven by flow pressures and discharge delays. Work with system partners to reduce patients with no criteria to reside and improve discharge processes remains a key priority.

Elective and Cancer Recovery

Elective recovery performance continues to improve against revised recovery trajectories, though our overall RTT position continues to be an area of concern with RTT waiting times performance amongst the lowest nationally, Although the overall waiting list remains above original plan at 23,100 patients, it reduced during August and indications suggest delivery of September recovery milestones. The proportion of patients waiting less than 18 weeks achieved recovery trajectories in both July and August.

Performance against 52-week waits also achieved recovery trajectories, reducing from 379 patients in July to 370 in August. Additional capacity, validation activity, specialty-specific recovery initiatives and implementation of Medefer pathways are expected to support sustained improvement.

Cancer performance remains mixed. The Trust achieved recovery trajectories for the 62-day standard in August but did not achieve trajectories for the 28-day Faster Diagnosis Standard or the 31-day Decision to Treat pathway. Capacity constraints, workforce availability and delays within colorectal and tertiary

Setchell Ryan
08/10/2026 11:05:42

pathways continue to impact performance. Recovery actions are in place and are supported through Dorset Cancer Board and Wessex Cancer Alliance arrangements.

Workforce
Mandatory training compliance remains stable at 88%, although several individual training elements remain below required thresholds. Staff turnover has continued to improve, reducing to 8.75%, and reported vacancy rates have fallen to 6.8%, supported by establishment data cleansing work.

However, appraisal compliance remains significantly below the 90% target at 74%, and sickness absence increased to 4.83%, driven primarily by stress, anxiety and depression-related absence. Joint work across Dorset County Hospital and Dorset HealthCare is underway to strengthen attendance management, wellbeing support and workforce retention.

Finance and Sustainability
The Trust reported an adjusted deficit of £4.743m at the end of August, £0.209m adverse to plan. This is largely attributable to industrial action costs and additional activity associated with supporting neighbouring service pressures.

Pay expenditure remains challenged, with bank and agency spending exceeding plan due to vacancies, sickness absence and operational pressures. While actions are in place to reduce temporary staffing reliance, delivery of the national agency reduction target remains challenging.

Cash performance remains favourable, with a closing position of £27.9m, £4.2m ahead of plan. Capital expenditure is behind trajectory due primarily to the timing of major schemes, though no significant risks to year-end delivery have been identified.

Efficiency delivery remains broadly on track year to date; however, 14% of the full-year savings programme remains unidentified and a further 15% is assessed as high risk, requiring continued executive oversight and acceleration of scheme development.

Conclusion
The Trust continues to deliver high-quality care while managing significant operational, workforce and financial pressures. August saw encouraging progress against revised recovery trajectories for urgent and emergency care and elective services, with reductions in long waits and improved ambulance handover performance. Quality and safety indicators remain largely stable, and major strategic developments continue to progress. However, sustained focus is required on patient flow, cancer performance, workforce productivity, sickness absence and delivery of the financial recovery plan. The Board can take assurance from the progress being made against agreed recovery plans while recognising the continued risks associated with demand, workforce capacity and system-wide pressures.

Recommendation

The Board of Directors is asked to:

a) Receive the report for assurance.

Sep 2025 11:05:42

Dorset County Hospital
NHS Foundation Trust

Integrated Care Dashboard

October 2026
(July & August Data)

Secretary Ryan
09/10/2026 11:05:42

Healthier lives Empowered citizens Thriving communities

Celebrating Progress across Dorset County Hospital

Dorset County Hospital
NHS Foundation Trust

Improving Urgent and Emergency Care

A Topping Out ceremony has been held to mark the new building reaching its highest point with the installation of the rooftop helipad. The £100million building will provide two floors of clinical space and help transform the way the Trust provides emergency and urgent care in the future.

The new Emergency Department will allow DCH to treat more patients and will include a dedicated area for children and young people, as well as space designed for people experiencing difficulties with their mental health. The Critical Care Unit will expand from 11 to 16 beds with the potential to increase further in the future and it will also include a paediatric space.

Partnership working sees a new stroke service open across Somerset and Dorset

A new stroke service designed to help patients access specialist emergency hyperacute stroke care more quickly, 24 hours a day, seven days a week, across Dorset and Somerset is now live.

Understanding SPC Charts

Dorset County Hospital
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**

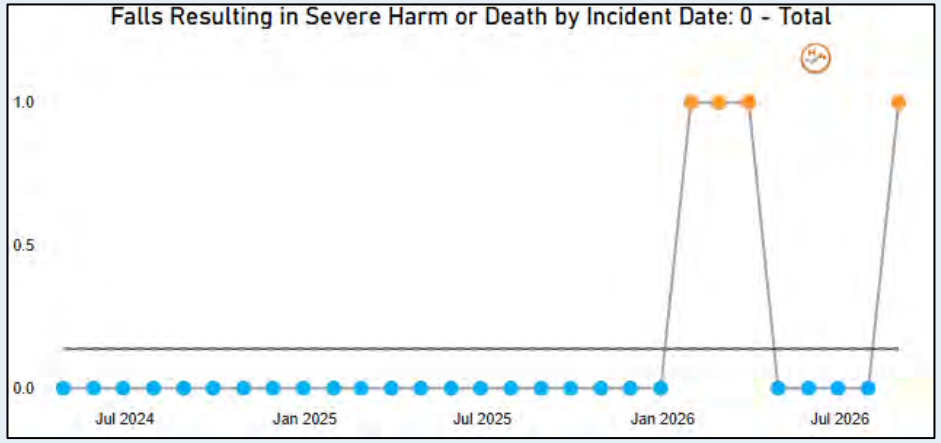
Selected by Dan
09/10/2026 11:05

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

Quality: Safety

CQC Question: Are we safe?

Dorset County Hospital
NHS Foundation Trust



Metric - Falls resulting in Severe Harm or Death (All fractured NOF now classed as severe harm.)

Currently no local target but ambition for zero falls resulting in serious harm

In month: 1

One incident was recorded in August 2026. Full investigation completed and case discussed at Falls Action Group on 01.09.26. Duty of Candor letter being actioned.

Learning showed good completion of falls assessments, safe and rapid clinical test for delirium completed (4AT), good patient location and regular checks and no gaps in care identified. Although the incident is graded as severe it did not meet all 3 classifications for a Notifiable Safety Incident.

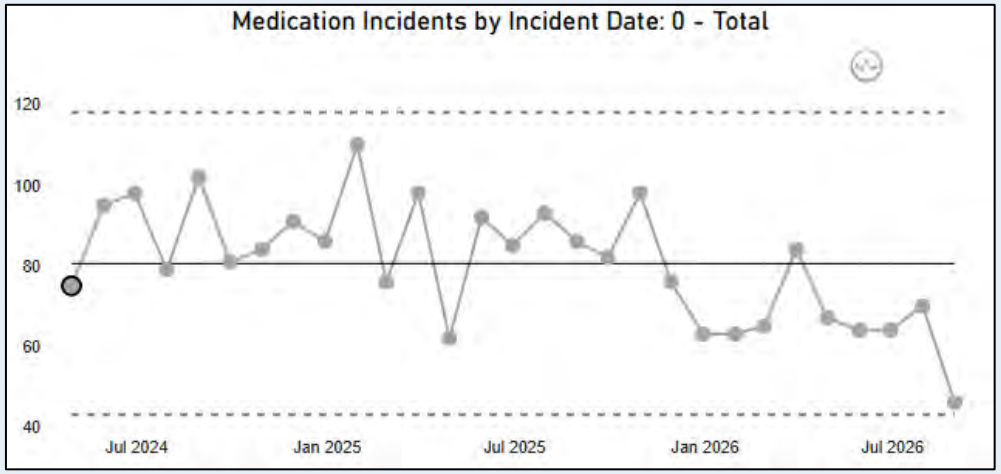
This cases was included and entered for the National Audit of Inpatient Falls data.

Setchell,Ryan
09/10/2026 15:05:42

Quality: Safety

CQC Question: Are we safe?

Dorset County Hospital
NHS Foundation Trust



Metric: Medication Incidents by Incident Date

Currently no national target but ambition for medicine incidents resulting in serious harm

Incidents Reported by Month and Category:

In July

70 medication incidents reported - 64 no harm, 6 low harm

36% administration, 24% prescribing, 24% security/storage, 16% dispensing

In August

48 medication incidents reported – 43 no harm, 4 low harm

45% administration, 23% prescribing, 17% security/storage, 15% dispensing

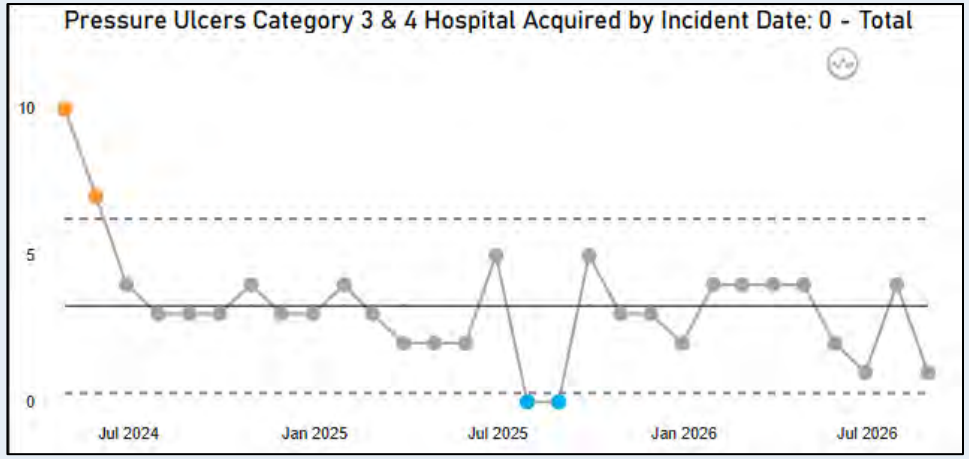
Of the 118 incidents reported during July & August 32 were near misses. All medication incidents are reviewed by the Medicines Committee on a quarterly basis. There were no moderate or severe harm medication incidents reported in July and August 2026

Setchell, Bryan
09/10/2026 10:05:42

Quality: Safety

CQC Question: Are we safe?

Dorset County Hospital
NHS Foundation Trust



Metric: Pressure Ulcers Category 3 & 4 Hospital Acquired by Incident date.

Thresholds for Category 2, 3 and 4 Pressure Damage are not currently set nationally. A local Trust priority was set to reduce prevalence of hospital acquired pressure ulcers by 30% by March 2027 (carried forward from 2025/2026).

We are currently on track to achieve this. The new National Oversight Framework will include the number of Grade 3 pressures ulcers and national comparators

July 2026 – 27 in total (63% Category 2s), Cat 3 = 3, Cat 4 = 1
The Category 4 pressure ulcer related to a complex case patient had several co-morbidities.

August 2026 - 26 Pressure ulcers (77% Category 2s) - Cat = 3 – 1 Cat 4 = 0

Throughout July and August Critical Care did not report any acquired pressure ulcers. (This trend has continued into September). This is a significant achievement which reflects the sustained commitment of the team and the successful implementation of a range of preventative interventions.

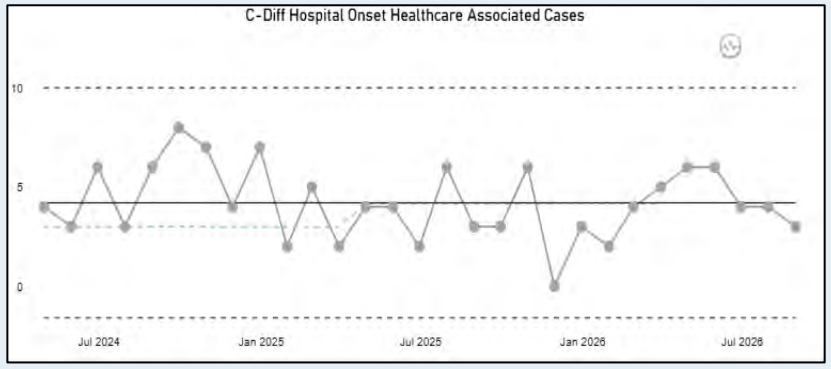
Setchell, Kylie
09/10/2026 11:05:42

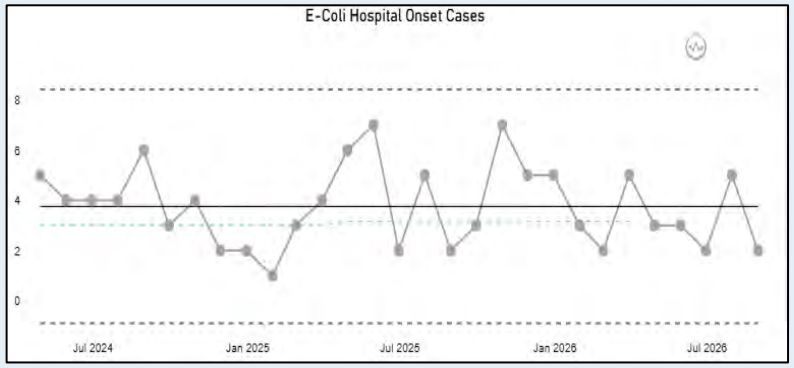
Trust level key contributor has been the introduction of OSKA 4H mattresses in December 2025, imbedded learning from pressure ulcer incidents and early interventions.

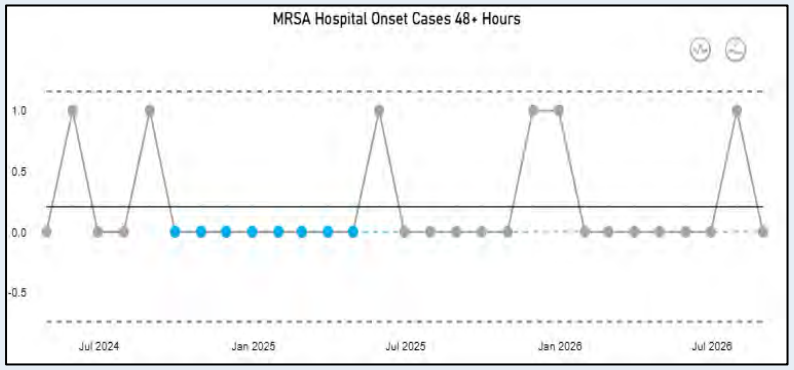
Quality: Safety

CQC Question: Are we safe?

Dorset County Hospital
NHS Foundation Trust







Metric:

- **C-Diff - HOHA & COHA**
- **E-Coli - HOHA & COHA**
- **MRSA - HOHA & COHA**

All the cases have followed the newly updated IPM PSIRF (Patient Safety Incident Response Framework) review process.

Gerard O'Ryan
09/07/2026 11:05:42

In July and August:
There were 2 Hospital Onset Healthcare Associated (HOHA) & 3 COHA (Community Onset Healthcare Associated) cases gram +ve reportable BSI cases

- *MRSA 1 case* *Running total for this year 1.*
- *MSSA 4 cases* *Running total for this year 11.*

There were 5 Hospital Onset Healthcare Associated (HOHA), and 2 Community Onset Healthcare Associated (COHA) C. difficile cases

- *Running total for this year 23.*

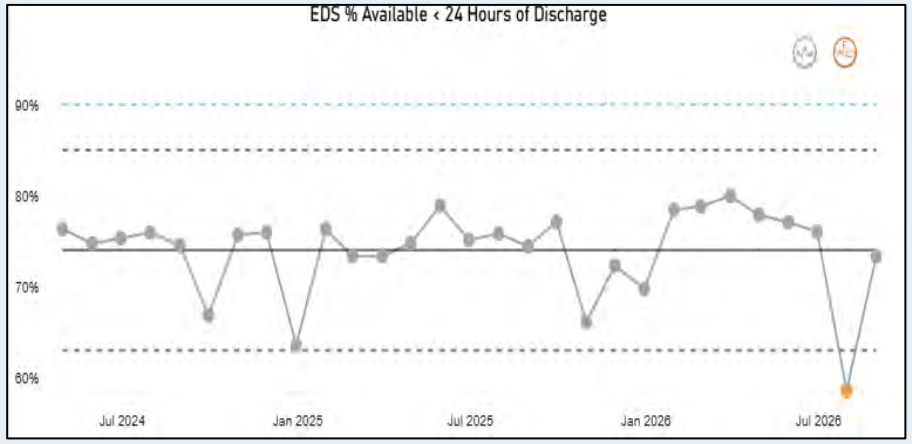
There were 8 Hospital Onset Healthcare Associated (HOHA) & 7 COHA (Community Onset Healthcare Associated) cases gram -ve reportable BSI cases

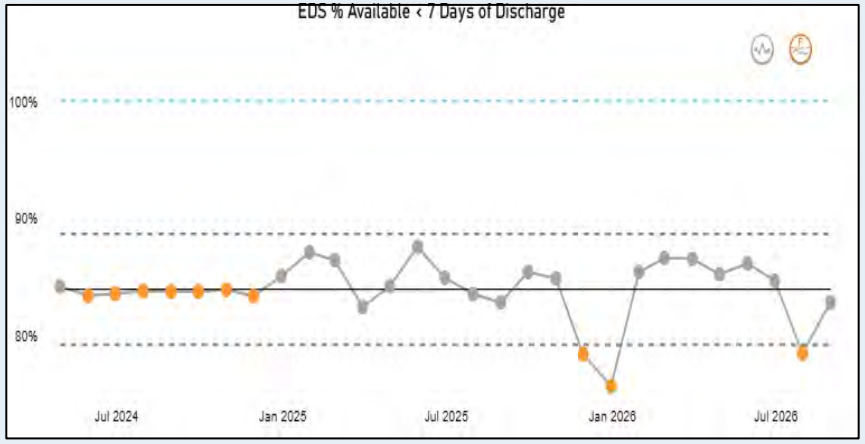
- E. *coli 7 cases* *Running total for this year 15.* *Trajectory 45 (TBC)*
- *P. aeruginosa 1 case* *Running total for this year 5.* *Trajectory 3 (TBC*
- *Klebsiella spp. 7 cases* *Running total for this year 12 .* *Trajectory 6 (TBC)*

Quality: Safety

CQC Question: Are we safe?

Dorset County Hospital
NHS Foundation Trust





Metric – Electronic discharge summaries

% of electronic discharge summaries available within 24 Hours of Discharge

% of electronic discharge summaries available within 7 Days of Discharge

In July

59% of electronic discharge summaries were available within 24 Hours of Discharge
78% of electronic discharge summaries were available within 7 Days of Discharge

In August

73% of electronic discharge summaries were available within 24 Hours of Discharge
83% of electronic discharge summaries were available within 7 Days of Discharge

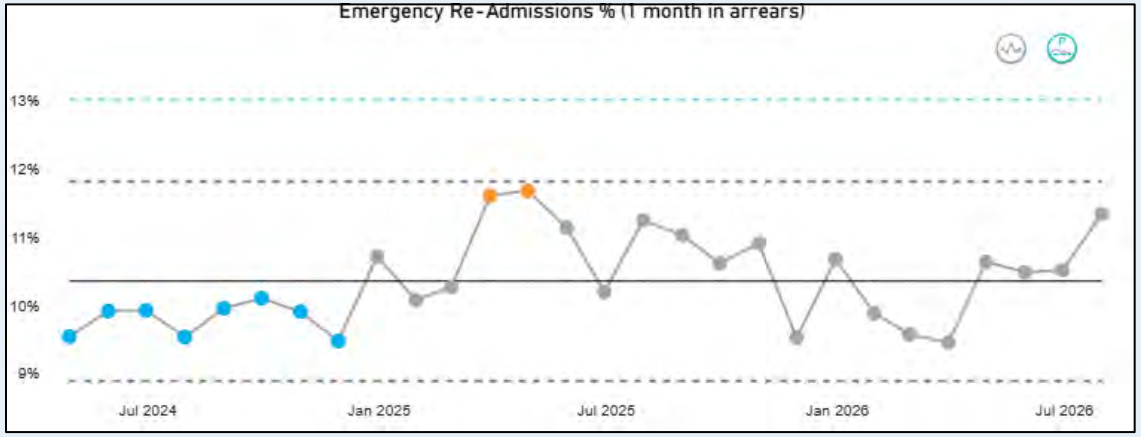
Sophie Ryan 09/10/2026 11:04:42

Next steps include the digital process map for EDS to include pharmacy. Discussions with transformation team to assist with facilitation are planned, recognised the current reprioritisation of transformation and improvement resources to focus on the recovery plans.

Quality: Safety

CQC Question: Are we safe?

Dorset County Hospital
NHS Foundation Trust



Metric: Emergency re-admissions

There is no national target

The increase in Emergency Readmission rates continues to show variation in July and August. This has been a pattern for a significant period of time, so the Quality Governance Group has agreed to commission a benchmarking exercise with other organisations.

The UEC Programme includes measures to improve the discharge experience of patients. This links to multi-agency review of arrangements post discharge to ensure all requirements are in place to support a person to stay at home. Further audit of discharges will be commissioned by the UEC Programme.

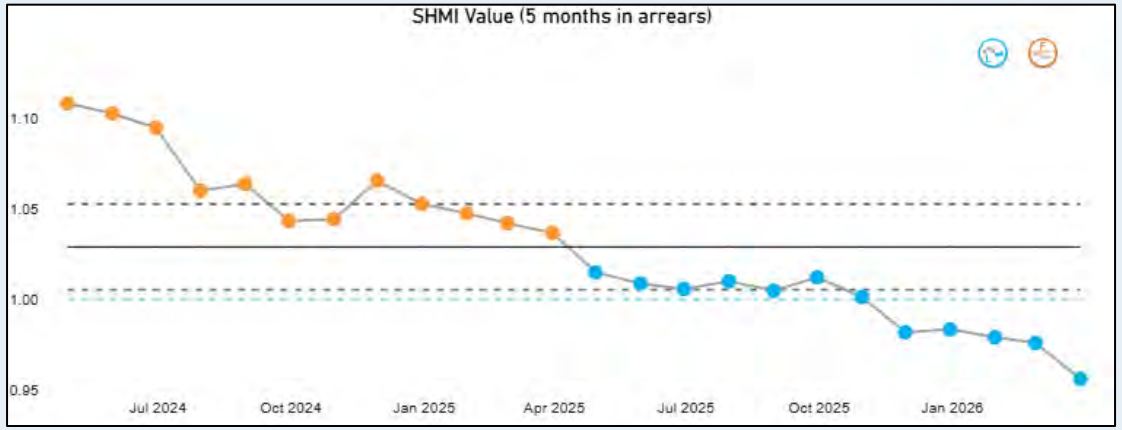
Setchell,Ryan
09/10/2026 11:05:42

Healthier lives Empowered citizens Thriving communities

Quality: Safety

CQC Question: Are we safe?

Dorset County Hospital
NHS Foundation Trust



Summary Hospital-level Mortality Indicator

The measure is a statistical metric that measures the ratio between the actual number of patients who die following hospitalisation vs the number of deaths that would be expected

Value (measures 5 months in arrears)

SHMI remains within the expected range at 0.9561 with observed deaths (1,185) remaining below expected deaths (1,235)

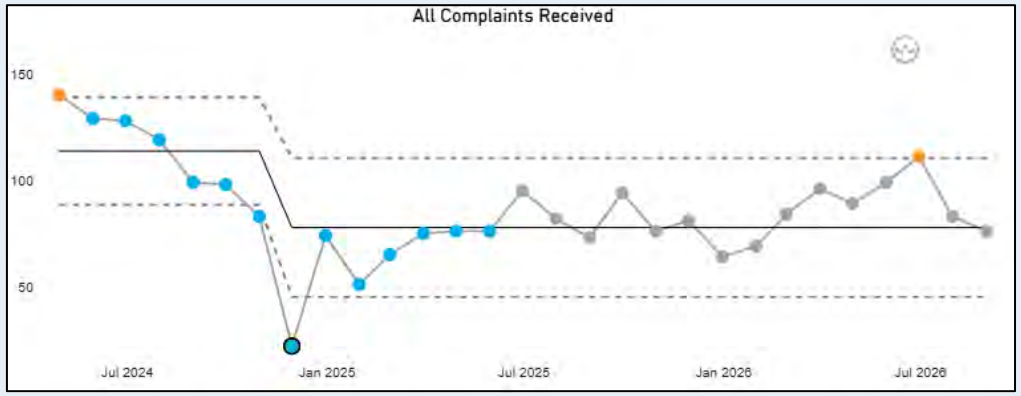
The data provides assurance that there is no evidence of excess or avoidable morality at DCH. Alongside Trust-wide mortality indicators, specialist mortality review processes continue to provide additional assurance.

Setchell,Ryan
09/10/2026 11:05:42

Quality: Patient Experience

CQC Question: Are we caring?

Dorset County Hospital
NHS Foundation Trust



Complaints

Metric - All complaints received

Acknowledgment of complaints within 3 working days, (national standard) and initial contact to discuss complaint, with focus on early resolution within 10 working days, (locally set standard).

Total complaints for **July**: 82
- Triaged for Early Resolution: 69
- Triaged for Closer Look Investigation: 13
- 50% of Early Resolution complaints resolved within 10 working days

Total complaints for **August**: 74
- Triaged for Early Resolution: 63
- Triaged for Closer Look Investigation: 11
- 24% of Early Resolution complaints resolved within 10 working days

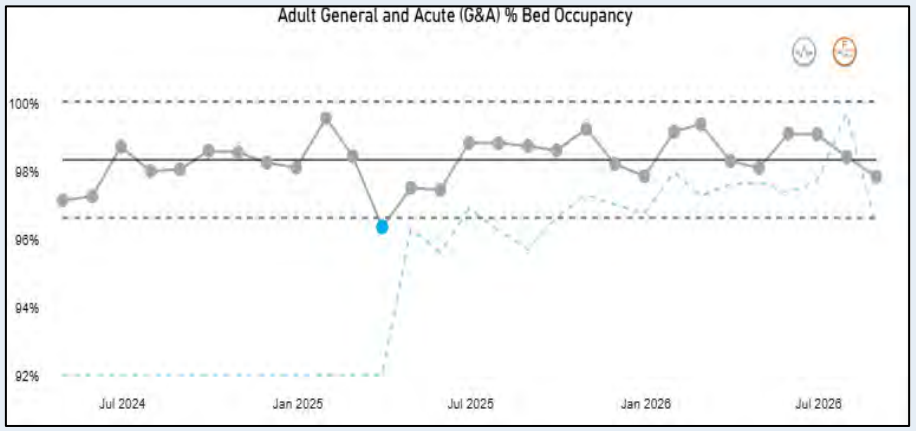
Setchell, Ryan
09/10/2026 14:05:42

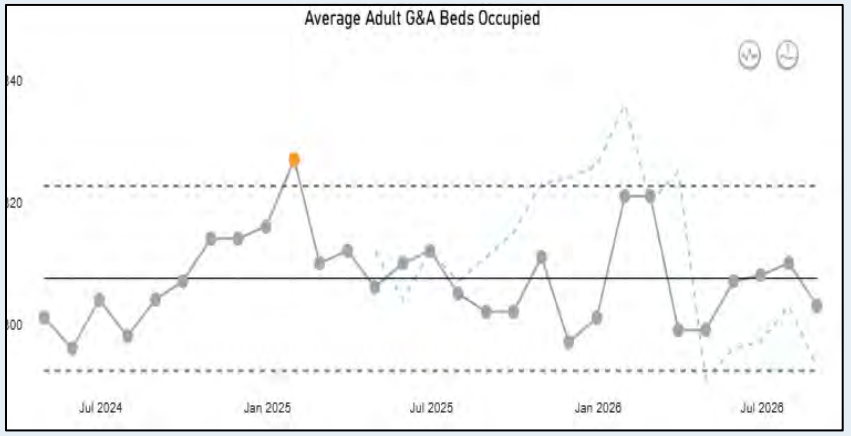
Common themes: consent, communication & confidentiality, access, admission, transfer & discharge & treatment procedure.

Performance: Patient Experience

CQC Question: Are we effective?

Dorset County Hospital
NHS Foundation Trust





Metric:

- **Adult General and Acute % Bed Occupancy**
- **Average Adult G&A Beds Occupied**

The number of occupied and open beds has remained above plan all year. This has been driven by a higher average length of stay. In August length of stay did hit plan, however, the number of discharges was lower than plan, driving a higher use of beds.

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. Other actions underway include:

- Criteria to Admit Audit completed with action plan for further changes across admission and alternative pathways within the UEC Improvement Programme
- Audit commissioned on patients leaving after 16:00, intention under UEC Programme to create actions to release capacity earlier in the day
- Remove discharge lounge barriers (TTOs, EDS, CDs; engage RDs) – part of the Bed Reconfiguration Programme includes alterations to the Discharge Lounge approach – moving to the National Model which promotes a ‘pull’ approach to discharges for the week.

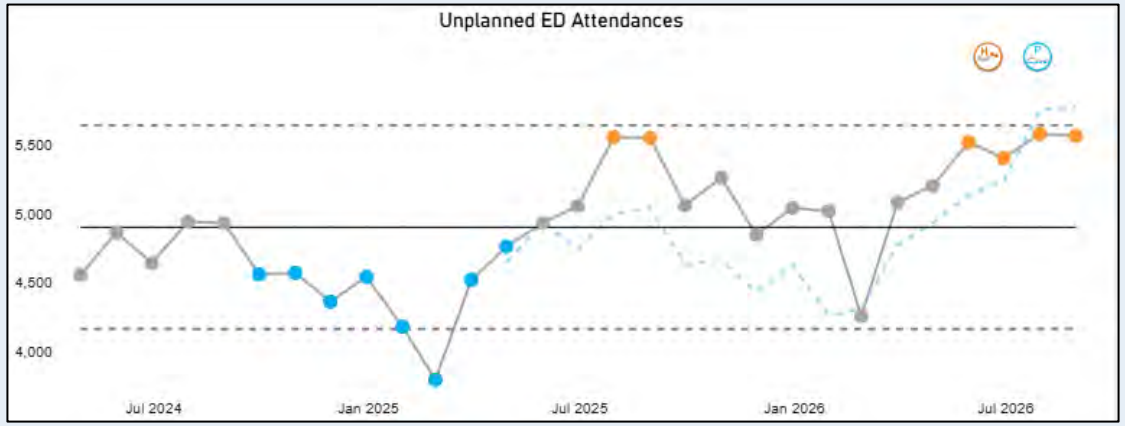
Setchell,Ryan
09/10/2025 11:35:47

Healthier lives Empowered citizens Thriving communities

Performance: Access and Target Waiting Times

CQC Question: Are we responsive?

Dorset County Hospital
NHS Foundation Trust



Metric: Unplanned ED Attendances

Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Number of A&E attendances (DCH)	plan	4928	5132	5236	5742	5769
	actual	5199	5504	5393	5572	5558
	variance	271	372	157	-170	-211

Year to date, against medium–term plan, ED attendances are 1.50% over plan. For Q1, demand was 5.23% over plan, but against Q2 to date, demand is 3.4% below plan. Demand compared to last year is 5.29% up, year to date. For Q1, demand growth was 9.16%, Q2 demand Vs last year is 0.14% up.

In July – 5572 attendances

In August – 5558 attendances

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), in partnership with DHC
- Increase referrals into community services directly from ED (Pilot)
- Trial Virtual Ward pharmacist to increase capacity (DCH)
- ‘Command Centre’ in the West – that is, Dorset HealthCare Single Point of Access will support referring parties to use alternatives pathways to a conveyance to ED e.g. community service support or booking into Same Day Emergency Care. First iteration live from 12 October
- Working with ICB system partners on 1.2% of patients driving demand, cohort accounts for 16.5% of ED attendances & 21.3% of emergency admissions.

Setchell, Ryan
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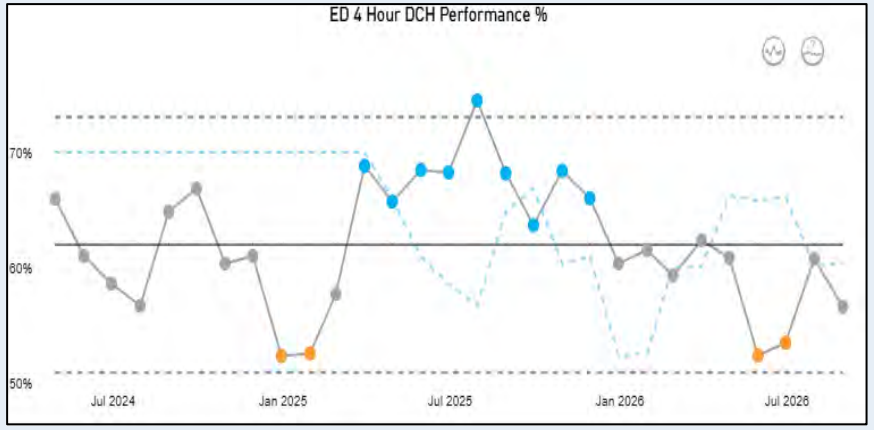
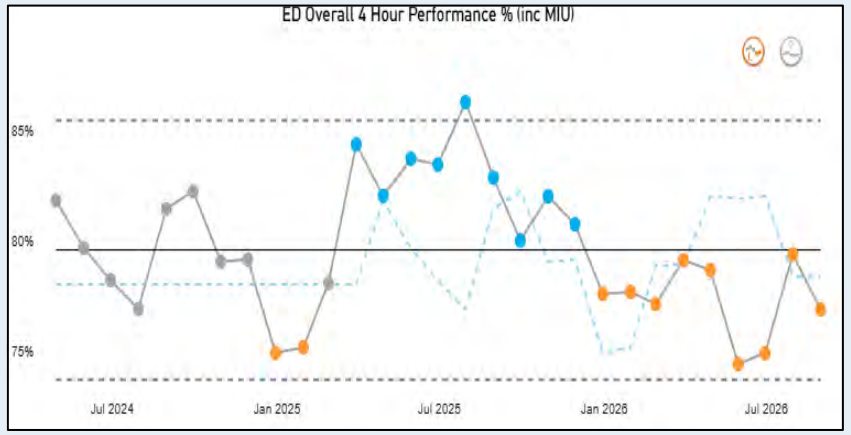
Performance: Access and Target Waiting Times

CQC Question: Are we responsive?

Dorset County Hospital
NHS Foundation Trust





Metric: Emergency Department

- **4 Hour DCH Performance %**
- **Overall 4 Hour Performance %**

Metric	Ops plan 26/27	Jul-26	Aug-26
4 hour wait (all)	Recovery plan	73.50%	75.00%
	actual	79.37%	76.87%
	MTP plan	78.36%	78.34%
	variance to recovery	5.87%	1.87%
4 hour wait (DCH)	Recovery plan	53.20%	54.50%
	actual	60.80%	56.66%
	MTP plan	60.19%	60.41%
	variance to recovery	7.60%	2.16%

Performance against the 4-hour standard (including UTC data) has not met the medium-term plan trajectory, for 4 out of 5 months. The impact of increasing levels of demand, directly correlates with the declining performance against the 4-hour performance. 4hr performance recovery trajectories were included as part of the NHSE recovery plan.

In July - the recovery trajectory has been met (60.8% DCH only activity and 79.37% All Activity)
In August - the recovery trajectory has been met (56.66% DCH only activity and 76.87% All Activity)

The trust is working collaboratively with system partners on the Flow Through ED & Early Decision Making (Internal Professional Standards) actions:

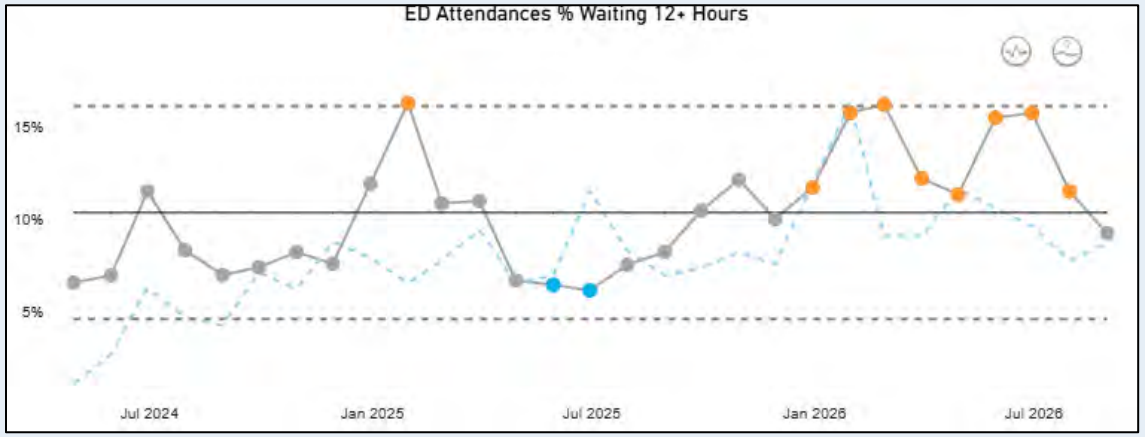
- Introducing a daily ED MDT first thing in the morning
- Consultant informed bed meetings (improved connections with medics to inform flow decisions and actions)
- Rapid streaming (minors / majors)
- Deploy EPIC role during peak pressure
- Dedicated transfer function with maximum wait standards
- Review and relaunch 'Your Next Patient' policy (October)
- The key Programme for consistent delivery of improvement is Bed Reconfiguration currently in go live process for delivery in late Q3. This provides greater assessment space, consolidated Frailty model (also supported in improvement) and the 'Pull' Discharge model which enables improved bed flow. ED flow follows improved bed flow.

Public Board 09/10/2025 1.10.4

Performance: Access and Target Waiting Times

CQC Question: Are we responsive?

Dorset County Hospital
NHS Foundation Trust



Metric: ED Attendances % Waiting 12+ Hours

Metric	Ops plan 26/27	Jul-26	Aug-26
% of attendances 12+ hours	Recovery plan	13.50%	12.50%
	actual	11.51%	9.23%
	MTP plan	7.72%	8.69%
	variance to recovery	-1.99%	-3.27%

Both the number of patients and the proportion of ED attendances that waited over 12 hours has not met the operating plan this year, however the proportion has reduced for three consecutive months. The most significant cause of these breaches is waiting for a bed. A recovery trajectory has been agreed.
In July - the recovery plan was achieved (11.51%)
In August - the recovery plan was achieved (9.23%)

The trust is also delivering actions to improve Front Door Pathways and the Service Model (Frailty), which will support 12-hour breach reduction:

- 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

Sketchy Kyle 09/10/2026 11:05:42

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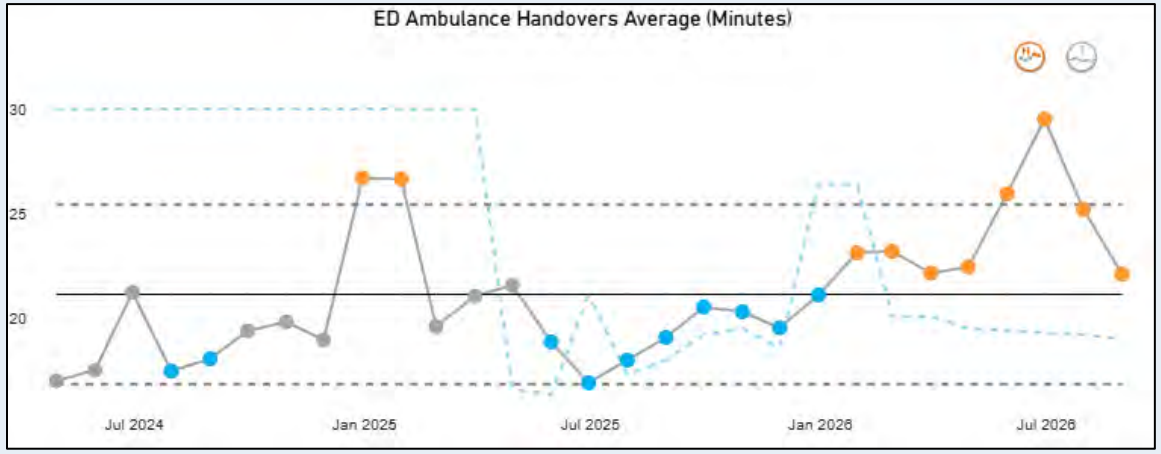
Performance: Access and Target Waiting Times

CQC Question: Are we responsive?

Dorset County Hospital
NHS Foundation Trust



Metric: Ambulance Handovers Average

Metric	Ops plan 26/27	Jul-26	Aug-26
% Ambulance handovers + 15mins	Recovery plan	74.00%	68.00%
	actual	74.37%	71.30%
	MTP plan	48.24%	45.70%
	variance to recovery	0.37%	3.30%
% Ambulance handovers + 45mins	Recovery plan	9.00%	7.00%
	actual	10.41%	4.68%
	MTP plan	4.01%	4.00%
	variance to recovery	1.41%	-2.32%

Year to date, the ambulance metrics within the medium-term plan have not been met and demand in July and August was under plan, having previously seen growth in Q1. Ambulance handover recovery trajectories were included as part of the NHSE recovery plan.

In July - the trajectory was not met for either metric. ED handovers over 15mins (74.37%) & ED handovers over 45 mins (10.41%) .
In August - the percentage of ambulances handed over at 45+ minutes dropped to 4.68%, which hit the recovery trajectory. ED handovers over 15mins did not hit the recovery trajectory (71.30%)

Setchell, Alan
09/10/2026 21:01:42

Actions to address performance of ambulance handover delays include:

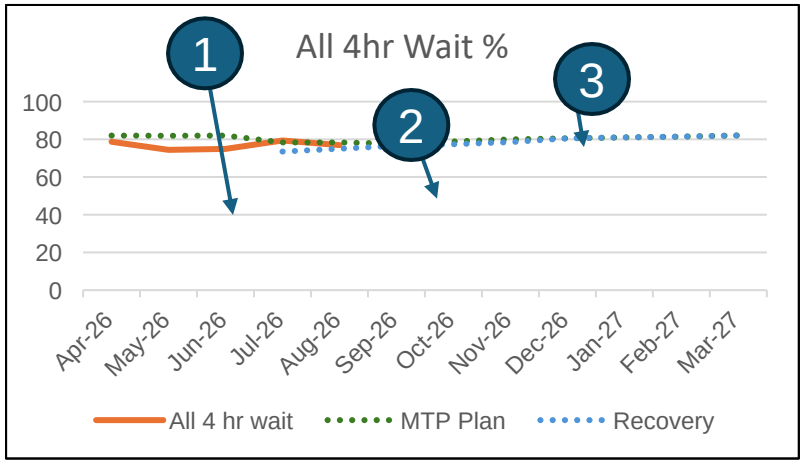
- Strengthening front door assessment, increasing consultant presence for rapid senior decision making
- Command Centre pilot, enabling the redirection of patients to the most appreciate care setting, including alternative pathways at DCH such as SDEC
- Bed reconfiguration, to get patients to the right bed, first time, reducing LoS and improving flow
- Re-launch your next patient policy in October, enabling fast movement out of ED, into a Ward base setting

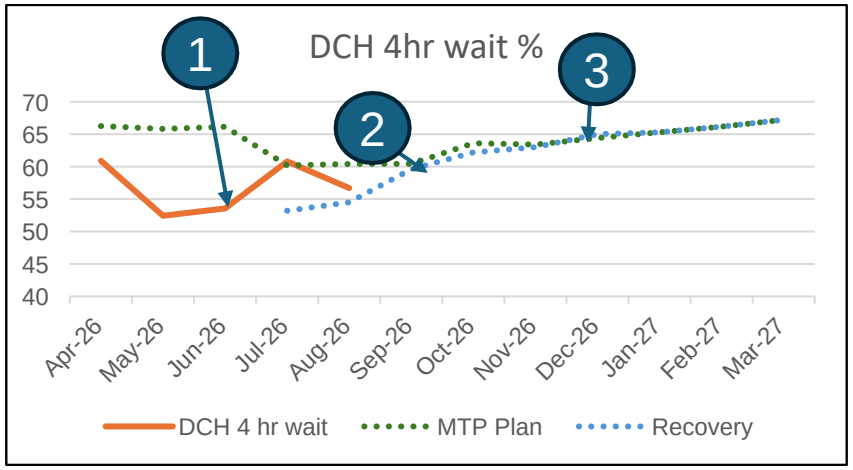
Performance: Access and Target Waiting Times

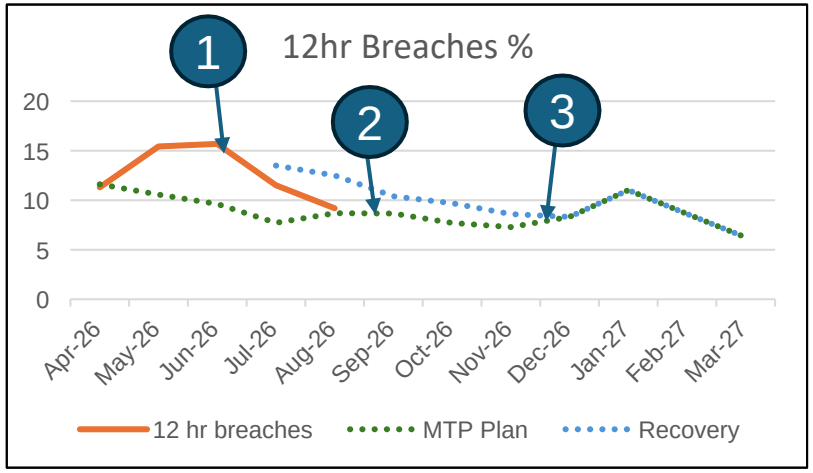
CQC Question: Are we responsive?

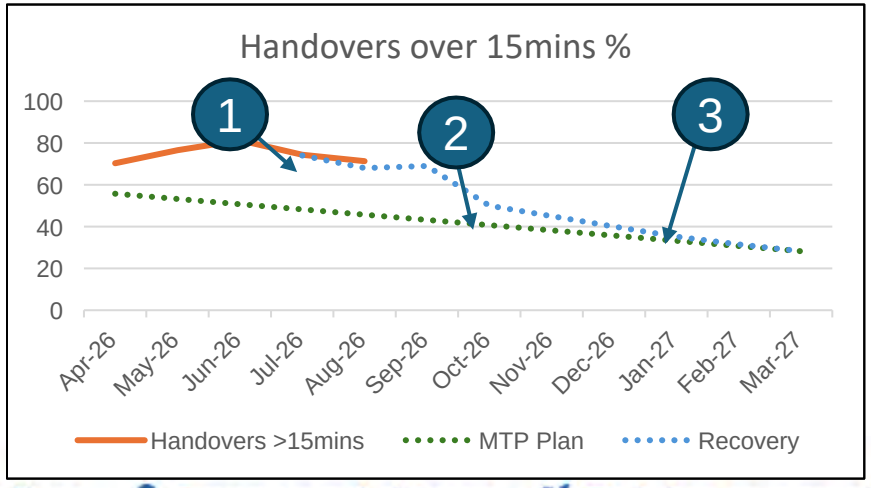
UEC Recovery Plan – Approved

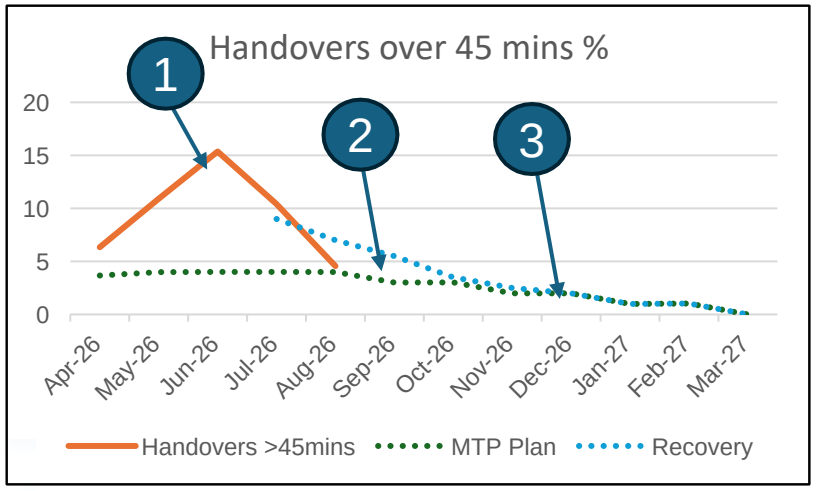
Dorset County Hospital
NHS Foundation Trust











Key
1 = Established MDT, increase nurse shift coordinators, EPIC role
2 = Frailty Sprint
3 = Bed reconfig.

Setchell,Ryan
09/10/2026 11:05:42

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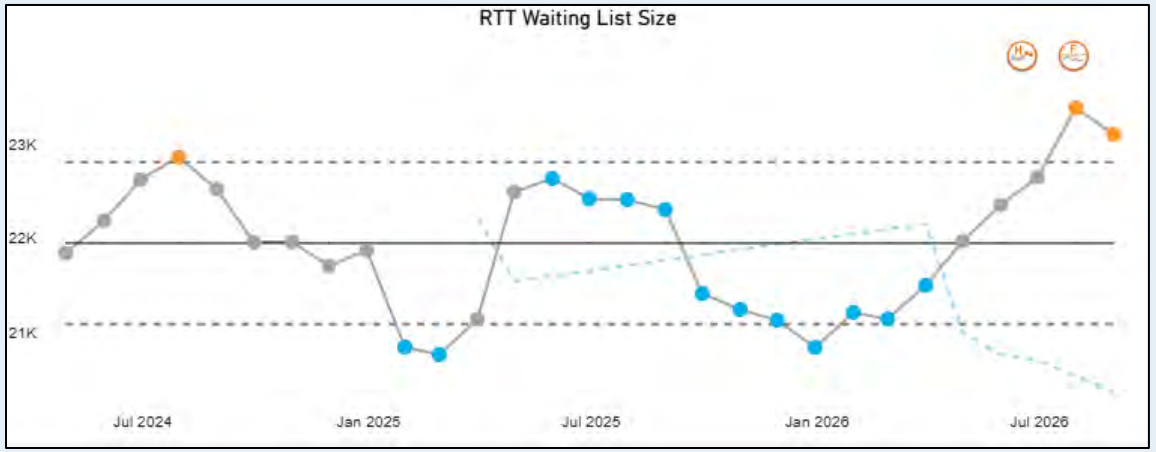
Performance: Access and Target Waiting Times

CQC Question: Are we responsive?

Dorset County Hospital
NHS Foundation Trust



Metric: RTT - Waiting List Size

Metric	Ops plan 26/27	Jul-26	Aug-26
RTT: Total Waiting List	Recovery plan	22,300	21,980
	actual	23,380	23,100
	MTP plan	20,539	20,366
	variance to recovery	-1060	-1120

The size of the waiting list has not met the medium-term plan trajectory all year. At the end of August, the waiting list was 2,737 patients higher than planned but did reduce compared to July rather than continue the upward trajectory. A 4% referral growth factor was applied as part of the medium-term plan, year to date referrals are 0.07% up, although there is variation in impact between urgent and routine by service. The other factor impacting the size of the waiting list, is the amount of activity undertaken. Against medium-term plan, activity levels for consultant led (RTT) activity is below plan.

A recovery trajectory RTT Waiting List Size was included as part of the NHSE recovery plan. The waiting list size has been re-forecasted as part of the recovery plan and was approved by Board in September.

Setchell Ryan
09/10/2026 21:09:42

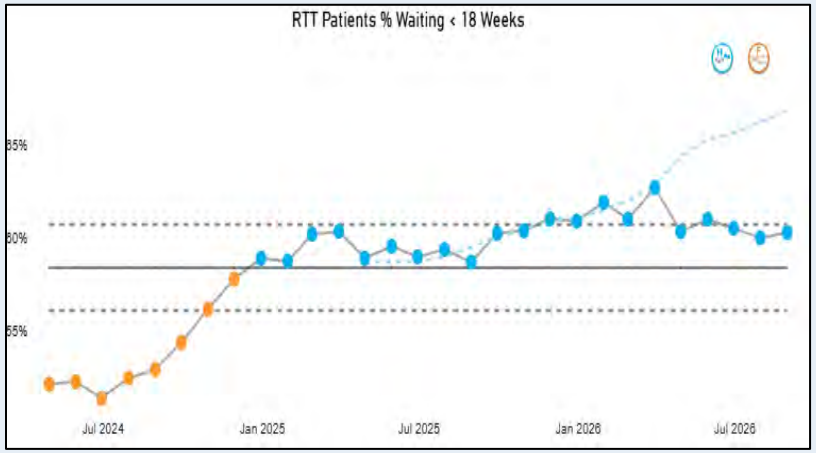
In July – 23,380 patients on the waiting list
In August – 23,100 patients on the waiting list

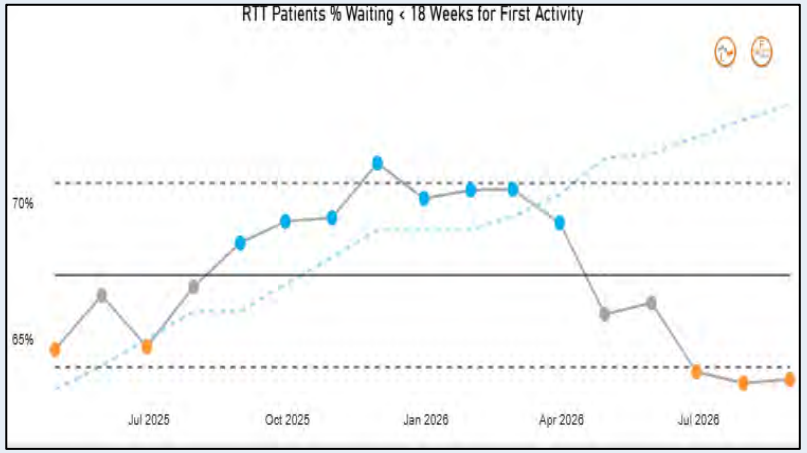
Indications are that the trust is on track to achieve the trajectory for the end of September,

Performance: Access and Target Waiting Times

CQC Question: Are we responsive?

Dorset County Hospital
NHS Foundation Trust





Metric:

- **Patients % Waiting < 18 Weeks for First Activity**
- **Patients % Waiting <18 weeks**

Metric	Ops plan 26/27	Jul-26	Aug-26
RTT: % patients waiting <18wks	Recovery plan	59.70%	60.20%
	actual	60.00%	60.28%
	MTP plan	66.26%	66.84%
	variance to recovery	0.30%	0.08%

Against the medium-term plan, performance is not delivering the trajectory. A recovery trajectory for % patients waiting <18 weeks was included as part of the NHSE recovery plan.

In July - performance against the recovery plan was met (60.0%)
In August - performance against the recovery plan was met (60.28%)

Recent progress has been made with locum posts secured, the additional insourcing activity set up with patients in place and the contracts signed with Medefer. The delivery of Medefer has been brought forward, with Gastro going live on the 12th October and both ENT and Cardiology due to be live by the end of November.

The validation contract has commenced and despite having a delayed start, is on track to deliver the target clock closing events, against the September data. It is anticipated that the recovery plan will be met in September.

Secretary Ryan
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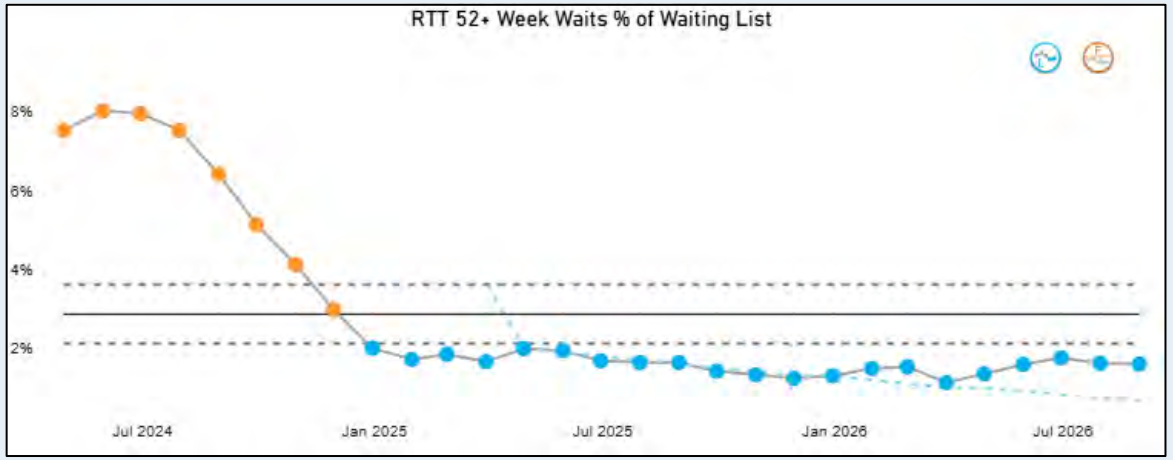
Performance: Access and Target Waiting Times

CQC Question: Are we responsive?

Dorset County Hospital
NHS Foundation Trust



Metric: RTT – 52+ Week Waits % of Waiting List

Metric	Ops plan 26/27	Jul-26	Aug-26
RTT: 52wk wait	Recovery plan	388	374
	actual	379	370
	MTP plan	151	137
	variance to recovery	-9	-4

Operational planning guidance required an improvement in the number of patients waiting 52+ weeks, 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. The trajectory against the operating plan has not been met, as activity levels are behind plan. A recovery trajectory for % of people waiting 52+ week were included as part of the NHSE recovery plan.

The recovery plan is set to deliver against the national ask, that no more than 1% of the waiting list, is waiting over 52+ weeks, this is an increase against the original operating plan submission.

In July - the number of 52+ week breaches reduced and achieved the recovery plan (379 patients waiting)
In August - the number of 52+ week breaches reduced and achieved the recovery plan (370 patients waiting)

Full details of all actions in the recovery plan were submitted to Board in September and are tracked in the CEO led Operational Performance Recovery Group. The ICB joins these weekly meetings, and a NED will be attending moving forward.

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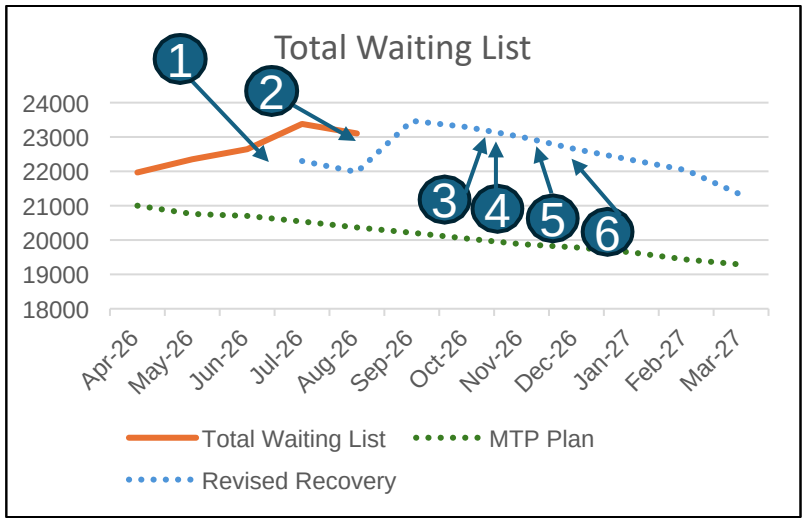
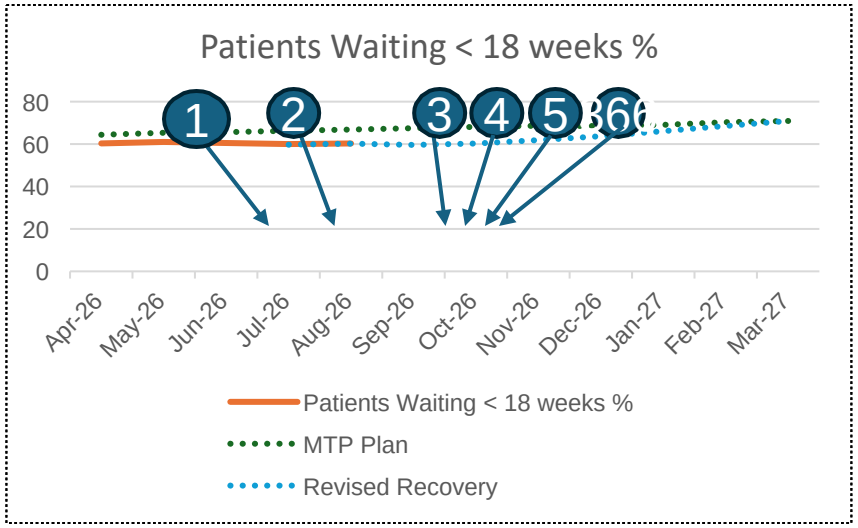
Performance: Access and Target Waiting Times

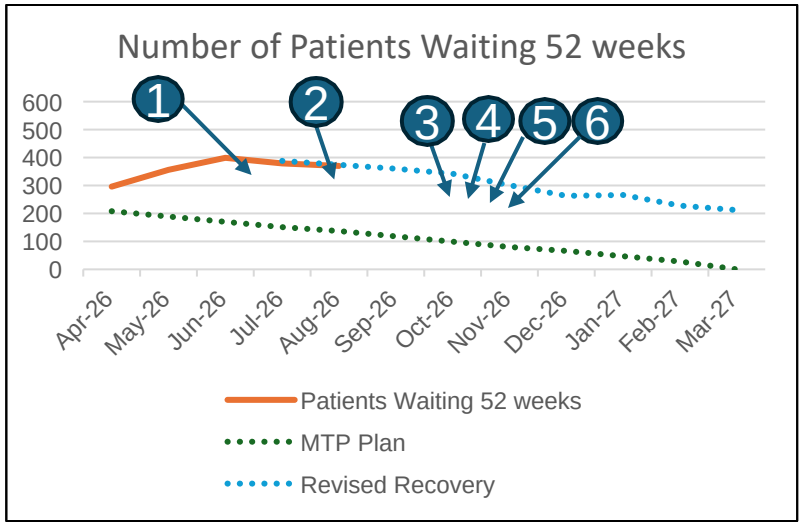
CQC Question: Are we responsive?

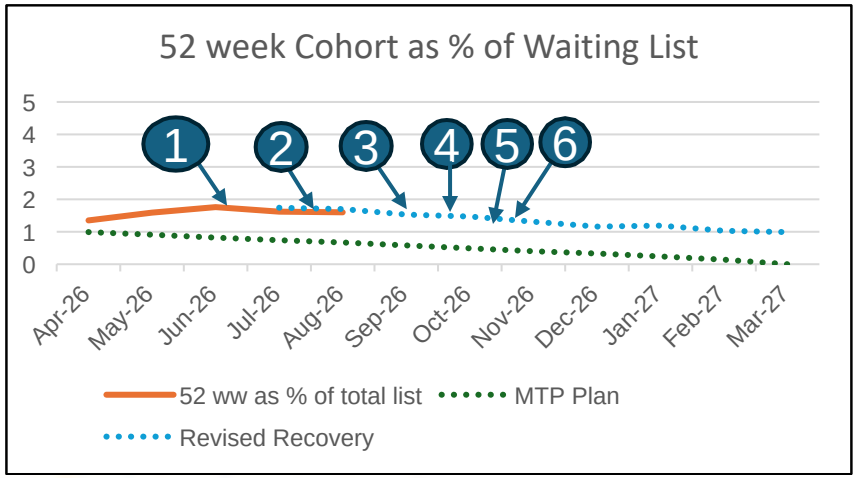
Dorset County Hospital
NHS Foundation Trust

Revised RTT Recovery Plan – Approved









Key

1 = Weekly oversight
2 = Validation
3 = Medefer – Gastro
4 = Medefer – Cardiology
5 = Medefer – ENT
6 = Outpatient Sprint Launch

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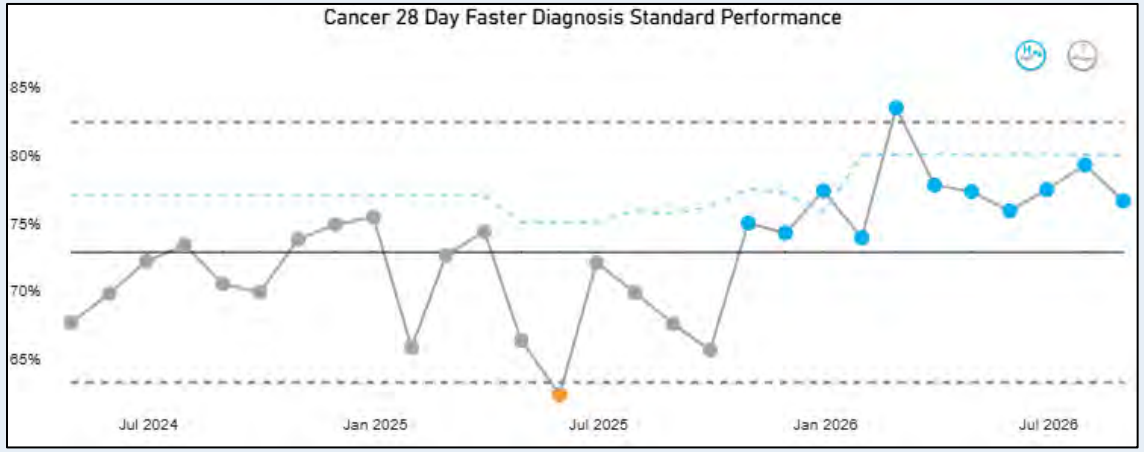
Performance: Access and Target Waiting Times

CQC Question: Are we responsive?

Dorset County Hospital
NHS Foundation Trust



Metric: Cancer 28 Day Faster Diagnosis Standard

Metric	Ops plan 26/27	Jul-26	Aug-26
Cancer: 28 days FDS	Recovery plan	78.20%	78.00%
	actual	78.57%	76.52%
	MTP plan	80.01%	80.00%
	variance ro recovery	0.37%	-1.48%

Performance of the 28-day standard, while not meeting medium-term plan has been of an improving nature compared to last year. A recovery trajectory for Cancer 28 Day FDS was included as part of the NHSE recovery plan.
In July – the recovery trajectory was met (78.57%)
In August - the recovery trajectory was not met (76.52%)

Colorectal has been impacted by challenged endoscopy performance & clinical team sickness. Endoscopy performance is recovering following targeted NHSE-supported improvement programme addressing workforce, booking and capacity issues, however, the long-term sickness in Colorectal, is impacting the wait to first seen, at the very start of the pathway. Colorectal recovery has stalled (locum falling through). Insourcing provision is commencing in 2026 with a clearance time of 3.5 weeks, which will return booking to 1st OPA to the optimum 7-10 days. Other actions to address 28-day performance are:

- Review patient comms for all non-cancers &where suitable and with clinical approve, introduce admin 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)
- 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

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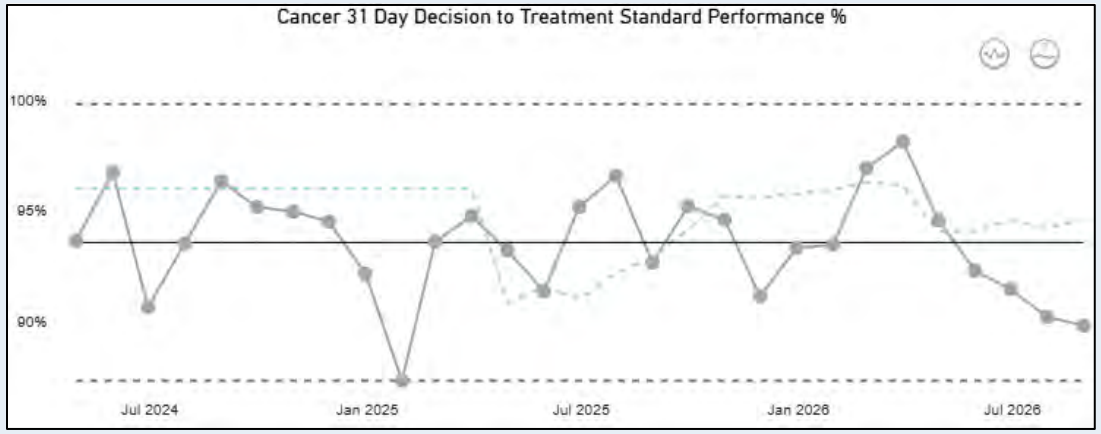
Performance: Access and Target Waiting Times

CQC Question: Are we responsive?

Dorset County Hospital
NHS Foundation Trust



Metric: Cancer 31 Day Decision to Treat

Metric	Ops plan 26/27	Jul-26	Aug-26
Cancer: 31 day DTT (combined)	Recovery plan	92.40%	92.20%
	actual	91.35%	90.00%
	MTP plan	94.23%	94.59%
	variance ro recovery	-1.05%	-2.20%

31-day performance hit the trajectory for the first two months of the year, but missed it for June, July and August. A recovery trajectory has been submitted as part of the Trusts overall operational recovery programme.
In July – the recovery trajectory was not met (91.35%)
In August - the recovery trajectory was not met (90.0%)

The following system actions are underway:

- Improve the wait from request to first appointment with oncologist- review across the system full D&C at tumour level
- Increased capacity for outpatient appointments at the Tertiary centre with the treating Gynaecologist - review across the system full D&C needed
- Increased capacity for Dorset Prostate patients for RARP- review across the system full D&C needed to access if there is viability in pooling the list
- Increased capacity for Dorset patients for radical lung treatments SABR or Surgery- review across the system full D&C needed

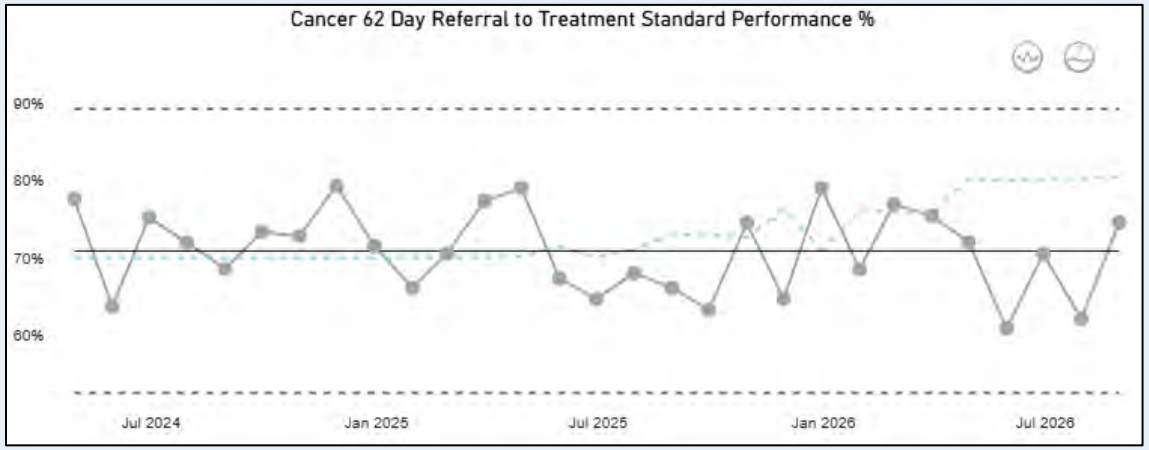
Setchell,Ryan
09/10/2026 11:05:42

Wessex cancer alliance and Dorset Cancer Board are supporting the trust in progressing these key system wide (and beyond) actions.

Performance: Access and Target Waiting Times

CQC Question: Are we responsive?

Dorset County Hospital
NHS Foundation Trust



Metric: Cancer 62 Day Referral to Treatment

Metric	Ops plan 26/27	Jul-26	Aug-26
Cancer: 62 RTT (combined)	Recovery plan	69.40%	69.00%
	actual	62.60%	74.50%
	MTP plan	80.13%	80.41%
	variance ro recovery	-6.80%	5.50%

Performance of the 62-day combined standard did not achieve the trajectory for any month this year. 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. A recovery trajectory has been submitted as part of the Trusts overall operational recovery programme.

In July – the recovery trajectory was not met (62.60%)
In August - the recovery trajectory was met (74.50%)

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.

The backlog (the number of patients waiting over 62 days) remains materially lower than last year and is being actively managed through clinical prioritisation. The backlog position has reduced in August but will be impacted be the colorectal delays at the front of the pathway, in October.

Setchell,Ryan
09/10/2026 11:05:42

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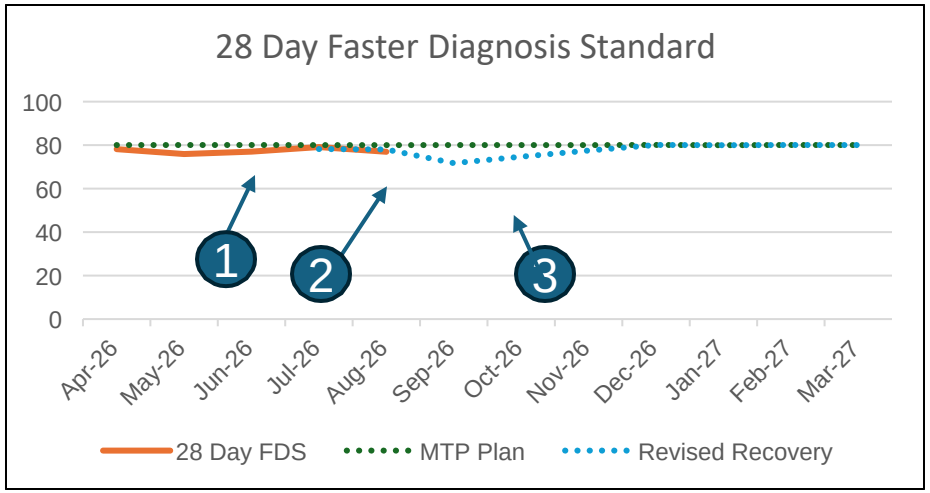
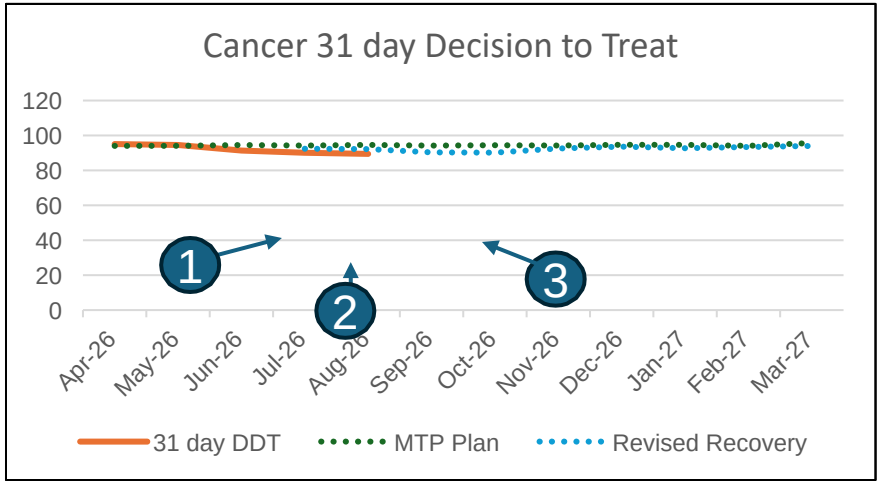
Performance: Access and Target Waiting Times

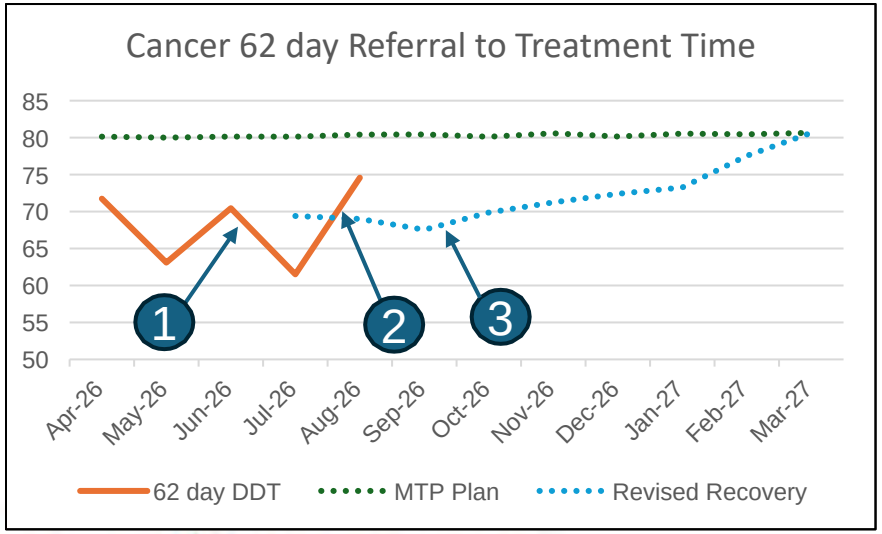
CQC Question: Are we responsive?

Revised Cancer Recovery Plan – Approved

Dorset County Hospital
NHS Foundation Trust







Key

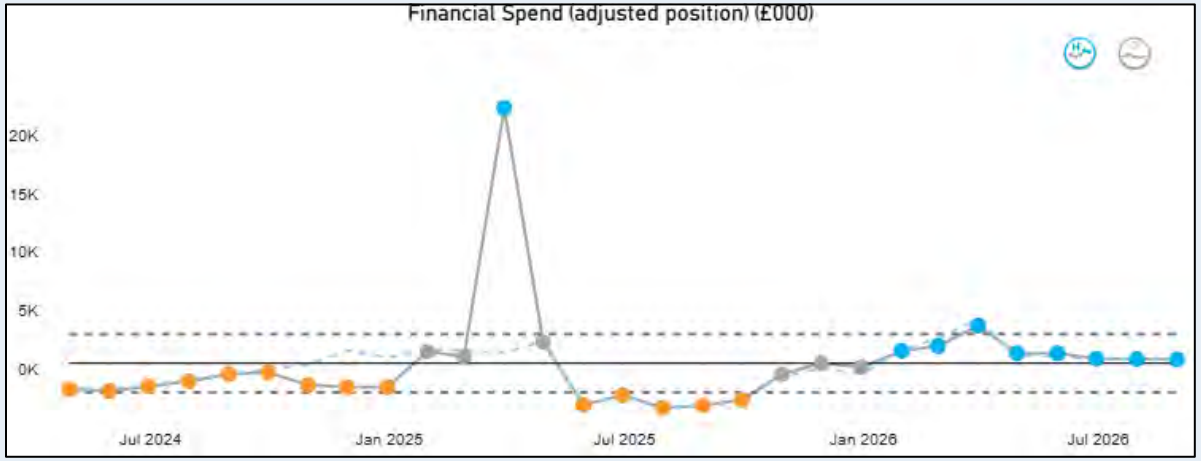
1= Weekly recovery meetings
2 = New equipment & scopes
3 = Colorectal initiative

Setchell,Ryan
09/10/2026 11:05:42

Finance: Sustainability

CQC Question: Are we well led?

Dorset County Hospital
NHS Foundation Trust



Metric: Financial Spend (adjusted position)

During August 2026, Dorset County Hospital NHS Foundation Trust (DCH) has delivered a £4.743 million deficit after technical adjustments, an adverse performance against planned levels (£4.533 million deficit) of £0.209 million.

This variance is the direct result of costs incurred supporting Industrial Action in month 1, at this stage funding has not been confirmed to support the spend impact and mitigations have yet to be identified to date. The position also includes £0.287m 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.

Setchell, Jan
09/10/2026 10:05:18

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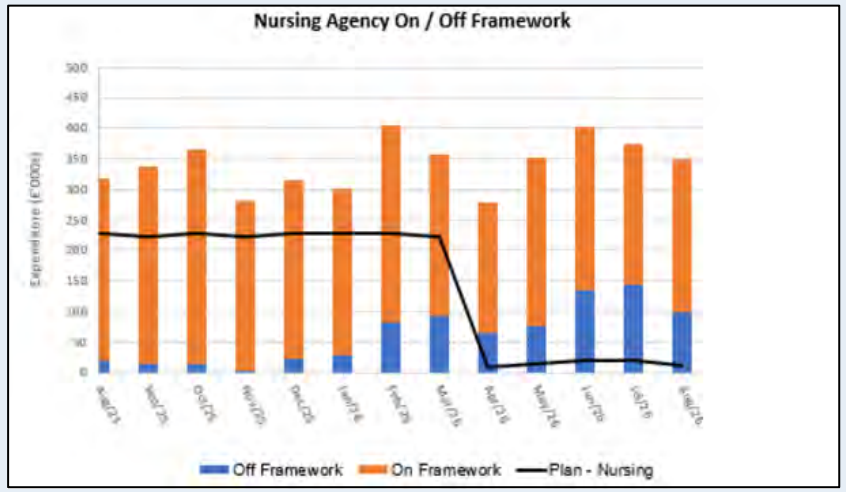
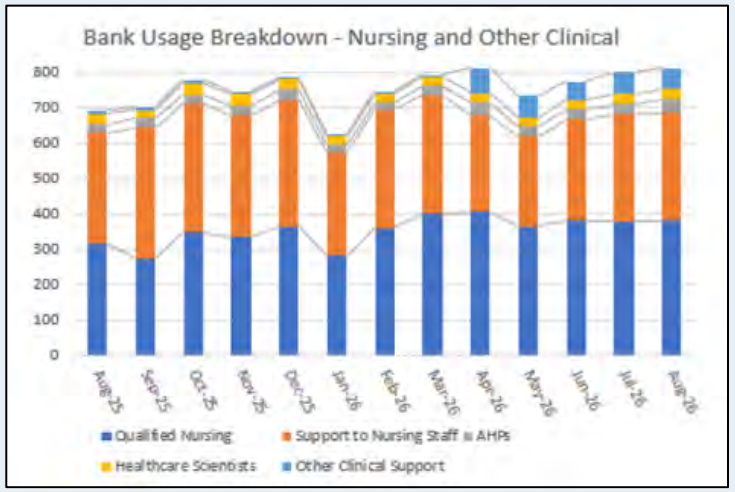
Finance: Sustainability

CQC Question: Are we well led?

Dorset County Hospital
NHS Foundation Trust





Metric:

- **Agency spend**
- **Bank spend**
- **Off Framework Agency Spend**

Pay: overall c.£1.2m away from plan largely driven by costs supporting Industrial Action costs(£0.2m) and high bank and agency use due to operational pressures and vacancies.

Agency expenditure: In month £0.6m, YTD £1.8m over plan. Main causes are vacancies, high sickness, operational pressures and long waiting MH patient (£0.3m YTD). National requirement to reduce agency by 30% with reflected phasing in place within plan. Daily break glass process in place, M5 off framework costs £0.5m YTD with £0.1m in month.

Bank expenditure: In month £1.3m, YTD £3.2m above plan. Drivers YTD include those listed above but also: IA impact and medical bank cover. Workforce reviews with NHSE 11 & 12 August focusing on roster practice, headroom and analysis - unavailability.

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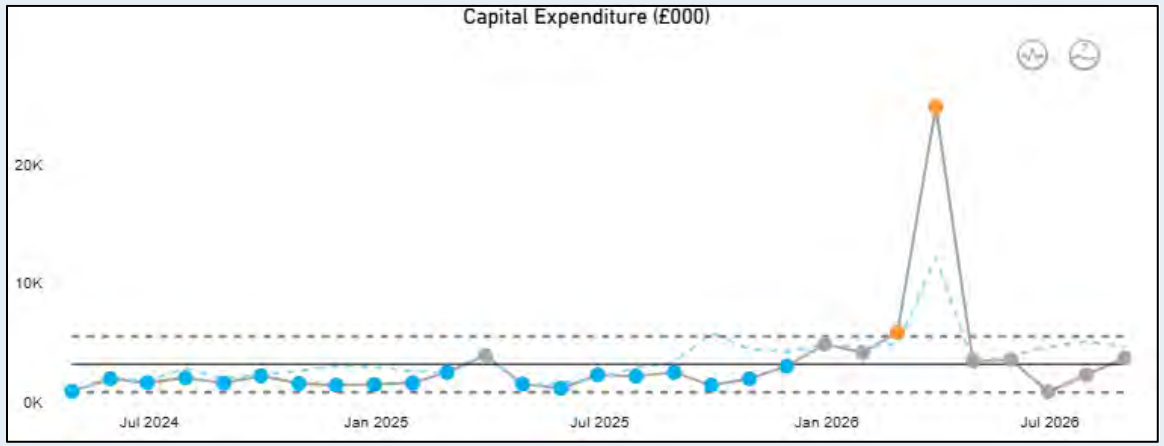
Finance: Sustainability

CQC Question: Are we well led?

Dorset County Hospital
NHS Foundation Trust



Metric: Capital expenditure

The Trust is progressing with the capital programme for 2026/27 with month 5 YTD spend totalling £13.7 million, which is behind plan by £7.8 million.

Externally funded projects are £4.3 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 £3.5 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. Despite current delays, at this stage there are no significant concerns to capital delivery by the end of the financial year.

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Finance: Sustainability

CQC Question: Are we well led?

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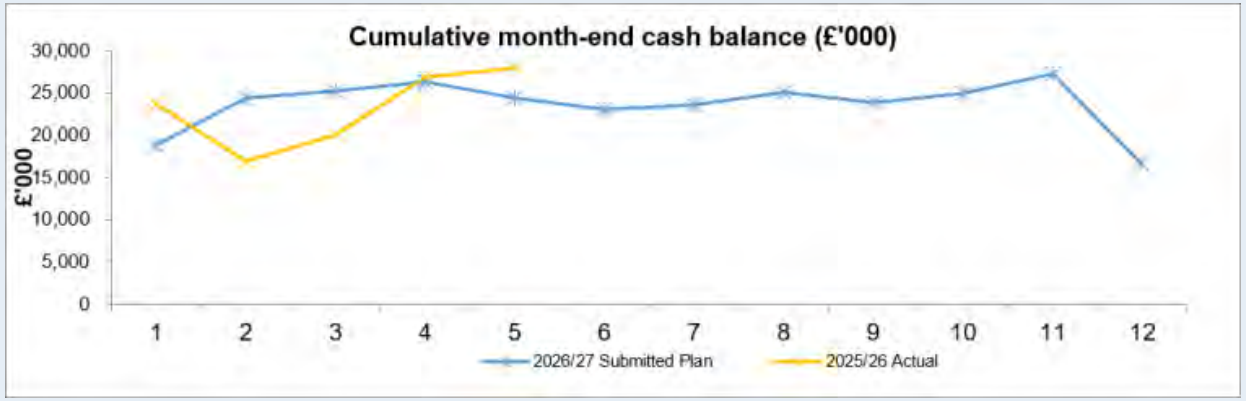
NHS Foundation Trust



Metric: Cash position

The cash position at the end of August was £27.9 million, which is £4.2 million above the adjusted plan. This favourable variance primarily reflects the impact of working capital timing differences, including the scheduling of payments and the receipt of income in advance. The latter contributed a benefit of £1.1 million from HEE income and £1.6 million from Deficit Support Funding. Depreciation Funding from Dorset ICB for the first four months of 2026/27 is still owed to the Trust. Discussions are underway to facilitate the prompt receipt of this funding.

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Finance: Sustainability

CQC Question: Are we well led?

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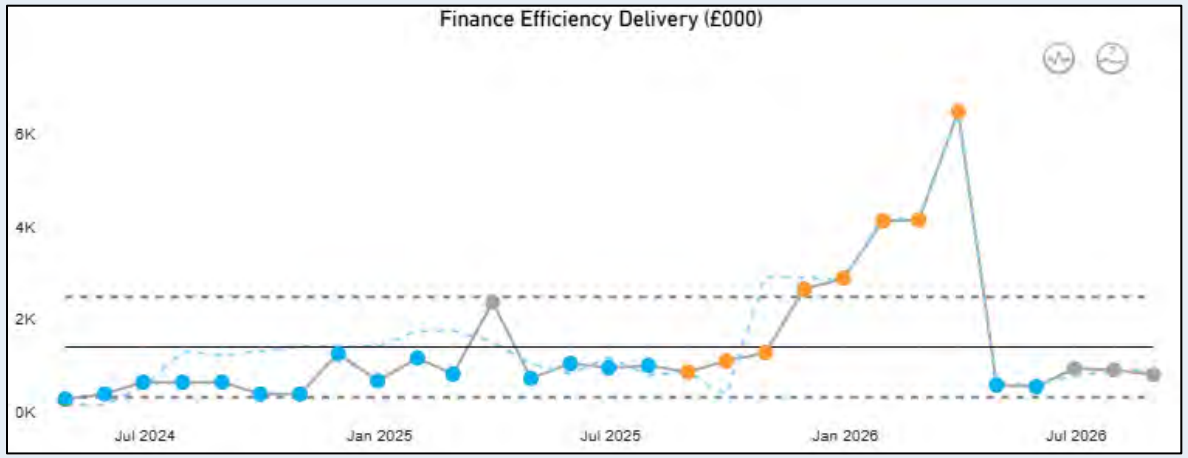
NHS Foundation Trust



Metric: Efficiency Delivery

The Trust plan included a £0.898 million efficiency target for month 5, which was underachieved by £0.099 million due to timing of scheme delivery however as the result of prior months, delivery still results in a YTD position ahead of plan by £0.01 million of the £3.724 million planned target. Savings were mainly the result of efficiencies in pay schemes, Bank Interest and biosimilar drugs savings with further traction needed to progress identified efficiency schemes.

The total efficiency plan for the year is £23.3 million and 14% of this remains unidentified and a further 15% 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.

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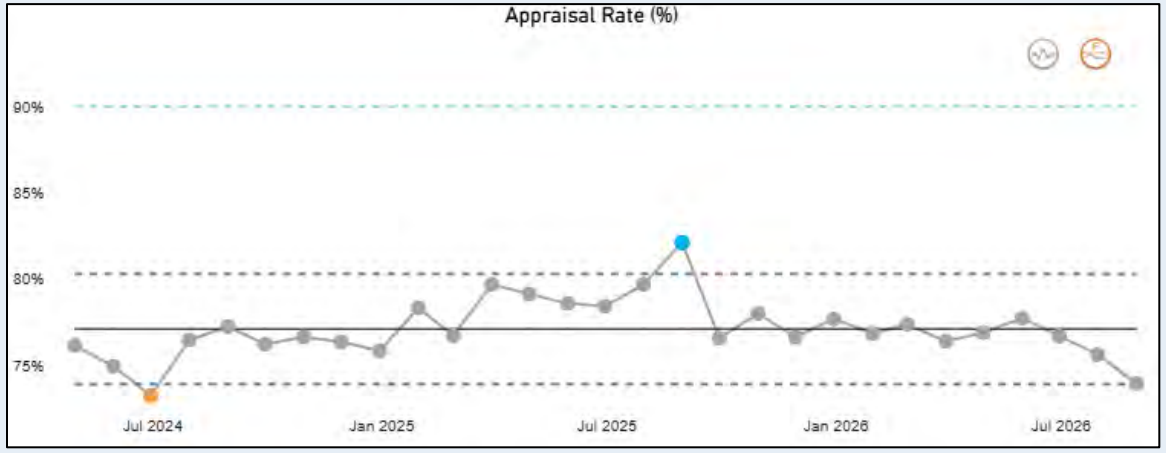
Workforce

CQC Question: Are we well led?

Dorset County Hospital
NHS Foundation Trust



Metric: Percentage of staff having recorded an appraisal conversation within the past 13 months.

Threshold: target 90%

The appraisal rate at DCH has declined over the past quarter. In Month 5, the overall compliance rate was 74%. From a divisional perspective, in-month increases were achieved through three divisions in Month 5, with a particularly promising increase in Director of Nursing and Operations.

Both clinical divisions track appraisal rates via the weekly meeting with the Service Managers/Care Groups.

Two relevant sessions are offered as part of the Management Matters programme, Meaningful Appraisals (for managers) and Making the Most of Your Appraisal (for all staff). There have been over 80 attendees at these sessions in the first six months.

A new national appraisal framework is being developed to support more consistent appraisal conversations across the NHS and align with the recently launched Leadership and Management Framework.

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People: Workforce

CQC Question: Are we safe?

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Metric: Percentage of staff at month end having completed the Mandatory training requirements, as set nationally by the UK Core Skills Training Framework (2013).
(Information sourced from ESR via Learning and Development team.)

Threshold: 80-90% (target 90%)

Overall compliance has remained at 88% for the past quarter, but 18 of the 26 elements of mandatory training saw a reduction in month. It is likely that the increased levels of sickness and operational pressures in this period has contributed to this position.

Five elements of training sit below the 80% lower threshold - Dementia awareness training (at 78%, a 2% increase in month), Level 2 Infection Control (at 79%, a reduction of 1% in month), Level 2 Manual Handling (at 79%, a reduction of 1% in month), Adult Basic Life Support (at 73%, a 1% reduction in month) and Level 3 Safeguarding Children (at 78%, no change in month). Actions are in place to increase compliance in these areas, including the provision of additional courses.

Email reminders are sent to remind staff when elements of their essential skills training are due for renewal. Overall compliance rates are sent to each division monthly and line managers have access to a live compliance dashboard of their team members.

'Get me green' support days continue each month. These sessions, run by the Education Team in the E-Learning suite are to help staff to improve their essential skills compliance.

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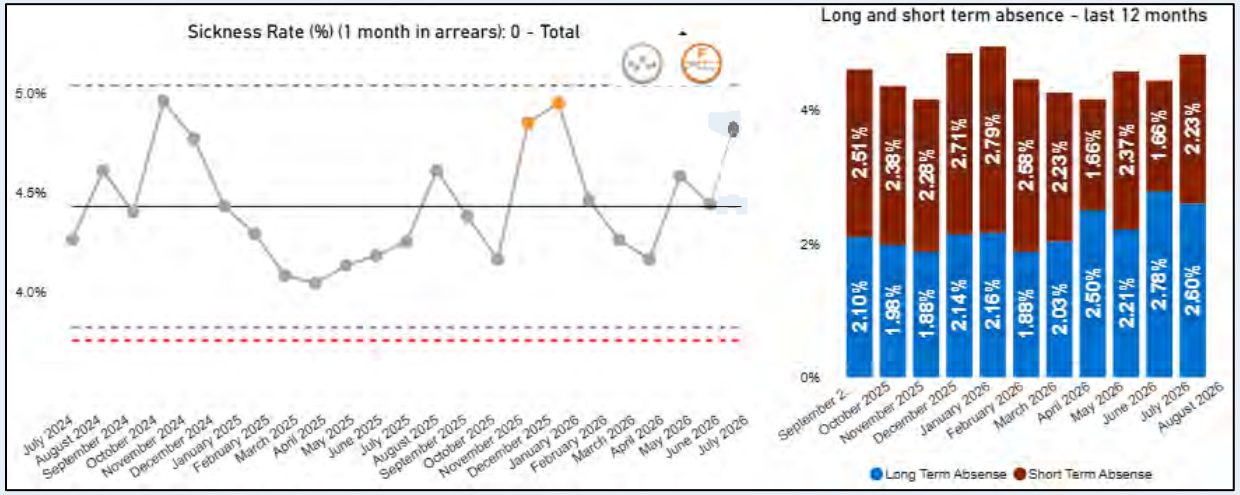
People: Workforce

CQC Question: Are we well led?

Dorset County Hospital
NHS Foundation Trust



Metric: SPC is a rolling 24-month period, Information sourced from ESR and is one month in arrears. Sickness Rate is the Full Time Equivalent (FTE) / FTE Days Available.
(Information sourced from Wellbeing Practice (onsite counselling provider) and Vivup (EAP and telephone counselling provider).

Threshold: Target 3.75%
(previous People Plan)

Overall sickness percentage increased in M4 (July) by 0.4% to 4.83%. Long term absence decreased in month by 0.17% to 2.60%. Short term absence increased by 0.57% to 2.23%. Three divisions experienced a small decrease in their overall absence rate (Director of Nursing, Finance & Resources, People Division). The other divisions saw an increase ranging from 0.08% for Urgent & Integrated Care and 2.21% for Corporate Services.

The top reason for absence in Month 4 remained as Anxiety/Stress/Depression. Requests for on-site counselling service reduced over the summer months, but management referrals to Occupational Health have increased. There has also been an increase in staff accessing the online EAP portal.

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A joint sickness deep dive was presented to People and Culture Committee in September. Both Trusts perform favourably against the relevant sector benchmarks. Stress, anxiety and depression are the largest causes of absence in both organisations and are major contributors to long-term absence, which accounts for approximately 60% of sickness days at DHC and 53% at DCH. The analysis identifies service-level and workforce variations requiring further investigation. Immediate priorities are to strengthen practical attendance-management support at DHC, align policies and processes across both Trusts, review support for colleagues experiencing psychological ill health, and improve performance monitoring. The Committee will receive a further report in March 2027.

People: Workforce

CQC Question: Are we well led?

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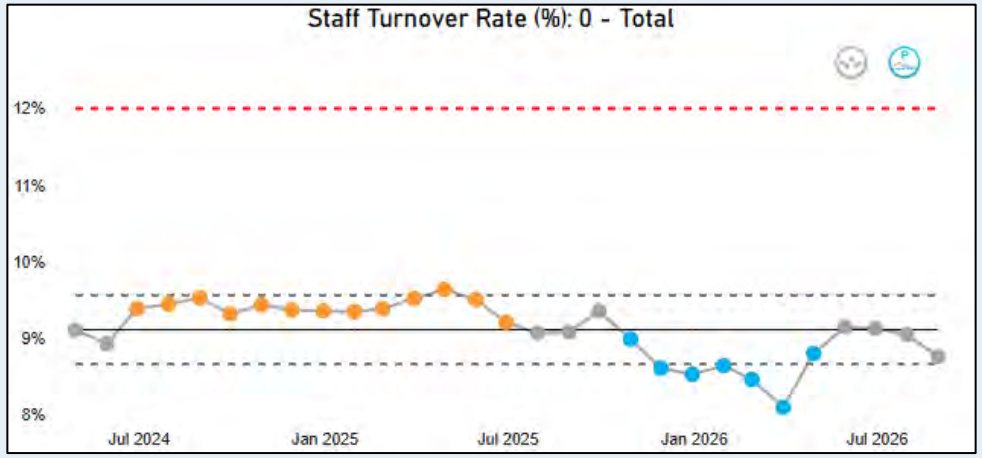

Metric: SPC is a rolling 24-month period
(Information sourced from ESR Percentage showing staff turnover rate based on a 12-month rolling view.)

Threshold: 10-12%. Target 7% (previous People Plan)

Turnover has reduced for the past quarter, reaching 8.75% in Month 5. The majority of contracts ended over the past 12 months were bank contracts that had not been used.

Top 5 Reasons for Leaving (all staff types)

Leaving Reason	Less than one year	One year or more	Total
Voluntary Resignation - Other/Not Known	22	99	121
Has Not Worked	7	108	115
Voluntary Resignation - Relocation	12	100	112
Retirement Age	3	67	70
Bank Staff not fulfilled minimum work requirement	2	45	47

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Leavers' data is regularly reviewed through Divisional Management Groups and other governance forums to identify turnover trends and inform retention activity. Career conversations are now embedded within the appraisal process to support retention, career development and succession planning

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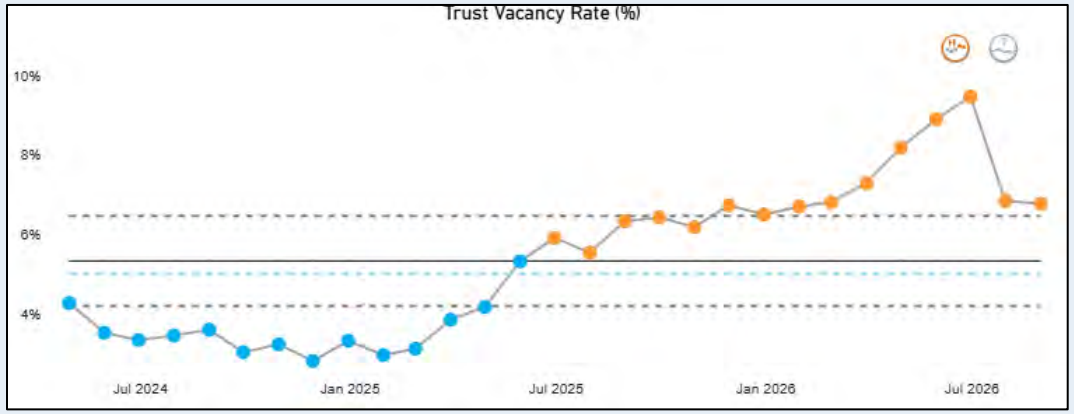
People: Workforce

CQC Question: Are we well led?

Dorset County Hospital
NHS Foundation Trust



Metric: SPC is a rolling 24-month period. Trust vacancy rate (budgeted FTE minus staff in post)
(Information sourced from ESR.)

Threshold: Target 5% (previous People Plan)

Vacancy rate reduced to 6.8% in July, reflecting improvements in establishment data quality rather than a substantive change in workforce capacity. During the month, vacant posts associated with Procurement and DiiS functions that had transferred to other organisations through TUPE arrangements were removed from the establishment, together with approximately 50 duplicate Resident Doctor posts identified within ESR. These corrections provide a more accurate baseline from which workforce metrics can be monitored and reported.

To strengthen data quality and reporting assurance, regular establishment cleansing activity will be incorporated into business-as-usual processes, and guidance on managing establishment changes will be reissued to managers to ensure organisational changes are reflected promptly within ESR.

A joint paper reviewing recruitment timeliness across DHC and DCH was shared with People and Culture Committee in September. It showed that both Trusts move approved vacancies to advertisement within target. However, material delays occur in vacancy authorisation, shortlisting and notifying candidates of interview. Plans are in place to streamline vacancy approval, better support managers with high application volumes, improve candidate communication and strengthen monitoring across the whole recruitment journey. A progress and impact report will return to the Committee in March 2027.

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Report to	Board of Directors in Common	
Date of Meeting	13th October 2026	
Report Title	Operational Performance Report; July and August data 2026	
Prepared By	Adam Savin, Director of Operations and Performance	
Approved by Accountable Executive	Anita Thomas, Chief Operating Officer	
Previously Considered By	Finance and Performance Committee in Common	
Action Required	**Approval**	
	Assurance	x
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues		No
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR1 Safety and Quality, SR4 capacity and demand	
Financial	Elective Recovery Fund	
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 July and August 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:**
  - Year to date, against the 2026/27 operating plan, ED attendances are 1.50% over plan. For Q1, demand was 5.23% over plan, but against Q2 to date, demand is 3.4% below plan.
  - Four-hour standard has not met the operating plan trajectory, but is meeting the recovery plan
  - Persistent 12-hour breaches remain a concern, primarily due to bed availability, but is meeting the recovery plan
  - Ambulance handover delays against the mean time, is not meeting trajectory or against the 15 and 45min target and is an area of risk, as it is not meeting the recovery trajectory.

- **Elective Care:**
  - RTT trajectories are not meeting the operational plan trajectory; but the recovery KPIs are being met.
  - 52+ week breaches have reduced and are meeting the recovery trajectory
  - Follow-up backlog reduced to pre-COVID levels.
  - Cancer standards have not met the operation planning standards and the recovery trajectories have been revised to reflect a new emerging issue.

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

Overall Position:
Performance standards across UEC and Elective care are not being met. A recovery programme for cancer, UEC and Elective care has been established, presented to Board and approved.

Recommendation

The Board is asked to:

a) To note the ambulance handover times and the introduction of timely handover protocol of 30 minutes from January 2027
b) To note the challenges in Elective performance and the approved recovery trajectory
c) To note the improved diagnostic position and achievement of the operating plan trajectory

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Operational Performance Report – October 2026 (July and August 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 July and August 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.

Where the trust is off plan for Elective Care, Urgent and Emergency care (UEC) and cancer waiting times, a recovery plan has been approved at Board. This paper will track against these trajectories, noting key actions and any risks to delivery.

Urgent and Emergency Care (UEC)

2.0 Operational performance for UEC

2.1 Demand at the front door - ED: 2026/27 year to date

Year to date, against the 2026/27 operating plan, ED attendances are 1.50% over plan. For Q1, demand was 5.23% over plan, but against Q2 to date, demand is 3.4% below plan.

Demand compared to last year is 5.29% up, year to date. For Q1, demand growth was 9.16%, Q2 demand Vs last year is 0.14% up. It is important to note, demand last year was over 10% up compared to 2024/25, the step change is demonstrated on the SPC chart below.

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	5572	5540							
	variance	271	372	157	-170	-229							

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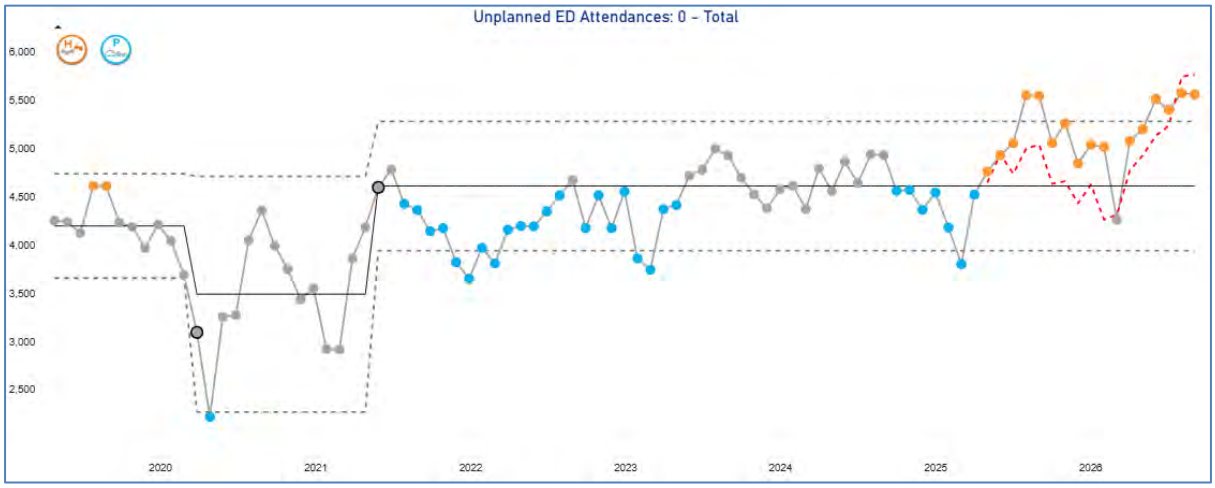

Analysis of where the demand is coming from for Q1 was completed and reported on in the last performance paper. The headlines were:

- Against the operating plan, ambulance demand (all areas) is 7.99% over plan.
- Growth in Q1 this year, compared to Q1 2025/26, is 9.16% 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%
- 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.
- 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.

Demand analysis for Q2 will be completed at the end of the quarter and compared to Q1. This will be used to refine the demand models in preparation for the 2nd half of the year. For the first two months of Q2, the biggest reduction in demand is from the East.

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.

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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), in partnership with DHC
- Increase referrals into community services directly from ED (Pilot)
- Trial Virtual Ward pharmacist to increase capacity (DCH)
- Address weekend and community capacity gaps (DHC)
- System UEC SPOA enhancements to deliver alternative pathways to conveyance and admission with focus on Frail Elderly – working with two command centres East and West (all System partners)

Ensuring 'Care in the Right place at the right time', is achieved will also 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 go live of the Urgent Treatment Centre (pending staffing model and funding), the bed reconfiguration project, with the aim to realign inpatient bed base to fit with demand and establishing an Ortho-Geriatrics Service.
- Optimise and extend the model for Acute Assessment to improve flow and reduce avoidable admissions. This will be achieved by expanding the Acute Assessment Unit (AAU) capacity (14 → 24 beds plus 6 trolleys), this is linked to the bed reconfiguration work. The implementation of the Hot Clinic model (admission avoidance) and strengthened specialty pathways into AAU.

2.2 A&E performance against the four-hour standard 2026/27 year to date

Performance against the 4-hour standard (including UTC data) has not met the operating plan trajectory, for 4 out of 5 months. Compared to the national performance, DCH has been above the national aggregate performance for the 4-hour standard, in July and August.

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%	79.37%	76.93%							
	variance	-3.30%	-7.48%	-7.08%	1.01%	-1.41%							

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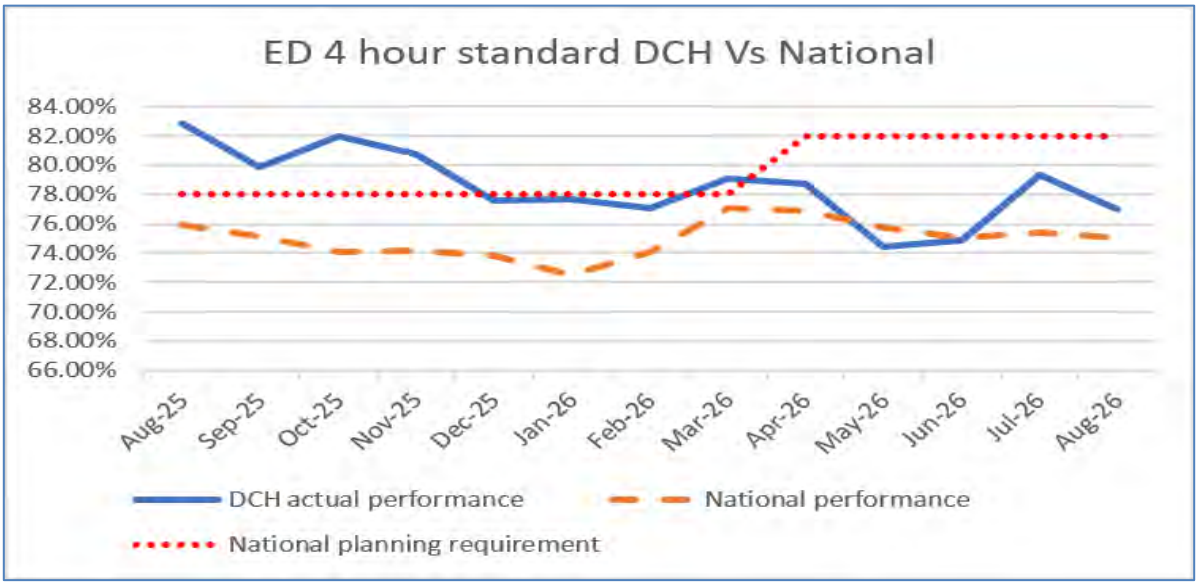

The UEC, Board agreed, recovery trajectory for the 4-hour standard is set out below and returns DCH to the original operating plan from December. For July and August, the recovery trajectory was met.

		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	79.37%	76.93%							
	MTP plan	78.36%	78.34%	77.69%	78.87%	79.97%	80.52%	81.01%	81.43%	82.06%
	variance to recovery	5.87%	1.93%							
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	60.80%	56.70%							
	MTP plan	60.19%	60.41%	60.43%	63.61%	63.40%	64.40%	65.29%	66.16%	67.22%
	variance to recovery	7.60%	2.20%							

A recovery trajectory for Children's 4 hour wait was not submitted, with the expectation that DCH returns to the operating plan as soon as possible. While DCH performs well in comparison with other Trusts, against the metric, DCH has not improved, with the variance to plan increasing in the month of August.

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 Children 4 hour wait %(all)	plan	95.41%	95.83%	95.30%	95.71%	95.49%	77.69%	78.87%	79.97%	80.52%	81.01%	81.43%	82.06%
	actual	93.30%	90.79%	91.44%	93.14%	91.02%							
	variance	-2.11%	-5.04%	-3.86%	-2.57%	-4.47%							

Action:
Utilising the new Urgent Treatment Centre (UTC) space, until the UTC is operational, a dedicate paediatric space has been agreed, so children (minor designated conditions) can be streamed quickly from the ED queue for prioritisation and swift action. This went live in September.
The Paediatric Team are also undertaking transformation work on Kingfisher to increase the capacity and capability within the Paediatric Assessment Unit for those who require more specialist input.

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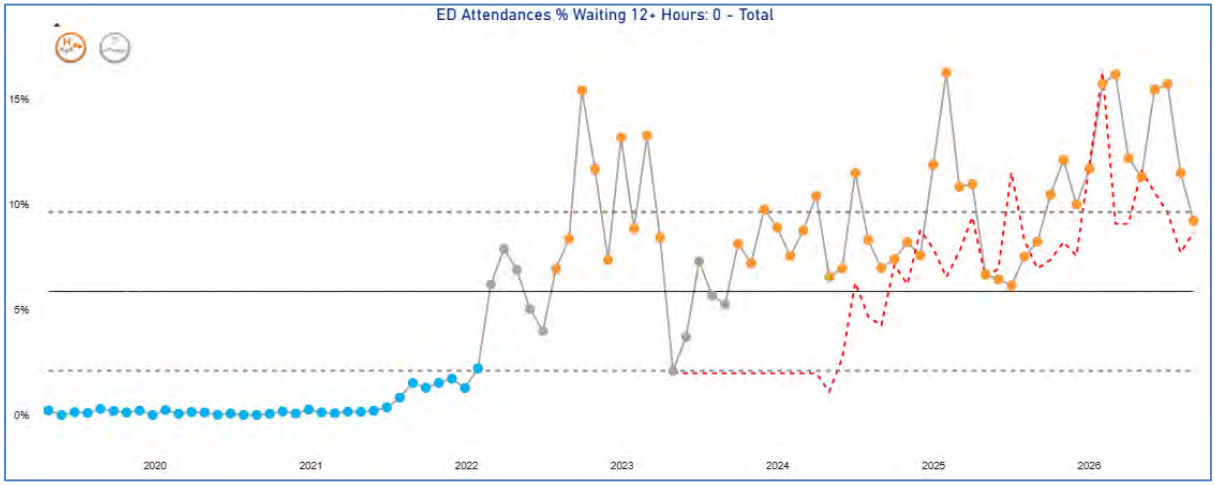
2.3 A&E performance 12-hour breaches; 2026/27 year to date

Both the number of patients and the proportion of ED attendances that waiting over 12 hours, has not met the operating plan this year, however the proportion has reduced for three consecutive months. The most significant cause of these breaches is waiting for a bed.

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	644	509							
	variance	15	303	344	200	8							
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%	11.51%	9.19%							
	variance	-0.31%	4.86%	6.07%	3.79%	0.50%							



The Board agreed a recovery trajectory for the % of attendances that have waited over 12+ hours. The recovery trajectory was met for July and August.

Metric	Ops plan 26/27	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
% 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	11.51%	9.19%							
	MTP plan	7.72%	8.69%	8.66%	7.71%	7.29%	8.32%	11.02%	8.62%	6.25%
	variance to recovery	-1.99%	-3.31%							

Further improvement requires the delivery of the bed reconfiguration project to increase assessment capacity and the UEC improvement actions outlined within the New Models of Care Programme for flow ward optimisation.

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:

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- 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
- 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

2.3 Non-Elective Admissions; 2026/27 year to date

Non-elective admissions are below the operating plan. At a recent NHSE Winter Planning event, the National Director of Delivery confirmed that this was a pattern throughout the South West Region, with attendances up, but admissions down. This is being credited with increasing activity through SDEC's and similar unit, as well as the increase in virtual ward capacity.

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	1476	1444							
	variance	-23	-172	-16	-30	-11							
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	1306	1098							
	variance	-53	-242	-189	-102	-49							
Total Non-elective spells	Plan	2590	2525	2655	2914	2602	2529	2741	2618	2703	2703	2449	2703
	actual	2519	2422	2450	2782	2542							
	variance	-71	-103	-205	-132	-60							

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.

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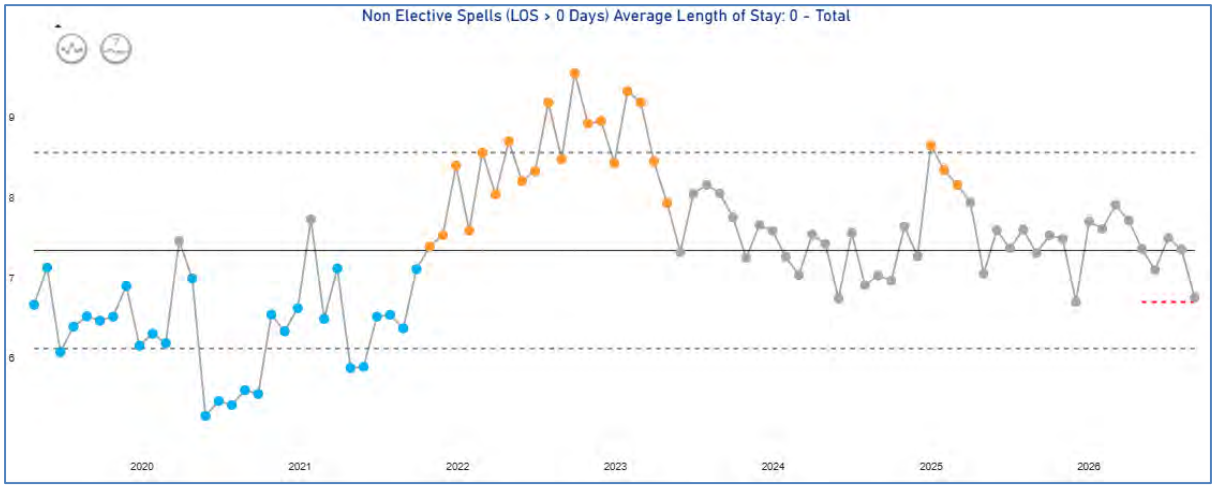
Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Total bed days for non-elective admissions	Plan	9702	9648	9300	10090	9749	9487	9641	9548	9856	9856	8931	9856
	actual	10521	10023	10312	10857	9750							
	variance	819	375	1012	767	2							
Total number of discharges for non-elective admissions	Plan	1448	1440	1388	1506	1455	1416	1439	1425	1471	1471	1333	1471
	actual	1303	1268	1243	1378	1367							
	variance	-145	-172	-145	-128	-88							
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	7.00	6.74							
	variance	0.68	0.43	0.82	0.30	0.0							

For July, Non-elective LoS was 0.30 above plan, but it further reduced in August and achieved plan. The trust did have fewer discharges than planned, but also fewer admissions. Total bed days for non-elective admissions was only 2 above plan in August.



A trajectory was not required for patients with no criteria to reside within 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%	89.62%	90.78%							
	variance	-3.60%	0.19%	-2.19%	-1.61%	0.23%							
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	8	7.12							
	variance	0.21	-0.25	-2.02	-3.22	-4.81							
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	45	57							
	variance	14	2	-1	-4	8							

The number of patients occupying a bed with no reason to reside was 4 below the locally agreed trajectory in July but 8 above in August. Looking ahead to September, it is expected the locally agreed trajectory of 49 will be achieved.

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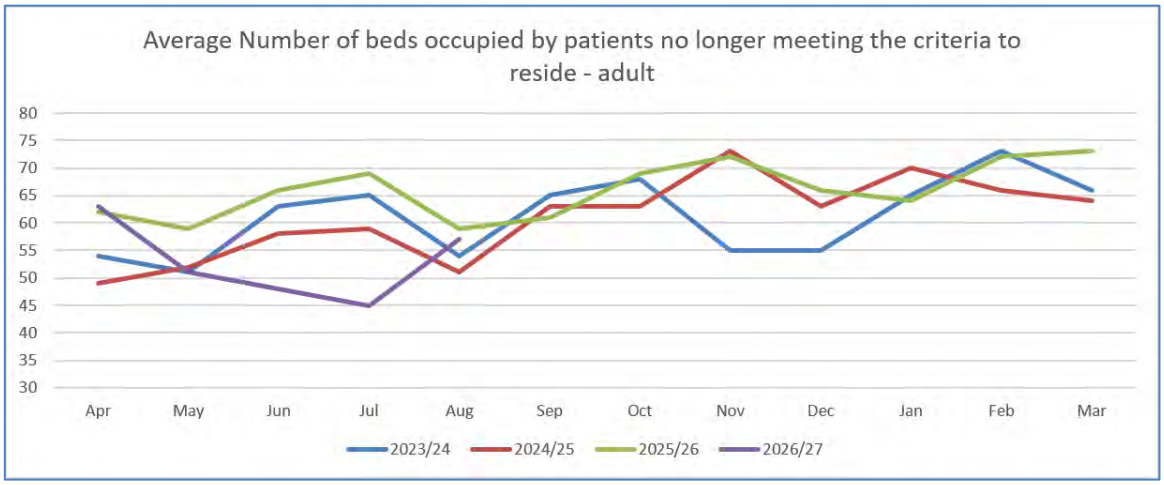

While hitting the locally agreed trajectory, it should be noted that this is still high, at 18% of the bed base.

2.5 Occupied beds; 2026/27 year to date

The number of occupied and open beds has been above plan all year. This has been driven by a higher average length of stay. In August length of stay did hit plan, the number of discharges was lower than plan and this is anomalous and requires further monitoring. The metric is based on 'closed LoS i.e. patients who have been discharged and can be overly influenced by the discharge of even 1 very long stay patient.

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
Average number of overnight GA beds occup	plan	291	296	297	303	293	303	304	298	304	304	295	296
	actual	299	307	308	310	303							
	variance	8	11	11	7	10							
Average number of GA beds open	plan	298	304	304	304	304	304	304	304	304	304	304	304
	actual	305	310	311	315	310							
	variance	7	6	7	11	6							
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%	98.41%	97.83%							
	variance	0.45%	1.73%	1.37%	-1.26%	1.45%							

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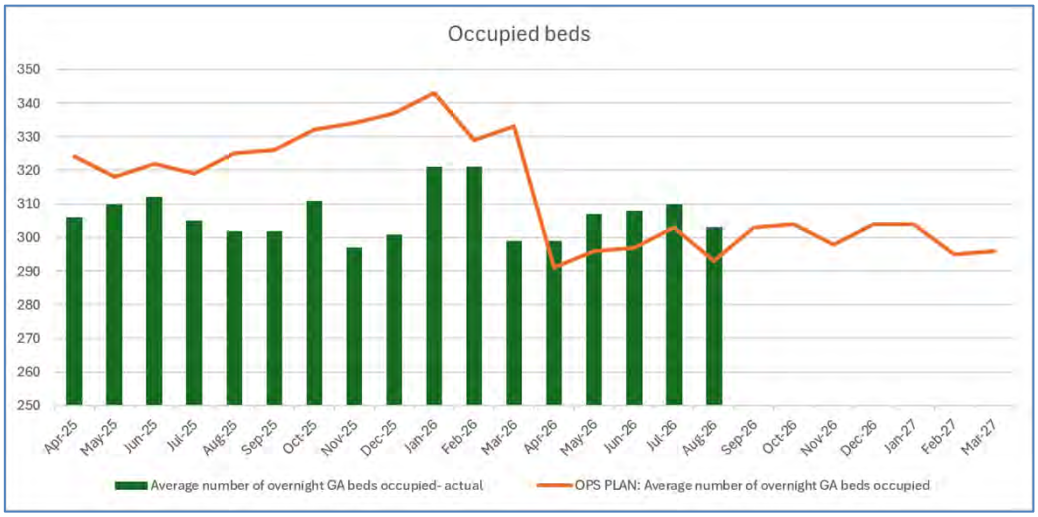

2.5.1 Actions to address no reason to reside and bed occupancy

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. Other actions underway include:

- Criteria to Admit Audit outputs with action plan for further change
- An audit of patients leaving until after 16:00, create actions to release capacity earlier in the day
- Remove discharge lounge barriers (TTOs, EDS, CDs; engage RDs) and move to a full ‘Pull’ Model
- 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 metrics.

In August 2026 NHS England South West issued a clear requirement that all ambulance handovers are to be completed within 45 minutes from September 2026, reducing to 30 minutes from January 2027. This means that from January, ambulances will be offloading and leaving patients at 30 minutes.

Year to date, the ambulance metrics within the operating plan have not been met and demand in July and August was under plan, having previously seen growth in Q1.

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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	1576	1603							
	variance	73	213	74	-269	-222							
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	00:25:00	00:22:00							
	variance	00:03:10	00:03:33	00:10:33	00:05:48	00:03:00							
% 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%	10.41%	4.68%							
	variance	2.67%	6.92%	11.35%	6.40%	0.68%							
% 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%	74.37%	71.30%							
	variance	14.57%	23.31%	30.59%	26.13%	25.60%							

Ambulance handover recovery trajectories were included as part of the NHSE response package. For July, this trajectory was not met for both metrics. In August the percentage of ambulances handed over at 45+ minutes dropped to 4.68%, which hit the recovery trajectory and was 0.68% away from the original operating plan.

		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
% Ambulance handovers + 15mins	Recovery plan	74.00%	68.00%	69.00%	50.00%	45.00%	40.00%	35.20%	31.50%	28.23%
	actual	74.37%	71.30%							
	MTP plan	48.24%	45.70%	43.20%	40.70%	38.20%	35.69%	33.20%	30.70%	28.23%
	variance to recovery	0.37%	3.30%							
% Ambulance handovers + 45mins	Recovery plan	9.00%	7.00%	5.50%	3.50%	2.50%	1.99%	0.99%	1.03%	0.00%
	actual	10.41%	4.68%							
	MTP plan	4.01%	4.00%	3.01%	3.02%	1.99%	1.99%	0.99%	1.03%	0.00%
	variance to recovery	1.41%	-2.32%							

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 in 2026/27.

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.

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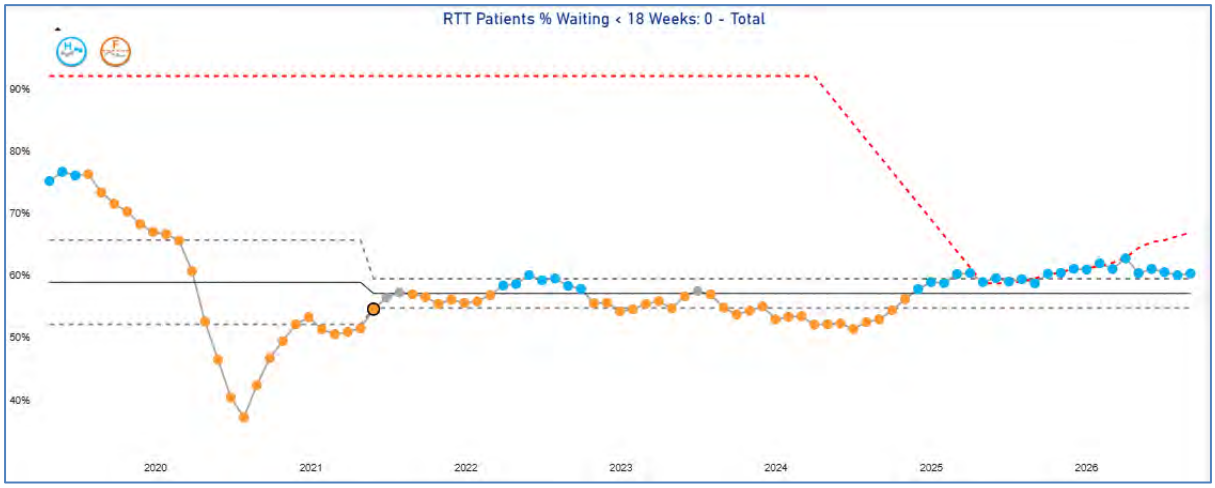
Financial risk– Several capacity solutions (for example the Urgent Treatment Centre) require recurrent funding and estate investment to deliver their full impact.
The Capital funding submissions have been successful and require to now be operationalised at pace alongside the planned flow improvements. Revenue funding will be dependent on funding changes aligned to UHD changes and contract triggers associated with growth of demand.

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%	60.00%	60.23%							
	variance	-4.08%	-4.32%	-5.12%	-6.37%	-6.61%							
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%	64.31%	64.68%							
	variance	-5.75%	-6.15%	-7.19%	-8.75%	-8.96%							



Against the operating plan, performance is not delivering the trajectory, remaining static, with variances less than a percentage point each month. The level of growth in activity required to hit the performance standards, exceeded the 2% productivity improvement target (implied productivity) set out in the planning guidance. The growth in activity at Point of Delivery level was flagged to FPC and is shown in the table below.

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% growth required for 26/27	
Consultant-led first outpatient attendances (Spec acute)	5.15%
Consultant-led follow-up outpatient attendances (Spec acute)	4.34%
Consultant-led follow-up outpatient attendances - of which Outpatient Procedures	4.34%
Total outpatient attendances (All TFC, Consultant and Non consultant led)	4.00%
Total number of specific acute elective day case spells in the period	7.96%
Total number of specific acute elective ordinary spells in the period	6.26%
Total number of specific acute elective spells in the period	7.84%

Elective activity volumes have impacted for a variety of reasons including breakdown of key equipment, sickness absences in high volume services such as ophthalmology and endoscopy. Other factors include:

- In ENT and Orthopaedics, the two areas with significant backlogs to treat suffered 3 unplanned consultant absences.
- 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. High humidity impacts the physical theatre space and the theatre packs, due to increased moisture levels, creating an infection risk.

In addition to the loss of planned activity levels in Q1 it is acknowledged following full analysis of the Q1 circumstances that the late planning submission phased expected productivity gains earlier than plans could have been expected to deliver. This learning has been fully embedded in the plans for recovery and for the DCH response for planning for 2026/27.

3.2 Waiting list size

The size of the waiting list has not met trajectory all year. At the end of August, the waiting list was 2,737 patients larger than planned but did reduce compared to July rather than continue the upward trajectory.

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	23,380	23,103							
	variance	967	1,591	1,942	2,841	2,737							

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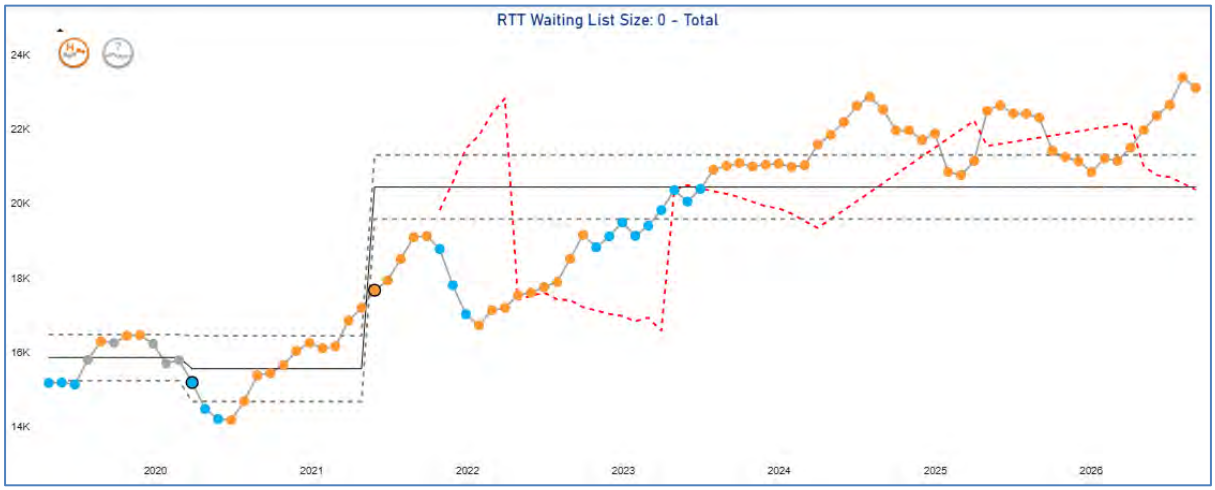

A 4% referral growth factor was applied as part of the operating plan, year to date referrals are 0.07% up.

The other factor impacting the size of the waiting list, is the amount of activity undertaken.

Against operating plan, activity levels for consultant led (RTT) activity are below plan, as covered in the section above.

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	Aug year to date
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	28,126
	actual	4,790	4,721	5,231	5,478	5,035								25,250
	variance	-521	-431	-731	-767	-421								-2,876
Consultant-led follow-up outpatient attendances (Spec acute)	plan	8461	8088	9338	9785	8502	9330	9357	8916	8866	8509	8504	8925	44,174
	actual	8819	8407	9511	9469	8392								44,668
	variance	358	319	173	-316	-110								494
Consultant-led follow-up outpatient attendances - of which Outpatient Procedures	plan	1529	1462	1687	1768	1536	1686	1691	1611	1602	1538	1537	1613	7,982
	actual	1528	1290	1468	1577	1582								7,674
	variance	-1	-172	-219	-191	46								-308
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	13,244
	actual	2,388	2,476	2,711	2,896	2,358								12,831
	variance	-124	43	-90	-33	-211								-413
Total number of specific acute elective ordinary spells in the period	plan	198	193	223	234	205	223	224	214	211	203	204	213	1,053
	actual	183	179	206	196	181								945
	variance	-15	-14	-17	-38	-24								-108
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	14,297
	actual	2,571	2,655	2,917	3,092	2,539								13,776
	variance	-139	29	-107	-71	-235								-521

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. The trajectory against the operating plan has not been met, as activity levels are behind plan. The number of 52+ week breaches has reduced in July and August.

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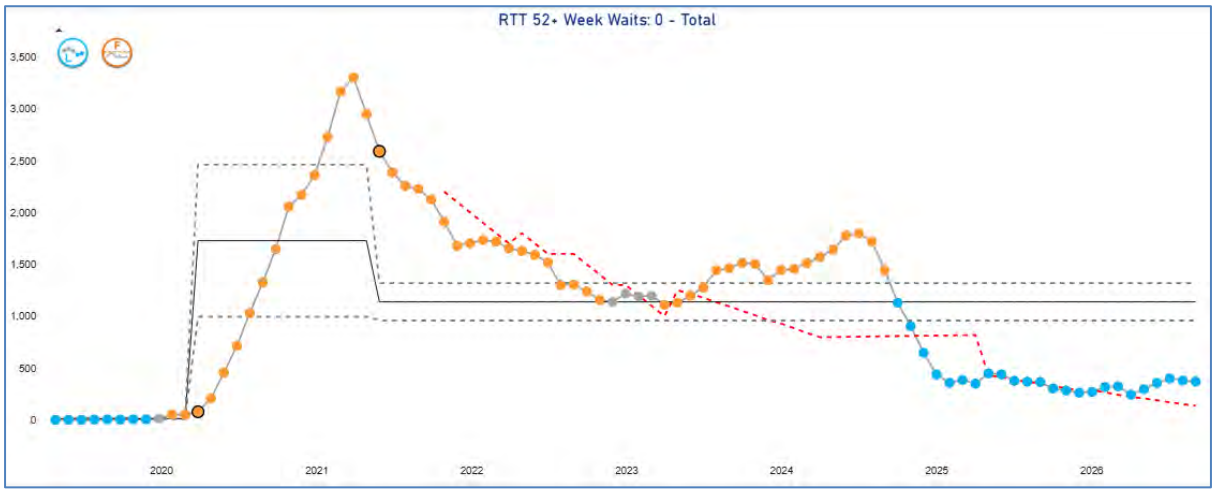
Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
RTT: 52wk wait	plan	208	189	170	151	137	118	99	80	66	47	28	0
	actual	296	356	399	379	370							
	variance	88	167	229	228	233							
RTT: 52wk cohort % of Waiting List	plan	0.99%	0.91%	0.82%	0.74%	0.67%	0.58%	0.49%	0.40%	0.33%	0.24%	0.14%	0.00%
	actual	1.35%	1.59%	1.76%	1.62%	1.60%							
	variance	0.36%	0.68%	0.94%	0.89%	0.93%							



3.4 Recovery plan for elective care, RTT metrics

The first draft of the RTT recovery plan was not approved at Board, as assurance couldn't been given that the actions would deliver the required impact. A revised and bottom up modelled plan was presented to the Board in September and approved.

This plan delivers a trajectory that gets the trust to the required 70.89% RTT. It also delivers a reduced waiting list size (compared to last year) and no more than 1% of the waiting list waiting over 52 weeks. This meets the ask of the national planning guidance but does not return the trust to the original operating plan trajectory.

The table below details the modelled recovery plan trajectory, the actual performance and how it compares to the original operating plan (MTP plan). The variance is against the recovery plan.

The modelled trajectory is from September and is denoted with a colour change on the month row.

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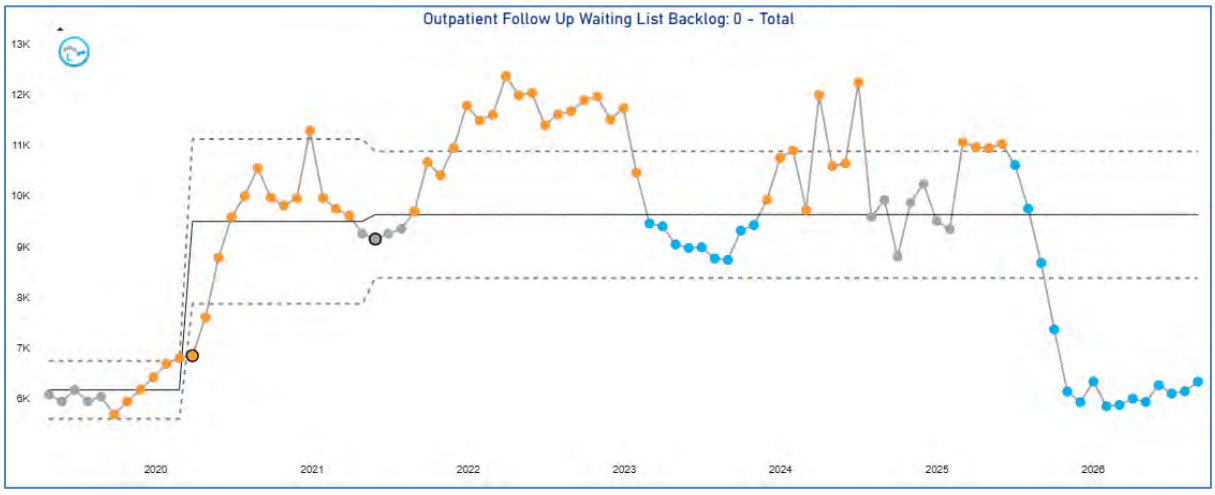
		Recovery forecast RTT approved at Board								
Metric	Ops plan 26/27	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
RTT: Total Waiting List	Recovery plan	22,300	21,980	23,470	23,290	23,001	22,640	22,334	22,033	21,318
	actual	23,380	23,100							
	MTP plan	20,539	20,366	20,213	20,043	19,879	19,784	19,642	19,432	19,287
	variance to recovery	-1080	-1120							
RTT: 52wk wait	Recovery plan	388	374	360	342	301	263	266	228	212
	actual	379	370							
	MTP plan	151	137	118	99	80	66	47	28	0
	variance to recovery	-9	-4							
RTT: 52wk cohort % of Waiting List	Recovery plan	1.74%	1.70%	1.53%	1.47%	1.31%	1.16%	1.19%	1.03%	0.99%
	actual	1.62%	1.60%							
	MTP plan	0.74%	0.67%	0.58%	0.49%	0.40%	0.33%	0.24%	0.14%	0.00%
	variance to recovery	-0.12%	-0.10%							
RTT: % patients waiting <18wks	Recovery plan	59.70%	60.20%	59.60%	60.26%	61.86%	63.70%	66.09%	68.53%	70.89%
	actual	60.00%	60.28%							
	MTP plan	66.26%	66.84%	67.48%	68.09%	68.64%	68.49%	69.06%	70.31%	70.89%
	variance to recovery	0.30%	0.08%							

Against the draft recovery plan, all metrics apart from the waiting list size were achieved in July and August. Looking ahead to September, all recovery metrics are forecasted to hit the modelled trajectory.

Full details of all actions in the recovery plan were submitted to Board in September and are tracked in the CEO led Operational Performance Recovery Group. The ICB joins these weekly meetings, and a NED will be attending moving forward.

3.5 Follow up backlog

The follow up backlog has slightly increased since the start of the financial year, but has continued at below 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 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. PIFU is to be re-launched as part of the Outpatient Transformation programme. A Management lead has now

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been appointed, alongside a clinical lead, with the programme of work due to be presented to the RTT Recovery Board in October.

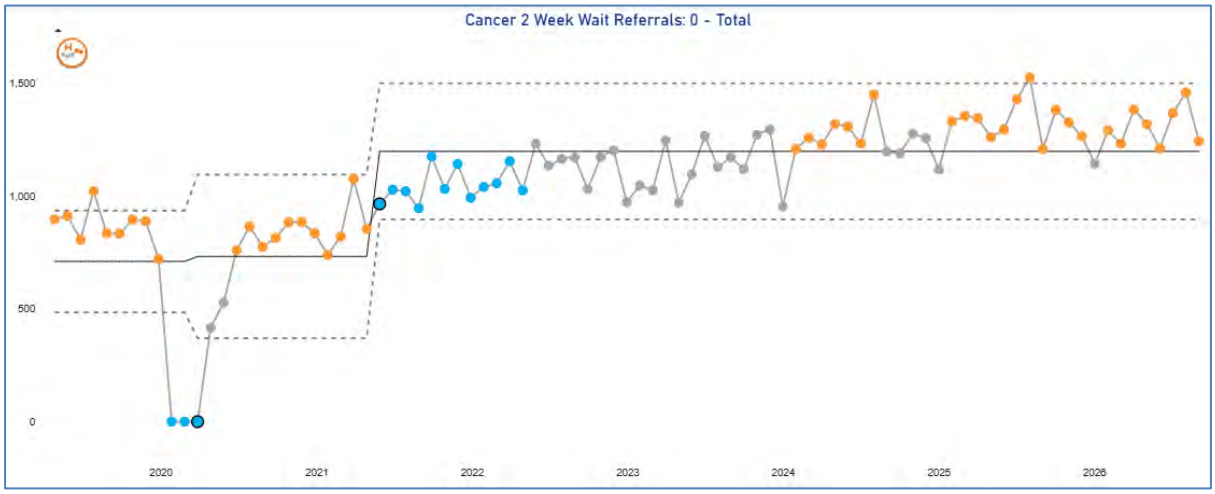
Metric	Ops plan 26/27	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
PIFU	Plan	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%
	actual	3.20%	3.27%	3.68%	3.99%	3.78%							
	variance	-4.80%	-4.73%	-4.32%	-4.01%	-4.22%							

3.6 Cancer waiting times standards

For April and May, the Trust did achieve the 31-day (combined) trajectory but has not hit the operating plan trajectory for any other month 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
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%	75.90%	77.01%	79.11%	76.94%							
	variance	-1.88%	-4.15%	-3.05%	-2.50%	-3.06%							
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	95.07%	94.55%	91.36%	90.09%	89.45%							
	variance	1.03%	0.48%	-3.16%	-3.10%	-5.14%							
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%	63.10%	70.45%	61.51%	74.58%							
	variance	-8.39%	-16.90%	-9.69%	-18.35%	-5.83%							

Referrals are 1.68% lower than last year; however, specialty-level performance varies significantly. Gynaecology for example, has seen a 16.6% increase. Whilst referrals year to date are down, August spiked, with a 3.07% increase compared to August 2025.



The total waiting list (cancer) has reduced significantly over the last year and while it had started to increase, for August it has reutrned ot the median level.

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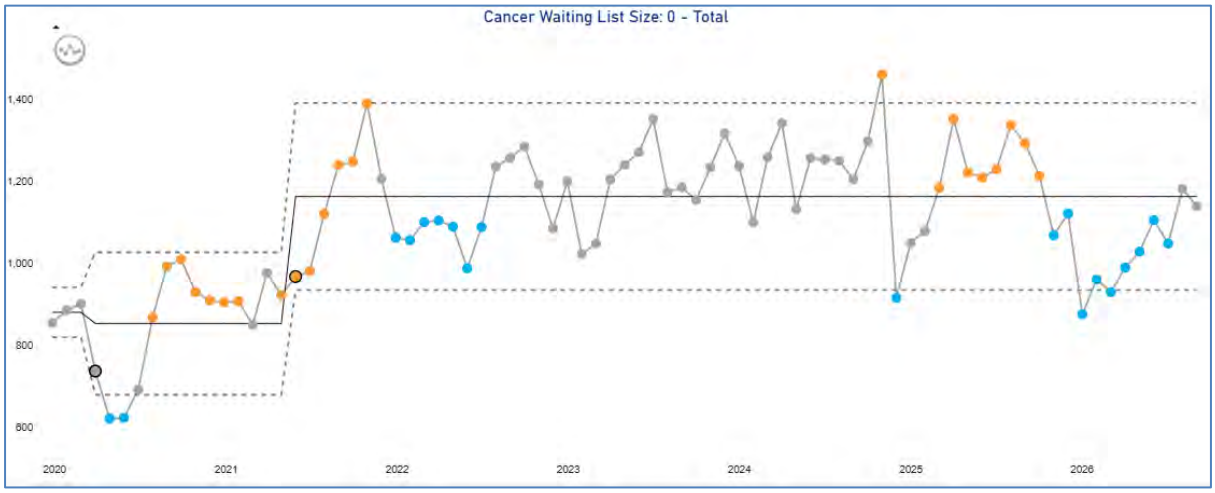
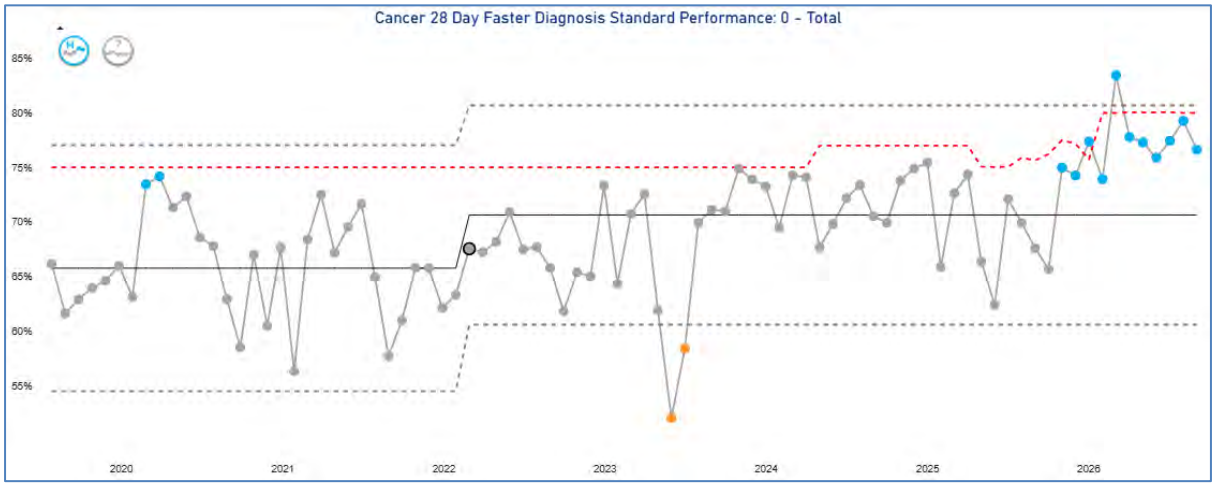


3.6.1 Faster Diagnosis Standard (28 days)

Performance of the 28-day standard has not met the trajectory for any month 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
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%	75.90%	77.01%	79.11%	76.94%							
	variance	-1.88%	-4.15%	-3.05%	-2.50%	-3.06%							



Cancer Site	Apr-2026	May-2026	Jun-2026	Jul-2026	Aug-2026
Brain					
Breast	91.89%	92.64%	93.91%	93.48%	95.29%
Colorectal	48.65%	40.22%	49.75%	39.67%	26.14%
CUP	100.00%		50.00%		0.00%
Gynaecology	69.52%	71.57%	59.06%	62.50%	54.84%
Haematology	100.00%	100.00%	66.67%	50.00%	87.50%
Head and Neck	82.03%	83.20%	81.51%	78.51%	78.76%
Lung	91.67%	78.18%	89.58%	85.29%	96.67%
Other			0.00%		
Paediatric	75.00%	100.00%	50.00%	50.00%	100.00%
Sarcoma					
Skin	92.83%	89.53%	92.27%	97.49%	94.14%
Upper GI	62.50%	69.70%	54.90%	57.76%	60.58%
Urology	66.13%	75.18%	83.21%	88.10%	87.83%

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Performance of the 28-day standard, while not meeting trajectory, has been of an improving nature compared to last year. Colorectal has been impacted by challenged endoscopy performance and clinical team sickness. Endoscopy performance is recovering following a targeted NHSE-supported improvement programme addressing workforce, booking and capacity issues, however the long-term sickness in Colorectal, is impacting the wait to first seen, at the very start of the pathway.

3.6.2 31-day Referral to Treatment (combined)

31-day performance, has hit the trajectory for the first two months of the year, but missed it for June, July and August.

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	95.07%	94.55%	91.36%	90.09%	89.45%							
	variance	1.03%	0.48%	-3.16%	-3.10%	-5.14%							

Cancer Site	Apr-2026	May-2026	Jun-2026	Jul-2026	Aug-2026
Brain	100.00%	100.00%	100.00%	100.00%	
Breast	97.22%	96.72%	91.55%	94.94%	96.23%
Colorectal	80.00%	71.43%	80.65%	72.41%	86.36%
CUP			100.00%		
Gynaecology	90.00%	75.00%	66.67%	88.89%	100.00%
Haematology	100.00%	87.50%	100.00%	90.00%	100.00%
Head and Neck	100.00%	0.00%	100.00%	100.00%	100.00%
Lung	100.00%	100.00%	100.00%	90.91%	92.31%
Other Paediatric Sarcoma			100.00%		
Skin	95.00%	95.00%	93.62%	86.11%	75.38%
Upper GI	92.86%	90.00%	81.82%	100.00%	88.89%
Urology	93.88%	91.67%	95.56%	93.94%	100.00%

3.6.3 62-day Referral to Treatment (combined)

Performance of the 62-day combined standard did not achieve the trajectory for any month this year. 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.

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%	63.10%	70.45%	61.51%	74.58%							
	variance	-8.39%	-16.90%	-9.69%	-18.35%	-5.83%							

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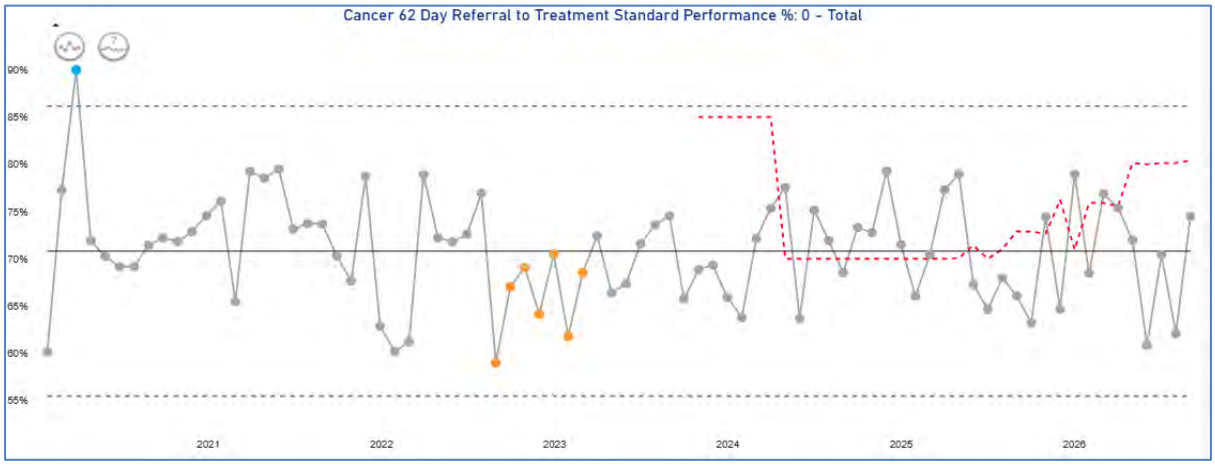
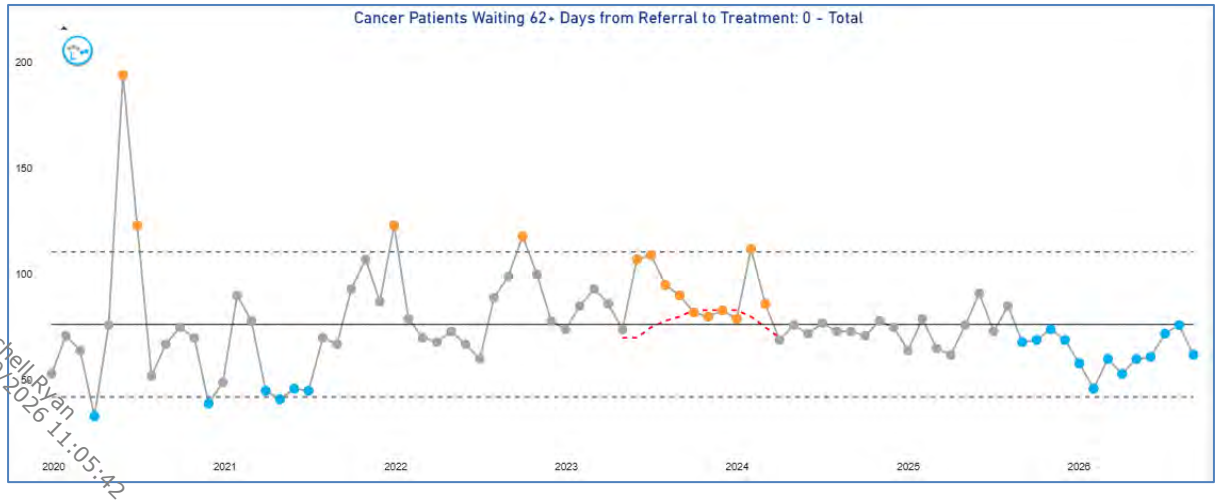


Cancer Site	Apr-2026	May-2026	Jun-2026	Jul-2026	Aug-2026
Brain	66.67%		100.00%	100.00%	
Breast	83.33%	45.65%	80.00%	60.66%	60.98%
Colorectal	50.00%	46.67%	58.06%	42.31%	41.67%
CUP			75.00%		
Gynaecology	46.15%	22.22%	85.71%	37.50%	0.00%
Haematology	64.71%	60.00%	87.50%	66.67%	66.67%
Head and Neck	37.50%	50.00%	40.00%	14.29%	71.43%
Lung	70.37%	26.32%	52.63%	64.00%	67.86%
Other Paediatric Sarcoma			100.00%		
Skin	100.00%	92.59%	92.68%	97.96%	95.56%
Upper GI	65.38%	88.89%	57.89%	66.67%	80.00%
Urology	62.69%	53.73%	59.38%	46.81%	78.38%

The backlog (the number of patients waiting over 62 days) remains materially lower than last year and is being actively managed through clinical prioritisation. The backlog position has reduced in August.

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.



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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 comms for all non-cancers and where suitable and with clinical approve, introduce admin 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)
- 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

Since submitting this plan, the colorectal sickness has worsened, and a revised trajectory was presented to the Operational Recovery Group on the 22nd of September. This modelled the impact of a colorectal locum starting in September.

The revised trajectory is set out below:

		Revised Recovery forecast cancer						
Metric	Ops plan 26/27	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Cancer: 28 days FDS	Recovery plan	71.72%	74.68%	77.51%	80.08%	79.70%	80.06%	80.03%
	actual							
	MTP plan	80.04%	80.03%	80.01%	80.08%	79.97%	80.06%	80.03%
	variance ro recovery							
Cancer: 31 day DTT (combined)	Recovery plan	90.32%	90.17%	92.54%	93.60%	92.70%	93.40%	94.00%
	actual							
	MTP plan	94.20%	94.41%	94.24%	94.66%	94.63%	94.07%	95.68%
	variance ro recovery							
Cancer: 62 RTT (combined)	Recovery plan	67.54%	69.87%	71.24%	72.40%	73.26%	77.54%	80.65%
	actual							
	MTP plan	80.43%	80.12%	80.58%	80.15%	80.54%	80.45%	80.65%
	variance ro recovery							

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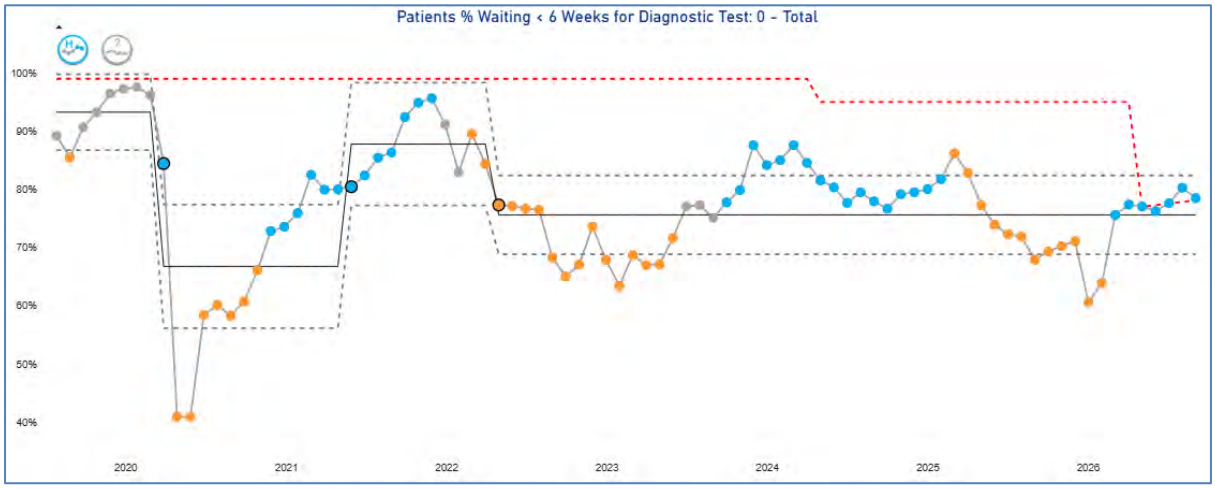
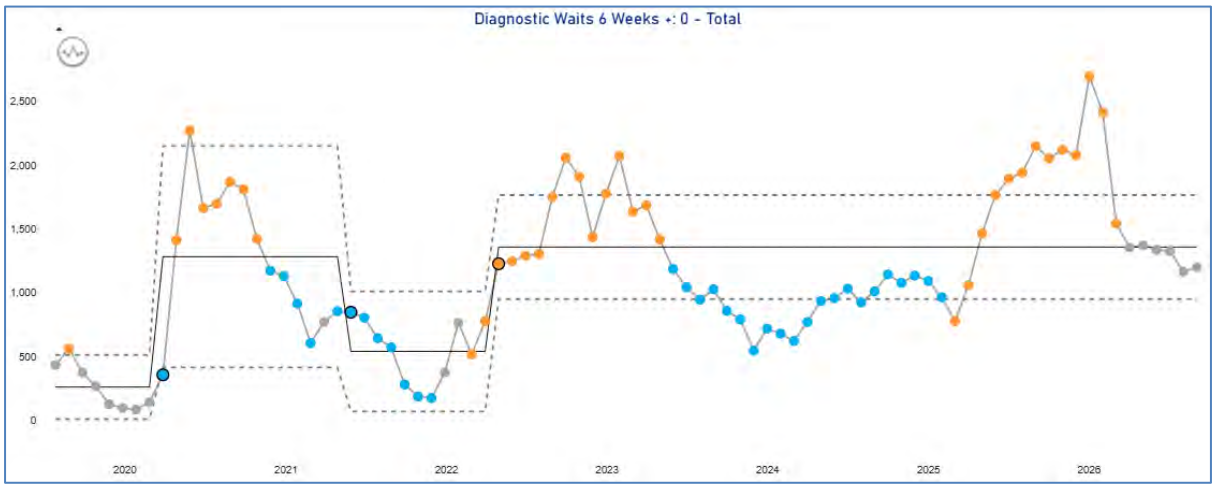
3.7 Diagnostic waiting times

The trust has met the diagnostic performance trajectory for 4 out of 5 months. This is the original operating plan trajectory.

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%	80.26%	78.50%							
	variance	0.02%	-1.06%	0.06%	2.44%	0.42%							

The backlog and total waiting list size has reduced, giving a sustainable performance improvement.





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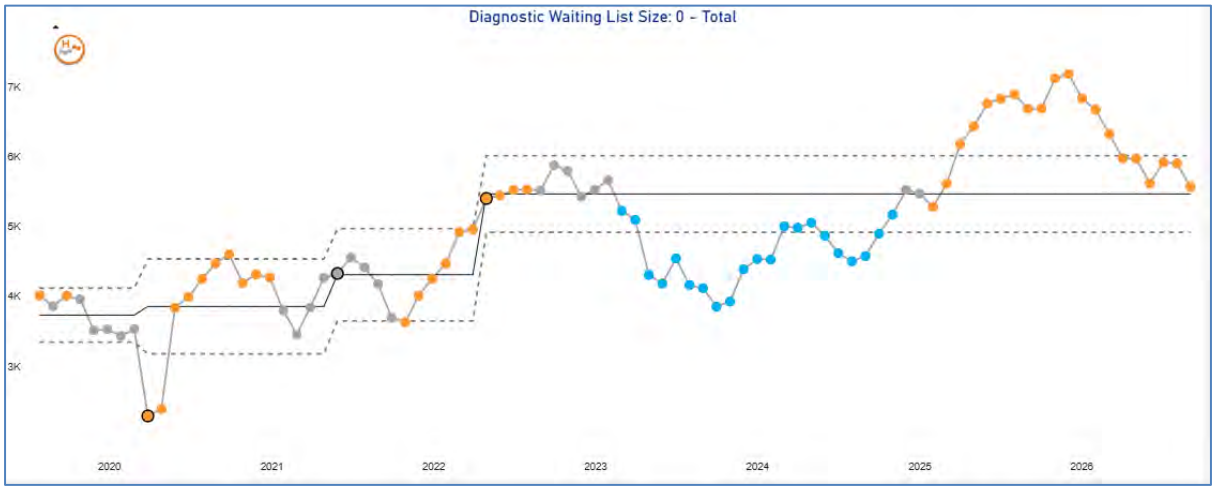

Performance by modality

Procedure	April - 2026	May - 2026	June - 2026	July - 2026	August - 2026
Cardiology	67.5%	61.0%	54.2%	55.6%	50.0%
Colonoscopy	54.5%	61.5%	65.6%	67.6%	64.5%
Computed Tomography (Imaging)	98.3%	96.4%	95.6%	93.6%	92.4%
Cystoscopy	66.5%	66.0%	65.0%	64.2%	70.3%
Dexa Scan	87.8%	80.7%	84.2%	79.5%	67.7%
Flexi Sigmoidoscopy	65.3%	60.3%	84.7%	71.3%	69.9%
Gastroscopy	48.7%	58.9%	64.7%	81.8%	73.7%
Magnetic Resonance Imaging (Imaging)	97.6%	94.0%	97.3%	98.1%	97.4%
Neurophysiology	78.3%	81.1%	87.3%	84.4%	77.0%
Non-Obstetric Ultrasound (Imaging)	98.8%	99.2%	98.9%	99.0%	99.1%
Sleep Studies	91.1%	92.1%	86.4%	91.7%	100.0%
Urodynamics Gynacology	66.7%	50.0%	75.0%	40.0%	62.5%
Urodynamics Urology	61.5%	44.4%	50.0%	45.5%	76.5%
Total	77.0%	76.2%	77.6%	80.3%	78.5%

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.

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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.

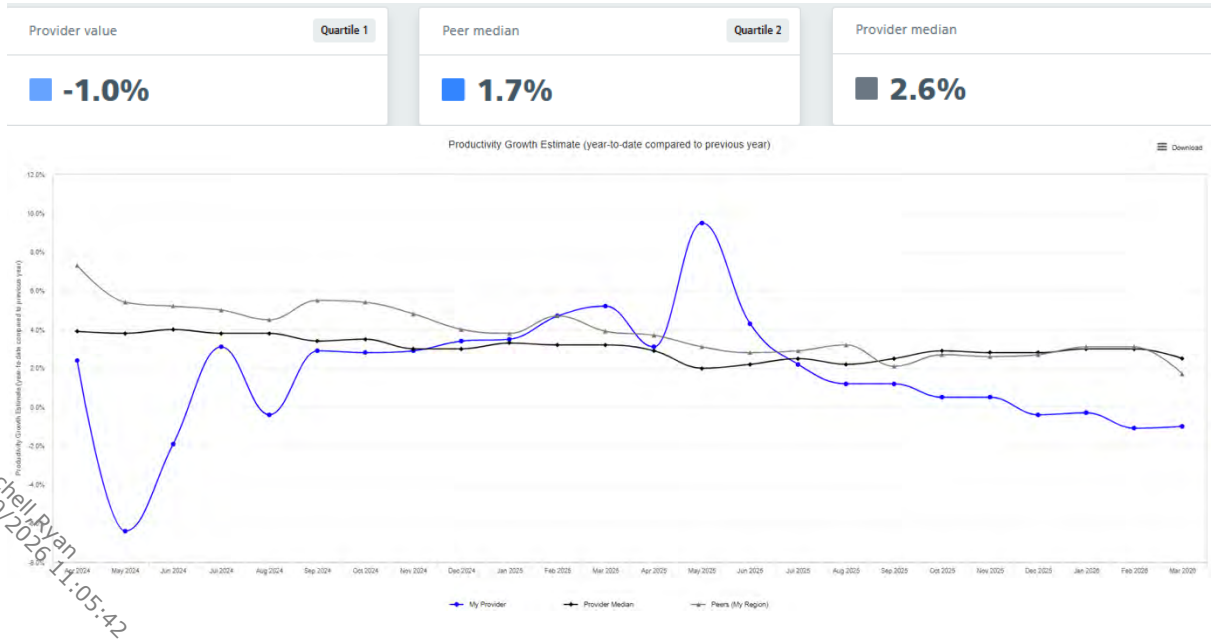
Model Health (formerly Model Hospital) has published a suite of productivity metrics at the trust level, enabling benchmarking across providers. These metrics are used to drive improvement by comparing performance against regional, national, and local peers. This report includes those metrics and highlights how DCH compares across these benchmarks.

4.1 Headline metric- Implied Productivity Growth (year-to-date compared to last year). Latest data March 2026 (not updated on Model Hospital since last report)

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.



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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 (not updated on Model Hospital since last report)

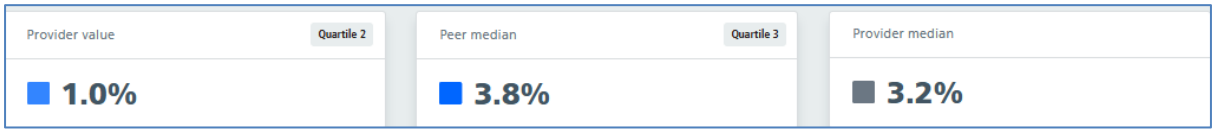
As a core headline metric, improving this value means outputs (cost-weighted activity) relative to inputs (workforce) are improving resulting in an improvement in Implied Workforce Productivity.

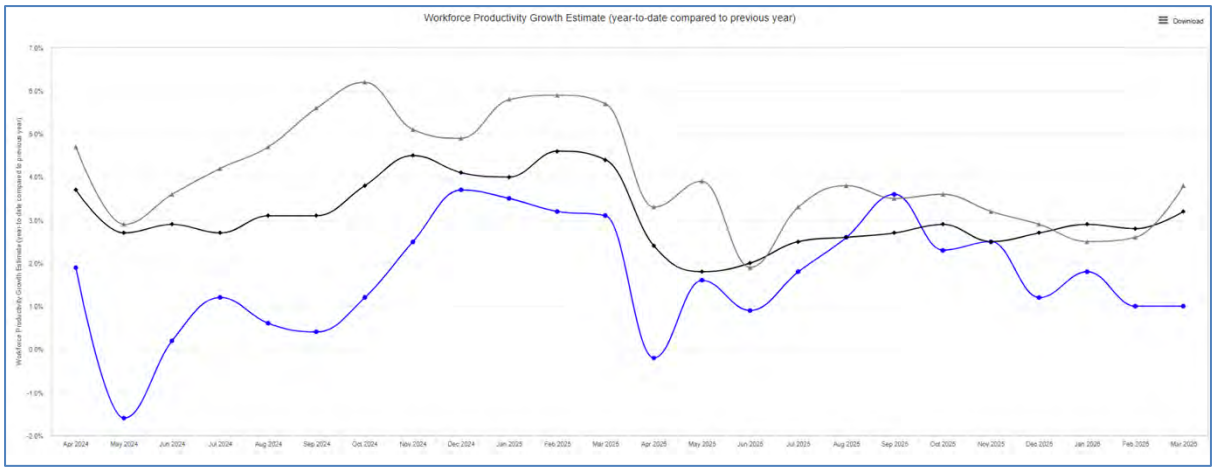
Implied Workforce Productivity Growth of acute and specialist trusts is calculated by comparing output growth (cost-weighted activity) to input growth (workforce) against a baseline period. The measure examines the current year's YTD activity and costs to the same period in the previous financial year.

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 (not updated on Model Hospital since last report)

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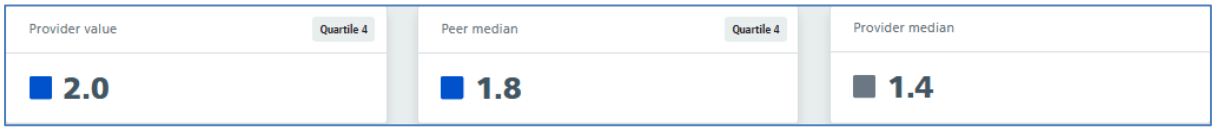
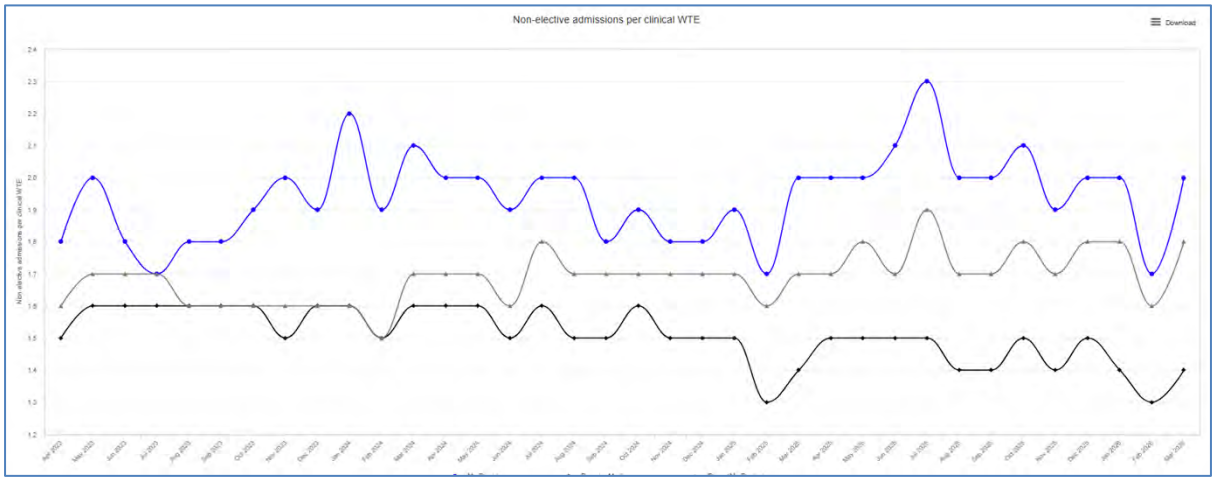
Increasing this value means outputs (non-elective admissions) relative to inputs (clinical WTEs) are improving and more non-elective admissions are being treated per clinical WTEs.

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.





4.5 Elective admissions per clinical WTE. Latest data March 2026 (not updated on Model Hospital since last report)

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.

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DCH has a higher number of elective admissions, per clinical WTE compared to the national provider and regional median.

4.6 Outpatient attendances per consultant WTE. Latest data March 2026 (not updated on Model Hospital since last report)

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.

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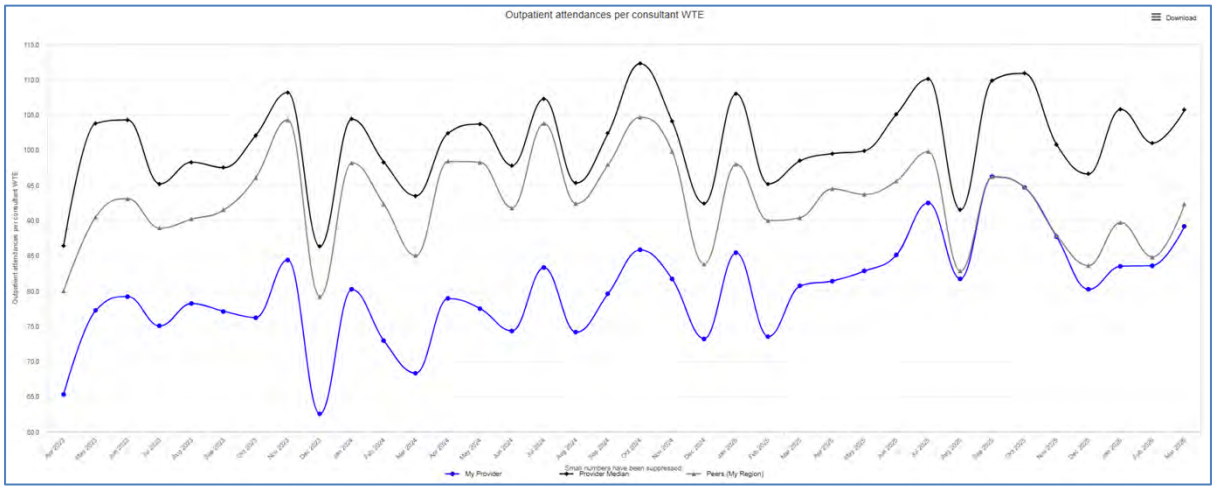
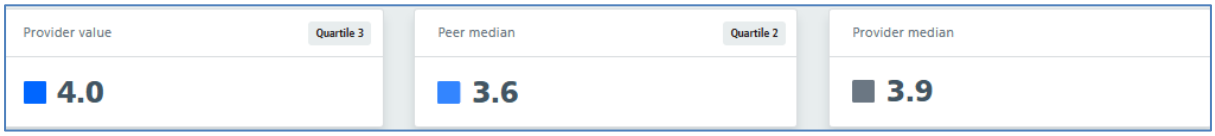
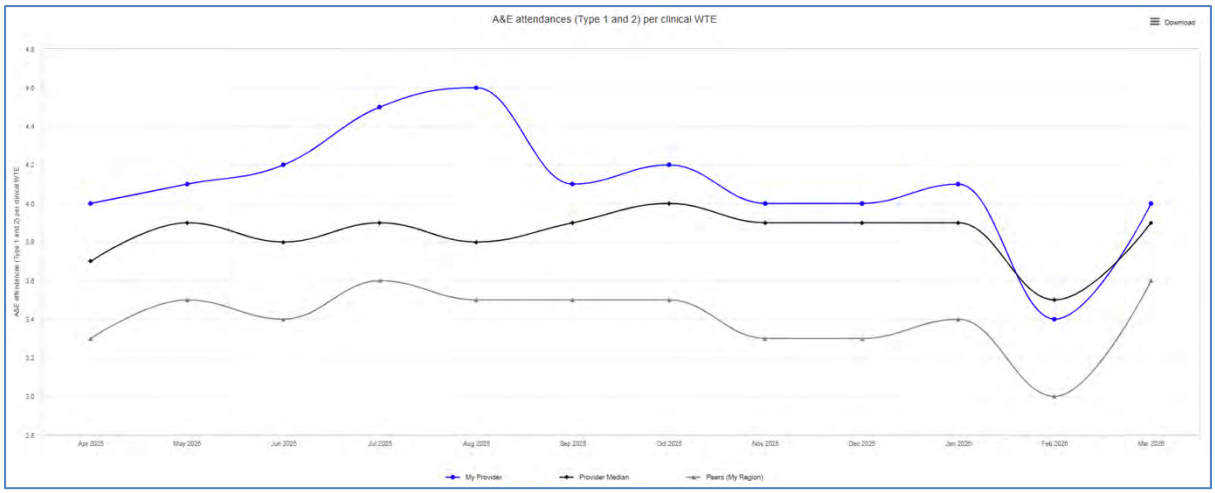


4.7 A&E attendances (Type 1 and 2) per clinical WTE. Latest data March 2026 (not updated on Model Hospital since last report)

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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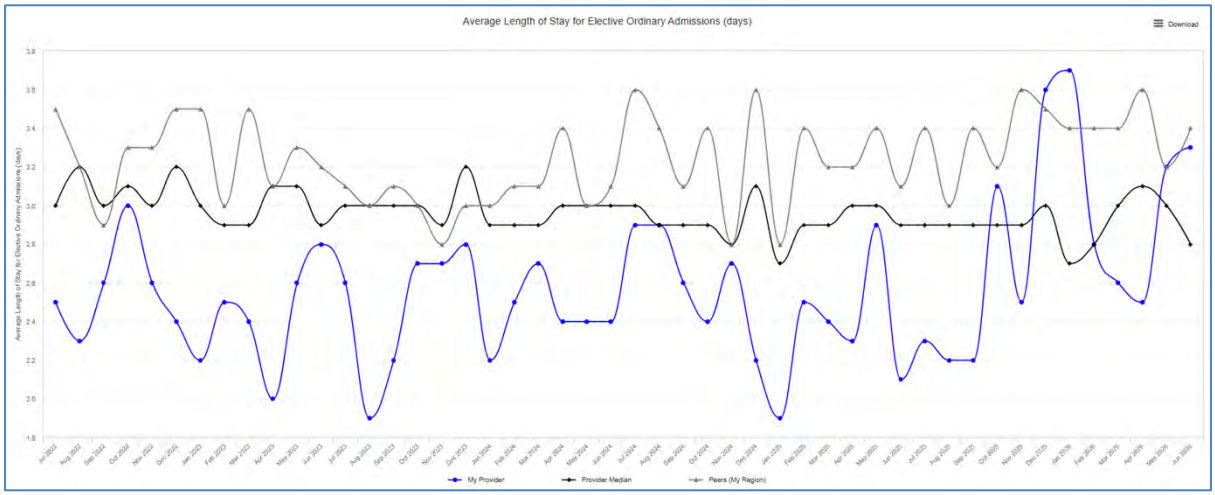
4.8 Average LOS for elective admissions (excluding day cases). Latest data June 2026

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 historically performs well for elective length of stay, but has seen higher than normal fluctuation which is under investigation.

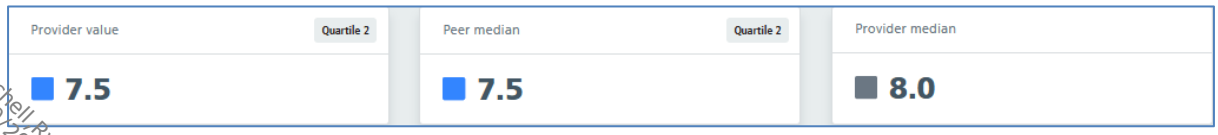


4.9 Average length of stay (days) of emergency admissions, excluding admissions with a length of stay of 0 or 1 day. Latest data June 2026.

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, which is better than the national median.



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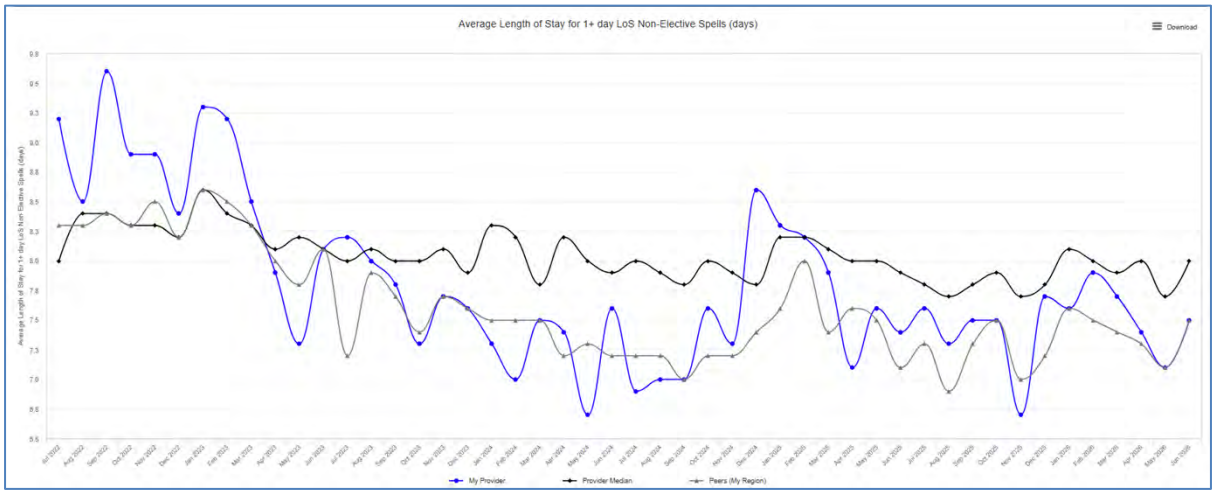
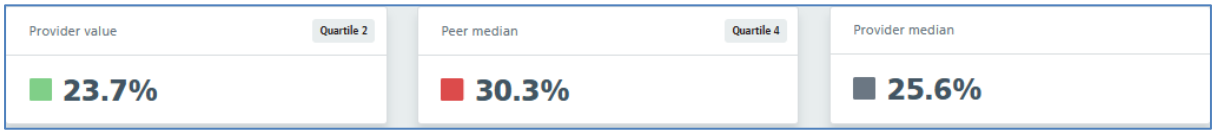
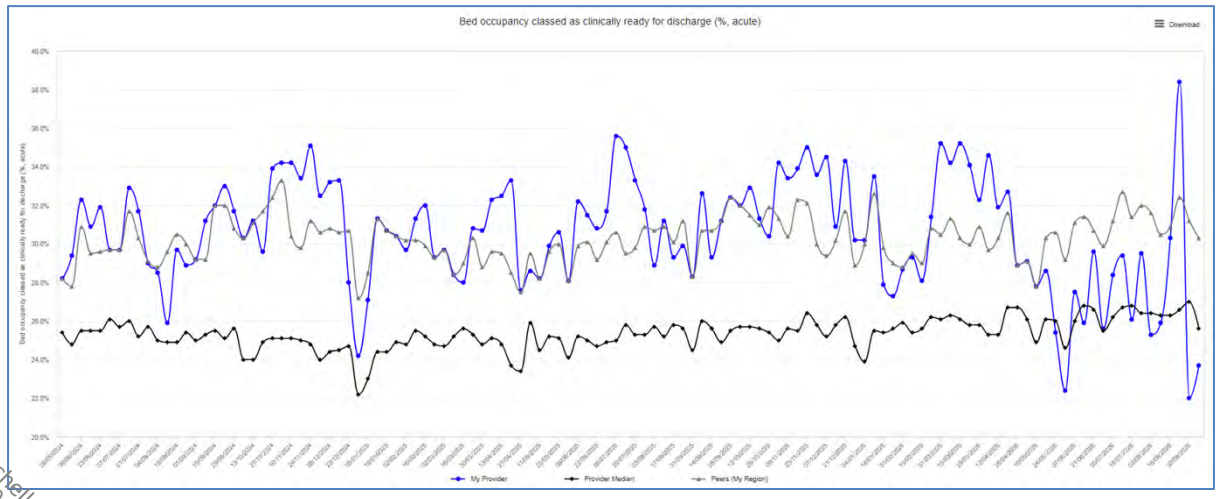


4.10 Bed occupancy classed as clinically ready for discharge (%, acute). Latest data week ending 06/09/26

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 and the National median for the latest weekly reporting.





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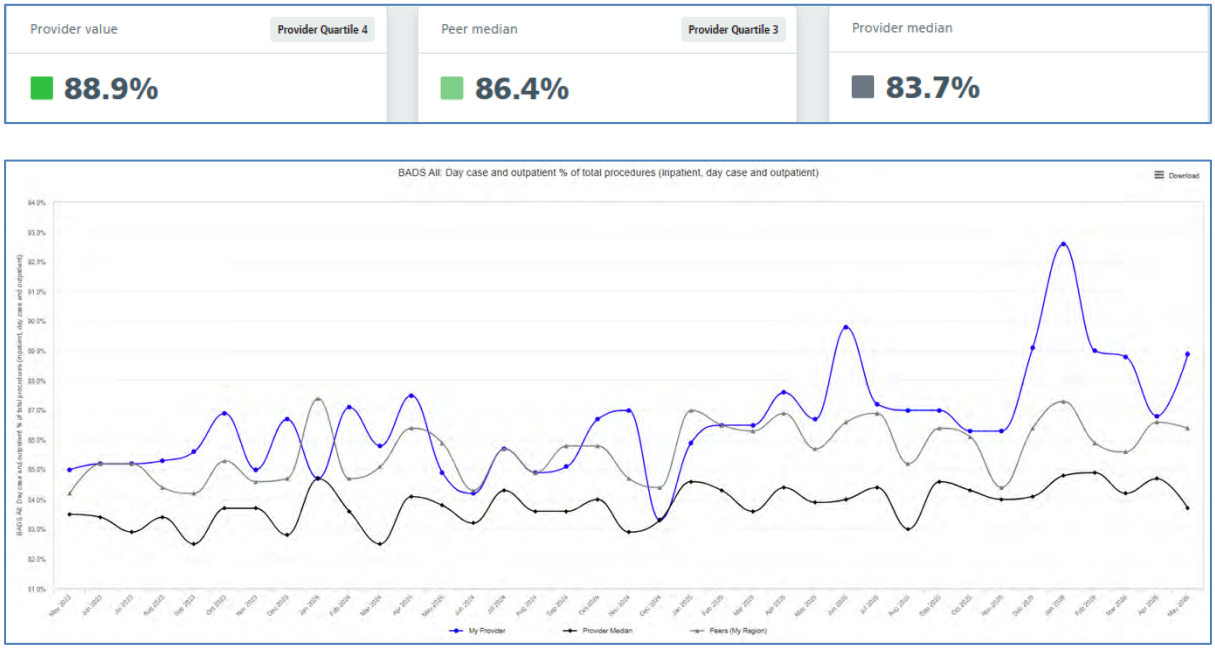
4.11 BADS All: Day case and outpatient % of total procedures (inpatient, day case and outpatient) (3mths to period end) Latest data May 2026

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 (DCH)	
Date of Meeting	13 October 2026	
Report Title	DCH Finance Report – Month 5 2026/27	
Prepared By	Claire Abraham, Deputy CFO DCH	
Accountable Executive	Chris Hearn, Chief Finance Officer	
Previously Considered By	Finance & Performance Committee in Common 30/09/2026	
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	SR6 Finance Identify risks and mitigations associated with plan delivery, financial sustainability	
Financial	Value for money and financial sustainability	
Statutory & Regulatory	Monitoring, active intervention to deliver operational plan	
Equality, Diversity & Inclusion	n/a	
Co-production & Partnership	Federation working and organisational financial plan delivery	

Executive Summary

Dorset County Hospital NHS Foundation Trust (DCHFT) submitted a break even plan to NHS England (NHSE) on 18th April 2026 for the financial year 2026/27, noting the inclusion of £2.6 million Deficit Support Funding to reach balance.

Key Messages
Month five delivered a deficit of £4.7 million after technical adjustments, being £0.2 million away from the planned deficit of £4.5 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 stand at £1.8 million away from plan YTD. Whilst over plan, this plan reflects national expected reduced expectation of 30% reductions in temporary workforce spend. Actual in month performance demonstrates a slight improved run rate from prior months although are reflective of pressures described in both performance and finance report details. Month five Off framework usage of £0.1 million has been incurred noting break glass limited usage in place, and the YTD position now totaling £0.5 million. Actions linked to performance recovery are detailed in relevant reports.

Bank remains a challenged area with increased usage noting in year performance challenges and plan caveat as mentioned above. In month run rates have remained consistent however month five has shown reductions in spend. 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, with delays to substantive recruitment expected to curb the usage of temporary workforce in the coming months.

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Efficiency delivery for the year is £23.3m at 6.5%, with in month delivery of £0.8 million against a plan of £0.9 million being £0.099 million behind plan in month however over plan YTD by £0.010 million with

£3.7 million delivered. 43.1% of operational targets have been delivered recurrently (2.6 million) however all of central schemes have delivered non recurrently, 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 five, the Trust has 14% unidentified (£3.4m) and 15% 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 for oversight.

Cash is currently ahead of plan due to impact of timing of working capital and receipt of income in advance. There still remains 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 £7.8 million behind plan year to date largely due to impact of internally funded schemes and donated schemes behind plan (£2.9m) and timing of New Hospital Programme (NHP) works behind plan (£4.3m).

Key Actions
There are a number of challenged performance areas which have significant focus and active mitigations in place noting requirement and expectation 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 schemes in addition to the impact of operational pressures and recovery. Further focused work around pay variance control, in particular agency and bank expenditure, unavailability levels is 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 senior leadership teams has clear focus and oversight in these areas, with active engagement from all areas in place, however noting the risk that remains to close the unidentified gap and de-risk plans at pace, further mitigations are being developed, as shared with Trust Board.

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:

1) Note the month five financial position for the financial year 2026/27.
2) Receive the report for assurance.

Stephen Ryan
09/12/2026 11:05:42

NHS
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Financial Position Update 2026/27

August 2026 - Month 5

Chris Hearn
Chief Financial Officer

Healthier lives Empowered citizens Thriving communities

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Financial Position Update August 2026 - Month 5

Executive Summary

A summary of progress for August 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 August 2026, Dorset County Hospital NHS Foundation Trust (DCH) has delivered a £4.743 million deficit after technical adjustments, an adverse performance against planned levels (£4.533 million deficit) of £0.209 million. This variance is the direct result of costs incurred supporting Industrial Action in month 1, at this stage funding has not been confirmed to support the spend impact and mitigations have yet be identified to date. The position also includes £0.287m 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 £0.898 million efficiency target for month 5, which was underachieved by £0.099 million due to timing of scheme delivery however as the result of prior months, delivery still results in a YTD position ahead of plan by £0.01 million of the £3.724 million planned target. Savings were mainly the result of efficiencies in pay slippage, Bank Interest and biosimilar drugs savings with further traction needed to progress identified efficiency schemes. The total efficiency plan for the year is £23.3 million and 14% of this remains unidentified and a further 15% 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 M5 is £0.3m away from planned levels and £1.8m adverse YTD, run rate in month 5 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, identified operational pressures, sickness, heatwaves and meningitis support are driving high use. 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 £0.6m in Month 5, £3.3m 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 with delays to substantive recruitment plans. Reduction in agency and bank expenditure includes 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 NHSE Workforce Oversight Meetings (WOM) in place and oversight internally by FRB.

Elements of Non Pay are overspending at M5 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 M5, although mitigated by increases in out of contract income.

The Trust is progressing with the capital programme for 2026/27 with month 5 YTD spend totalling £13.7 million, which is behind plan by £7.8 million. Externally funded projects are £4.3 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 £3.5 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.

The cash position at the end of August was £27.9 million, which is £4.2 million above the adjusted plan. This favourable variance primarily reflects the impact of working capital timing differences, including the scheduling of payments and the receipt of income in advance. The latter contributed a benefit of £1.1 million from HEE income and £1.6 million from Deficit Support Funding. Depreciation Funding from Dorset ICB for the first four months of 2026/27 is still owed to the Trust. Discussions are underway to facilitate the prompt receipt of this funding.

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Financial Position Update August 2026 - Month 5

Key Risks

Dorset County Hospital NHS Foundation Trust

Operational Recovery
Recovery of operational underperformance against key operational targets remains a significant focus for the Trust. Detailed modelling and action plans have been developed with discussions continuing in partnership with the Commissioner regarding supporting recovery of activity and focus to deliver RTT targets. The Trust's response to addressing recovery is being discussed with NHSE at a Board to Board meeting with Regional NHSE colleagues early October, with detailed updates presented to September Trust Board.

Efficiency Delivery Risk
Forecast delivery is currently highlighted as a risk, noting unidentified and high risk schemes which remain at M5. 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. The Trust continues to deploy targeted support towards this achievement with a substantive Improvement Director across the Federation starting October, and the CEO chaired Financial Recovery Board (FRB), supported by the wider Executive team and senior leads 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 impacting 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, with work underway to appropriately assess scheme viability for 2027/28.
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 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.

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Financial Position Update August 2026 - Month 5

Key Risks

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.

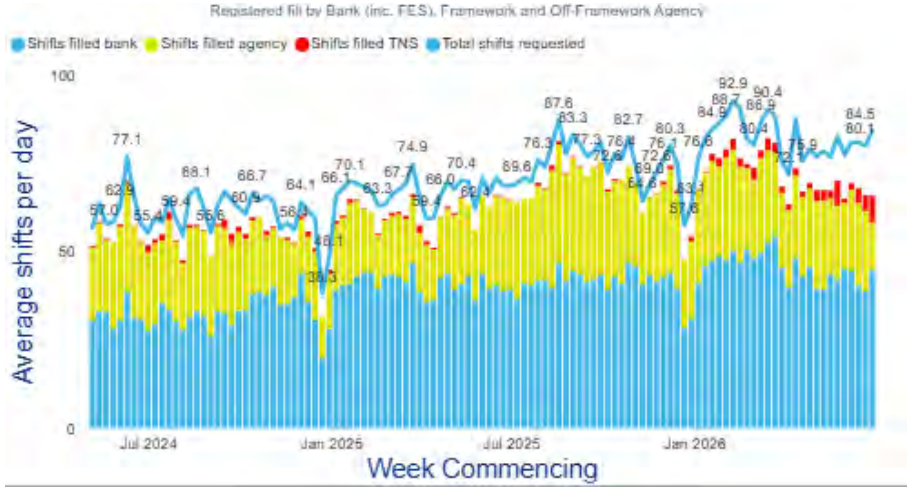
At Month 5, agency expenditure finished £0.3m overspent (£0.6m actual vs £0.3m plan), and YTD of £3.0m spend against a plan of £1.2m. The overspend is primarily driven by Nursing (£1.6m adverse YTD) and Medical (£0.02m adverse), partially offset by favourable positions within Other Clinical and Admin & 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 5, off-framework agency is being increasingly utilised across ED, Purbeck and SCBU with a YTD spend of £520k. 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 5 finished £0.6m overspent (£1.3m actual vs £0.7m plan). The overspend is largely driven by Nursing (£1.6m adverse) and Medical (£1.1m adverse), with further pressure across Admin & Clerical (£0.5m adverse) and Other Clinical (£0.07m 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 7% 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 5 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.

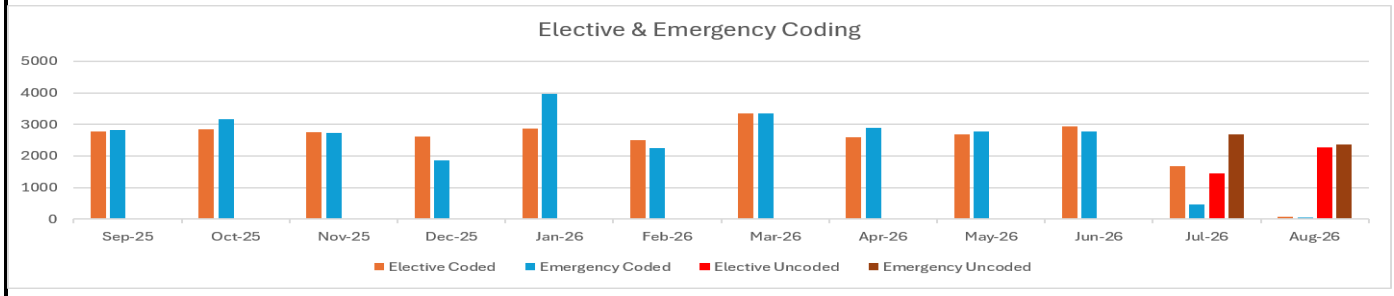
The fixed element of the contract will be agreed between NHS providers and commissioners for the provision of specified services, this will be paid on a block basis across the year regardless of activity delivery. The fixed element of the contract will pay for any activity not covered under the variable 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 3,710 uncoded elective spells & 5,062 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 levels of uncoded activity which risks income being under reported and the ICB clawing back income, with recruitment issues in train to help resolve.



Month	Flex	Freeze
Apr-26	20/05/2026	17/06/2026
May-26	17/06/2026	17/07/2026
Jun-26	17/07/2026	19/08/2026
Jul-26	19/08/2026	17/09/2026
Aug-26	17/09/2026	19/10/2026
Sep-26	19/10/2026	18/11/2026
Oct-26	18/11/2026	16/12/2026
Nov-26	16/12/2026	20/01/2026
Dec-26	20/01/2027	17/02/2027
Jan-27	17/02/2027	17/03/2027
Feb-27	17/03/2027	19/04/2027
Mar-27	19/04/2027	20/05/2027

Key Risk Status
Red - Significant risk of non-delivery. Additional actions need to be identified urgently.
Amber - Medium risk of non-delivery which requires additional management effort to ensure success
Green -. Low risk of non-delivery – current actions should deliver.

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Healthier lives Empowered citizens Thriving communities

Financial Position Update August 2026 - Month 5
Income & Expenditure

Dorset County Hospital NHS Foundation Trust

Income and Expenditure

The overall revenue position of the Trust at Month 5 is a deficit of £4.7 million, which is £0.209 million adverse to a plan of £4.58 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 £1.8 million overspent (£3.0m actual vs £1.2m plan) and Bank expenditure £3.3 million overspent (£6.7m actual vs £3.4m 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	26,744	28,194	1,450	136,632	140,500	3,868
Other operating income	2,234	2,663	429	12,334	12,381	47
Employee expenses:	0	0	0	0	0	0
- Substantive	(18,007)	(17,441)	566	(91,340)	(87,442)	3,898
- Bank	(685)	(1,301)	(616)	(3,444)	(6,733)	(3,289)
- Agency	(261)	(576)	(315)	(1,167)	(2,957)	(1,790)
Operating expenses excluding employee expenses	(10,367)	(11,977)	(1,610)	(55,360)	(58,677)	(3,317)
OPERATING SURPLUS/(DEFICIT)	**(342)**	**(438)**	**(96)**	**(2,345)**	**(2,928)**	**(583)**
FINANCE COSTS						
Finance income	91	129	38	453	602	149
Finance expense	(60)	(58)	2	(301)	(304)	(3)
PDC dividend expense	(460)	(461)	(1)	(2,302)	(2,302)	(0)
NET FINANCE COSTS	**(430)**	**(390)**	**40**	**(2,150)**	**(2,004)**	**146**
Other gains/(losses) including disposal of assets	0	16	16	0	16	16
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 liabili	0	0	0	0	0	0
Corporation tax expense	(2)	0	2	(12)	0	12
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(774)**	**(812)**	**(38)**	**(4,506)**	**(4,916)**	**(409)**

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	(774)	(812)	(38)	(4,506)	(4,916)	(409)
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	**(774)**	**(812)**	**(38)**	**(4,506)**	**(4,916)**	**(409)**
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	(27)	173	200
Adjusted financial performance surplus/(deficit) including PSF as per a	**(779)**	**(777)**	**2**	**(4,533)**	**(4,743)**	**(209)**
Adjusted financial performance surplus/(deficit)	**(779)**	**(777)**	**2**	**(4,533)**	**(4,743)**	**(209)**

Setchell,Ryan
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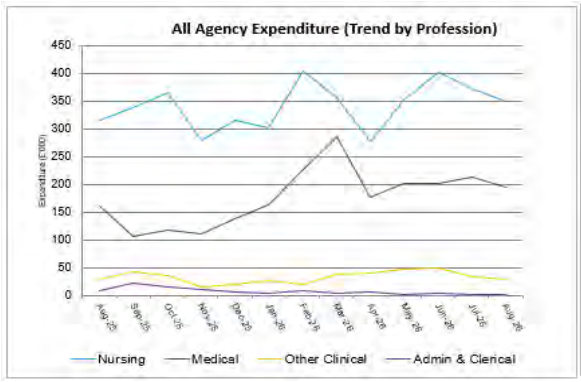
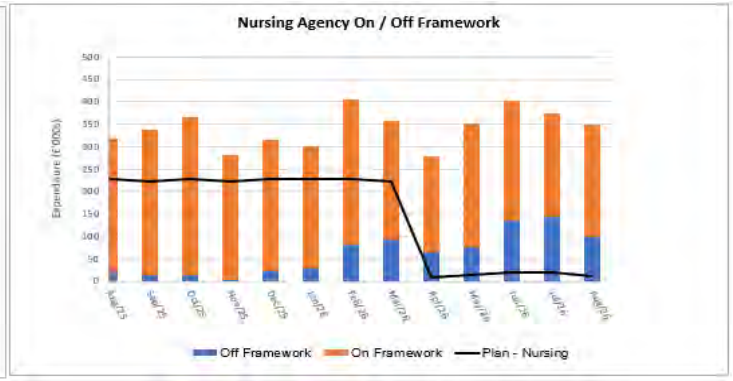
Financial Position Update August 2026 - Month 5
Trust Wide Performance: Agency

Pay Analysis - Agency
Agency costs in month 5 were £0.577 million against a plan of £0.261 million. This is a deterioration of £0.6m against spend in August last year (£513k) and an improvement against prior months spend by £42k. 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 August of 25/26 by £34k, 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)	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Nursing	317	339	366	280	315	302	406	357	278	353	403	373	351
Medical	161	106	118	111	137	164	227	287	176	203	202	213	196
Other Clinical	28	42	35	15	20	27	20	37	39	47	50	32	29
Admin & Clerical	7	21	16	10	6	3	7	3	6	2	3	1	1
Total	**513**	**508**	**535**	**416**	**478**	**496**	**660**	**684**	**499**	**605**	**658**	**619**	**577**
Plan – Total Agency	*464*	*548*	*500*	*432*	*387*	*426*	*404*	*354*	*259*	*197*	*221*	*229*	*261*
Variance to Plan	**(49)**	**40**	**(35)**	**76**	**(90)**	**(70)**	**(256)**	**(330)**	**(240)**	**(408)**	**(437)**	**(390)**	**(316)**

Nursing Agency Category	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Off Framework	19	15	14	3	22	28	81	92	65	77	135	143	100
On Framework	298	324	352	277	293	274	325	265	213	276	268	230	250
Total	**317**	**339**	**366**	**280**	**315**	**302**	**406**	**357**	**278**	**353**	**403**	**373**	**350**
Plan - Nursing	*227*	*223*	*227*	*223*	*227*	*227*	*227*	*223*	*10*	*15*	*20*	*20*	*11*
Variance to Plan – Nursing	**(90)**	**(116)**	**(139)**	**(57)**	**(88)**	**(75)**	**(179)**	**(134)**	**(268)**	**(338)**	**(383)**	**(353)**	**(339)**

YTD Actual	YTD Plan	Variance
1,758	76	(1,682)
990	968	(22)
197	98	(99)
13	25	12
2,958	**1,167**	**(1,791)**

Pay Metrics	In Month Actual	YTD Actual
Agency expenditure as % of total pay	3.0%	3.0%
Off framework expenditure as % of total agency	17.3%	17.6%

Areas Using Nursing Agency Including Off Framework Y			
Area	**On Framework**	**Off Framework**	**Tot Nurs Ager**
Emergency Dept Main Dept	275	147	
Purbeck Wd	189	92	
Maternity Unit	141	1	
Day Surgery Unit	121	9	
Lulworth Ward	66	53	
Kingfisher Ward	43	50	
Abbotsbury Ward	60	19	
Crcu	1	62	
Moreton Ward - Respiratory	52	1	
Sobu	5	47	
Stroke Unit	48	0	
Ilchester Integrated Assessmen	44	1	
Sdec	14	31	
The Mary Anning Unit	41	2	
Frailty Sdec	38	(0)	
Fortuneswell Ward	37	-	
Ridgeway Wd	21	4	
Prince Of Wales	19	-	
Surge Area	13	1	
Cardiology Care Ward	8	1	
Paediatric Dsu	2	-	
Grand Total	**1,236**	**520**	**1**

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Financial Position Update August 2026 - Month 5
Trust Wide Performance: Bank

NHS
Dorset County Hospital
NHS Foundation Trust

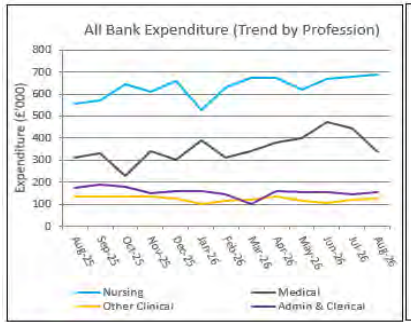
Pay Analysis - Bank

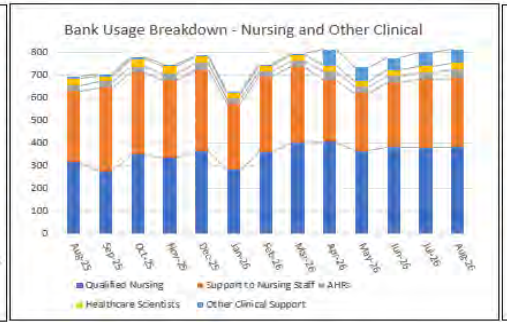
Bank costs in month 5 were £1.301 million against a plan of £0.691 million, higher than the levels seen in 25/26 - in Month 5 in part due to costs incurred supporting Industrial Action, holiday cover, sickness and operational pressures.

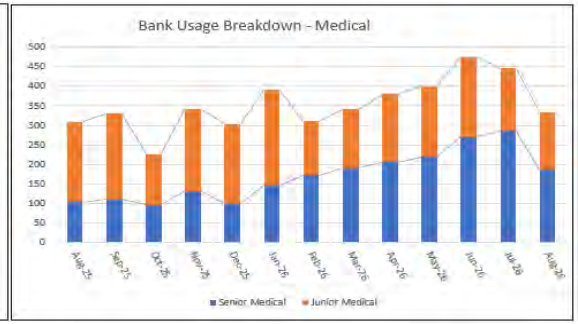
Reduction in bank expenditure is a key focus area nationally, with a minimum of 7.5% bank reduction expected, equating to a cost reduction of c.£1.0m.

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)	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Nursing	556	571	644	609	660	527	631	674	676	619	667	681	687
Medical	309	329	226	342	304	391	311	341	379	400	475	445	334
Other Clinical	137	133	134	137	126	99	114	120	136	114	107	120	125
Admin & Clerical	174	191	177	148	161	158	143	102	160	154	153	146	155
Total	**1,176**	**1,224**	**1,181**	**1,236**	**1,251**	**1,175**	**1,199**	**1,237**	**1,351**	**1,287**	**1,402**	**1,392**	**1,301**

YTD Actual	YTD Current Plan	Variance
3,330	1,718	(1,612)
2,033	931	(1,102)
602	531	(71)
768	265	(503)
6,733	**3,445**	**(3,288)**

Bank Category	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26
Qualified Nursing	315	276	350	334	366	282	360	401	406	366	383	380	382
Support to Nursing Staff	315	368	362	343	357	293	333	336	270	253	284	301	305
AHPs	23	28	24	29	30	22	23	26	39	30	29	30	37
Healthcare Scientists	32	22	34	32	28	23	22	26	27	23	25	27	29
Other Clinical Support	8	9	8	8	5	6	7	5	70	61	53	63	59
Management / Admin	174	191	177	148	161	158	143	102	160	154	153	146	155
Senior Medical	104	111	96	132	100	147	172	191	206	219	270	285	187
Junior Medical	205	219	130	210	204	244	139	150	173	181	205	160	147
Total	**1,176**	**1,224**	**1,181**	**1,236**	**1,251**	**1,175**	**1,199**	**1,237**	**1,351**	**1,287**	**1,402**	**1,392**	**1,301**
Plan	*867*	*855*	*715*	*676*	*702*	*739*	*657*	*857*	*688*	*690*	*689*	*688*	*691*
Variance to Plan	(309)	(369)	(466)	(560)	(549)	(436)	(542)	(380)	(663)	(597)	(713)	(704)	(610)

Pay Metrics	In Month Actual	YTD Actual
Bank expenditure as % of total	6.7%	6.9%

Healthier lives Empowered citizens Thriving communities

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Financial Position Update August 2026 - Month 5
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 14% of this remains unidentified and a further 15% 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 £9.4 million. Focus on scheme assessment and acceleration is in place to de-risk the programme, overseen by FRB, with 4 schemes being worked through at pace to support closing the unidentifed gap.

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	%	NH deter tion deliv
Unidentified	246	2,357	770	**3,373**	14%	0%
Opportunity	1,023	1,234	182	**2,438**	10%	25
Plans in Progress	1,448	5,300	845	**7,593**	33%	50
Fully developed - not yet started	307	1,231	240	**1,778**	8%	75
Fully Developed - in delivery	2,654	4,284	1,227	**8,165**	35%	100
Totals	**5,678**	**14,405**	**3,264**	**23,347**	**100%**	

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 Plan £'000	Actual £'000	d
Core - 5%												
Urgent & Integrated Care	6,349	6,349	-	100.0%	2,309	3,192	848	79.9%	20.1%	1,642	1,234	
Family & Surgical Services	5,938	5,938	-	100.0%	2,620	2,644	675	88.3%	11.7%	648	699	
Corporate & Commercial	229	218	(11)	95.3%	146	72	-	16.9%	83.1%	9	66	
Director of Nursing	126	126	-	100.3%	126	-	-	57.3%	42.7%	-	70	
Finance	372	372	-	100.0%	372	-	-	0.0%	100.0%	235	290	
Estates & Facilities	1,196	1,196	-	100.0%	394	509	293	73.4%	26.6%	330	181	
Digital	776	776	-	100.0%	685	-	91	17.1%	82.9%	55	-	
Operational Support	256	256	-	100.0%	256	-	-	0.0%	100.0%	35	28	
HR & Workforce	383	383	-	100.0%	150	233	-	100.0%	0.0%	63	40	

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Financial Position Update August 2026 - Month 5

Cash

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	26,800	27,949							

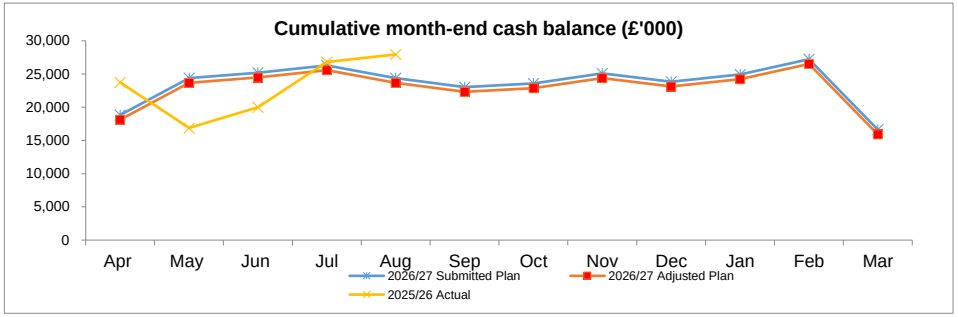
Cash Balance incl Forecast

The cash balance at the end of August was £27.9 million, which is £4.2 million above 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 favourable variance primarily reflects the impact of working capital timing differences, including the scheduling of payments and the receipt of income in advance. The latter contributed a benefit of £1.1 million from HEE income and £1.6 million from Deficit Support Funding. Depreciation Funding from Dorset ICB for the first five months of 2026/27 is still owed to the Trust. 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 heading into 2026/27 as a result of planned deficits at the beginning of the year and a challenging efficiency 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	M4 Actual	YTD Actual
Current Ratio (Net Current Assets / Current Liabilities)	Above 1	1.07	1.03	0.98
Quick Ratio (As above excluding Inventories from current assets)	Above 1	0.94	0.93	0.89
Creditor Days (Average days to pay creditors)	30-60	159	146	162
Debtor Days (Average days to receive payment for debtor invoices)	Below 30	23	29	28
Inventory Holding Days (Average days inventory is held)	Below 30	40	35	31

Both the current and quick ratios have reduced since last month, due to an increase in creditors whilst receivables balances remain broadly unchanged during the month. Creditor days increased from 146 to 162 during the month and remain substantially above the target level. The metric continues to be influenced by historic long-term NHS creditor balances, resulting in an elevated overall creditor days position, the monthly increase is attributable to growth in non-NHS creditor balances. Debtor days have decreased from 29 to 28 in month which reflects a slight increase in payment of invoices. Inventory holding days increased from 35 days to 31 in month reflecting decreased stock holdings.

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Financial Position Update August 2026 - Month 5

Capital

Capital Programme Narrative
Capital expenditure year to date to the end of August was £13.7 million, which is behind plan by £7.8 million.
Internally Funded Internally Funded schemes are behind plan at the end of August by £2.9 million.
Medical Equipment Schemes are behind plan for August due to the timing of expenditure associated with the replacement of theatre tables, ultrasound machines, phototherapy units along with the installation of X-Ray Room 1.
Estates schemes are behind plan due to expenditure on sterilisers, fire compliance, electrical replacement and the generator, which continues to remain behind plan year-to-date.
Digital Schemes are behind plan for August due to VM Hardware replacement, which was purchased at the end of 2025/26. This has been used to partially 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.
Leased expenditure is behind plan due to the lease re-measurement of the multi-storey car park and CEF scheme being lower than anticipated.
Internal Funding - Additional The disposed of Vespasian House right-of use asset earlier in the year and this provided additional capital funding of £0.1 million to the Trust
Externally Funded Externally funded capital expenditure was £4.3 million behind plan, primarily due to the timing of expenditure on the New Hospital Programme (NHP) and Acute Assessment Unit Development scheme.
2026/27 Capital Plan – 5% Over-Programming

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	311	-111	1,000	309	691	2,400	2,400	2,400	-
Estates Schemes	248	182	66	1,240	613	627	1,589	2,934	2,830	-104
Digital Services										
EHR Matched Funding	285	31	254	1,425	1,782	-357	2,071	3,423	3,423	-
IT Schemes	111	100	11	1,330	648	682	1,451	2,259	2,259	-
Equipment										
CT Scanner (2nd Machine)	-	-	-	-	-	-	-	1,800	1,800	-
Other Equipment	90	8	82	1,710	611	1,099	986	2,650	2,650	-
Sub-Total Internally Funded Expenditure	**934**	**633**	**301**	**6,705**	**3,964**	**2,741**	**8,497**	**15,466**	**15,362**	**-104**
Donated										
Other Donations	40	-	40	200	-	200	34	480	480	-
Sub-Total Planned Donated Expenditure	**40**	**-**	**40**	**200**	**-**	**200**	**34**	**480**	**480**	**-**
IFRS 16 Lease Additions										
MSCP Lease remeasurement	-	-	-	500	264	236	264	500	500	-
CEF Lease remeasurement	400	41	359	400	41	359	41	400	400	-
Accommodation & Vehicle Lease Remeasurements	-	-	-	-	-	-	50	50	50	-
Sub-Total Planned IFRS 16 Expenditure	**400**	**41**	**359**	**900**	**305**	**595**	**355**	**950**	**950**	**-**
Total Internal & Leased Capital Expenditure	**1,374**	**674**	**700**	**7,805**	**4,269**	**3,536**	**8,886**	**16,896**	**16,792**	**-104**
Additional funded schemes										
NHP Works	3,000	2,739	261	13,000	9,038	3,962	42,118	42,118	42,118	-
CIR Funding - Generator	90	266	-176	370	317	53	1,000	1,000	1,000	-
CIR Funding - Fire	30	-	30	90	-	90	-	360	360	-
Acute Assessment Unit Development	150	-	150	300	-	300	-	300	300	-
ED Diagnostic Equipment	-	5	-5	-	95	-95	360	750	750	-
ENT Stacks	-	-	-	-	-	-	-	200	200	-
MH suite fit out (Dorchester)	-	-	-	-	-	-	-	256	256	-
Total Externally Funded Capital Expenditure	**3,270**	**3,010**	**260**	**13,760**	**9,450**	**4,310**	**43,478**	**44,984**	**44,984**	**-**
Total Capital Expenditure	**4,644**	**3,684**	**960**	**21,565**	**13,719**	**7,846**	**52,364**	**61,880**	**61,776**	**-104**
								Additional Internal Capital Funding:		**104**
									Total Variance	**-**
Expenditure as a % of Plan			79%			64%				0%

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09/10/2026 11:05:42

Report to	Board of Directors in Common	
Date of Meeting	13 October 2026	
Report Title	EPRR Annual Core Standards Assurance Self-Assessment Report September 2026	
Prepared By	Sandra Hodgkyns Head of Emergency Planning / Deputy AEO	
Approved by Accountable Executive	Rachel Small Chief Operating Officer and Accountable Emergency Officer (AEO)	
Previously Considered By	Finance and Performance Committee in Common 30/09/26	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

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

Executive Summary

The purpose of the report is to provide an update on the outcome of the Trusts self-assessment of NHS England's Emergency Preparedness, Resilience and Response (EPRR) Core Assurance Standards for 2026. This report is submitted following the Head of Emergency Planning Response and Resilience (EPRR) and Accountable Emergency Officer (AEO) annual self-assessment of the Trusts positions against NHS England's EPRR Core Assurance Standards 2026, prior to review, confirm and challenge process by NHS Dorset. This is provided as a review of the self-assessment only.

All NHS-funded organisations must meet the requirements of:

- the Civil Contingencies Act 2004,
- the NHS Act 2006,
- the Health and Care Act 2022,
- the NHS standard contract,
- the NHS Core Standards for EPRR and;
- NHS England business continuity management framework.

In 2025 the Trust achieved full compliance in the Core Standard Assurance for the fourth year consecutively.

The EPRR team continues to plan, prepare, respond and recover to the ever-changing ways of supporting the Trusts operational delivery of key services whilst dealing with incidents, events or emergencies as and when they arise.

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Following almost 7 months of gathering evidence and completing the self-assessment requirement primary stages, the Head of EPRR and AEO believes that we have met our core standard compliance and are fully compliant again this year (2026) for the fifth consecutive year.

Both the AEO and Head of EPRR/Deputy AEO will meet with NHS Dorset in September for a 'confirm and challenge' meeting. Once this has concluded the outcomes of the assurance will be included in the annual EPRR system assurance summary letter which is submitted to NHS England.

An EPRR annual report will be submitted to the Audit Committee and Trust Board in the early part of 2027, once the outcome summary letter has been provided to the Trust.

Recommendation

Members are requested to:

- Receive the report for assurance

Setchell,Ryan
09/10/2026 11:05:42

Finance and Performance Committee in Common – Self Assessment against EPRR Core Standards 2026

1 Executive Summary

1.1 This report has been prepared to document the self-assessment outcomes of the Trust's Emergency Preparedness Resilience and Response (EPRR) compliance standards, in accordance with NHS England's EPRR Core Assurance Standards.

1.2 All NHS-funded organisations must meet the requirements of

- the Civil Contingencies Act 2004,
- the NHS Act 2006,
- the Health and Care Act 2022,
- the NHS standard contract,
- the NHS Core Standards for EPRR and;
- NHS England business continuity management framework

2 NHS Core Standards

2.1 The annual NHS Core Standards are published annually, normally in early summer in line with the EPRR framework. The standards cover all NHS providers, with most completing approx. 50+ standards.

2.2 As an internal process, the EPRR Team complete their draft core standards along with their essential evidence for presentation to the Trusts Accountable Emergency Officer (AEO) where an internal self-assessment standard is then agreed and confirmed.

2.3 Trusts are required to provide a paper for their Trust Board on the outcome of their Annual EPRR Core Standards Assurance Self – assessment outcome.

2.4 Following the internal self- assessment, a 'confirm and challenge' meeting is arranged with NHS Dorset where the AEO and Head of EPRR, present their submitted evidence for review and if there are any challenges, are able to provide clarity as and where required.

2.4 Both NHS Dorset and NHS England assess and review the evidence submitted against the NHS Core Standards before agreeing and awarding any grading or outcome, which is formally sent to the AEO.

3 Assurances 2026

3.1 The NHS Core Standards set for 2026 has 67 standards. 58 with relevance for Community & Mental Health Trusts contained within. These are sub-divided into 10 key domains:

- Governance (Standards 1 – 6)
- Duty to Risk Assess (NHS Core Standards 7 – 8)
- Duty to Maintain Plans (NHS Core Standards 9 – 19)
- Command and Control (NHS Core Standards 20 - 21)
- Training and Exercising (NHS Core Standards 22 - 25)
- Response (NHS Core Standards 26 – 30)

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- Warning and Informing (NHS Core Standards 33 – 36)
- Cooperation (NHS Core Standards 37 – 39 & 43)
- Business Continuity (NHS Core Standards 44 – 53)
- Chemical, Biological, Radiological & Nuclear (CBRN) (NHS Core Standards 55, 56, 57, 58, 60, 61, 63, 64, 65 and 66)

3.2 Other standards outside of these numbers are not applicable for DHC and are based upon other NHS organisations criteria e.g. Acute Hospitals or Ambulance Trusts.

3.3 The Trust is assessed against the criteria shown in the below table:

Organisational Rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non- Compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

3.4 For 2026, the self-assessment exercise completed assesses that the Trust continues to achieve full compliance (100%) against the applicable standards.

4 Deep Dive

4.1 Traditionally within the NHS Core Standards, there is a Deep Dive Section, with a focus on a specific topic, in 2025 this was cyber security. However, this year NHSE have removed this element.

5 Summary

5.1 The EPRR team have continued to strive and improve over the last year through preparing and responding to the ever-changing operational delivery of key services whilst preparing and dealing with emergency situations and incidents. We continue to work closely with our EPRR colleagues within the ICB and support others in the system and wider NHS as and when required.

6 Recommendations

6.1 The Board is recommended to:

a. Receive the report for assurance
b. Note that the final outcome of the assessment is subject to NHS Dorset and NHSE review which will reported to the Trust board in early 2027.

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Report to	Board of Directors in Common	
Date of Meeting	13th October 2026	
Report Title	Emergency Preparedness, Resilience & Response (EPRR) Annual Assurance 2025/2026	
Prepared By	Ian Kilroy – Head of Emergency Preparedness, Resilience & Response & Security Management	
Approved by Accountable Executive	Anita Thomas, Chief Operating Officer (COO) Accountable Emergency Officer (AEO)	
Previously Considered By	EPRG May, Jul and Sep 2026 Finance and Performance Committee in Common	
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 Quality and Safety SR5 Estates	
Financial	Not applicable	
Statutory & Regulatory	The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006 and Health and Care Act 2022 underpin EPRR within health. All acts place EPRR duties on NHS England and the NHS in England. Additionally, the NHS Standard Contract Service Conditions (SC30) require providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England guidance.	
Equality, Diversity & Inclusion	No impact	
Co-production & Partnership	No impact	

Executive Summary

- In May and Jul 2026, the Emergency Planning Resilience Group (EPRG) was presented with the latest update on Incident Response Plans (IRP), Action Cards, SharePoint improvements and explained the current position statement relating to NHS England Emergency Preparedness Resilience and Response (EPRR) Core Standards. No comments to challenge the changes to the updates.

- In Sep 2026, the EPRG was presented with the update of the NHS England EPRR Core Standards (No Deep Dive required) to discuss, change and ratify the plans for the NHS England EPRR Core Standards and compliance report.

- Following internal meetings, work programme and targeting means, the Trust has been assessed as being **100% Full compliance** across all the 66 sections Emergency Preparedness, Resilience and Response (EPRR) Assurance Core Standards.

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- These rational decisions to explain the compliance position are based upon evidence base examples, practical input and planned subjects to meet the criteria. Link to all evidence-based information (211 items) is available for review on the S Drive, Operations Directorate, Emergency Planning and uploaded to Future NHS framework, as required by NHS Dorset (ICB)

- This assessment will now be taken to the NHS Dorset ICB's 'confirm and challenge' meeting on 1 Oct 2026 for further scrutiny and final confirmation as an element of the wider ICS EPRR Assurance process.

- An EPRR Annual Report will be submitted to the Audit Committee and Trust Board in the early part of 2027, once the outcome summary letter has been provided to the Trust

Recommendation

Members are requested to:

- Receive the report for **assurance**

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Emergency Preparedness, Resilience & Response (EPRR) Annual Self-Assessment Assurance Report 2025/2026

1. Executive Summary

1.1 This report has been prepared to document the self-assessment outcomes of the Trust's Emergency Preparedness Resilience and Response (EPRR) compliance standards, in accordance with NHS England's EPRR Core Assurance Standards.

1.2 All NHS-funded organisations must meet the requirements of

- the Civil Contingencies Act 2004,
- the NHS Act 2006,
- the Health and Care Act 2022,
- the NHS standard contract,
- the NHS Core Standards for EPRR and;
- NHS England business continuity management framework

2. Main narrative

2.1 The annual NHS Core Standards are published annually, normally in early summer in line with the EPRR framework. The standards cover all NHS providers, with most completing 62 standards.

2.2 As an internal process, the Head of EPRR & Security Management completed the draft core standards along with their essential evidence for presentation to the Trusts Accountable Emergency Officer (AEO) and Deputy Accountable Emergency Officer (Dep AEO) where an internal self-assessment standard is then agreed and confirmed at the DCHFT Emergency Preparedness Resilience Group (EPRG).

2.3 Trusts are required to provide a paper for their Trust Board on the outcome of their Annual NHS England EPRR Core Standards Assurance Self-Assessment.

2.4 Following the internal self-assessment, a 'confirm and challenge' meeting is arranged (1 Oct 2026) with NHS Dorset AEO and Head of EPRR/Operations & DCHFT Deputy AEO and Head of EPRR & Security

Management, to present their submitted evidence for review and if there are any challenges, are able to provide clarity as and where required.

2.4 Both NHS Dorset and NHS England assess and review the evidence submitted against the NHS Core Standards before agreeing and awarding any grading or outcome, which is formally sent to the AEO.

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3. Assurances 2026

3.1 The NHS Core Standards set for 2025 has 66 standards. 66 with relevance for Acute Trusts contained within. These are sub-divided into 10 key domains:

- Governance (Domain 1)
- Duty to Risk Assess (Domain 2)
- Duty to Maintain Plans (Domain 3)
- Command and Control (Domain 4)
- Training and Exercising (Domain 5)
- Response (Domain 6)
- Warning and Informing (Domain 7)
- Cooperation (Domain 8)
- Business Continuity (Domain 9)
- Chemical, Biological, Radiological & Nuclear (CBRN) (Domain 10)

3.2 The Trust is assessed against the criteria shown in the below table:

Organisational Rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non- Compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

4. Deep Dive

4.1 Traditionally within the NHS England EPRR Core Standards, there is a Deep Dive Section, with a focus on a specific topic. For clarity; this year NHSE have removed this element.

5 Summary

5.1 The Head of EPRR & Security Management has continued to strive and improve over the last years through preparing and responding to the ever-changing operational delivery of key services whilst preparing and dealing with emergency situations and incidents. Continuity to work closely with our EPRR colleagues within the ICB and Provider Services others as and when required.

6. Recommendations

The Board is recommended to receive the report for **assurance**

Appendices – NHS England EPRR Core Standards 2025 – This report is available in the Board of Directors in Common document folder on AdminControl, for the October 2026 meeting – titled '*06.4bi. DCH New EPRR Sep 2026 (Final)*'.

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Dorset County Hospital
Dorset HealthCare

People and Culture Committee in Common Assurance Report for the meeting held on Monday 28 September 2026

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	• Work ongoing regarding the Transforming People Services Programme, with an outline business case to be presented to the Regional Programme Board on 6th October. A virtual update to the Committee may be required ahead of that meeting, so the Committee can be sighted on the business case. • DCH & DHC WRES and WDES noting areas of improvement and areas for further work. • DCH GOSW: concerns around delays in confirming and recruiting to the right level of establishment for Trauma and Orthopaedics. • Positive, strengthened governance around policies, with a great progress in reducing the number of overdue policies. • The committee discussed the general difference between DCH and DHC in resourcing for clinical office functions such as medical job planning, appraisals and revalidation. DHC was better resourced than DCH for proportionately fewer doctors and this posed a risk to DCH.
Key issues / matters discussed at the meeting	**Chief People Officer Update** highlighting a number of key national, regional, and local matters: • Positively, both DCH and DHC were in segment one of the National Oversight Framework (NOF) for people metrics. • Discussion around the International Holocaust Remembrance Alliance definition of antisemitism, with further consideration to be given by Executives before a proposal on the adoption of the definition is returned to Committee. • Work ongoing regarding the Transforming People Services Programme, with an outline business case to be presented to the Regional Programme Board on 6th October. A virtual update to the Committee may be required ahead of that meeting, so the Committee can be sighted on the business case. • Discussion around the EHRC Code of Practice, following the Supreme Court's definition of sex. Feedback from and conversations with staff continued to happen, with a focus on respecting the rights of all involved and managing situations on a case-by-case basis.

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Workforce KPI Dashboard (Joint) noting the below KPIs for month 5:

Trust	Sickness	Vacancy Rate	Turnover Rate	Appraisals	Mandatory Training
DCH	*4.83% (at month 4)	6.8%	8.75%	74%	88%
DHC	5.56%	7.24%	8.6%	82.4%	92.3%

- The KPI dashboard highlights a generally stable workforce position across both trusts. Performance remains strong in several core workforce metrics, with a number of positive indicators alongside some key areas requiring continued focus and improvement.
- Positively, there have been improvements in mandatory training compliance, turnover is stable and in line with regional levels, and improvements in vacancy rate
- Decline in appraisal compliance at DCH; urgent work is ongoing to understand and address this. Improvement in DHC appraisal compliance but still remains below target.
- Resources remain stretched in both DCH and DHC teams with a business case being drafted for a new structure for HR ops and HR business partner teams.
- Sickness absence remains a significant workforce challenge.
- Discussion around thresholds for metrics as some were different between DCH and DHC, without a clear reason for variation.

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Reports (DHC/DCH)

DCH:

- WRES: the Trust continues to have a diverse workforce, but there is still a disparity between in recruitment outcomes and experience reported to the trust by ethnic minority colleagues. The trust need to focus on fair recruitment, career progression and tackling discrimination.
- WDES: Recruitment outcomes were broadly positive, but results show that disabled people do not experience the workplace in the same way as non-disabled people. The trust needs to remain focused on workplace adjustments, career development and ensuring colleagues feel supported and valued.

DHC:

- WRES: Continued progress in workforce representation and recruitment, but persistent inequalities in experience and career progression.
- WDES: Improvements in representation and recruitment close to parity, and harassment from patients and public had reduced for the third consecutive year. However, data highlights continuing inequalities in staff experience, career progression and capability processes.

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Many actions were already underway through the Joint Inclusion and Belonging programme, the We All Belong campaign and work to become anti-racist organisations. New actions from the reports will be added to the Joint Inclusion and Belonging strategy to monitor progress.

There had been improvements in staff reporting incidents of discrimination, but further work was needed to improve staff understanding of the support they can be offered when reporting.

Discussion about the action plan, with feedback that the action plan could be more proactive.

NHS Staff Standards Report (DHC/DCH). The standards were now part of the NOF. There were six standards, with initial mapping exercises against the standards complete with much work already underway through a various existing plans, strategies and groups. It was important to ensure that this ongoing work was having the intended impact. Wellbeing, flexible working, and discrimination requires improvement. Committee members congratulated the teams for current NOF scores which were in the upper quartile for both trusts.

Workforce Operational Plan 2026/27 Progress Update (Joint)

- DCH: Workforce remains 111 WTE below plan, with recruitment and retention challenges continuing. Reliance on bank and agency staff remains above target, although agency use has reduced. Recruitment campaigns for healthcare support workers and newly qualified nurses are underway.
- DHC: Workforce is 104 WTE above plan, supported by successful recruitment. Agency usage has fallen significantly, but bank staffing remains high due to service pressures. The temporary staffing reduction programme has delivered £500k in savings.
- Overall, both trusts are making progress with substantive recruitment and reducing agency use, but workforce pressures, sickness absence, and delays to service changes mean bank staffing remains higher than planned.
- The committee had a thorough discussion regarding ongoing workforce pressures, particularly high bank staffing costs linked to substantive vacancies, sickness absence, and difficulties recruiting healthcare support workers. Delays to planned service changes and workforce growth initiatives have also affected staffing plans. Members noted positive progress in recruiting newly qualified nurses and registrants, while NHS England reviews highlighted workforce availability issues. The committee agreed that further analysis of temporary staffing, hard-to-fill vacancies, and recruitment barriers is needed, but received assurance that workforce, finance, and quality teams are working closely together on solutions. The committee was partially assured by the paper.

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Guardian of Safe Working (GOSW) Report (DHC/DCH)
DHC: Relatively few exception reports with no immediate safety concerns. The GOSW is assured that Resident Doctors working hours are safe.

DCH: Many more exception reports at DCH, given the higher number of resident doctors. The GOSW reviews all immediate safety concerns to consider whether they are truly immediate safety concerns. 30% of immediate safety concerns submitted from Trauma and Orthopaedics, primarily due to late finishes, due to issues with getting substantive posts through Recruitment Control Panel (RCP). Concerns around delays in confirming the right level of establishment for Trauma and Orthopaedics.

Policy Status Report (DHC/DCH) Bi-annual update on the policies in the scope of the committee. Five overdue policies for DHC; some had only recently passed their review date, while others were >12 months overdue and needed attention. Verbal updates on the progress of those policies. No overdue policies for DCH. Positive, strengthened governance around policies, with a great progress in reducing the number of overdue policies.

Provider Capability Assessment: People and Culture (DCH) The assessment covered six domains, each of which was assigned to a committee; for this committee the domain was “People and Culture”. The self-assessment asks trusts to consider whether they are capable of managing it’s challenges in relation to each domain. The proposed rating from the review process for “People and Culture” is ‘green’. The committee recommended the outcome to the DCH board for approval.

Nursing and Midwifery Job Profiles (Joint) The Trusts were working together on this matter. A workshop had recently reviewed job description and profiles for inpatient settings with comms in development to that first group of affected colleagues. A paper regarding the financial implication was being drafted. The trusts were working with regional colleagues and there was support from unions.

Medical Job Planning (DHC/DCH)
DHC: Updating on the implementation of electronic job planning, noting that medical job planning was now linked closely to service-level job planning and is a high-priority for NHS England. Positively, the Trust reached 95% job plans on Health Rota and was now moving focus to service-level job planning. Thanks were extended to the Medical Job Plan Coordinator for their work.

DCH: a great deal of work was ongoing to progress electronic medical job planning, but the Trust did not have dedicated administrative support to get demand and capacity planning matched with job plans and the job plans added to Health Rota. The committee discussed the general difference

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between DCH and DHC in resourcing for clinical office functions such as this, appraisals and revalidation. DHC was better resourced than DCH for proportionately fewer doctors and this posed a risk to DCH. The committee noted its commitment to effective job planning.

Sickness Absence Deep Dive (Joint) noting:

- DCH and DHC perform relatively well in sickness absence. Average rate for the region is 4.9%. DHC is currently 5.5%, DCH is 4.83%
- Stress, anxiety, and depression continue to be the leading cause of sickness in both trusts, totalling 25-29% of all recorded sickness absences, and 53% (DCH) and 60% (DHC) of all days lost
- The deep dive found differences in formal sickness case management between the trusts, with 144 current cases in DCH and 37 in DHC. Further work was ongoing to understand this, although this work was dependent on resourced in HR ops team.
- The wellbeing support available to staff and a recognition that poor mental health can be caused by factors inside and outside of work.
- Discussion around the spread of stress, anxiety and depression sickness absences across age ranges, with further investigation in to this ongoing.

Recruitment timeliness performance review (DHC/DCH) noting that DHC is performing well in recruitment, being the second best within the region. Additional focus was needed at DCH on the recruitment approval process, and on hard to fill posts. Further consideration to be given to this topic in a future informal session.

Ward ID Checks Audit (DHC/DCH) presenting the internal audit report in to ward identity checks and the resulting action plan.
DHC:

- Assurance provided that the Chief Nursing Officer reviewed ID check compliance reports on a daily basis and followed up any instances of non-compliance.
- A workshop was scheduled for this week to educate ward managers on the risk of counter fraud and importance of ID checks and that those who present fraudulently are often victims of organised crime.

DCH:

- Confirmation of daily compliance reports. Any issues were able to be reported live through Datix.
- A standard operating procedure (SOP) was in place with clinical site managers recognising the importance and ensuring this is enacted appropriately.

Cross-referred to t Quality Committee in Common is to consider whether there are any known quality impacts from ward ID check issues. Further detail will be provided to the next meeting. While there was limited

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assurance from the report, assurance was provided that both Chief Nursing Officers have grip on the issue and remedial work continues.

Progress against the Joint People Plan (Joint) was broadly on track, and the people directorate was working hard to deliver the plan.

The below items were taken under consent, without discussion:

Assurance reports from below sub-groups of the People and Culture Committee in Common

DHC:

- Workforce Wellbeing Group, noting the increasing request for TRiM, such that it is now a stretch to deliver. This will be addressed in the review of the health and wellbeing strategy.
- Trade Union Partnership Forum
- Equality, Diversity, Inclusion and Belonging Steering Group
- Local Negotiating Committee

DCH:

- Partnership Forum
- Local Negotiating Committee
- Equality, Diversity, Inclusion and Belonging Steering Group

Joint:

- Culture and Inclusion Reference Group

Decisions made at the meeting

- Recommended to Board the approval of the DCH Provider Capability Assessment (People and Culture)

Issues / actions referred to other committees / groups

- To Quality Committee in Common: Any known quality impacts from ward ID check issues

Quoracy and Attendance						
	27 May 2026	28 Jul 2026	29 Sep 2026	24 Nov 2026	26 Jan 2027	23 Mar 2027
Quorate?	Y	Y	Y			
Eiri Jones	Y	Y	Y			
Suresh Ariaratnam	Y	Y	Y			
Margaret Blankson	Y	Y	A			
Nick Brailsby (from Aug 2026)			Y			
Dawn Dawson	A					

(to 27/07/26)						
Jo Howarth (to 29/09/26)		Y	A			
Emma Hoyle (from 29/09/26)			Y			
Lucy Knight	Y	Y	Y			
Nicola Plumb	Y	Y	Y			
Cara Southgate		Y	Y			
Rachel Wharton	Y	A	Y			

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Report to	Board of Directors in Common	
Date of Meeting	13 October 2026	
Report Title	Guardian of Safe Working Report of Safe Working Hours of Doctors in Training Q1 (Feb-Apr 2026)	
Prepared By	Claire Vick (Guardian of Safe Working Hours)	
Approved by Accountable Executive	Dr Lucy Knight, Chief Medical Officer	
Previously Considered By	People and Culture Committee in Common, 28/09/2026	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives? *Delete as required*	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability	Yes	

Implications	Describe the implications of this paper for the areas below.
Board Assurance Framework	SR1 Safety & Quality
Financial	Fines are incurred for breaches of safe working
Statutory & Regulatory	NA
Equality, Diversity & Inclusion	Adherence to the GOSW provisions helps us treat resident doctors fairly and consistently.
Co-production & Partnership	NA

Executive Summary

The introduction of the 2016 contract for resident doctors established the role of the Guardian of Safe Working Hours, who is required to provide assurances to the Trust Board in relation to the compliance with these hours on a quarterly basis.

- This report covers the period 04/02/2026 – 30/04/2025, in-line with the rotation of resident doctors
- There were 14 exception reports raised during this period
- Thirteen of the exception reports raised were in relation to breaches of continuous rest between 10pm and 7am during on-call shifts and incurred a fine to the Trust.
- One of the reports related to a resident's working additional hours during the week for which TOIL was allocated.
- There were no other reports relating to missed educational opportunities.
- No reports raised an immediate safety concern.
- No reports required an escalation.

The 2024 amendments to the contract have brought about changes to exception reporting. Our processes have been amended slightly to ensure compliance with these changes.

The Guardian of Safe Working is assured that Resident Doctors working hours are safe.

Recommendation

Members are requested to:
Receive the report for **assurance.**

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1. Background

1.1 Following the introduction of the 2016 resident doctor contract, the role of guardian of safe working hours (GOSWH) was created to provide assurances to both the board and resident doctors that their working hours would be safe (in line with the new contract.) These reports are intended to provide an overview and assurance of the Trust's compliance with safe working hours for doctors in training and to detail any areas of concern.

1.2 All doctors in training are issued with a work schedule (which details hours to be worked and educational opportunities expected in each job) and a proposed Rota (detailing frequency as well as Rota dates) prior to the start of each rotation. The Trust currently operates a normal intensity Rota which is compliant in terms of weekend frequency and number of consecutive days worked.

1.3 Deviations from the work schedule that result in additional hours worked or inability to take appropriate rest periods during a scheduled workday should result in the resident raising an exception report. Residents should also raise an exception report if they do not achieve the required 5 hours continuous rest between 10pm and 7am and or 8 hours total rest during a 24 hour on-call period. These exception reports are overseen by the Guardian of Safe Working Hours.

1.4 The amendments to the contract also require residents to raise an exception report when they have been unable to attend training related activities due to clinical commitments. These are discussed with their educational or clinical supervisor in the first instance as above and are passed to the Director of Medical Education for information. Exception reports raised in relation to education are beyond the remit of the Guardian of Safe Working Hours but the number of reports raised will however be added to this report for completeness.

1.5 The 2024 amendments to the contract aim to make it easier for resident doctors to exception report and be paid or take TOIL (as is their preference) in a timely fashion. It also imposes more significant financial penalties on Trusts if they do not meet these additional requirements.

1.6 All resident doctors are provided with access to Healthrota for exception reporting at induction and are requested to provide a test report to ensure the system is working.

1.7 Remuneration/ TOIL (at the resident's discretion) for substantiated additional hours worked is automatically authorised by a medical HR advisor for all exception reports relating to less than 2 hours of overtime.

1.8 The Guardian of Safe Working Hours currently reviews all exception reports where there is dispute over the hours worked, the exception report relates to more than two hours of overtime or the exception report results in a financial penalty.

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1.9 There are clear processes in place to ensure TOIL can be taken in a timely fashion or remunerated promptly if this cannot be facilitated.

1.10 The details in exception reports are managed in strict confidence to prevent identification of the doctor. Information that may need to be provided to find a solution to an area of difficulty and which might lead to identification of the doctor is only shared with express permission from the doctor concerned.

1.11 Any breaches in confidentiality, failure of the Trust to provide access to an exception reporting system within 7 days of starting the job and any incidents of threat or perceived threat to a resident in relation to exception reporting will result in a financial penalty to the Trust.

1.12 Financial penalties in the above instances are paid directly to the GOSW fund and not to the doctor they relate to.

1.13 Exception reports raised by Foundation Doctors are dealt with by the GOSW in the acute trusts and are therefore beyond the remit of this report.

2 Information for consideration

2.1 A: Exception reports relating to working hours from 04/02/2026- 30/04/2026

Training programme	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
CT/ GPVTS	13	13	0
ST	1	1	0
Total	14	14	0

2.2 Outcomes of exception reports relating to working hours

2.2.1 Thirteen of the exception reports related to breaches of the 5-hour continuous rest period between 10pm and 7am.

2.2.2 One report related to a resident working additional hours during the normal working week.

2.2.3 All reports were from resident doctors placed in psychiatry posts. There were no issues raised by residents in community hospital or sexual health posts, which do not entail on-call work with the Trust.

2.2.5 There have been no instances of exception report outcomes not being agreed by a trainee and therefore needing a level 2 or 3 resolution.

2.3 Exception report raising immediate safety concern

2.3.1 There were no exceptions raised as an immediate safety concern.

2.4 B: Exception reports related to missed education/ training

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2.4.1 No exception reports were raised in relation to missed education or training.

2.5 **C: Work schedule reviews**

2.5.1 There have been no new work schedule reviews required over the last period

2.6 **D: Exception reports relating to information breaches and access and completion Difficulties**

2.6.1 There were no exception reports relating to information breaches and none relating to lack of access or difficulty completing an exception report.

2.7 **E: Vacancies and locum bookings**

2.7.1 There were vacancies in three core training posts. Two remained vacant and the third (Dorchester CMHT) has a Trust Grade Doctor in post.

2.7.2 There are five vacant higher training posts. There is a locum in place in Alumhurst ward and the vacant training post is in the Bournemouth West CMHT is part covered by a Consultant locum in place to cover other vacancies.

2.8 **E: Financial Penalties**

2.7.1 The amendments to the contract which have been rolled out since September 2019 and amended in 2024 have introduced stricter adherence to aspects of the contract, which has increased the number of financial penalties/ fines.

2.7.2 Financial penalties are paid in part to the doctor who has worked additional hours and the remainer to the GOSW Fund.

2.7.3 Financial penalties apply to the following breaches in working hours:

- A breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule); or
- A breach of the maximum 13 hour shift length; or
- A breach of maximum of 72 hours worked across any consecutive 168 hour period
- Where 11 hours rest in a 24 hour period has not been achieved (excluding on-call shifts); or
- Where 5 hours of continuous rest between 22:00 and 07:00 during a non-resident on-call shift has not been achieved; or
- Where 8 hours of total rest per 24 hour non-resident on-call shift has not been achieved

2.7.4 Thirteen of the exception reports registered relate to breaches of five hours of continuous rest overnight.

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2.7.4 Monies raised through the fines process are to be used to improve the education, training and working environment for trainees. Disbursement of these funds are discussed at each quarterly Resident Doctors Forum.

2.7.5 Fines by Rota:

Fines by Rota		
Rota	Number of fines levied	Value of fines levied against department
CT/ GPVTS	12	£2244.60
ST	1	£113.36
Total	13	£2357.96

2.7.6 Cumulative Balance in Guardian Cost Centre

Cumulative fines in Guardian Cost Centre (Total fines less payment to Trainee)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£4055.54	£1467.42	0	£5522.96

2.8 **F: Additional Information**

2.8.1 The Resident Doctors Forum continues to meet quarterly and is well attended.

3 Guardian of Safe Working Hours Safety Statement

3.1 As Guardian of Safe Working Hours I am assured that the working hours of the resident doctors are safe and that the Trust is compliant with the new amendments to the contract which came into effect in February 2026.

Contact for further information:
Dr Claire Vick
Consultant Psychiatrist and Guardian of Safe Working Hours for the Trust

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Report to	Board of Directors in Common	
Date of Meeting	13th October 2026	
Report Title	Quarterly Guardian Report of Safe Working report: Resident Doctors Q1 2026	
Prepared By	Dr Andy Macklin, Guardian of Safe Working (GoSW)	
Accountable Executive	Dr Rachel Wharton, Interim Chief Medical Officer, DCH	
Previously Considered By	People and Culture Committee in Common	
Action Required	**Approval**	-
	Assurance	X
	Information	-

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities		No
Sustainability		No
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	Relates to Board Assurance Framework: SR1: Safety and Quality SR2: Empowerment SR3: Workforce Capacity The guardian of safe working ensures that issues of compliance with safe working hours are addressed by the doctor and the employer or host organisation as appropriate. It provides assurance to the board of the employing organisation that doctors' working hours are safe.	
Financial		
Statutory & Regulatory	Adhering to requirements of the Junior Doctor Contract 2016	
Equality, Diversity & Inclusion	People Plan Principle – we will improve safety and care by creating a culture of openness, innovation, and learning, where staff feel safe themselves	
Co-production & Partnership	The report is also shared with the Local Negotiating Committee for Medical and Dental staff once seen by PCCiC.	

Executive Summary

1. This is the Q1 GoSW Report submitted to the Trust Board by the Guardian of Safe working (Dr Andy Macklin). Dates from 1st April 2026 – 30th June.

2. During Q1 2026/27, 331 exception reports were submitted, consistent with recent reporting levels of approximately 100 reports per month. The majority of reports (76%) related to unscheduled late finishes, reflecting ongoing workload pressures. There were no concerns raised regarding detriment associated with exception reporting, confidentiality breaches.
3. Reporting rates were significantly higher at weekends. Over half of all exception reports were submitted by Foundation Year 1 doctors. There were 15 exception reports containing Immediate Safety Concerns, predominantly submitted by Foundation doctors, highlighting themes of inadequate staffing, insufficient supervision, and IT-related barriers to safe working. Every exception report is reviewed within 24 hours by the GOSW with any time critical concerns escalated to clinical leads or educational supervisors.
4. Twenty-seven reports met the threshold for financial penalties, equating to 23.5 fineable hours and an estimated cost of £1,800. Fines will be raised from Division from August 2026.

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5. Trauma & Orthopaedics remains the most significant area of concern, generating 53 exception reports, approximately 25% more than the next highest specialty. T&O accounted for a disproportionate number of exception reports that were >2 hours, fineable or safety-related. Longstanding concerns regarding staffing levels, support arrangements and induction processes remain unresolved. The Guardian of Safe Working Hours, the Director of Medical Education and the Clinical Leads are working on solutions including additional Resident Doctor cover and creating a new orthogeriatric post.

Recommendation

The Board is requested to:

- Receive the report for **assurance of compliance with processes.**
- **Note** area of concern in Trauma & Orthopaedics.
- **Note** financial risk of fines for exception reports.

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Dorset County Hospital
Dorset HealthCare

Report to	Board of Directors in Common	
Date of Meeting	13th October 2026	
Report Title	Dorset County Hospital (DCH) and Dorset HealthCare (DHC) Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) Reports 25-26	
Prepared By	Jan Wagner (DCH) and Manpreet Aujla-Gudgeon (DHC) - EDI Leads	
Accountable Executive	Nicola Plumb – Joint Chief People Officer	
Previously Considered By	People & Culture Committee in Common, 28th September 2026	
Action Required	**Approval**	
	Assurance	X
	Information	

Alignment to Strategic Objectives	Does this paper contribute to our strategic objectives	
Care	Yes	
Colleagues	Yes	
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below	
Board Assurance Framework	SR2 Culture - The reports demonstrate the development of fair and inclusive leadership, practice and culture and contribute to the 'Well Led' CQC Domain. Inclusive workplaces report better staff health and wellbeing, which is linked to markedly higher patient satisfaction and better patient outcomes, meaning that there is potential for progress in EDI work to positively contribute to all CQC Domains.	
Financial	Non-compliance with EDI legislation would create risks for the organisation in terms of reputation and potential fines.	
Statutory & Regulatory	The general equality duty is set out in section 149 of the Equality Act 2010. Public organisations including NHS Trusts are subject to the general duty and must have due regard to the need to: eliminate unlawful discrimination, harassment and victimisation. The Public Sector Equality Duty (PSED) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.	
Equality, Diversity & Inclusion	The reports signal our intention to truly value our disabled staff and those from minority ethnic communities. Our people are our most important asset, and we want them to feel valued, welcomed, respected, they belong and matter. We recognise the link between high levels of staff satisfaction and improving patient experience and outcomes.	
Co-production & Partnership	Championing Equality, Diversity and Inclusion is a key ambition of the Trust's Social Value pledge. It also supports delivery of equitable services that are informed by engagement and involvement.	

Executive Summary
The Workforce Disability Equality Standard (WDES) and the Workforce Race Equality Standard (WRES) are mandated by the NHS Standard Contract and apply to all NHS Trusts and Foundation Trusts. Following approval, the data and narrative will be published on our public websites along with our action plans, in line with regulatory requirements.

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Healthier lives Empowered citizens Thriving communities

The WRES is a data-based standard and uses a series of nine indicators (measures) as a strategic framework for NHS Trusts to address racial inequality. The measures aim to improve the representation and experiences of BME staff across all levels in the NHS, with a key focus on improving representation at senior levels. The nine indicators encompass workforce data (Indicators 1-4), Staff Survey data (Indicators 5-8) and Board representation (Indicator 9).

The WDES is also a data-based standard and uses a series of ten measures (metrics) to improve the experiences of disabled staff in the NHS. The ten key metrics comprise workforce metrics (1-3), Staff Survey metrics (4-9a), narrative evidence of actions taken (9b) and a metric based on Board representation (10).

The WRES results for Dorset County Hospital are included in Appendix A:
Overall, the submitted 2025/26 results show a diverse workforce, broadly equitable access to CPD and near parity in perceptions of career progression. The current-year disciplinary ratio is below 1.0, although case numbers are small. However, the recruitment gap widened, and inequalities persist in experiences of harassment and discrimination. Board representation remains below the workforce profile, with one ethnic minority Voting Board member and no ethnic minority Executive Board members.

The WRES results for Dorset HealthCare are included in Appendix B:
Overall, the 2025/26 WRES results show continued progress in workforce representation, recruitment and disciplinary outcomes, alongside broadly equitable access to non-mandatory training and CPD. However, inequalities persist in staff experience, particularly harassment and perceptions of equal opportunities for career progression. Board representation remains below the overall workforce profile, with one ethnic minority Voting Board member and no ethnic minority Executive Board members.

The WDES results for Dorset County Hospital are included in Appendix C:
Overall, the 2025/26 WDES results show broadly equitable recruitment outcomes and reasonable adjustment results close to the national benchmark, alongside persistent inequalities in staff experience. Key areas of focus remain capability processes, harassment, pressure to work when unwell, career progression and feeling valued. Disabled representation on the Voting Board is slightly above the overall workforce profile, although no Disabled Executive Board members are recorded.

The WDES results for Dorset HealthCare are included in Appendix D:
Overall, the 2025/26 WDES results show continued improvement in workforce representation and broadly equitable recruitment outcomes, alongside persistent inequalities in staff experience. Key areas of focus remain capability processes, workplace experience, career progression and reasonable adjustments. Board representation has improved but remains below the overall workforce profile.

Action is already underway to target areas of concern identified in these reports. New actions identified through this process will be added to the overarching Inclusion and Belonging Strategy Action Plans in both organisations.

Recommendation
The Board is recommended to receive the reports for assurance.

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APPENDIX A

Dorset County Hospital

Workforce Race Equality Standard Report

2025-26

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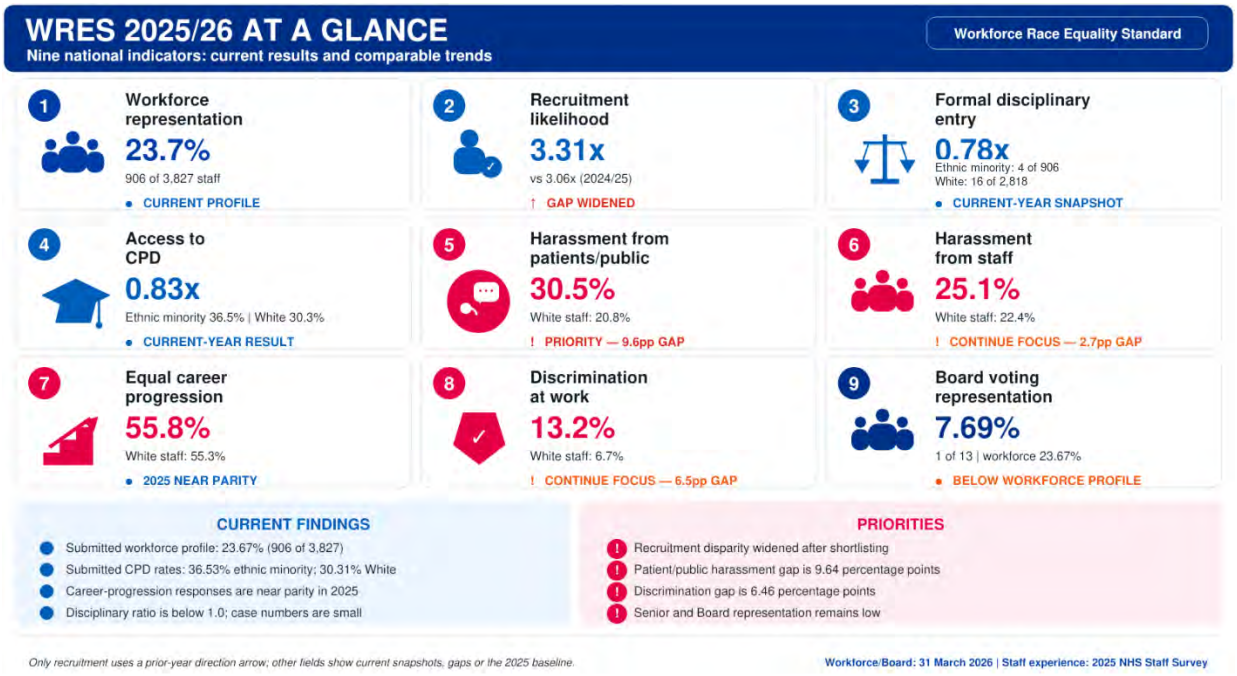
Executive summary

Ethnic minority colleagues account for 23.67% of the submitted workforce (906 of 3,827), showing substantial workforce diversity. The submitted Continuing Professional Development (CPD) result is broadly equitable, career-progression responses are near parity, and the current-year disciplinary ratio is below 1.0, although it is based on small numbers and is not treated as a trend.

The clearest disparity is recruitment after shortlisting: White candidates were 3.31 times as likely as ethnic minority candidates to be appointed. Ethnic minority colleagues also reported higher rates of harassment and discrimination, while ethnic minority representation on the Voting Board was 7.69% and there were no ethnic minority Executive Board members. These findings give DCH a focused evidence base for action through We All Belong, joint anti-racism work and the wider Inclusion and Belonging programme.



Data sources

- Indicators 1 and 9 use the workforce and Board snapshot at 31 March 2026.
- Indicator 2 uses recruitment data for 1 April 2025 to 31 March 2026.
- Indicator 3 uses formal disciplinary-entry data for 1 April 2025 to 31 March 2026.
- Indicator 4 uses the non-mandatory training and CPD figures in the final submitted 2025/26 WRES return.
- Indicators 5 to 8 use the 2025 NHS Staff Survey. The benchmark figures are unweighted medians for the Acute and Acute & Community Trusts benchmarking group and are reference points, not targets.

Prior-year results are shown only where the population, question and calculation are sufficiently comparable; otherwise the report presents a current snapshot or new baseline.

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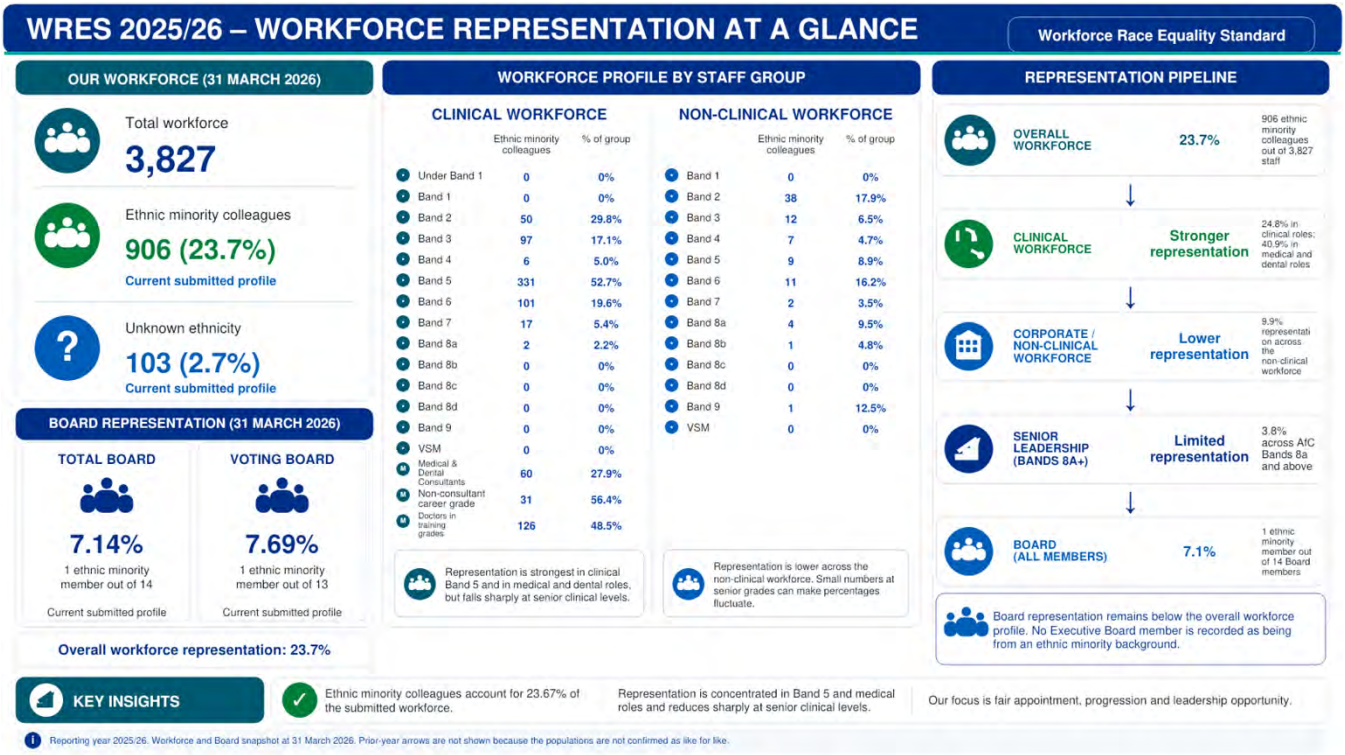
What the data tells us

Representation across the workforce



At 31 March 2026, 906 colleagues in the submitted WRES workforce were from ethnic minority backgrounds, representing 23.67% of 3,827 colleagues; 103 colleagues (2.69%) had unknown ethnicity. This represents substantial workforce diversity. The current submitted profile is used as the baseline; no longer-term growth claim is made where populations have not been confirmed as like for like.

Representation varies substantially by staff group and level. Ethnic minority colleagues account for 24.78% of the clinical workforce, 40.94% of medical and dental roles and 9.88% of the non-clinical workforce. Within the clinical workforce, representation is 52.7% at Band 5, 19.6% at Band 6, 5.4% at Band 7 and 2.2% at Band 8a. Across AfC Bands 8a and above it is 3.77%, showing that overall diversity is not yet reflected consistently at senior levels.

The submitted Board profile records one ethnic minority member among 14 Board members (7.14%), one among 13 Voting Board members (7.69%), one among eight Non-Executive Board members (12.5%) and none among six Executive Board members. These are the submitted 2025/26 classifications.

DCH operates within a federated leadership model, with some joint and some Trust-specific executives. The 2025/26 submission includes people working for DCH even where their employing organisation differs. Because that inclusion method and the prior-year Board groupings are not directly comparable, no prior-year Board trend is stated.

Taken together, the current profile combines substantial workforce diversity with lower representation through senior AfC and Board levels. The priority is therefore not simply to increase overall representation, but to improve fair appointment, progression and leadership opportunities.

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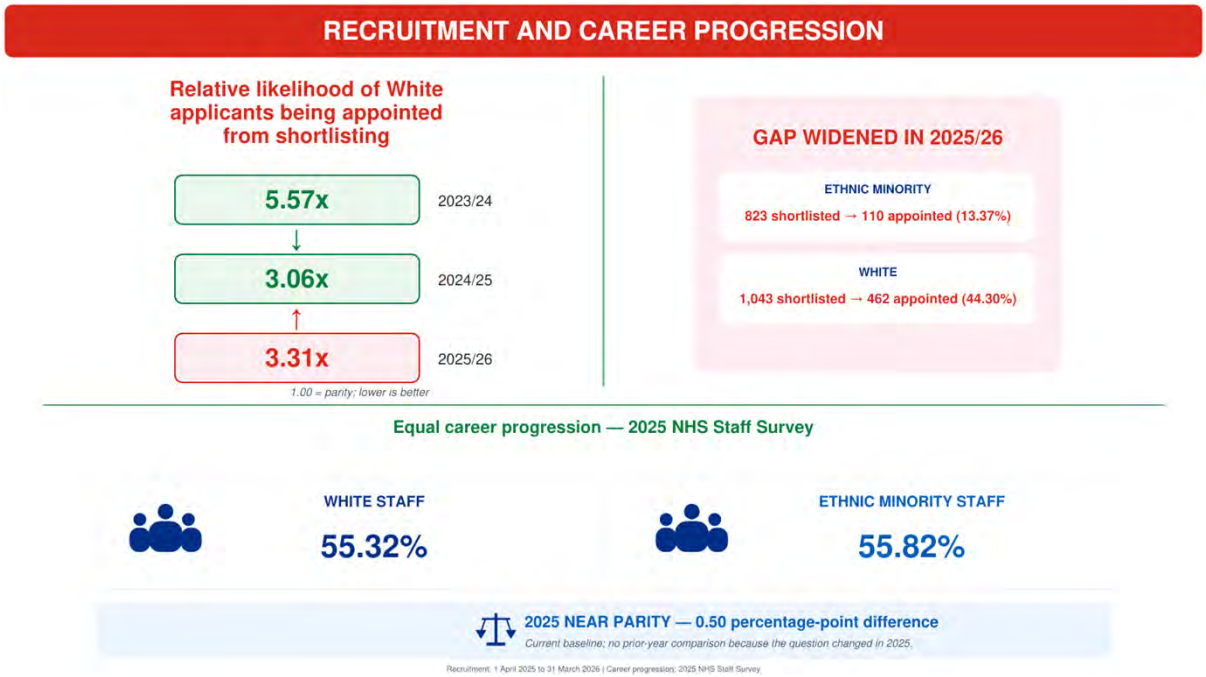
Recruitment and career progression

In 2025/26, 110 of 823 shortlisted ethnic minority candidates were appointed (13.37%), compared with 462 of 1,043 shortlisted White candidates (44.30%). White candidates were therefore 3.31 times as likely to be appointed from shortlisting, compared with 3.06 in 2024/25. The gap has widened and points to the decision stage after shortlisting as a clear process priority.



For career progression, 55.82% of ethnic minority respondents and 55.32% of White respondents believed that DCH provides equal opportunities for progression or promotion. The difference is 0.50 percentage points and the ethnic minority result is above the benchmarking-group median of 49.11%. Because the question changed in 2025, this is treated as a new baseline rather than an improvement trend.

The final submitted CPD return records participation by 331 ethnic minority colleagues (36.53%) and 854 White colleagues (30.31%). The relative likelihood of White staff accessing non-mandatory training and CPD compared with ethnic minority staff is 0.83. This is a broadly equitable submitted position, while monitoring by band and staff group remains important because overall participation rates can mask barriers to particular opportunities.

Staff experience

Formal disciplinary entry is a current-year, small-number snapshot. Four of 906 ethnic minority staff (0.44%) and 16 of 2,818 White staff (0.57%) entered a formal disciplinary process, giving a relative likelihood of 0.78 for ethnic minority staff compared with White staff. The result should not be interpreted as a stable trend and does not support a comparison with the previously used rolling method.

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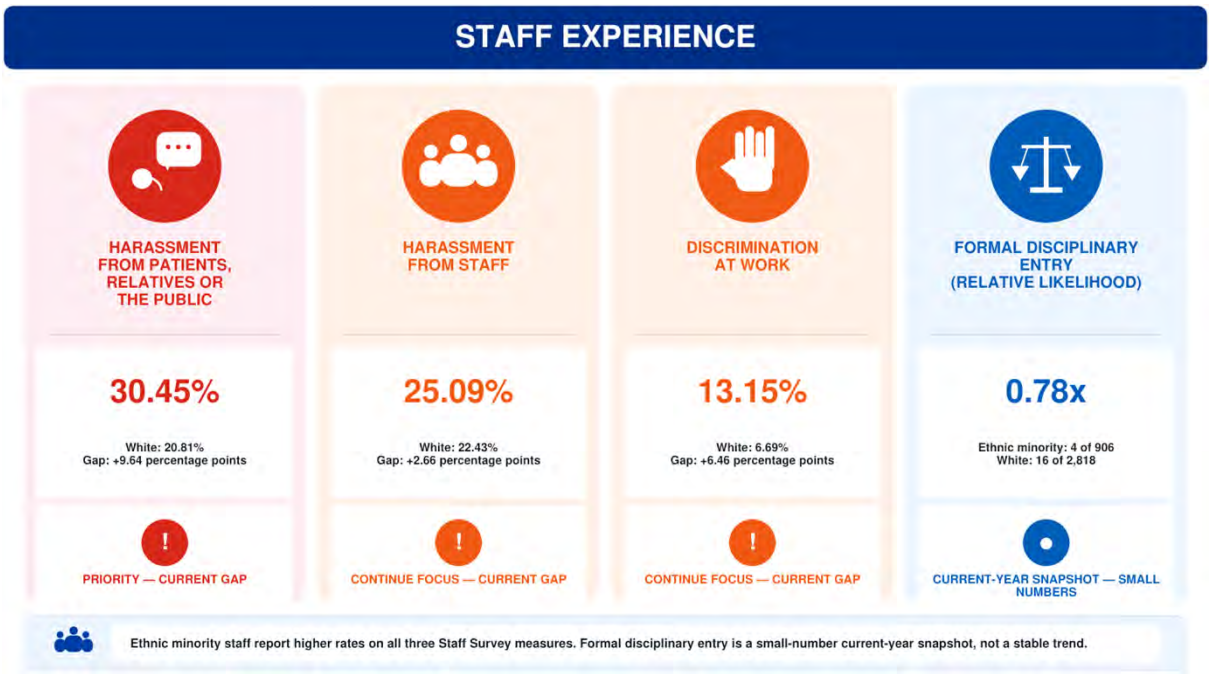

Harassment from patients, relatives or the public is the largest current staff-experience gap. It was reported by 30.45% of ethnic minority respondents and 20.81% of White respondents, a difference of 9.64 percentage points. The ethnic minority result is also above the benchmarking-group median of 28.98%.

Harassment from other staff was reported by 25.09% of ethnic minority respondents and 22.43% of White respondents, a gap of 2.66 percentage points; the benchmarking-group median for ethnic minority respondents was 24.06%. Discrimination from managers, team leaders or colleagues was reported by 13.15% of ethnic minority respondents and 6.69% of White respondents, a gap of 6.46 points; the ethnic minority result was below the 14.70% benchmark median, but the internal disparity remains.

Response bases vary across the Staff Survey measures (289 to 292 ethnic minority respondents and 1,286 to 1,293 White respondents). The figures are point estimates and no statistical-significance test is presented, so conclusions focus on the size and direction of current gaps rather than claiming a causal or definitive change.

How we're responding

During 2025/26, DCH continued to develop race equity through the Joint Inclusion and Belonging Strategy 2024–26, the UNISON Anti-Racism Charter, inclusive leadership learning, staff engagement and work on dignity and respect. We All Belong is the shared campaign and identity through which this work is increasingly communicated. It grew from the joint anti-racism and inclusion work and now has a broader belonging focus; it remains distinct from both the Joint Anti-Racism and Inclusion Framework and the successor to the current Joint Inclusion and Belonging Strategy 2024–26, which is currently being developed.

Building inclusive leaders

Conscious Inclusion and Inclusive Leadership learning supports managers to recognise bias, understand the effect of behaviour and apply fair people practice. DCH will continue embedding the approved manager-learning approach and connect it with recruitment, disciplinary and respectful-workplace practice, using WRES evidence and staff experience to focus the content.

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Creating fair opportunities
DCH introduced a mandatory EDIB interview question and scoring guidance in 2025. The next phase is to reinforce structured assessment, transparent scoring and consistent selection practice, with agreed diverse-panel arrangements for Band 6 and above. Recruitment outcomes will be monitored by level and staff group so that action is directed at the post-shortlisting stage where the disparity is visible.

Tackling racism and discrimination
DCH and Dorset HealthCare have adopted the UNISON Anti-Racism Charter and continue joint work on an Anti-Racism and Inclusion Framework. DCH manager guidance for colleagues experiencing unacceptable behaviour, the Zero Acceptance approach and Respectful Workplace Conversations provide practical support. We All Belong will help communicate expectations and invite staff participation. Any proposal for a supporting joint Anti-Racism Policy will be developed with Dorset HealthCare and remain subject to each Trust's governance.

Listening to staff
Staff voice is essential to understanding what the WRES figures mean in practice. The Overseas Staff Network has more than 400 members and provides an established route for peer support and feedback. Work to strengthen the Ethnic Diversity Network continues, alongside Freedom to Speak Up and WorkInConfidence. The Joint Culture and Belonging Group provides a structured forum for staff and staff network representatives to share lived experience with Executive Directors and help shape organisational priorities and culture across both Trusts. These routes will inform recruitment, progression, anti-racism and respectful-workplace priorities, including the joint staff-network programme.

Embedding race equity
Race equity is embedded in organisational oversight through WRES, the Equality Delivery System, workforce and ethnicity pay-gap reporting, the annual EDIB programme and established people-governance routes. Reporting will distinguish current snapshots from comparable trends and combine workforce data with Staff Survey results and lived experience. The successor to the current Joint Inclusion and Belonging Strategy 2024–26 is being developed to bring this evidence and shared delivery together. It would connect belonging, anti-racism, inclusive leadership, fair opportunity and accountability across DCH and Dorset HealthCare while allowing each Trust to respond to its own data and governance requirements.

Our focus 2026/27
The 2025/26 results support a smaller set of priorities that can be evidenced and reviewed. Detailed measures and functional owners are set out in the WRES Action Plan 2026/27 at the end of this appendix.

- **Fair recruitment:** reduce the post-shortlisting appointment disparity through structured assessment, transparent scoring, the mandatory EDIB question and monitoring by level and staff group.
- **Safer, respectful experience:** reduce harassment and discrimination through manager guidance, Zero Acceptance, trusted reporting routes and proportionate responses to Staff Survey, incident and staff-voice themes.
- **Progression and senior representation:** make career conversations and progression routes clearer, use data and lived experience to identify barriers, and apply inclusive selection to senior and Board appointments.

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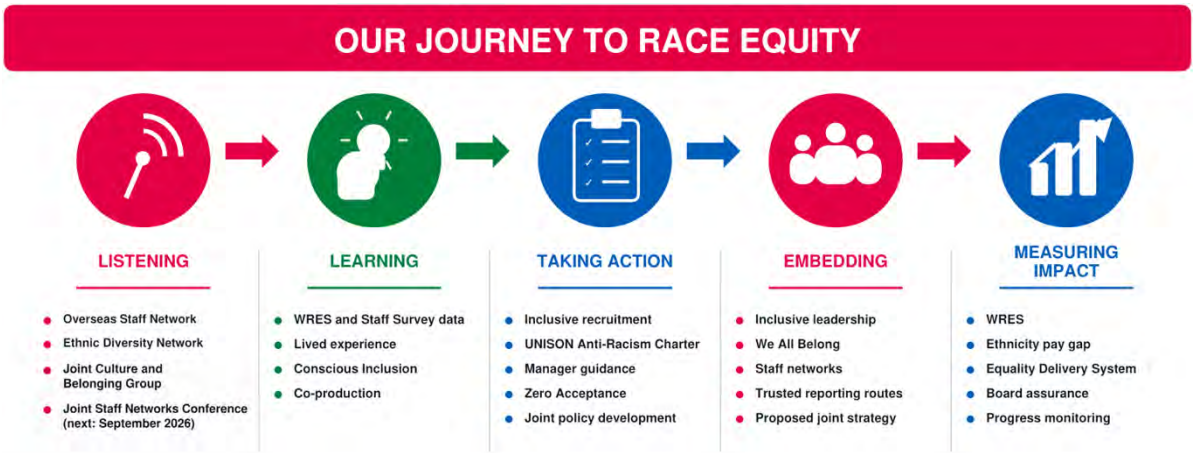
- **Inclusive and anti-racist practice:** continue We All Belong, the UNISON Anti-Racism Charter, Conscious Inclusion and Inclusive Leadership learning, and joint development of the Anti-Racism and Inclusion Framework.
- **Evidence and accountability:** monitor each WRES indicator, keep snapshot and trend claims distinct, and use the proposed Joint Inclusion Strategy 2026–29 to align shared delivery.



Delivery will use established DCH and joint partnership arrangements, with transparent evidence and review.

Conclusion

The submitted results show a diverse workforce locally and broadly equitable CPD access, but also a widened recruitment gap, persistent harassment and discrimination disparities, and low senior and Board representation. DCH will use We All Belong, the UNISON Anti-Racism Charter, the Joint Anti-Racism and Inclusion Framework, alongside work to develop the successor to the current Joint Inclusion and Belonging Strategy 2024–26, while distinguishing snapshots from trends.

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WRES AT A GLANCE

2025/26 snapshot and comparable trends

Current results 2025/26

Comparable trends shown where available

1 WORKFORCE REPRESENTATION

Current submitted profile
906 of 3,827 staff

23.67%

Current profile
No like-for-like prior-year trend shown.

2 RECRUITMENT

White applicants compared with ethnic minority applicants
1.00 = parity; lower is better

5.57 → 3.06 → 3.31

Priority
The appointment gap widened in 2025/26.

3 FORMAL DISCIPLINARY ENTRY

Ethnic minority compared with White staff
4 of 906 vs 16 of 2,818

0.78

Current-year snapshot
Small numbers; no stable trend conclusion.

4 ACCESS TO CPD

White compared with ethnic minority staff
36.53% vs 30.31%

0.83

Current-year result
Submitted access rate is higher for ethnic minority staff.

5 HARASSMENT FROM PATIENTS, RELATIVES OR THE PUBLIC

% of ethnic minority staff
White comparator: 20.81%

29.8 → 22.0 → 25.1 → 30.5

Priority
Current gap with White staff: 9.64 percentage points.

6 HARASSMENT FROM STAFF

% of ethnic minority staff
White comparator: 22.43%

32.4 → 25.8 → 24.2 → 25.1

Continue focus
Current gap with White staff: 2.66 percentage points.

7 EQUAL OPPORTUNITIES FOR CAREER PROGRESSION

2025 baseline
Ethnic minority 55.82%
White 55.32%

55.82%

2025 baseline
Near parity; question wording changed in 2025.

8 DISCRIMINATION FROM MANAGER OR TEAM LEADER OR COLLEAGUES

% of ethnic minority staff
White comparator: 6.69%

16.6 → 18.0 → 17.9 → 13.2

Continue focus
Point estimate lower; current gap remains at 6.46 points.

CURRENT SUBMITTED BOARD PROFILE

Voting Board	Overall workforce	
7.69%	23.67%	No prior-year Board trend
1 of 13	906 of 3,827	Population and grouping are not confirmed as like for like.

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2025/26 LEADERSHIP SNAPSHOT

TOTAL BOARD	VOTING BOARD	NON-EXECUTIVE BOARD	EXECUTIVE BOARD
7.14%	7.69%	12.50%	0%
1 of 14	1 of 13	1 of 8	0 of 6

Reporting year 2025/26. Workforce and Board: 31 March 2026; recruitment, disciplinary and CPD: 1 April 2025 to 31 March 2026; Indicators 5–8: 2025 NHS Staff Survey.

REPORTING KEY

- **Current snapshot** — No robust trend conclusion
- **Continue focus** — Current gap remains
- **Priority** — Significant gap – continued focus needed

2025/26 BOARD REPRESENTATION SNAPSHOT

as at 31 March 2026

Group	Ethnic minority	White	Unknown	Total
Total Board	1 | 7.14%	13 | 92.86%	0 | 0.00%	14
Voting Board	1 | 7.69%	12 | 92.31%	0 | 0.00%	13
Non-Executive	1 | 12.50%	7 | 87.50%	0 | 0.00%	8
Executive	0 | 0.00%	6 | 100%	0 | 0.00%	6

DIFFERENCE COMPARED WITH OVERALL WORKFORCE (23.67% ETHNIC MINORITY)

Total Board	Voting Board	Executive Board
-16.53pp	-15.98pp	-23.67pp

Ethnic minority representation on the Voting Board is 7.69% (1 of 13), compared with 23.67% across the submitted workforce. No Executive Board member is from an ethnic minority background. No prior-year Board trend is shown.

KEY MESSAGES

- Current submitted workforce representation is 23.67%; no like-for-like trend is shown.
- Recruitment is the clearest priority: the post-shortlisting appointment gap widened.
- Patient/public harassment and discrimination gaps are 9.64 and 6.46 percentage points.
- CPD is a submitted current-year result; disciplinary entry is a small-number snapshot.

The actions below combine targeted interventions with ongoing monitoring and evaluation. Where monitoring is identified as an action, its purpose is to assess the impact of activity already underway, identify emerging or persistent inequalities and inform further targeted intervention where required.

Trust	Dorset County Hospital NHS Foundation Trust
Year	2026/27
Primary author of the action plan	Jan Wagner (Equity, Diversity, Inclusion and Belonging Lead)
Sources of information underpinning the plan	WRES 2025/26 submitted data; NHS Staff Survey; workforce data and lived experience; national WRES reports and guidance; NHS EDI Improvement Plan; NHS Staff Standards; NHS 10 Year Health Plan for England; Joint Inclusion and Belonging Strategy 2024–26; proposed Joint Inclusion Strategy 2026–29; Joint Anti-Racism and Inclusion Framework; UNISON Anti-Racism Charter; We All Belong campaign.

WRES Indicator	Actions 2026/27	Measure	Owner(s)
Indicator 1 Workforce representation	• Monitor ethnic minority representation across AfC bands, staff groups, senior leadership and the Board. • Use workforce data and lived experience to inform agreed workforce priorities and the development of the proposed Joint Inclusion Strategy 2026–29.	• Monitor the submitted 23.67% workforce baseline and 2.69% unknown-ethnicity baseline. • Review representation by level and record agreed responses to material underrepresentation.	**EDIB** Workforce Reporting OD Recruitment
Indicator 2 Appointment from shortlisting	• Monitor recruitment outcomes by job group and level, focusing on the decision stage after shortlisting, to assess impact and identify where further action is required. • Embed structured assessment and transparent scoring, including the mandatory EDIB interview question, manager learning and agreed diverse-panel arrangements for Band 6+ appointments.	• Reduce the 3.31 relative-likelihood baseline towards parity (1.00); monitor appointment rates from 13.37% ethnic minority and 44.30% White. • Report use of the EDIB question, scoring guidance, relevant learning and diverse-panel arrangements.	**Recruitment** EDIB OD Staff Network Chairs
Indicator 3 Formal disciplinary entry	• Maintain oversight of formal disciplinary entry and process by ethnicity, using appropriate aggregation where numbers are small, to identify where further action is required. • Apply fair, race-responsive practice in line with the NHS Staff Standards and approved manager learning.	• Monitor the submitted 0.78 current-year baseline without treating the small-number result as a stable trend. • Record a proportionate response where a material difference in entry or process emerges.	**People Services / Employee Relations** EDIB

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WRES Indicator	Actions 2026/27	Measure	Owner(s)
Indicator 4 Non-mandatory training and CPD	• Maintain equitable access to non-mandatory training and CPD. • Monitor participation by ethnicity, band and staff group and use staff voice to understand material barriers.	• Monitor the submitted 0.83 baseline (36.53% ethnic minority; 30.31% White). • Act where participation by workforce level or staff group shows a material gap.	**OD and Education** EDIB Workforce Reporting
Indicator 5 Harassment from patients, relatives or the public	• Embed DCH manager guidance for unacceptable behaviour, Zero Acceptance, clear reporting, immediate support and follow-up. • Use Staff Survey, incident, security/risk and staff-voice evidence through existing violence-prevention arrangements.	• Reduce the 30.45% ethnic minority baseline and the 9.64-point gap with White staff. • Promote guidance and reporting/support routes and evidence action in response to identified themes.	**Nursing and Quality** Security / Risk People Services EDIB
Indicator 6 Harassment from staff	• Embed DCH Respectful Workplace Conversations guidance and Zero Acceptance expectations, with clear People Services, WorkInConfidence and Freedom to Speak Up routes. • Use Staff Survey, employee-relations, speaking-up and staff-network insight to inform proportionate action.	• Reduce the 25.09% ethnic minority baseline and the 2.66-point gap with White staff. • Promote guidance and trusted routes and evidence action in response to themes and lived experience.	**People Services / Employee Relations** Freedom to Speak Up EDIB OD
Indicator 7 Equal opportunities for career progression	• Make career and development conversations a consistent part of appraisal and promote transparent progression routes. • Use progression data and lived experience to understand barriers across the Band 5 to Band 6/7 and senior-leadership pipeline.	• Maintain parity while improving experience from the 2025 baseline: 55.82% ethnic minority and 55.32% White. • Monitor development participation, applications and progression by ethnicity and respond to staff feedback.	**OD** EDIB People Services Staff Network Chairs
Indicator 8 Discrimination at work	• Continue joint Anti-Racism and Inclusion Framework work and UNISON Anti-Racism Charter commitments, informed by WRES and lived experience. • Use We All Belong, manager learning and trusted staff-voice routes; progress any joint Anti-Racism Policy proposal through each Trust's governance.	• Reduce the 13.15% ethnic minority baseline and the 6.46-point gap with White staff. • Report framework, Charter and any policy-development progress through established governance, with evidence of staff voice informing action.	**EDIB** People Services Freedom to Speak Up Communications

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WRES Indicator	Actions 2026/27	Measure	Owner(s)
Indicator 9 Board and workforce representation gap	• Monitor Voting Board, Executive Board and senior-workforce representation and apply fair, inclusive selection to relevant appointments. • Meet NHS Staff Standards requirements for published Board SMART objectives on tackling racism and a CEO or COO senior responsible officer. • Progress the Non-Executive Director Succession Plan, which recognises WRES and WDES findings and the need to improve Board diversity, including exploring engagement of a NExT Director through the NHS England programme and developing links with the Mary Seacole Group.	• Monitor Voting Board representation from 7.69% against the 23.67% workforce profile and Executive Board representation from 0%. • Review relevant recruitment outcomes; publish Board objectives and confirm the CEO or COO senior responsible officer. • Progress against the Non-Executive Director Succession Plan monitored, including exploration of the NExT Director programme and engagement with the Mary Seacole Group.	**Chair / Trust Secretary** CEO or COO Recruitment EDIB

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APPENDIX B

Dorset HealthCare

Workforce Race Equality Standard Report

2025-26

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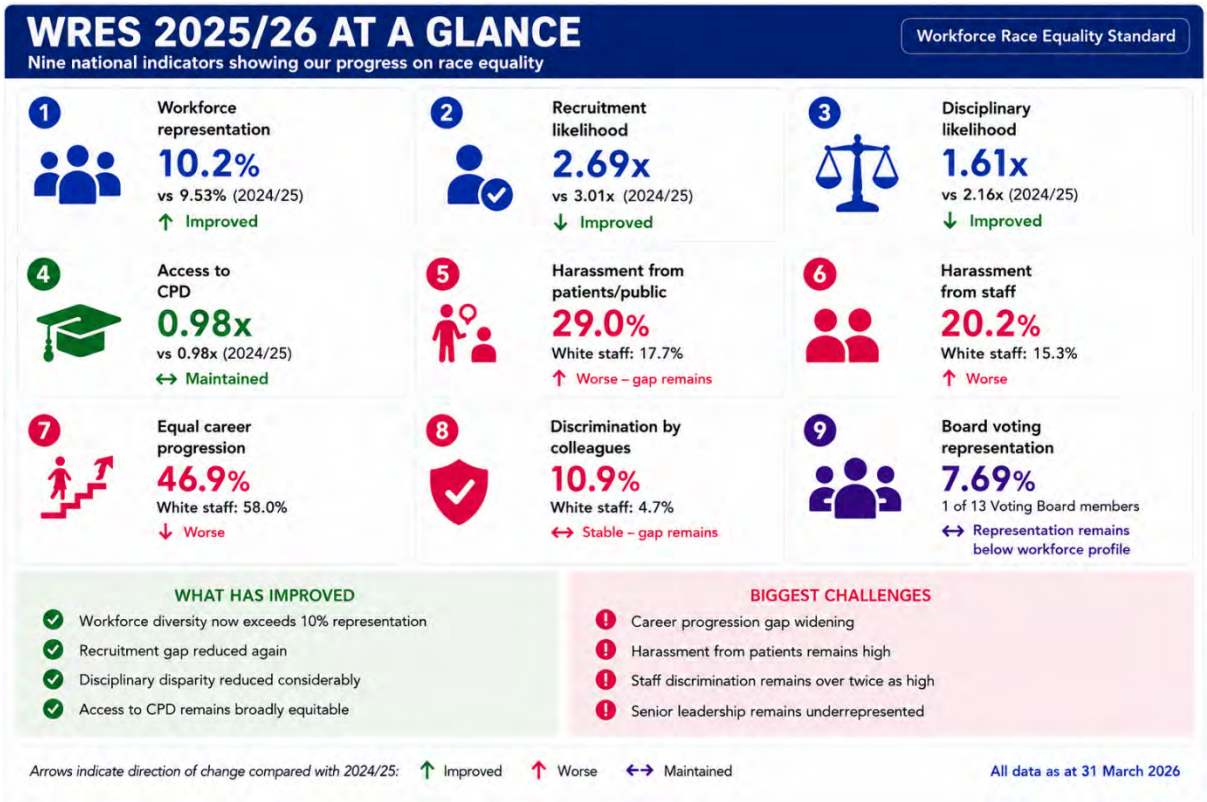
Executive summary

The Workforce Race Equality Standard (WRES) is the NHS's nationally mandated framework for measuring race equality within the workforce. At Dorset HealthCare, we use the WRES alongside staff feedback and workforce data to understand where inequalities exist and to inform an equity-focused approach that removes barriers and creates fair opportunities for colleagues from ethnic minority backgrounds. This year's WRES results demonstrate encouraging progress across several indicators. Workforce representation has increased, while recruitment and disciplinary disparities have reduced. These improvements reflect the sustained work delivered through our Inclusion and Belonging Strategy and our wider programme of race equity initiatives.

Despite this progress, the data continues to demonstrate inequalities in staff experience, career progression and representation within senior leadership. Ethnic minority colleagues remain more likely to experience harassment, bullying and discrimination and less likely to believe the Trust provides equal opportunities for career progression. These findings reinforce the importance of continuing to embed race equity across every stage of the employee journey. Creating an equitable and inclusive workplace is fundamental to attracting, retaining and developing a diverse workforce that is better equipped to deliver high-quality, compassionate care for the communities we serve. Our focus is not simply on achieving equal treatment, but on creating equitable experiences and outcomes, recognising that different groups may require different support to remove barriers and thrive within our organisation.

Data sources



- Indicators 1 and 9 are based on workforce and Board data recorded at the snapshot date of 31 March 2026.
- Indicator 2 is based on TRAC recruitment data for the period 1 April 2025 to 31 March 2026.
- Indicator 3 is based on HR records for the period 1 April 2025 to 31 March 2026.
- Indicator 4 is based on Trust training and CPD data for 2025/26.

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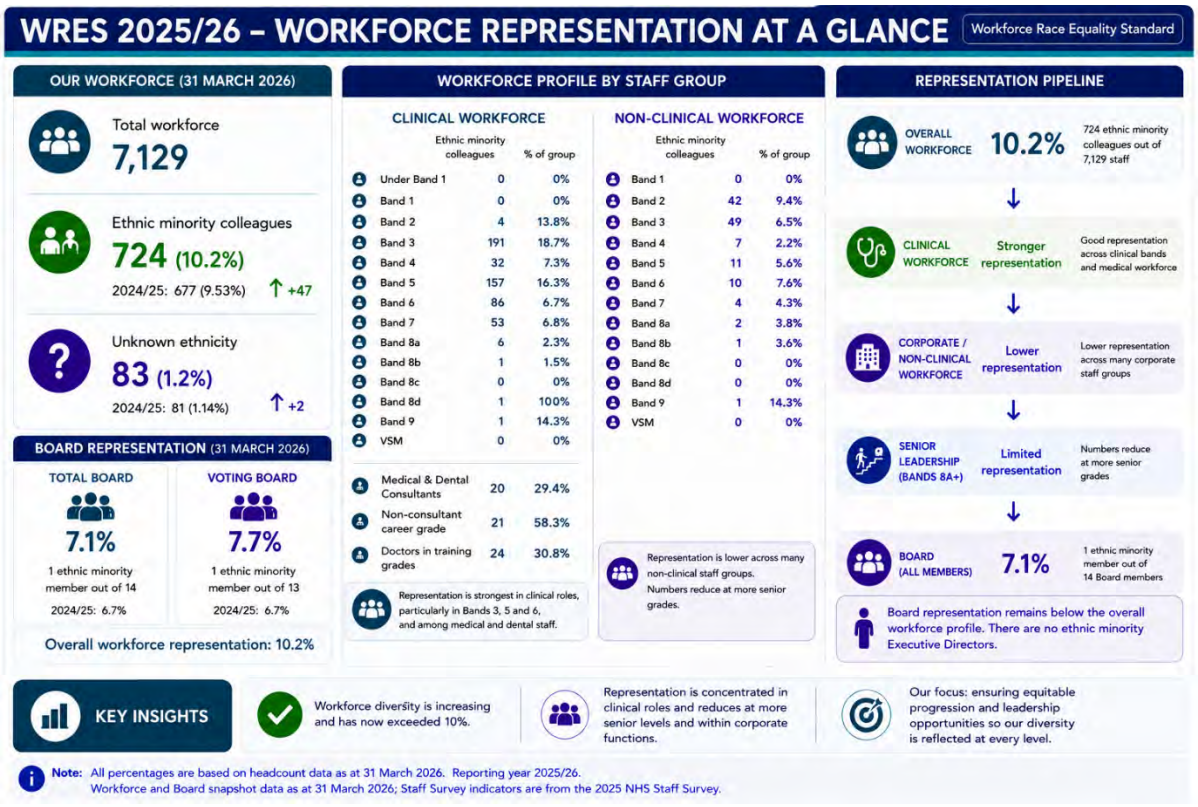
- Indicators 5 to 8 are based on the 2025 NHS Staff Survey, collected between October and December 2025.

What the data tells us

Representation across the workforce



The proportion of colleagues from ethnic minority backgrounds has continued to increase and now stands at 10.2% of the workforce (724 colleagues), compared with 9.53% (677 colleagues) in 2024/25. This represents an increase of 47 colleagues over the last year and is the highest level of ethnic minority representation recorded by the Trust through WRES reporting. The proportion of colleagues with an unknown ethnicity remains low at 1.2%, providing confidence that the data accurately reflects the composition of our workforce.

The workforce profile demonstrates that a substantial number of ethnic minority colleagues work across several clinical professions. There are 191 ethnic minority colleagues in Clinical Band 3, 157 in Clinical Band 5, 86 in Clinical Band 6, 53 in Clinical Band 7, alongside 20 Medical and Dental Consultants, 21 non-consultant career grade doctors and 24 doctors in training grades. This reflects the growing diversity of our clinical workforce and the important contribution colleagues from ethnic minority backgrounds make across frontline services.

However, representation is not yet consistent across the organisation. Within non-clinical services, ethnic minority representation is lower across many staff groups and generally reduces at more senior grades. Whilst there is representation at Bands 8A, 8B and Band 9, there are currently no ethnic minority colleagues in non-clinical Bands 8C, 8D or Very Senior Manager (VSM) roles. Across the wider workforce, representation is generally lower at senior levels, although the small number of posts within some senior bands means percentages can fluctuate considerably.

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Ethnic minority representation on the Voting Board is 7.69% in 2025/26 (one ethnic minority member out of 13 Voting Board members), compared with 6.7% in 2024/25. The change in

percentage reflects a change in the overall number of Voting Board members rather than an increase in ethnic minority membership. Representation remains below the overall workforce profile of 10.2%, and there are currently no ethnic minority Executive Directors.

Overall, the data presents a positive picture of a workforce that is becoming increasingly diverse, while also highlighting where further progress is needed. The WRES demonstrates that although ethnic minority representation has continued to grow, this diversity is not yet consistently reflected across all staff groups or at the most senior levels of the organisation. This aligns with the wider findings from our WRES data, which show improving recruitment outcomes but continuing disparities in career progression. Strengthening equitable development opportunities and continuing to work with colleagues across the organisation to reduce barriers to progression will therefore remain a key priority in ensuring the diversity of our workforce is reflected at every level of the organisation.

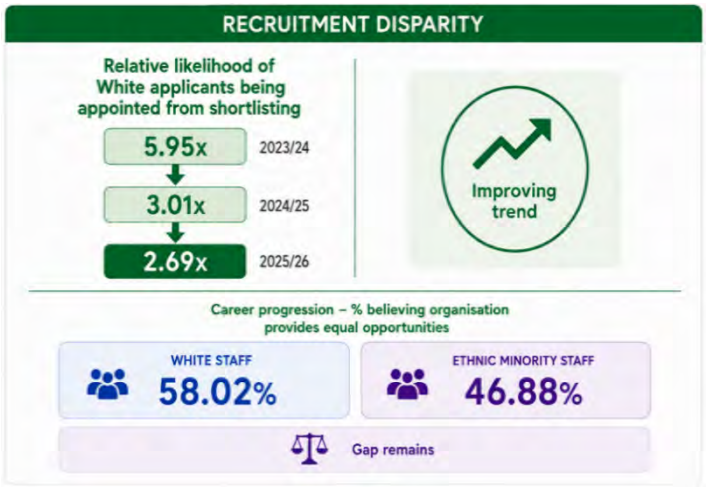
Recruitment and career progression

The relative likelihood of White applicants being appointed from shortlisting compared with ethnic minority applicants has continued to reduce, improving from 3.01 in 2024/25 to 2.69 in 2025/26. Whilst White applicants remain more likely to be appointed, this represents continued progress and suggests that the gap is narrowing over time.

In 2025/26, 163 of 2,043 shortlisted ethnic minority applicants were appointed (7.98%), compared with 1,034 of 4,817 shortlisted White applicants (21.47%). This means that, despite the improvement in the relative likelihood measure, a substantial difference in appointment rates remains.

However, recruitment is only one part of the employee journey. The WRES continues to highlight a significant disparity in colleagues' perceptions of career progression. Whilst 58.02% of White colleagues believe the Trust provides equal opportunities for career progression or promotion, this falls to 46.88% for ethnic minority colleagues.

Taken together, these findings suggest that whilst the disparity in recruitment outcomes is narrowing, further work is required to ensure equitable outcomes at appointment and throughout colleagues' careers. Addressing barriers to progression and continuing to work collaboratively across the organisation to improve equitable recruitment and career opportunities will therefore remain an important area of focus.



Staff experience

Whilst the relative likelihood of ethnic minority staff entering the formal disciplinary process has improved significantly, the WRES continues to demonstrate substantial disparities in colleagues' day-to-day workplace experiences.

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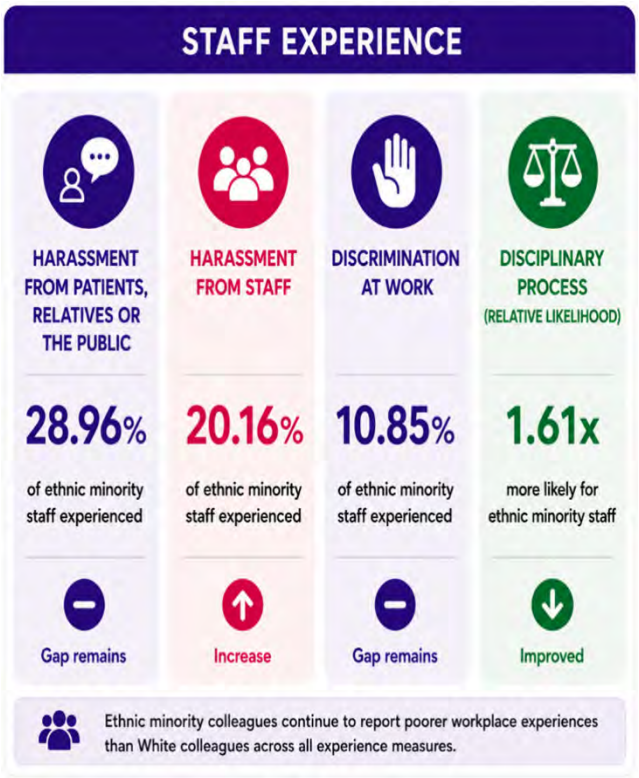
Ethnic minority colleagues remain significantly more likely to experience harassment, bullying or abuse from patients, relatives and the public (28.96% compared with 17.74%), harassment from colleagues (20.16% compared with 15.32%) and discrimination at work (10.85% compared with 4.70%). Although the relative likelihood of ethnic minority staff entering the formal disciplinary process has reduced from 2.16 to 1.61, these findings demonstrate that inequitable workplace experiences persist.



Creating psychologically safe workplaces where colleagues feel respected, valued and able to thrive remains fundamental to delivering race equity. Reducing experiences of harassment, bullying and discrimination will therefore continue to be a key priority through our Inclusion and Belonging Strategy and wider anti-racism programme.

How we're responding

During 2025/26 we continued to deliver a comprehensive programme of work through our Inclusion and Belonging Strategy and *We All Belong* – our Anti-Racism and Inclusion Framework to improve race equity, reduce inequalities and create a more inclusive workplace. Our approach recognises that achieving equitable outcomes requires more than treating everyone the same; it requires understanding where barriers exist, listening to lived experience, working in partnership with colleagues, and taking targeted action to remove them. Our programme of work brings together inclusive leadership, fair recruitment, anti-racism, staff engagement and organisational governance into a coordinated approach to improving race equity across Dorset HealthCare.

Building inclusive leaders

Inclusive leadership remains central to improving race equity across Dorset HealthCare. During the year we continued delivering Conscious Inclusion and Inclusive Leadership training, which is now mandatory for all line managers. These programmes support leaders to recognise bias, understand inequity and create inclusive, psychologically safe teams where everyone feels they belong. Further cohorts of our Reciprocal Mentoring Programme continued to strengthen leaders' understanding of lived experience, whilst Active Bystander eLearning equips colleagues with the confidence to safely challenge inappropriate behaviours and foster a culture of collective responsibility.

Creating fair opportunities

We continued to strengthen inclusive recruitment through Inclusive Recruitment and Selection training and began preparing for the introduction of Diverse Recruitment Panels for senior appointments. Alongside ongoing monitoring of recruitment data, these initiatives aim to reduce barriers to employment and ensure recruitment decisions are fair, transparent and inclusive. Whilst inclusive recruitment is an important part of improving race equity, recruitment alone will not address inequalities. We will therefore continue working with colleagues across the organisation to reduce barriers to progression and support equitable career opportunities.

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Tackling racism and discrimination
Creating an equitable workplace requires an active organisational response to racism and discrimination. During the year we continued embedding the Trust's *We All Belong* – Anti-Racism and Inclusion Framework, strengthening our organisational response to racism and promoting collective responsibility for tackling racism and creating an inclusive culture. This included establishing the Violence, Aggression and Discrimination Task and Finish Group, developing guidance to support managers responding to unacceptable behaviours from patients, relatives and visitors, and embedding our Respect and Resolution Policy and Zero Acceptance approach to racism, discrimination, bullying and harassment. Together, these initiatives aim to create safer workplaces where colleagues feel supported to speak up and confident that concerns will be addressed appropriately.

Listening to staff
Listening to colleagues remains fundamental to delivering meaningful and sustainable change. Throughout the year we continued working closely with our Multicultural Staff Network, Executive Sponsors and colleagues across the organisation to better understand lived experience and co-produce improvements. Black History Month, Dorset Mela, listening events, the Joint Culture and Belonging Group and our wider *We All Belong* campaign continue to amplify staff voice, celebrate diversity and inform organisational priorities.

Embedding race equity
Race equity continues to be embedded within organisational governance through our Inclusion and Belonging Strategy, WRES, the Equality Delivery System (EDS), workforce and pay gap reporting, and regular Board reporting. These arrangements provide oversight of progress, strengthen organisational accountability and ensure race equity is embedded within organisational decision-making and continuous improvement.

Our focus 2026/27

Whilst the 2025/26 WRES demonstrates encouraging progress across several indicators, it also highlights areas where continued focus is needed. During 2026/27 we will build on the progress made to date by embedding race equity across the organisation, improving colleagues' workplace experiences and continuing to use workforce data to inform targeted action. Our priorities for 2026/27 are to:

- **Continue improving recruitment equity:** Continue embedding inclusive recruitment practices and training for Recruiting Managers, including Diverse Recruitment Panels, and monitor recruitment outcomes to identify and address inequalities.
- **Improve staff experience:** Reduce experiences of harassment, bullying and discrimination through continued delivery of our anti-racism programme, Zero Acceptance approach, manager guidance, Active Bystander eLearning and wider work to promote psychologically safe workplaces.
- **Embed inclusive leadership:** Continue embedding Conscious Inclusion and Inclusive Leadership learning to support psychologically safe, inclusive teams where all colleagues feel respected, valued and able to thrive.
- **Refresh our Inclusion and Belonging Strategy:** Develop a refreshed Inclusion and Belonging Strategy through co-production with colleagues, Staff Networks, patients, carers and communities, ensuring it reflects our evolving organisational priorities, the NHS 10-Year Health Plan and continues to drive equitable outcomes for both our workforce and the people who use our services.
- **Embed our Anti-Racism Framework:** Continue embedding the Trust's Anti-Racism Framework through delivery of its action plan and develop and implement a supporting Anti-Racism Policy to strengthen our organisational approach to preventing, responding to and addressing racism.
- **Embed *We All Belong:*** Continue embedding the *We All Belong* campaign by promoting inclusion, celebrating diversity, encouraging allyship and creating

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opportunities for colleagues to connect, learn and contribute to an inclusive culture where everyone feels they belong.

- **Strengthen organisational accountability:** Continue monitoring WRES indicators, workforce data, Staff Survey findings and lived experience to evaluate progress, identify inequalities and inform organisational decision-making, ensuring race equity remains embedded within organisational governance and continuous improvement.

These priorities will continue to be delivered in partnership with our Staff Networks, Executive Sponsors, colleagues, patients, carers and communities through a co-produced and evidence-informed approach.

Conclusion

The 2025/26 WRES demonstrates both the progress Dorset HealthCare has made and the opportunities that remain. Increasing workforce diversity, improving recruitment outcomes and reducing disciplinary disparities provide encouraging evidence that sustained action is making a difference. At the same time, continued disparities in staff experience, career progression and senior representation demonstrate that achieving race equity requires sustained commitment and continuous improvement. Our focus will therefore remain on listening to lived experience, embedding inclusive leadership, tackling racism and discrimination, and using evidence to inform meaningful organisational change. Through our refreshed Inclusion and Belonging Strategy, We All Belong Anti-Racism and Inclusion Framework, and continued partnership with colleagues, Staff Networks, Executive Sponsors, patients, carers, communities and system partners, we will continue to build a culture where everyone feels they belong and has equitable opportunities to thrive.

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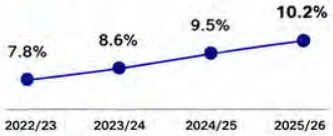
WRES AT A GLANCE

Key trends across the 9 WRES indicators | Four-year journey 2022/23 – 2025/26 | Key trends across the 9 WRES indicators

1 WORKFORCE REPRESENTATION

Percentage of staff from ethnic minority backgrounds



Good progress
Workforce diversity continues to increase year-on-year.

2 RECRUITMENT

Relative likelihood of appointment from shortlisting (White staff compared to ethnic minority staff)

Good progress
Recruitment disparities continue to reduce.
(Lower is better)

3 DISCIPLINARY

Relative likelihood of ethnic minority staff entering the formal disciplinary process compared to White staff

Good progress
Significant improvement compared with previous years.
(Lower is better)

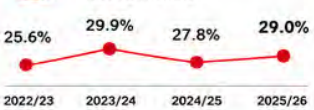
4 ACCESS TO CPD

Relative likelihood of White staff accessing non-mandatory training & CPD compared to ethnic minority staff

Good progress
Equitable access has been maintained.
(1.0 = no difference)

5 HARASSMENT FROM PATIENTS, RELATIVES OR THE PUBLIC

% of staff experiencing harassment in the last 12 months



Priority
Significant disparity remains.

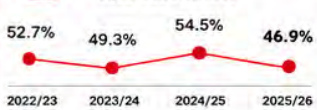
6 HARASSMENT FROM STAFF

% of staff experiencing harassment in the last 12 months

Priority
Gap remains for ethnic minority staff.

7 EQUAL OPPORTUNITIES FOR CAREER PROGRESSION

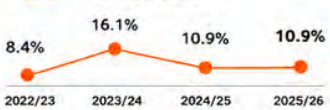
% of staff believing the Trust provides equal opportunities



Priority
Perceptions remain significantly lower.

8 DISCRIMINATION FROM MANAGER OR TEAM LEADER OR COLLEAGUES

% of staff experiencing discrimination in the last 12 months



Continue focus
Disparity persists – continued action required.

9 BOARD REPRESENTATION – VOTING BOARD

(compared with overall workforce)

2024/25	2025/26
6.7% ethnic minority	7.69% ethnic minority (1 of 13)
Overall workforce: 9.5%	Overall workforce: 10.2%

DIRECTION OF TRAVEL

Representation remains below the overall workforce profile.

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2025/26 LEADERSHIP SNAPSHOT

Total Board	Voting Board	Non-Executive Board	Executive Board
7.14%	7.69%	14.29%	0%
1 of 14	1 of 13	1 of 7	0 of 7

Note: All percentages are based on headcount data.

Reporting year 2025/26. Workforce and Board snapshot data as at 31 March 2026; Staff Survey indicators are from the 2025 NHS Staff Survey.

BOARD ASSURANCE KEY

- **Good progress** – Positive improvement
- **Continue focus** – Further improvement required
- **Priority** – Significant gap – continued focus needed

2025/26 BOARD REPRESENTATION SNAPSHOT

as at 31 March 2026

Group	Ethnic Minority		White		Unknown		Total
	No.	%	No.	%	No.	%	No.
Total Board members	1	7.14%	13	92.86%	0	0.00%	14
Voting Board members	1	7.69%	12	92.31%	0	0.00%	13
Non-Executive Board members	1	14.29%	6	85.71%	0	0.00%	7
Executive Board members	0	0.00%	7	100.00%	0	0.00%	7

DIFFERENCE COMPARED WITH OVERALL WORKFORCE (10.2% ETHNIC MINORITY)

Total Board	Voting Board	Executive Board
-3.1pp	-2.5pp	-10.2pp

Ethnic minority representation on the Voting Board is 7.69% in 2025/26 (1 of 13 Voting Board members), compared with 6.7% in 2024/25. The percentage change reflects a change in the overall number of Voting Board members rather than an increase in ethnic minority membership. Representation remains below the workforce profile of 10.2%, with no ethnic minority Executive Directors.

KEY MESSAGES

- Good progress has been made across representation, recruitment, disciplinary and access to CPD.
- Continue to focus on board representation and discrimination.
- Priority action is required to improve staff experience, career progression and to increase ethnic minority executive representation.
- We remain committed to creating a fair, inclusive and equitable workplace for all.

The actions below combine targeted interventions with ongoing monitoring and evaluation. Where monitoring is identified as an action, its purpose is to assess the impact of activity already underway, identify emerging or persistent inequalities and inform further targeted intervention where required.

Trust	**Dorset HealthCare University NHS Foundation Trust**		
Year	2026/27		
Primary author of the action plan	Manpreet Aujla-Gudgeon (Equality, Diversity and Inclusion Lead)		
Sources of information underpinning the plan	WRES 2025/26 data; NHS Staff Survey; workforce data and lived experience; national WRES reports and guidance; NHS EDI Improvement Plan; Inclusion and Belonging Strategy; We All Belong – Anti-Racism and Inclusion Framework.		
WRES Indicator	**Actions 2026/27**	**Measure**	**Owner(s)**
Indicator 1 Workforce Representation	• Continue monitoring ethnic minority representation across AfC bands, occupational groups and senior leadership to identify areas of underrepresentation. • Use workforce data alongside lived experience to understand potential barriers to recruitment, retention and progression. • Use findings to inform the refreshed Inclusion and Belonging Strategy and targeted workforce improvement activity.	• Overall representation monitored against current 10.2% baseline. • Representation monitored across workforce levels rather than overall headcount alone. • Areas of underrepresentation identified, and appropriate action developed.	EDI Workforce Reporting OD Recruitment
Indicator 2 Likelihood of being appointed from shortlisting across all posts	• Monitor recruitment outcomes to evaluate the impact of inclusive recruitment interventions and identify where disparities remain or further targeted action is required. Embed Inclusive Recruitment and Selection learning for recruiting managers. • Introduce Diverse Recruitment Panels for senior appointments, beginning with Band 8a+ roles. • Work with Staff Networks and colleagues to identify and remove barriers within recruitment and selection.	• Reduction in appointment disparity from current 2.69. • Uptake of Inclusive Recruitment learning. • Diverse Recruitment Panels implemented and evaluated. Recruitment outcomes monitored by ethnicity.	Recruitment Staff Network Chairs EDI

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Indicator 3 Staff entering formal disciplinary process	• Maintain oversight of disciplinary data, building on the improvement from 2.16 to 1.61 is sustained and identify where further action is required. • Continue mandated Conscious Inclusion and Inclusive Leadership learning for line managers. • Monitor application and outcomes of the Respect and Resolution Policy by ethnicity. • Use workforce data to identify and respond to emerging disparities.	• Maintain/reduce relative likelihood from 1.61, with movement towards parity (1.0). • Training compliance monitored. • Disciplinary and Respect and Resolution outcomes reviewed by ethnicity.	Human Resources EDI
Indicator 4 Staff accessing non-mandatory training and CPD	• Maintain equitable access to non-mandatory training and CPD. • Monitor participation in development opportunities by ethnicity and other protected characteristics. • Continue the Reciprocal Mentoring Programme and evaluate learning and impact. • Support meaningful career and development conversations through appraisal.	• Maintain relative likelihood close to parity (currently 0.98). • Participation in development opportunities monitored by ethnicity. • Reciprocal Mentoring learning and impact evaluated.	EDI
Indicator 5 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	• Continue embedding Zero Acceptance of racism, discrimination, bullying, harassment and violence. • Implement and embed manager guidance for supporting colleagues experiencing unacceptable behaviours. • Continue actions arising from the Violence, Aggression and Discrimination work. • Use Ulysses data, Staff Survey findings and lived experience to identify themes and hotspots. • Promote reporting and available support.	• Reduction in ethnic minority staff reporting harassment/abuse from current 29.0%, and reduction in the gap with White staff (17.7%). • Manager guidance implemented and promoted. • Ulysses trends regularly reviewed and reported. • Evidence of actions in response to identified themes.	Human Resources EDI SAFE Team Nursing and Quality
Indicator 6 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	• Strengthen action in response to the increase from 15.6% to 20.2% among ethnic minority colleagues. • Continue embedding the Respect and Resolution Policy and Zero Acceptance approach. • Promote and embed Active Bystander eLearning. • Analyse Staff Survey, employee relations and other available workforce data to identify themes and areas requiring targeted action. • Work with Staff Networks and FTSU to understand lived experience and co-produce improvements.	• Reduction from current 20.2% and reduction in the gap with White staff (15.3%). • Active Bystander uptake monitored. • Themes/hotspots identified, and appropriate action taken. • Evidence of staff voice informing improvement activity.	Human Resources EDI FTSUG

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Indicator 7 Percentage believing that trust provides equal opportunities for career progression or promotion	• Undertake further analysis and engagement with ethnic minority colleagues to understand the reduction from 54.5% to 46.9% and identify barriers to progression. • Use findings to develop targeted improvement actions. • Continue Conscious Inclusion and Inclusive Leadership learning and EDI content within manager development. • Continue the Reciprocal Mentoring Programme. • Monitor participation and outcomes in development and progression opportunities by ethnicity to evaluate impact and identify where further action is required.	• Improvement from current 46.9% and reduction in the gap with White staff (58.0%). • Staff engagement/lived experience work completed, and themes identified. • Targeted actions developed in response. • Development and progression data monitored by ethnicity.	EDI Organisational Development
Indicator 8 In the last 12 months have you personally experienced discrimination at work from any of the following: Manager/team leader or other colleagues	• Continue embedding We All Belong – Anti-Racism and Inclusion Framework and its actions. • Develop an Anti-Racism Policy to strengthen the organisational approach to preventing and responding to racism. • Embed Active Bystander learning and continue Conscious Inclusion and Inclusive Leadership learning. • Work with the Multicultural Staff Network, FTSU and colleagues to understand lived experience and inform action.	• Reduction from current 10.9% and reduction in the gap with White staff (4.7%). • Anti-Racism Policy developed and implemented. • Framework actions monitored and impact evaluated. • Evidence of lived experience informing organisational action.	FTSUG Human Resources EDI

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Indicator 9 Percentage difference between the organisations' board voting membership and its overall workforce	• Continue monitoring Board and senior leadership representation. Ethnic minority representation on the Voting Board is 7.69% in 2025/26 (1 of 13), compared with 6.7% in 2024/25; the percentage change reflects a change in the overall number of Voting Board members rather than an increase in ethnic minority membership. Representation remains below the overall workforce profile of 10.2%. • Introduce Diverse Recruitment Panels for senior appointments. Review recruitment and selection arrangements for senior and Board appointments to support fair and inclusive processes. • Monitor senior workforce representation to identify potential barriers to progression. • Ensure findings inform the refreshed Inclusion and Belonging Strategy and wider workforce priorities. • Progress the Non-Executive Director Succession Plan, which recognises WRES and WDES findings and the need to improve Board diversity, including exploring engagement of a NExT Director through the NHS England programme and developing links with the Mary Seacole Group.	• Further improvement in Voting Board representation and reduction in the current 2.5 percentage-point gap with the workforce. • Senior workforce representation monitored by ethnicity. • Diverse Recruitment Panels implemented for relevant senior appointments. • Recruitment outcomes for senior appointments reviewed. • Progress against the Non-Executive Director Succession Plan monitored, including exploration of the NExT Director programme and engagement with the Mary Seacole Group.	Recruitment EDI

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APPENDIX C

Dorset County Hospital

Workforce Disability Equality Standard Report

2025-26

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Executive summary

The Workforce Disability Equality Standard (WDES) is the NHS's nationally mandated framework for measuring disability equality within the workforce. At Dorset County Hospital, we use the WDES alongside workforce information, the NHS Staff Survey and staff voice to understand where Disabled colleagues face barriers and where improvement is required. This year's results contain a clear positive finding: recruitment from shortlisting is close to parity and slightly favours Disabled applicants. Harassment from patients and the public and from managers also reduced, while reporting after harassment increased and is now close to the result for colleagues without a long-term condition or illness.

Those improvements sit alongside persistent inequalities in experience after joining the organisation. Disabled staff were 2.14 times as likely to enter a formal capability process, although this is based on very small numbers. Staff with a long-term condition or illness were more likely to experience harassment from colleagues and pressure to attend work when unwell and were less likely to feel valued or believe that career opportunities are equal. Positive responses on reasonable adjustments fell to 73.33%, and engagement reduced to 6.47 compared with 7.06 for colleagues without a long-term condition or illness.

The proportion of the submitted workforce recorded as Disabled remained broadly stable at 6.59%, representing 256 colleagues. One of 13 Voting Board members was recorded as Disabled, slightly above the workforce proportion. Among six Executive Board members, none was recorded as Disabled and one had an unknown or not-stated disability status. The results show a contrast between broadly equitable recruitment and continuing gaps in workplace support, day-to-day culture, recognition, progression and capability practice.

DCH's response will use the WDES findings to strengthen delivery through relevant DCH work and agreed joint DCH–DHC activity. The emphasis is on removing practical barriers, improving consistency and testing whether existing policies, learning and support make a difference in everyday experience. The accompanying Action Plan brings these commitments together and identifies accountable functions and supporting roles. Agreed joint work with Dorset HealthCare (DHC) and proposals requiring approval are identified separately in the Action Plan, which marks the capability case review as the only new WDES action.

Data sources

- Metrics 1 and 10 are based on workforce and Board data recorded at the snapshot date of 31 March 2026.
- Metric 2 is based on known TRAC recruitment data for the period 1 April 2025 to 31 March 2026.
- Metric 3 is based on HR records and uses a two-year rolling average covering 1 April 2024 to 31 March 2026.
- Metrics 4 to 9a are based on the 2025 NHS Staff Survey.
- Metric 9b is based on Trust information about action taken to facilitate the voices of Disabled staff to be heard.

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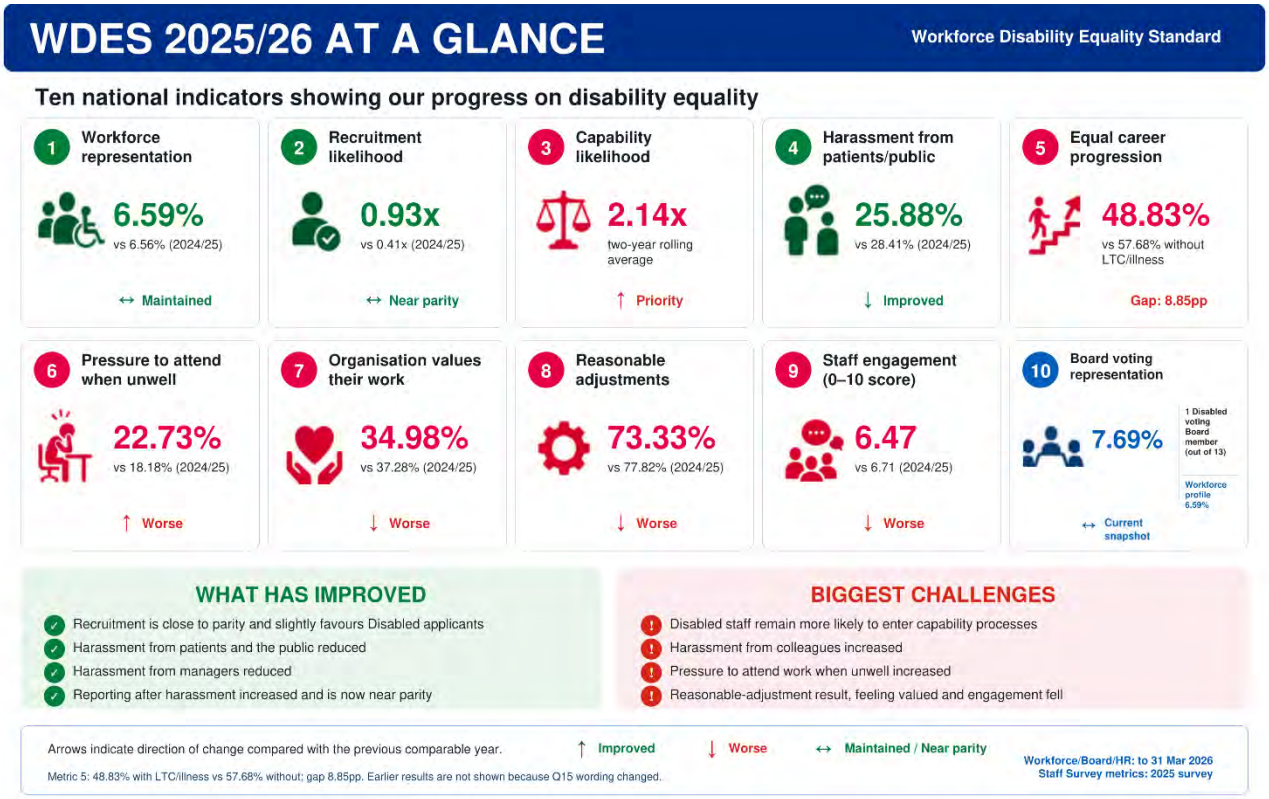

What the data tells us

Representation across the workforce

At 31 March 2026, 256 of 3,882 colleagues in the submitted WDES workforce were recorded as Disabled, representing 6.59%. This is broadly unchanged from 251 colleagues and 6.56% in the previous comparable submission. A further 339 colleagues, or 8.73%, had no disability status recorded or were recorded as unknown. The headline therefore needs to be read both as a measure of representation and as an indication of how confident colleagues feel about recording disability information on ESR.

The submitted workforce profile is not evenly distributed across staff groups. It records 177 Disabled colleagues in the clinical grouping, representing 7.1% of 2,490 colleagues, and 66 in the non-clinical grouping, representing 7.7% of 860. Within clinical AfC bands, recorded representation is 8.9% across Bands 1 to 4 and 6.7% across Bands 5 to 7, falling to 2.7% across Bands 8a and 8b and 0% across Bands 8c to VSM. In the non-clinical grouping, representation is 8.4% across Bands 1 to 4 and 7.1% across Bands 5 to 7. The 13.0% recorded across Bands 8c to VSM represents only three colleagues, illustrating how small denominators can move senior percentages substantially.

Medical and dental data has a different profile. The submitted return records three Disabled consultants out of 216, two Disabled non-consultant career-grade doctors out of 56 and eight Disabled doctors in training out of 260. This gives overall recorded representation of 2.4% across the medical and dental workforce, with 15.0% of records in those groups recorded as unknown. For assurance and action, it is therefore important to look at the underlying headcount, the percentage of unknown records and changes over time, rather than treating a single percentage as a complete account of workforce experience.

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One of 13 Voting Board members was recorded as Disabled. This gives a current snapshot of 7.69%, compared with 6.59% across the workforce. Across all 14 Board members, one was recorded as Disabled and one had an unknown disability status. Among the six Executive

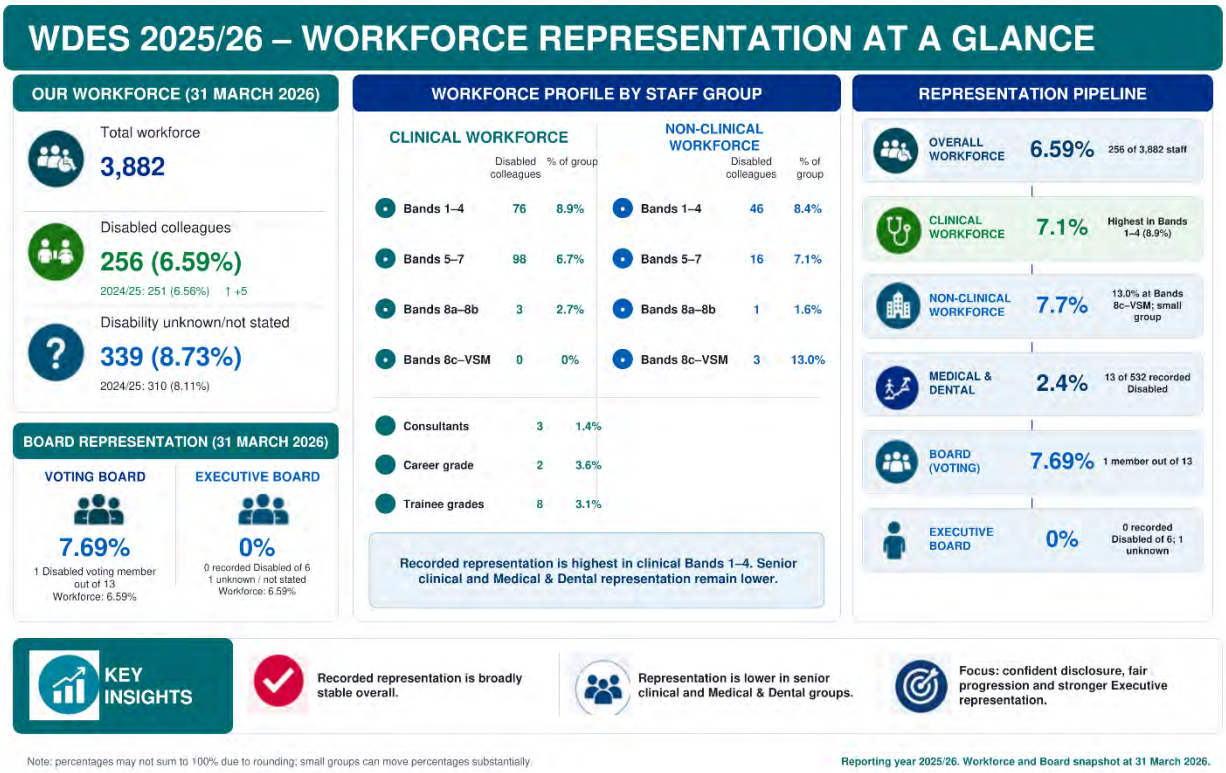
Board members, none was recorded as Disabled and one had an unknown or not-stated disability status. The Voting Board figure should be interpreted cautiously because it represents one person; Executive representation and confident recording remain areas for attention.

Overall, recorded disability representation is stable rather than showing a material increase. The main assurance questions are whether colleagues feel safe to disclose, whether representation is sustained through progression into senior roles, and whether workforce data is being used alongside lived experience. Disclosure will remain voluntary; the organisational task is to make the purpose of recording clear, protect confidentiality and demonstrate that information leads to better support and fairer decisions.

The workforce figures provide an important baseline, but they do not by themselves show whether Disabled colleagues can access adjustments, feel valued, progress or raise concerns safely. Those outcomes are better understood by reading the representation data alongside recruitment, capability and Staff Survey results.

Recruitment and career progression

Recruitment is the clearest positive finding in the 2025/26 WDES. Disabled applicants had a 32.87% appointment rate from shortlisting, compared with 30.47% for non-disabled applicants. The relative likelihood of a non-disabled applicant being appointed compared with a Disabled applicant was 0.93. A value close to 1.00 indicates parity; the current result is close to parity and slightly favours Disabled applicants. This is an outcome to sustain through accessible recruitment, timely adjustments and consistent selection practice.



The 2025 Staff Survey presents a less positive picture after people join the organisation. 48.83% of staff with a long-term condition or illness believed the Trust provides equal opportunities for career progression or promotion, compared with 57.68% of staff without one, a gap of 8.85 percentage points. Earlier results are not shown because the wording of Staff Survey Q15 changed in 2025 and the official WDES output therefore does not report a trend.

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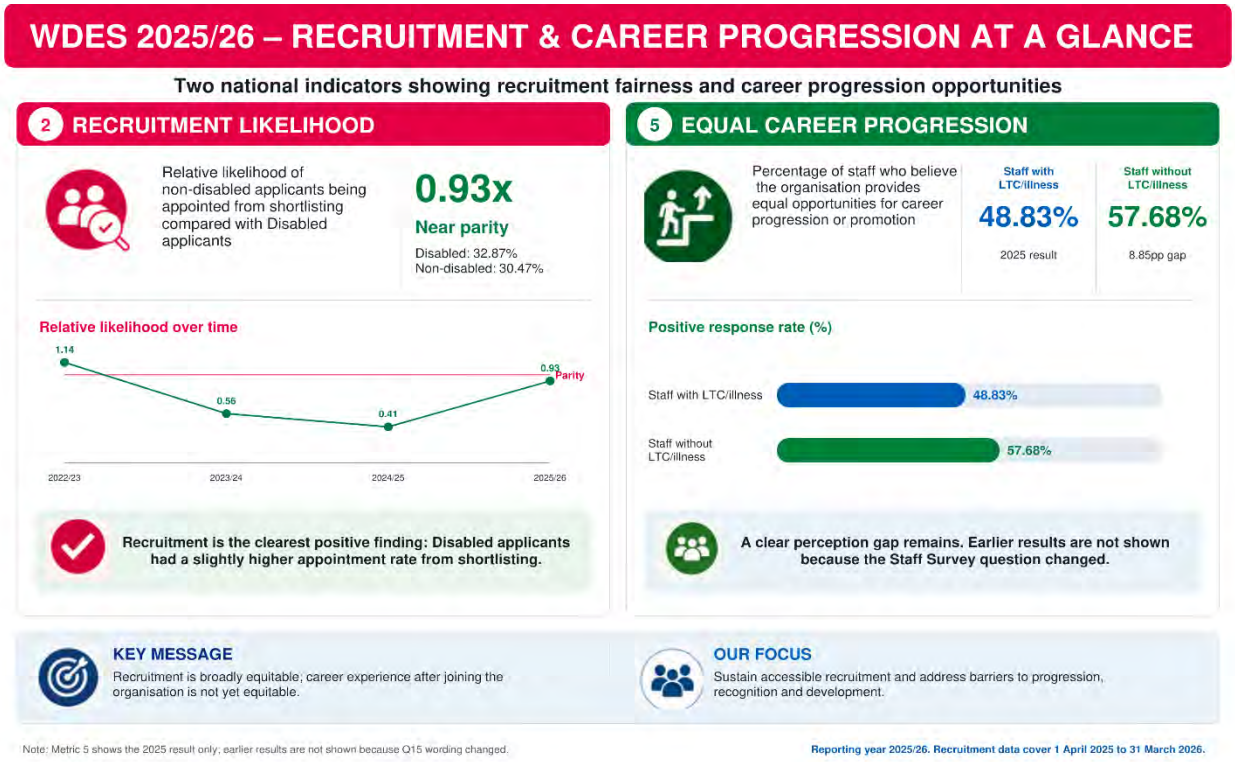
The contrast between the two results is important: recruitment from shortlisting is close to parity, while staff with a long-term condition or illness report less confidence in equal career opportunity once employed at DCH. The response therefore needs to examine career conversations, access to development, recognition, progression routes and whether workplace adjustments enable people to take up opportunities. Staff voice will help explain the barriers behind the percentage and assess whether existing delivery routes are changing colleagues' experience.



Staff experience

The 2025 Staff Survey shows improvement in some forms of harassment. 25.88% of staff with a long-term condition or illness reported harassment, bullying or abuse from patients, relatives or the public, down from 28.41% in 2024. Harassment from managers reduced from 13.72% to 12.47%. Both results remain higher than for colleagues without a long-term condition or illness, at 21.29% and 6.84% respectively, so the direction is positive but the gaps have not been eliminated.

Harassment from other colleagues is the strongest culture concern. The result increased from 24.45% to 27.63% for staff with a long-term condition or illness, compared with 16.65% for those without. Reporting after harassment moved in a more encouraging direction: 53.41% said that they or a colleague reported the last incident, up from 47.24% and now close to the 51.51% comparison result. This suggests greater willingness to report, but the increased experience of colleague harassment means prevention, manager response and support still require sustained attention.

Pressure from managers to attend work when not well enough to perform duties increased from 18.18% to 22.73%, compared with 14.90% for staff without a long-term condition or illness. Feeling valued also deteriorated: 34.98% of staff with a long-term condition or illness were satisfied with the extent to which the organisation values their work, down from 37.28% and substantially below the 47.32% comparison result. These measures point to the importance of psychologically safe wellbeing conversations, flexible support and management practice that does not treat health needs as a lack of commitment.

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Reasonable adjustments remain positive for almost three quarters of respondents, but the result fell from 77.82% to 73.33% and is just below the 2025 NHS Staff Survey average of 73.65% for the Acute and Acute & Community benchmarking group. The staff engagement score for colleagues with a long-term condition or illness also fell, from 6.71 to 6.47, compared with 7.06 for colleagues without one.

Disabled staff were 2.14 times as likely as non-disabled staff to enter the formal capability process. The calculation uses a two-year rolling average of one Disabled case and six non-disabled cases, so one case materially affects the ratio. The movement from 2.83 in 2023/24 to 0.00 in 2024/25 and 2.14 in 2025/26 should not be read as a stable trend. A proportionate, anonymised case review is therefore the one new WDES action. It will check whether disability was identified, reasonable adjustments and Occupational Health advice were considered, and decisions were applied consistently.

The overall staff-experience picture is therefore mixed. Recruitment, reduced patient/public and manager harassment, and increased reporting are positive. The main priorities are colleague-to-colleague behaviour, pressure to attend work when unwell, feeling valued, consistent reasonable adjustments, lower engagement and the capability disparity. These are connected issues: timely support, confident managers, respectful teams and trusted staff voice all influence whether Disabled colleagues can participate and progress on an equitable basis.

How we're responding

WDES will be used as evidence within existing People, EDIB and workforce delivery rather than as a separate programme. The report brings together Staff Survey findings, workforce and pay-gap data, and staff voice to identify where established work needs to be strengthened.

Making workplace support work consistently

DCH already has a Reasonable Adjustments Policy, manager guidance, a Health Passport and Access to Work support. The WDES result indicates that the main issue is consistency: colleagues need a route that is timely, clear and followed through. A centralised reasonable-adjustment process has been proposed to improve coordination and oversight; this will be scoped further by a Joint Reasonable Adjustments Task and Finish Group. The group will compare practice and identify useful, shared work in this space.

Strengthening day-to-day management

Managers' decisions shape whether disability and health needs are recognised early and whether attendance, capability and career processes are fair. DCH's existing learning and guidance—including Conscious Inclusion, Inclusive Leadership, neurodiversity support, Oliver McGowan training and wellbeing routes—provide the main delivery channels.

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Fair opportunity beyond appointment

The 0.93 recruitment result is a strength to sustain through accessible recruitment, timely adjustment offers and structured selection. Existing Inclusion and Belonging actions already cover recruitment learning, career conversations and the promotion of development opportunities.

The more difficult issue begins after appointment. Perceptions of career opportunity, feeling valued and engagement are all lower for colleagues with a long-term condition or illness, while recorded representation is lower in senior clinical and Medical and Dental roles. Where recruitment or career-development work is approved through WRES or Organisational Development, the same work should include disability and accessibility rather than create a parallel WDES audit or pilot.

DCH's Disability Confident commitments provide an external reference point, but the test of progress will be whether recruitment, development and progression are accessible in practice and whether barriers identified through staff voice lead to change.

Safer teams and trusted responses

DCH already has several routes for prevention, early intervention and reporting, including Dignity at Work, the review of the Harassment and Bullying Policy, Respectful Workplace Conversations, Freedom to Speak Up and WorkInConfidence. The rise in colleague harassment means these routes need to produce a more consistent response, clearer follow-up and visible action where themes or hotspots emerge.

The joint Zero Acceptance commitment with DHC provides common expectations on violence, aggression, discrimination and hate. At DCH, manager guidance adapted from DHC practice supports local responses to unacceptable behaviour from patients, relatives and visitors. This is a clear example of shared learning: each Trust applies its own policies, reporting routes and accountable functions.

The increase in pressure to attend work when unwell will be considered through the agreed joint scoping of sickness-absence policy work and through existing DCH wellbeing and manager-support routes. Staff Survey, absence, Occupational Health, Employee Relations and staff-voice evidence will be considered together so that the response is based on patterns of experience rather than a single indicator.

Staff voice that changes decisions

Disabled and neurodivergent colleagues have already shaped DCH's reasonable-adjustment guidance, Health Passport and wider inclusion work. The revised Staff Network Policy provides a stronger basis for renewing Without Limits after a period without a Chair, including clearer sponsorship, protected time and a route into organisational governance.

The Joint Staff Networks Conference provides an opportunity for shared learning across DCH and DHC. Any longer-term links between networks should be shaped by members and retain local identity and accountability. DCH's established staff-voice routes will inform implementation and review of the WDES response.

The difference between disability recorded in ESR and disability reported through the Staff Survey remains significant. Declaration is voluntary. The task for DCH is to explain why the information is collected, how it is protected and how colleagues can update their record, without creating pressure to disclose.

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One line of sight for delivery
WDES will be reported through established People and Board assurance alongside the Equality Delivery System, disability pay-gap reporting and Inclusion and Belonging work. It will not create a separate WDES tracker or governance route. National requirements will be used as assurance criteria within those arrangements rather than turned into additional local plans.

Work to develop the successor to the current Joint Inclusion and Belonging Strategy 2024–26 will consider how shared oversight and delivery assurance should operate across DCH and DHC. Until then, accountability remains within current Trust arrangements.

Our focus 2026/27

During 2026/27, the focus is on closing the widest gaps in day-to-day experience while sustaining the positive recruitment outcome. Five outcomes will guide delivery:

- **Support that works in practice:** Disabled and neurodivergent colleagues can obtain timely, effective adjustments and do not have to renegotiate support unnecessarily.
- **Fair and informed management:** Health and disability are recognised early, and attendance, capability and career decisions reflect adjustments, Occupational Health advice and individual circumstances.
- **Equity after appointment:** Accessible recruitment is matched by fair access to development, progression, recognition and senior opportunities.
- **Safe and respectful teams:** Harassment and pressure to work when unwell reduce, reporting is followed by support and feedback, and emerging hotspots lead to accountable action.
- **Staff voice and accountable evidence:** Disabled and neurodivergent colleagues influence decisions, workforce data is used responsibly, and progress is reviewed through one clear governance route.

The Action Plan translates these outcomes into named actions, evidence, owners and timescales. It builds on work already under way within DCH and through agreed joint DCH–DHC delivery routes, with progress reported through People and Board assurance.

The agreed areas of work with DHC are: staff-network learning, convening the Reasonable Adjustments Task and Finish Group, joint scoping of sickness-absence policy work, the common leadership-learning foundation, and Zero Acceptance and shared learning on unacceptable-behaviour guidance.

Conclusion

The 2025/26 WDES gives DCH a clear and balanced picture. Recruitment is close to parity, patient/public and manager harassment reduced, reporting improved. One of 13 Voting Board members was recorded as Disabled, giving a current snapshot of 7.69%. These positives sit alongside substantial inequalities in colleague harassment, pressure to work when unwell, feeling valued, career opportunity, engagement and the consistency of reasonable adjustments. The capability result also warrants a proportionate review, while its small-number volatility must remain visible. DCH's response is therefore to connect and sharpen work already under way, add focused assurance where the evidence requires it and use staff voice to judge whether change is felt in everyday working life.

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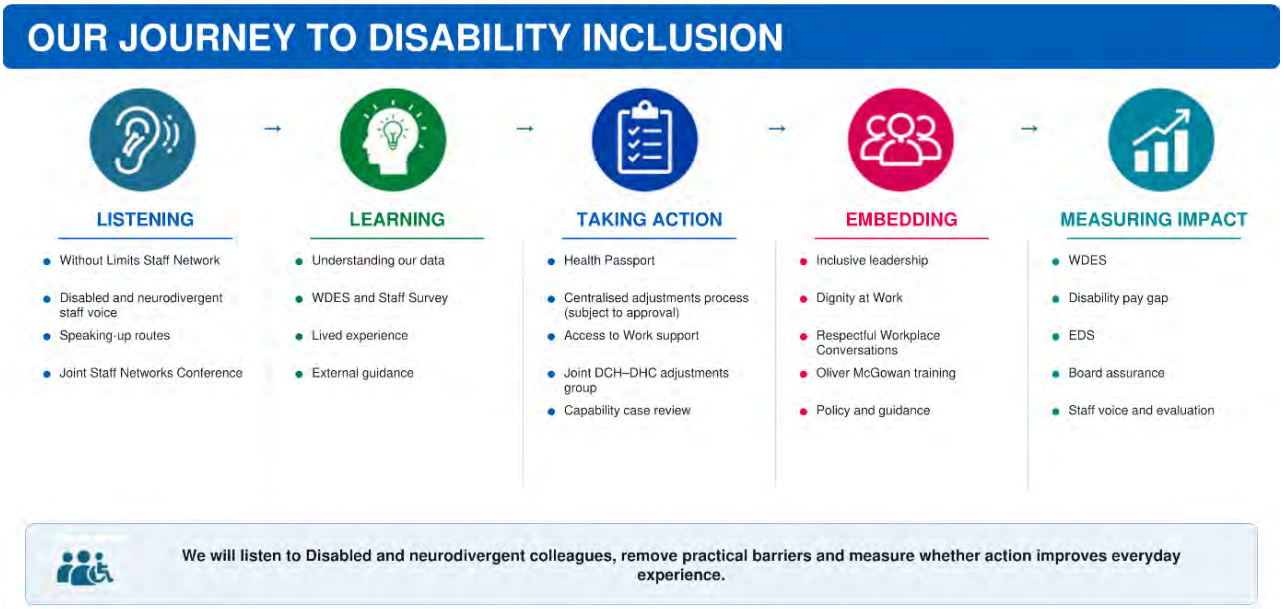

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WDES AT A GLANCE

Key trends across the 10 WDES indicators

Trend window where comparable 2022/23 – 2025/26

Key trends across the 10 WDES indicators

M1 WORKFORCE REPRESENTATION

% of staff recorded as Disabled

Continue focus
Recorded representation is broadly stable.

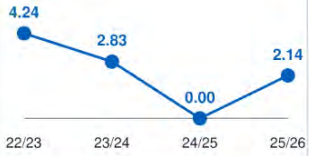
M2 RECRUITMENT

Relative likelihood of non-disabled applicants being appointed

Good progress
Current outcome is close to parity.

M3 CAPABILITY

Two-year rolling relative likelihood; small case numbers



Priority
Current ratio needs proportionate review.

M4a(i) HARASSMENT FROM PATIENTS/PUBLIC

% of staff with LTC/illness reporting harassment

Good progress
Reduced in the latest year.

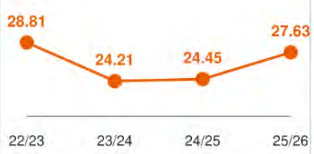
M4a(ii) HARASSMENT FROM MANAGERS

% of staff with LTC/illness reporting manager harassment

Good progress
Manager harassment reduced again.

M4a(iii) HARASSMENT FROM COLLEAGUES

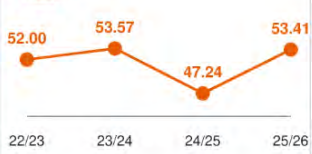
% of staff with LTC/illness reporting colleague harassment



Priority
Colleague harassment increased.

M4b REPORTED HARASSMENT

% saying they or a colleague reported the last incident



Good progress
Reporting increased and is near parity.

M5 CAREER PROGRESSION

Positive response to 2025 Staff Survey Q15

2025 result
Q15 changed; earlier results not shown.

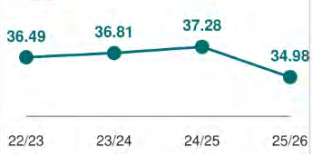
M6 PRESSURE TO WORK WHEN UNWELL

% feeling pressure to work when not well enough

Priority
Pressure increased in the latest year.

M7 ORGANISATION VALUES MY WORK

% saying the organisation values their work



Priority
Feeling valued fell and the gap widened.

M8 REASONABLE ADJUSTMENTS

% saying reasonable adjustments were made

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Continue focus
Positive response fell.

M9a STAFF ENGAGEMENT SCORE (0–10)

Engagement score for staff with LTC/illness

Priority
Score fell and remains below 7.06.

M9b STAFF VOICE

YES

DCH has taken action to facilitate Disabled staff voice. Renewal of Without Limits will strengthen this route.

M10 BOARD REPRESENTATION

VOTING BOARD	EXECUTIVE BOARD
7.69%	0%
1 recorded Disabled of 13	0 recorded Disabled of 6 1 unknown / not stated

Disabled workforce representation: 6.59%

Where comparable, trends cover 2022/23–2025/26. Metric 5 shows the 2025 result only; earlier results are not shown because Q15 wording changed.

BOARD ASSURANCE KEY

Good progress
Positive improvement

Continue focus
Further improvement required

Priority
Significant gap – continued focus needed

KEY MESSAGES

- Recruitment is close to parity.
- Patient/public and manager harassment reduced.
- Colleague harassment and presenteeism increased.
- Capability disparity requires focused review.
- Adjustments, feeling valued and engagement fell.
- Voting Board representation is slightly above the workforce profile.

Healthier lives · Empowered citizens · Thriving communities

The actions below combine targeted interventions with ongoing monitoring and evaluation. Where monitoring is identified as an action, its purpose is to assess the impact of activity already underway, identify emerging or persistent inequalities and inform further targeted intervention where required.

Trust	**Dorset County Hospital NHS Foundation Trust**
Year	2026/27
Primary author of the action plan	Jan Wagner (Equity, Diversity, Inclusion & Belonging Lead)
Sources of information underpinning the plan	WDES 2025/26 submission; 2025 NHS Staff Survey and benchmark report; workforce and Board data; DCH disability pay-gap analysis; DCH Inclusion and Belonging Action Plan; Joint Inclusion and Belonging Strategy 2024–26; proposed Joint Inclusion Strategy 2026–29; DCH reasonable-adjustment policy, guidance and Health Passport; proposal for a centralised reasonable-adjustment process; DCH Staff Network Policy; documented DCH–DHC reasonable-adjustments and sickness-absence planning; DCH WRES 2025/26 report (for alignment); NHS WDES and NHS EDI Improvement Plan; 10 Year Health Plan for England.

WDES metric	Actions 2026/27	Measures / evidence	Owner(s)
Cross-cutting **Governance and staff voice**	• Use established DCH staff-voice routes to inform WDES delivery. • Use the Joint Staff Networks Conference as a shared-learning opportunity with DHC and feed relevant learning into formal governance and delivery. • Review WDES delivery through People and Board assurance. Work to develop the successor to the current Joint Inclusion and Belonging Strategy 2024–26 will consider how shared oversight and delivery assurance should operate across DCH and DHC.	• Relevant feedback and resulting delivery changes are recorded through the assurance cycle. • Each metric has an accountable function, support roles, a measure and a current status. • Progress is reported through People and Board assurance and annual WDES reporting.	**EDIB** Support: Staff Network leads People Services DHC EDI relevant executive sponsor / Board SRO
Metric 1 **Workforce representation**	• Use existing workforce reporting and disability pay-gap assurance to review representation by AfC band, Medical and Dental and non-clinical groups, senior roles and Board, applying safe small-number rules. • Use existing staff-information routes to explain voluntary ESR disability declaration, confidentiality and how to update a record, clearly distinguishing workforce recording from the anonymous NHS Staff Survey. • Use WDES evidence within the proposed Joint Inclusion Strategy 2026–29; any further response should be assigned through an existing approved plan or governance route.	• 2025/26 result: 6.59% of the workforce recorded as Disabled; 8.73% unknown or not stated. • Band, staff-group, senior and Board profiles and unknown-status rates are monitored through established workforce and pay-gap reporting. • Any further action is assigned to an accountable function and recorded through the relevant approved delivery route.	**People Services / Workforce** Support: Workforce Reporting EDIB Communications Staff Networks

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WDES metric	Actions 2026/27	Measures / evidence	Owner(s)
Metric 2 **Appointment from shortlisting**	• Maintain accessible recruitment, timely adjustment offers, inclusive recruitment learning and structured selection through existing recruitment and Inclusion and Belonging work. • If recruitment recommendations in the WRES plan are approved, include disability and accessibility within the same review and use that route for any related candidate feedback. • Maintain current Disability Confident requirements and review the next step through the normal accreditation route.	• 2025/26 relative likelihood: 0.93; monitor material movement away from 1.00 and identify where further action is required. • Recruitment assurance records adjustment offers and any identified accessibility barriers through existing processes. • Any approved WRES recruitment review includes disability evidence; the Disability Confident status and next step are recorded through the normal route.	**Recruitment / People Services** Support: EDIB OD and Education Hiring managers Staff Networks
Metric 3 **Formal capability process**	• **NEW WDES ACTION:** Complete a proportionate, anonymised review of the small number of capability cases, checking disability identification, reasonable adjustments, Occupational Health input, attendance or capability routes, key decisions and outcomes. • Implement any learning through established Employee Relations and manager-development routes. Repeat a focused review only if the disparity persists, worsens or staff voice identifies concern.	• 2025/26 relative likelihood: 2.14, interpreted with the small-number and two-year rolling-average caveats. • The accountable functions agree and record the review timetable through People governance; findings and resulting learning are documented. • Annual monitoring reports case numbers as well as the ratio.	**People Services / Employee Relations** Support: Occupational Health EDIB Staff-side Line managers
Metric 4a(i) **Harassment from patients / public**	• Embed DCH manager guidance adapted from DHC practice alongside the joint Zero Acceptance commitment, covering immediate support, reporting, follow-up and escalation. • Use existing Staff Survey, incident, Security, Risk, Freedom to Speak Up, WorkInConfidence and staff-network evidence to identify themes and feed accountable responses into established violence-prevention work.	• 2025 result: 25.88% of staff with a long-term condition or illness, compared with 21.29% of staff without one. • Use of the guidance, identified themes and resulting actions are evidenced through existing risk and violence-prevention governance. • Existing processes evidence support and follow-up for affected staff.	**Clinical Leads** Support: Security and Risk Safeguarding People Services EDIB Health and Wellbeing

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WDES metric	Actions 2026/27	Measures / evidence	Owner(s)
Metrics 4a(ii–iii) and 4b **Harassment at work and reporting**	• Continue the Harassment and Bullying Policy review and embed Respectful Workplace Conversations, Dignity at Work and Conscious Inclusion or Inclusive Leadership learning through their agreed delivery routes. • Use Employee Relations, NHS Staff Survey, Freedom to Speak Up, WorkInConfidence and staff-network evidence to identify themes, explain what happens after reporting and assign action where concerns emerge. • Compare learning and materials with DHC to identify useful shared practice.	• 2025 results: manager harassment 12.47% versus 6.84%; colleague harassment 27.63% versus 16.65%; reporting after the last incident 53.41% versus 51.51%. • Policy, guidance and learning progress are reported to their agreed timetables. • Identified themes and accountable responses are recorded through existing governance.	**People Services / Employee Relations** Support: Freedom to Speak Up EDIB OD and Education Staff Networks Staff-side
Metric 5 **Equal career progression**	• Use existing career-conversation, appraisal and development-opportunity work to improve accessibility and involve Disabled and neurodivergent colleagues in understanding barriers. • Where a mentoring, sponsorship or other career-development route is approved through WRES or Organisational Development, include disability and accessibility in its scope and evaluation. • Use representation, disability pay-gap and staff-voice evidence to inform established progression and talent work.	• 2025 result: 48.83% of staff with a long-term condition or illness, compared with 57.68% of staff without one; current gap 8.85 percentage points. • Earlier results are not reported because Staff Survey Q15 wording changed in 2025. • Approved career and development work records how disability and accessibility are considered; participation and outcomes are reviewed by disability status where safe and available.	**OD / Talent** Support: People Services EDIB Staff Network leads Senior sponsors
Metric 6 **Pressure to work when unwell** Setchell,Ryan 09/10/2026 11:05:42	• HR, EDIB, Staff Side and Occupational Health will agree the scope, roles and timing for joint sickness-absence policy work. Delivery dates will be set once those arrangements are agreed. • Use existing DCH reasonable-adjustment, Occupational Health, wellbeing and manager-learning routes to reinforce early support before formal escalation. • Consider NHS Staff Survey, absence, Occupational Health, Employee Relations and staff-voice evidence together to identify pressure points through existing People governance.	• 2025 result: 22.73% of staff with a long-term condition or illness, compared with 14.90% of staff without one. • The joint scoping records agreed roles, scope and timetable once confirmed. • Relevant DCH themes and responses are recorded through existing People governance; the annual WDES trend is reviewed.	**People Services / Health and Wellbeing** Support: Occupational Health OD and Education EDIB Line managers Staff-side DHC counterparts (joint policy scoping)

WDES metric	Actions 2026/27	Measures / evidence	Owner(s)
Metric 7 **Organisation values their work**	• Address the result through coordinated work on manager behaviour, recognition, appraisal and career conversations, workplace adjustments and staff voice. • Use established Staff Survey, directorate engagement and staff-network routes to understand relevant themes and assign responses through existing delivery arrangements.	• 2025 result: 34.98% of staff with a long-term condition or illness, compared with 47.32% of staff without one. • Relevant actions and staff feedback are tracked through existing delivery and engagement routes. • The annual WDES trend is reported.	**OD / Engagement** Support: People Services EDIB Staff Networks Line managers
Metric 8 **Reasonable adjustments**	• Seek a decision through the normal governance route on the proposed pilot for a centralised reasonable-adjustment process. The approved decision must define scope, duration, implementation and evaluation; if it is not approved, record the alternative route. • Participate in the Reasonable Adjustments Task and Finish Group meeting on 29 September 2026. The group will agree its scope and next steps after reconvening. • Continue to use the existing policy, Health Passport, guidance and Access to Work support. Any policy or process change will follow DCH approval and implementation arrangements.	• 2025 result: 73.33% of staff with a long-term condition or illness said their employer had made reasonable adjustment(s) to enable them to carry out their work. • The governance decision and any approved pilot scope, timing, reporting and evaluation arrangements are recorded. • The joint group reconvenes on 29 September 2026; agreed scope and actions are recorded after the meeting.	**EDIB** Support: People Services Occupational Health Finance Procurement and IT DCH / DHC Task & Finish Group
Metric 9a **Staff engagement score**	• Improve engagement through coordinated action on progression, pressure to work when unwell, feeling valued, reasonable adjustments and staff voice. • Review engagement alongside related WDES metrics and qualitative staff voice, with the findings informing agreed delivery priorities and development of the successor to the current Joint Inclusion and Belonging Strategy 2024–26.	• 2025 engagement score: 6.47 for staff with a long-term condition or illness, compared with 7.06 for staff without one. • The next NHS Staff Survey result and relevant qualitative staff voice are considered together through existing reporting.	**OD / Engagement** Support: EDIB People Services Staff Networks

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WDES metric	Actions 2026/27	Measures / evidence	Owner(s)
Metric 9b **Disabled staff voice**	• Renew Without Limits in line with the Staff Network Policy, including agreed leadership, executive sponsorship, terms of reference, protected time and a route into governance. • Use the Joint Staff Networks Conference as a shared-learning opportunity. Any continuing links with DHC disability or neurodiversity networks should be member-led and retain each organisation's local identity. • Use existing staff-voice and co-production routes to inform DCH work affecting Disabled and neurodivergent colleagues.	• DCH's response to Metric 9b remains "Yes"; effectiveness is evidenced as well as existence. • Agreed network leadership, terms of reference and meeting arrangements are recorded when confirmed. • Evidence of staff voice influencing a decision, process or communication is captured through the Staff Network Policy and annual EDIB review routes.	**EDIB** Support: Executive Sponsor Without Limits members OD and Education DHC EDI
Metric 10 **Board representation**	• Apply an explicit disability and accessibility lens to senior and Board recruitment, representation and pay-gap assurance, including any approved WRES recommendations relevant to this work. • Assure accessible senior and Board recruitment, adjustment offers and stage outcomes and review senior workforce and Board data using safe small-number reporting. • Where senior or Board recruitment is undertaken jointly with DHC, apply common accessibility and adjustment expectations through the agreed recruitment route. • Progress the Non-Executive Director Succession Plan, which recognises WRES and WDES findings and the need to improve Board diversity, including exploring engagement of a NExT Director through the NHS England programme and developing links with the Mary Seacole Group.	• 2025/26 result: one of 13 Voting Board members was recorded as Disabled (7.69%), compared with 6.59% of the workforce. Among six Executive Board members, none was recorded as Disabled and one status was unknown or not stated. • Existing recruitment assurance records accessibility and adjustment evidence for relevant campaigns. • Senior and Board representation is reviewed through established annual reporting, with identified barriers and resulting actions assigned through an approved delivery route. • Progress against the Non-Executive Director Succession Plan monitored, including exploration of the NExT Director programme and engagement with the Mary Seacole Group.	**Chair / Nominations / Trust Secretary** Support: Chief People Officer Recruitment EDIB OD / Talent

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APPENDIX D

Dorset HealthCare

Workforce Disability Equality Standard Report

2025-26

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Executive Summary

The Workforce Disability Equality Standard (WDES) is the NHS's nationally mandated framework for measuring disability equality within the workforce. At Dorset HealthCare, we use the WDES alongside staff feedback, workforce data and lived experience to understand where inequalities exist and to inform an equity-focused approach that removes barriers and supports Disabled colleagues to thrive.

This year's WDES results demonstrate encouraging progress in several areas. The proportion of staff recorded as Disabled has increased, recruitment outcomes remain close to parity, experiences of harassment, bullying or abuse from patients and the public have reduced, and Disabled representation on the Voting Board has improved. These findings demonstrate positive movement in representation and access. The Trust's submitted return records 658 Disabled colleagues, representing 9.23% of the workforce, and one Disabled Voting Board member out of 13 (7.69%).

However, significant inequalities remain in the workplace experiences of Disabled colleagues. Disabled staff continue to report poorer experiences than their non-disabled colleagues across harassment, career progression, feeling valued and pressure to attend work when unwell. The proportion of Disabled staff reporting that adequate reasonable adjustments had been made has also reduced, while the relative likelihood of Disabled staff entering the formal capability process has increased from 2.03 to 5.43. The capability metric is based on a two-year rolling average and relates to formal capability on the grounds of performance rather than ill health.

These findings reinforce the importance of continuing to embed disability inclusion across the employee journey. Our focus is not simply on providing adjustments when barriers arise, but on creating an inclusive working environment where accessibility is considered from the outset, Disabled colleagues are listened to and involved in shaping improvements, and managers have the confidence and tools to provide appropriate support.

Data sources

- Metrics 1 and 10 are based on data recorded on ESR at the snapshot date of 31 March 2026
- Metric 2 is based on known data from TRAC for the period 1 April 2025 to 31 March 2026
- Metric 3 is based on HR records and uses a two-year rolling average covering 1 April 2024 to 31 March 2026
- Metrics 4 to 9a are based on 2025 NHS Staff Survey data, collected between October and December 2025
- Metric 9b is based on Trust information about action taken to facilitate the voices of Disabled staff to be heard

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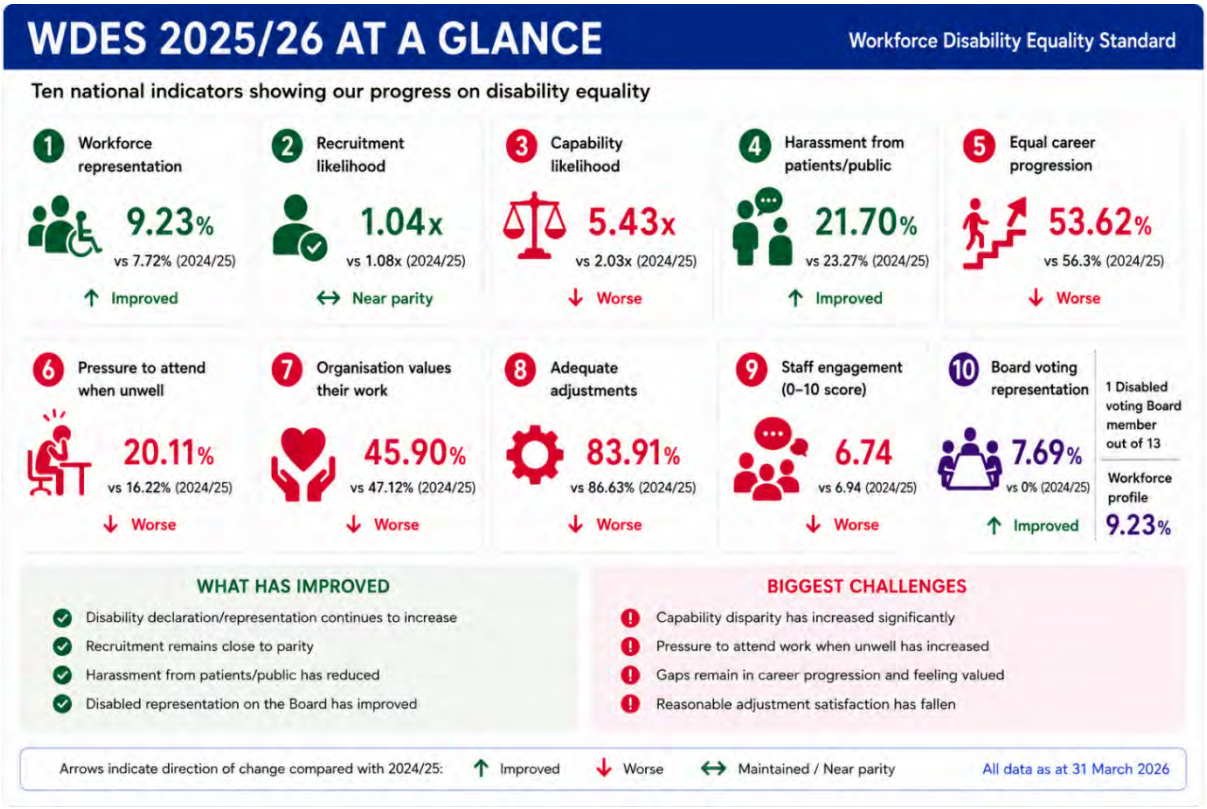

What the data tells us

Representation across the workforce

The proportion of colleagues recorded as Disabled has continued to increase, rising from 6.76% in 2023/24 to 7.72% in 2024/25 and 9.23% in 2025/26. At 31 March 2026, 658 colleagues were recorded as Disabled, compared with 5,761 non-disabled colleagues. A further 710 colleagues (9.96%) had no disability status recorded, or their status was unknown. This continued increase in recorded disability is encouraging and provides a stronger evidence base for understanding and addressing the experiences of Disabled colleagues.

However, the overall figure masks variation across different parts and levels of the workforce. Representation is broadly consistent between the clinical and non-clinical workforce, at 9.4% in each, but there are notable differences when the data is considered by pay band and staff group.

Within the non-clinical workforce, Disabled representation is highest at Band 6 (14.4%), followed by Band 8b (10.7%) and Band 3 (9.9%). Representation falls to 7.4% across Bands 8c to VSM collectively, with no Disabled colleagues recorded at Band 9 or VSM. These groups are small, so percentages should be interpreted with caution, but the pattern indicates that overall growth in disability representation is not yet consistently reflected at the most senior levels.

A similar pattern is evident within the clinical workforce. Representation is highest across Bands 5–7 collectively at 10.5%, compared with 9.9% at Bands 8a–8b, falling to 5.9% across Bands 8c to VSM. Disabled representation is particularly strong at clinical Band 6 (13.2%), but considerably lower within Medical and Dental roles, where 5 of 182 colleagues (2.75%) are recorded as Disabled. This suggests that the overall increase in representation is not evenly distributed across occupational groups or levels of seniority.

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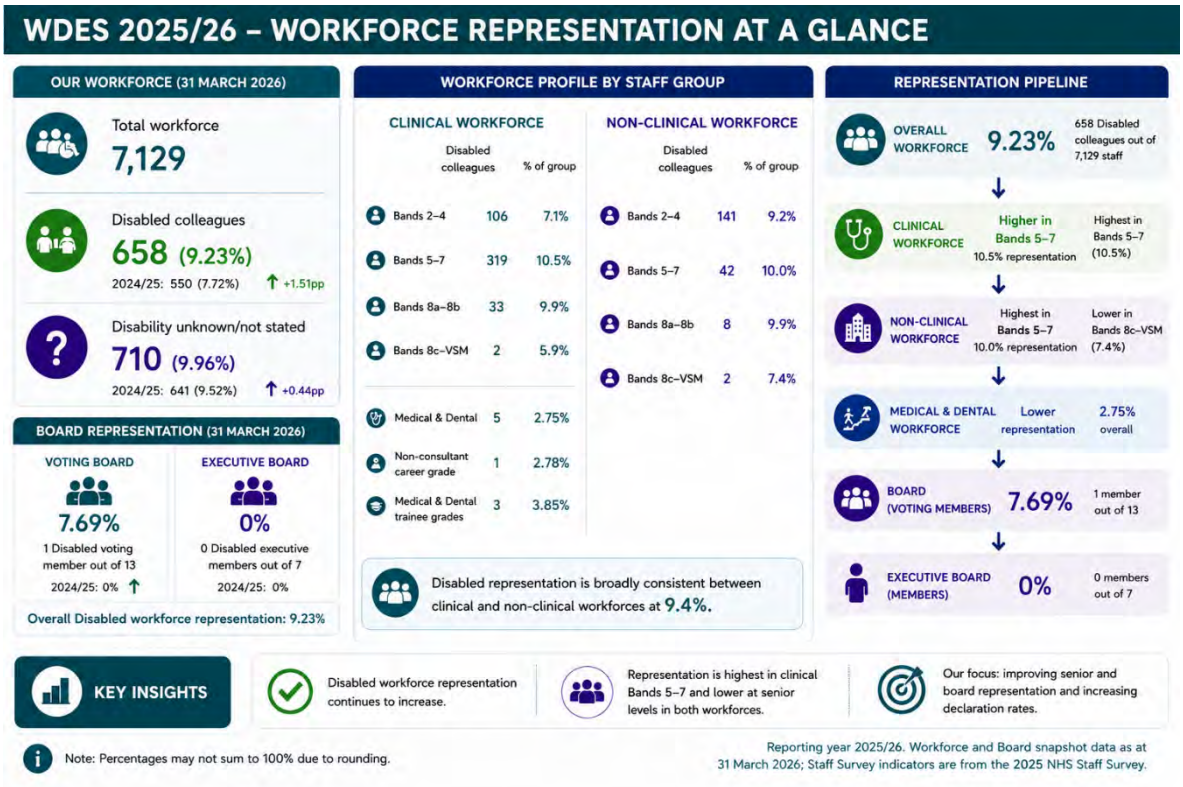
There has been positive movement in Board representation. At 31 March 2026, one of 13 Voting Board members was recorded as Disabled (7.69%), compared with no Disabled Voting Board members in 2024/25. However, this remains below the overall workforce representation of 9.23%, and there are currently no Disabled Executive Board members. As with the senior workforce data, small numbers mean that changes in individual Board membership can have a significant impact on percentages.

Overall, the data demonstrates continued progress in disability representation but also highlights the importance of looking beyond the headline workforce percentage. Further focus is needed on senior representation, Medical and Dental staff and disability declaration, alongside understanding the barriers that may affect recruitment, retention and progression for Disabled colleagues.



Recruitment and career progression

Recruitment outcomes remain broadly equitable. In 2025/26, non-disabled applicants were 1.04 times more likely to be appointed from shortlisting than Disabled applicants, improving slightly from 1.08 in 2024/25 and remaining close to parity. In 2025/26, 153 of 904 shortlisted Disabled applicants were appointed (16.92%), compared with 1,046 of 5,951 shortlisted non-disabled applicants (17.58%). This demonstrates that appointment rates are currently very similar, although continued monitoring will be important to ensure this position is sustained.

A more persistent inequality is evident in perceptions of career progression. In 2025, 53.62% of Disabled staff believed the Trust provides equal opportunities for career progression or promotion, compared with 58.61% of non-disabled staff. Positive responses among Disabled colleagues have fallen from 56.3% in 2024/25, although the gap between Disabled and non-disabled colleagues has narrowed slightly.

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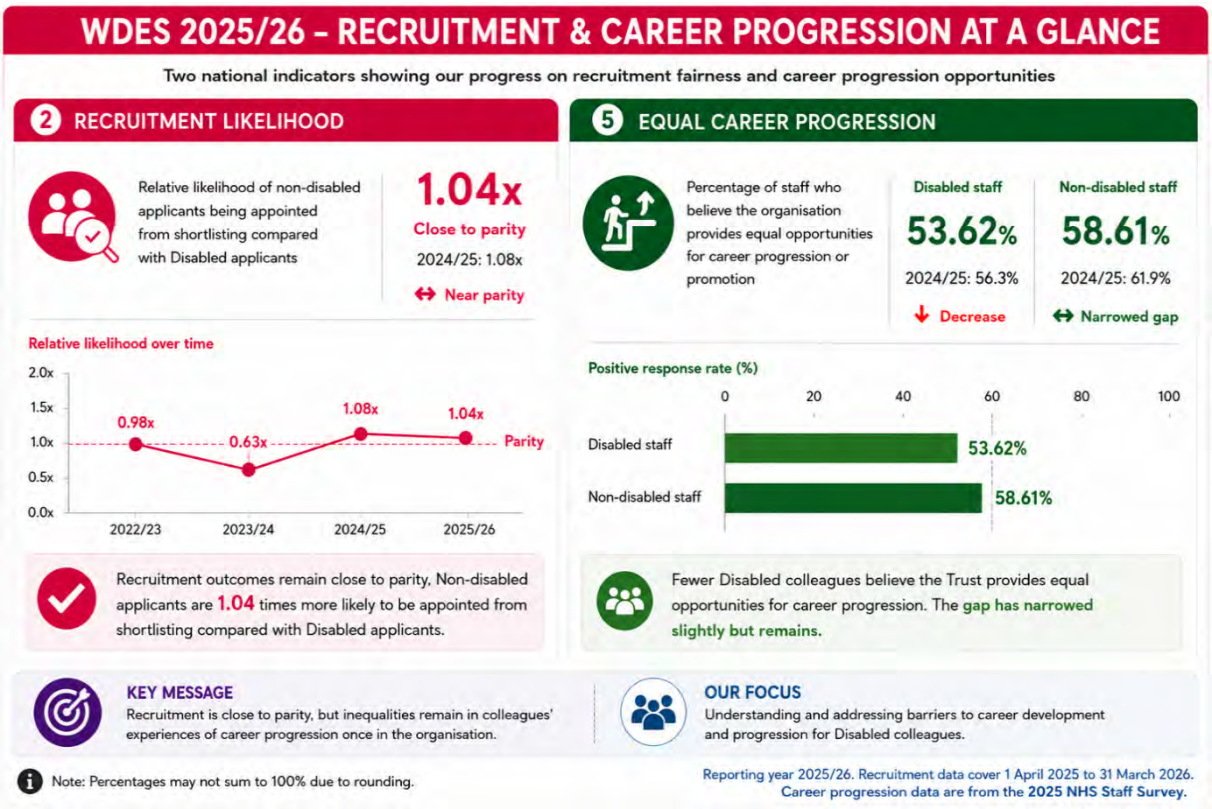
Taken together, the findings suggest that while appointment outcomes are broadly equitable, inequalities remain in colleagues' experiences of progression once in the organisation. Understanding and addressing barriers to career development and progression for Disabled colleagues therefore remains an important area of focus.



Staff experience

The WDES results show a mixed picture of staff experience, with improvement in some areas but persistent inequalities between Disabled and non-disabled colleagues. Experiences of harassment, bullying or abuse from patients, service users or the public have continued to improve. The proportion of Disabled staff reporting these experiences reduced from 23.27% to 21.70%, continuing the downward trend from 30.21% in 2022/23. However, Disabled staff remain more likely to experience harassment than non-disabled staff (17.32%).

Experiences within the workplace remain a greater concern. Harassment, bullying or abuse from managers increased from 9.53% to 10.33% for Disabled staff, more than double the 4.41% reported by non-disabled staff. Harassment from other colleagues also increased from 15.70% to 16.22%, compared with 10.28% for non-disabled colleagues. Reporting following an experience of harassment has improved slightly amongst Disabled staff, from 55.67% to 57.14%, although this remains below the 61.30% reported by non-disabled staff.

There has also been a notable deterioration in the proportion of Disabled colleagues reporting pressure from their manager to attend work despite not feeling well enough to perform their duties, increasing from 16.22% to 20.11%. This is almost twice the rate reported by non-disabled colleagues (10.83%). Disabled staff are also less likely to feel that the organisation values their work, with positive responses reducing from 47.12% to 45.90%, compared with 53.11% of non-disabled staff.

Reasonable adjustments remain an important part of enabling Disabled colleagues to thrive at work. 83.91% of Disabled staff reported that their employer had made adequate adjustments to enable them to carry out their work. While this remains a relatively high proportion, it has reduced from 86.63% in 2024/25 and 87.06% in 2023/24, highlighting the importance of continuing to improve the consistency and experience of accessing adjustments.

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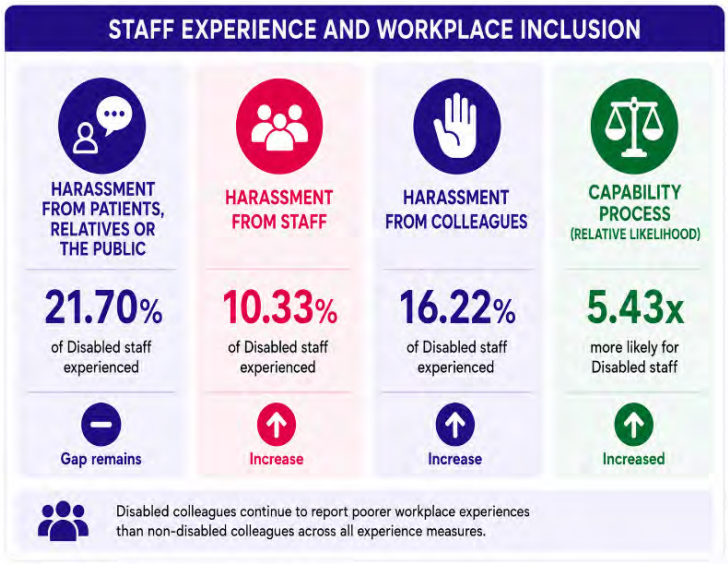

The relative likelihood of Disabled staff entering the formal capability process has increased from 2.03 to 5.43. This remains a key area of focus; however, analysis indicates that the increase is largely driven by a reduction in capability cases for non-disabled staff rather than a significant increase in Disabled staff entering the process. Given the small numbers involved, changes in individual cases can have a significant impact on the relative likelihood.

Overall, the findings suggest that while progress has been made in reducing harassment from patients and the public, inequalities remain in the day-to-day workplace experiences of Disabled colleagues, particularly in their experiences of managers and colleagues, pressure to attend work when unwell, feeling valued and accessing effective reasonable adjustments. Creating psychologically safe and inclusive workplaces, strengthening manager capability and ensuring Disabled colleagues receive timely and effective support therefore remain key areas of focus.

How we're responding

During 2025/26 we continued to strengthen our approach to disability inclusion through our Inclusion and Belonging Strategy, working with Disabled colleagues and our Staff Networks to better understand lived experience, identify barriers and improve workplace practices. Our approach recognises that disability inclusion requires both accessible organisational processes and an inclusive culture where colleagues feel valued, supported and able to thrive.

Improving reasonable adjustments and workplace support

Ensuring colleagues can access effective and timely reasonable adjustments remains a key priority. During the year we continued to promote the Health Passport as a practical tool to support conversations between colleagues and managers about workplace needs and adjustments, alongside guidance and support on Access to Work. This work aims to improve consistency, reduce barriers and support colleagues to remain well and effective at work. We have continued to use WDES and Staff Survey findings, alongside colleague feedback and lived experience, to understand where improvements are needed. This is particularly important given the reduction in colleagues reporting that adequate adjustments have been made and the increase in Disabled colleagues reporting pressure to attend work when they do not feel well enough.

Building inclusive and confident leaders

Managers play a critical role in the workplace experience of Disabled colleagues. Conscious Inclusion and Inclusive Leadership training, now mandatory for line managers, supports leaders to understand inequity, recognise barriers and create inclusive and psychologically safe teams. Our wider leadership and inclusion work, including our new Active Bystander eLearning, will also support colleagues and managers to recognise and challenge inappropriate behaviours and strengthen collective responsibility for creating an inclusive workplace.

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Creating fair opportunities
We continue to embed inclusive recruitment practices through Inclusive Recruitment and Selection training and the introduction of Diverse Recruitment Panels for senior appointments. As a Disability Confident accredited employer, we remain committed to removing barriers to employment and ensuring Disabled applicants are supported to access fair and inclusive recruitment opportunities. Recruitment outcomes for Disabled applicants are currently close to parity, and ongoing monitoring will help ensure this is maintained. Alongside recruitment, our focus increasingly includes colleagues' experiences once in the organisation. Reciprocal Mentoring, career conversations and wider organisational development and talent opportunities provide mechanisms through which barriers to development and progression can be better understood and addressed.

Improving staff experience and tackling unacceptable behaviours
Our Zero Acceptance approach and Respect and Resolution Policy provide a framework for preventing and responding to bullying, harassment and discrimination. Work through the Violence, Aggression and Discrimination Task and Finish Group, alongside the development of manager guidance for responding to unacceptable behaviours from patients, relatives and visitors, is intended to strengthen the support available when colleagues experience unacceptable behaviour. We continue to monitor workforce and Staff Survey data to identify inequalities and areas requiring further attention, including experiences of harassment from managers and colleagues, pressure to attend work when unwell and the increased relative likelihood of Disabled colleagues entering formal capability processes.

Listening to Disabled and Neurodivergent colleagues
Disabled and neurodivergent colleagues lived experience remains central to improving inclusion. We continue to work closely with our Disability Awareness Staff Network and Navigating Neurodiversity Staff Network, alongside wider engagement and listening opportunities, to understand colleagues' experiences, identify barriers and co-produce improvements. These networks provide important routes for colleagues to share their experiences, influence organisational priorities and contribute to the development of policies, processes and workplace practices. This helps ensure that our approach to disability and neuroinclusion is shaped by the voices and experiences of colleagues directly affected.

Embedding Disability Inclusion
Disability inclusion is embedded within organisational governance through our Inclusion and Belonging Strategy, WDES, Equality Delivery System (EDS), disability pay gap reporting, Staff Survey findings and regular Board reporting. Together, these provide oversight of progress, help identify persistent inequalities and strengthen accountability for improving the experiences and outcomes of Disabled colleagues.

Our focus 2026/27

Whilst the 2025/26 WDES demonstrates continued progress in workforce representation and broadly equitable recruitment outcomes, it also highlights persistent inequalities in the workplace experiences of Disabled colleagues. During 2026/27 we will build on the work already underway, with a particular focus on improving consistency of support, strengthening manager capability and ensuring Disabled and neurodivergent colleagues are able to thrive at work. Our priorities for 2026/27 are to:

- **Strengthen our approach to reasonable adjustments:** Review our current approach to reasonable adjustments, in conjunction with DCH, to improve consistency and timeliness across the organisation, including how adjustments are identified, agreed, implemented and reviewed. Continue to embed the Health Passport and Access to Work guidance to support colleagues and managers.

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- **Develop a Disability and Neurodiversity Policy:** Co-produce a new Disability and Neurodiversity Policy to provide a clear and consistent organisational approach to supporting Disabled and neurodivergent colleagues, bringing together expectations, responsibilities and available support.
- **Strengthen manager capability:** Scope the development of targeted learning for managers to increase confidence and capability in supporting Disabled and neurodivergent colleagues, including reasonable adjustments, inclusive management and responding appropriately when colleagues are experiencing barriers at work.
- **Support equitable recruitment and progression:** Maintain our focus on inclusive recruitment, including our Disability Confident commitments, Inclusive Recruitment and Selection training and Diverse Recruitment Panels, while continuing to use workforce data and colleague experience to understand and address barriers to career development and progression.
- **Strengthen Disabled and neurodivergent staff voice:** Continue working in partnership with our Disability Staff Awareness Network and Navigating Neurodiversity Staff Network, ensuring lived experience informs the development of policies, guidance and organisational improvements.
- **Strengthen organisational accountability:** Embed disability and neuroinclusion within the refreshed Inclusion and Belonging Strategy, developed through co-production with colleagues, Staff Networks, patients, carers and communities. Continue monitoring WDES indicators, workforce data, Staff Survey findings and lived experience to evaluate progress, identify inequalities and inform targeted action and organisational decision-making.

Conclusion

The 2025/26 WDES demonstrates continued progress in disability representation and broadly equitable recruitment outcomes, while highlighting persistent inequalities in the workplace experiences of Disabled colleagues. Our focus for 2026/27 will be on translating these findings into meaningful improvement by strengthening our approach to reasonable adjustments, improving consistency of support, building manager capability and continuing to listen to and work in partnership with Disabled and neurodivergent colleagues. Through continued monitoring, co-production and targeted action, we will work to create a more accessible and inclusive workplace where Disabled and neurodivergent colleagues feel valued, supported and able to thrive.

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WDES AT A GLANCE

Key trends across the 10 WDES indicators

Four-year journey 2022/23 – 2025/26

Key trends across the 10 WDES indicators

M1 WORKFORCE REPRESENTATION

Percentage of staff who declare a disability

Good progress
Representation continues to increase year-on-year.

M2 RECRUITMENT

Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff

Good progress
Recruitment outcomes remain close to parity.
(Lower is better)

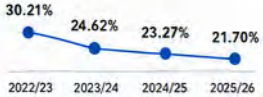
M3 CAPABILITY

Relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff

Priority
Gap has increased, driven mainly by fewer non-disabled cases.
(Above 1.00 is worse)

M4a(i) HARASSMENT FROM PATIENTS / PUBLIC

% of Disabled staff experiencing harassment, bullying or abuse from patients / public



Good progress
Incidents continue to reduce year-on-year.

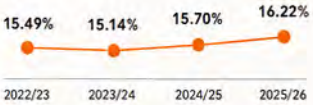
M4a(ii) HARASSMENT FROM MANAGERS

% of Disabled staff experiencing harassment from managers

Continue focus
Increase in latest year.

M4a(iii) HARASSMENT FROM COLLEAGUES

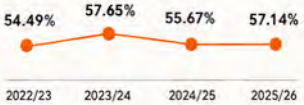
% of Disabled staff experiencing harassment from colleagues



Continue focus
Slight upward trend continues.

M4b REPORTED HARASSMENT

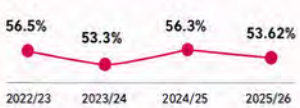
% of Disabled staff who reported harassment in the last 12 months



Continue focus
Decrease in latest year.

M5 CAREER PROGRESSION

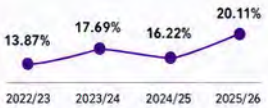
% of Disabled staff believing the Trust provides equal opportunities for career progression



Continue focus
Improvement in 2024/25 not sustained.

M6 PRESSURE TO COME TO WORK WHEN UNWELL

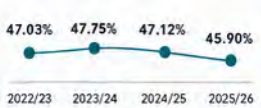
% of Disabled staff saying they felt pressure to come to work when not well enough



Priority
Gap remains and has increased.

M7 ORGANISATION VALUES MY WORK

% of Disabled staff saying their organisation values their work



Continue focus
Slight downward trend continues.

M8 REASONABLE ADJUSTMENTS

% of Disabled staff saying their employer has made adequate adjustments to enable them to carry out their work

Continue focus
Decrease in latest year.

M9a STAFF ENGAGEMENT SCORE (0–10)

Priority
Scores remain below organisation average.

M9b STAFF VOICE

YES

The Trust has taken action to facilitate the voices of Disabled staff through the Disability Staff Awareness Network, Navigating Neurodiversity Staff Network and co-production activity.

M10 BOARD REPRESENTATION (31 MARCH 2026)

VOTING BOARD
7.69%
(1 of 13)
Disabled representation

EXECUTIVE BOARD
0%
(0 of 7)
Disabled representation

Disabled workforce representation: 9.23%
(31 March 2026)

BOARD ASSURANCE KEY

Good progress
Positive improvement

Continue focus
Further improvement required

Priority
Significant gap – continued focus needed

KEY MESSAGES

- Disabled staff representation continues to increase.
- Disparities persist in staff experience, including pressure to work when unwell, feeling valued and harassment from managers and colleagues.
- Disabled staff remain more likely to enter formal capability processes, driven mainly by fewer non-disabled cases.
- Fewer Disabled staff report adequate adjustments and lower engagement scores.
- Improvement in patient/public harassment continues.
- We remain committed to creating a fair, inclusive and equitable workplace for all.

Note: All percentages are based on headcount data. Full definitions of WDES indicators can be found in the main report.

Reporting year 2025/26. Workforce and Board snapshot data as at 31 March 2026; Staff Survey metrics are from the 2025 NHS Staff Survey.

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The actions below combine targeted interventions with ongoing monitoring and evaluation. Where monitoring is identified as an action, its purpose is to assess the impact of activity already underway, identify emerging or persistent inequalities and inform further targeted intervention where required.

Trust	**Dorset HealthCare University NHS Foundation Trust**		
Year	2026/27		
Primary author of the action plan	Manpreet Aujla-Gudgeon (Equality, Diversity and Inclusion Lead)		
Sources of information underpinning the plan	WDES data, NHS Staff Survey, workforce data, lived experience and Staff Network feedback, national reports and NHS equality, diversity and inclusion priorities.		
WDES Metric	**Actions 2026/27**	**Measure**	**Owner(s)**
1. Workforce Representation	• Continue to monitor disability representation across pay bands, staff groups and senior leadership to identify areas of underrepresentation. • Encourage colleagues to record and update their disability status on ESR to improve workforce data quality. • Use workforce data alongside Staff Network feedback and lived experience to understand barriers to recruitment, retention and progression. • Embed disability and neuroinclusion within the refreshed Inclusion and Belonging Strategy.	• Maintain or improve overall Disabled workforce representation from 9.23%. • Reduce unknown/null disability status from 9.96%. • Evidence of disability and neuroinclusion priorities within the refreshed strategy and delivery plans.	EDI Human Resources Organisational Development

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2. Relative likelihood of non-disabled staff being appointed from shortlisting compared to Disabled staff	• Continue embedding Inclusive Recruitment and Selection training for recruiting managers, including reasonable adjustments and reducing bias. • Introduce Diverse Recruitment Panels for senior appointments and continue working with Staff Networks to strengthen diversity within recruitment and selection. • Maintain our Disability Confident accreditation and commitments, supporting accessible and inclusive recruitment practices. • Continue monitoring recruitment outcomes for Disabled applicants to identify emerging inequalities, to evaluate the impact of inclusive recruitment interventions, identify emerging inequalities and inform further action where required.	• Recruitment relative likelihood maintained close to parity (1.04 baseline). • Inclusive Recruitment and Selection training continues to be delivered. • Diverse Recruitment Panels implemented for relevant senior appointments. • Disability Confident accreditation maintained.	Recruitment EDI Staff Network Chairs
3. Relative likelihood of Disabled staff entering formal capability process compared to non-disabled staff	• Undertake further analysis of capability data to understand the increased relative likelihood for Disabled staff, recognising the impact of small numbers and the reduction in non-disabled capability cases. • Review relevant processes to strengthen early support and consideration of reasonable adjustments before and during formal capability processes. • Continue monitoring capability outcomes by disability to identify themes and inequalities to assess the impact of improvement activity and identify where further action is required. • Continue embedding Conscious Inclusion and Inclusive Leadership learning for line managers.	• Capability data reviewed and findings used to inform action. • Evidence that reasonable adjustments and appropriate support are considered within relevant processes. • Reduction in the disparity over time, recognising the impact of small case numbers and annual variation.	Human Resources EDI

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4a(i) Staff experiencing harassment, bullying or abuse from patients/ service users, their relatives or other members of the public in the last 12 months	• Continue embedding our Zero Acceptance approach to bullying, harassment, discrimination and violence. • Embed manager guidance for supporting colleagues experiencing unacceptable behaviours from patients, relatives and visitors. • Maintain collaboration with the SAFE Team and Dorset Police and work with FTSUG to support colleagues to raise concerns. • Continue monitoring Ulysses and workforce data to identify themes and inform improvement and hotspots, evaluate impact and inform targeted improvement activity.	• Reduction in Disabled staff reporting harassment, bullying or abuse from patients/public from 21.70%. • Manager guidance embedded and promoted. • Evidence of continued monitoring and action in response to identified themes.	Human Resources EDI SAFE Team Nursing and Quality
4a(ii) Staff experiencing harassment, bullying or abuse from managers in the last 12 months	• Embed Active Bystander eLearning, Conscious Inclusion and Inclusive Leadership learning. • Scope targeted manager learning to strengthen confidence and capability in supporting Disabled and neurodivergent colleagues. • Monitor Staff Survey findings and colleague feedback to understand and address inequalities in Disabled colleagues' experiences of managers.	• Reduction in Disabled staff reporting harassment, bullying or abuse from managers from 10.33% and narrowing of the gap with non-disabled staff (4.41%). • Targeted manager learning scoped, with recommendations agreed. • Continued delivery of inclusive leadership learning.	Human Resources EDI FTSUG
4a(iii) Staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	• Continue embedding the Zero Acceptance approach and Respect and Resolution Policy. • Continue monitoring workforce, Staff Survey and employee relations data to identify themes and areas requiring further attention. • Roll out Active Bystander learning to build confidence in recognising and challenging inappropriate behaviour. • Ensure colleagues experiencing unacceptable behaviours are aware of reporting and support routes.	• Reduction in Disabled staff reporting harassment, bullying or abuse from colleagues from 16.22% and narrowing of the gap with non-disabled staff (10.28%). • Evidence that identified themes and hotspots inform organisational action. • Continued promotion of reporting and support routes.	Human Resources EDI FTSUG SAFE Team

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4(b) Staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	• Continue promoting available routes for reporting unacceptable behaviour, including FTSUG and incident reporting processes. • Continue working with the SAFE Team and FTSUG to strengthen awareness of available support. • Monitor reporting data and Staff Survey findings to understand whether colleagues feel able and confident to raise concerns.	• Increase in Disabled staff reporting incidents from 57.14% and narrowing of the gap with non-disabled staff (61.30%). • Evidence of continued promotion of reporting and support routes. • Reporting themes reviewed and used to inform improvement.	Human Resources EDI FTSUG
5. Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.	• Use learning from the Reciprocal Mentoring programme to strengthen understanding of lived experience and barriers to progression. • Embed career conversations as part of the annual appraisal process. • Continue mandated Conscious Inclusion and Inclusive Leadership learning and EDI content within manager development. • Promote equitable access to development and talent opportunities, monitoring participation and outcomes for Disabled colleagues. • Work with Staff Networks to better understand barriers to career progression.	• Improvement from 53.62% of Disabled staff believing there are equal opportunities for progression and narrowing of the gap with non-disabled staff (58.61%). • Evidence of equitable access to development opportunities. • Staff Network/lived experience informs improvement activity.	Human Resources EDI Organisational Development
6. Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	• Continue promoting the Wellbeing Service, Wellbeing Plans and Health Passport to support conversations about health, wellbeing and workplace needs. • Scope targeted manager learning to strengthen confidence in supporting Disabled and neurodivergent colleagues appropriately. • Use Staff Survey findings and lived experience to understand factors contributing to the increased disparity and inform action.	• Reduction from 20.11% of Disabled staff reporting pressure to attend work when unwell and narrowing of the gap with non-disabled staff (10.83%). • Targeted manager learning scoped with recommendations agreed. • Continued promotion and use of relevant wellbeing and workplace support.	Human Resources Wellbeing EDI

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7. Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	• Work closely with the Disability Staff Awareness Network and Navigating Neurodiversity Staff Network to understand colleagues' experiences and co-produce improvements. • Continue inclusive leadership and wider culture work to strengthen psychologically safe workplaces where Disabled and neurodivergent colleagues feel valued and able to thrive. • Use Staff Survey findings and lived experience to identify areas requiring targeted improvement.	• Improvement from 45.90% of Disabled staff reporting that the organisation values their work and narrowing of the gap with non-disabled staff (53.11%). • Evidence that Staff Network feedback and lived experience informs organisational improvement.	Organisational Development EDI Staff Networks
8. Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	• Review the Trust's approach to reasonable adjustments to improve consistency and timeliness, including how adjustments are identified, agreed, implemented and reviewed. • Continue embedding the Health Passport and Access to Work guidance, including practical guidance and resources for managers and colleagues. • Develop a Disability and Neurodiversity Policy to provide a clear and consistent organisational approach to supporting Disabled and neurodivergent colleagues. • Scope targeted manager learning on disability, neurodiversity and reasonable adjustments. • Continue working with Occupational Health and relevant services to support colleagues requiring workplace adjustments.	• Improvement in Disabled staff reporting adequate adjustments from 83.91%. • Disability and Neurodiversity Policy developed and approved. • Reasonable adjustment approach reviewed with agreed improvements to consistency and timeliness. • Health Passport and Access to Work guidance embedded and promoted. • Manager learning scoped and recommendations agreed.	EDI Human Resources Occupational Health Organisational Development
9(a) The staff engagement score for Disabled staff, compared to non-disabled staff	• Continue senior sponsorship and engagement with the Disability Staff Awareness Network and Navigating Neurodiversity Staff Network. • Use WDES, Staff Survey and lived experience to identify themes affecting Disabled and neurodivergent colleagues' engagement and inform improvement. • Embed disability and neuroinclusion within the refreshed Inclusion and Belonging Strategy.	• Improvement in the Disabled staff engagement score from the 2025 baseline of 6.74. • Narrowing of the gap between Disabled staff (6.74) and the organisation average (7.09). • Evidence that Staff Network and lived experience insights inform organisational improvement.	Organisational Development EDI Staff Networks

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9(b) Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?	• Continue working in partnership with the Disability Staff Awareness Network and Navigating Neurodiversity Staff Network. • Continue senior leadership and Board engagement with Staff Networks through established governance arrangements. • Ensure Disabled and neurodivergent colleagues are represented within relevant co-production, engagement and improvement activity. • Co-produce relevant policies, guidance and improvements, including the Disability and Neurodiversity Policy.	• Trust continues to report Yes against WDES Metric 9b, supported by clear evidence of action. • Evidence of Disabled and neurodivergent staff involvement in co-production and organisational improvement. • Staff Network feedback demonstrably informs policy, guidance and/or organisational action.	EDI Staff Networks Organisational Development
10. Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated by Exec/non-exec and Voting/non-voting.	• Continue monitoring Disabled representation at senior leadership and Board level against the overall workforce profile to identify underrepresentation and inform further action. • Introduce Diverse Recruitment Panels for senior appointments and continue embedding inclusive recruitment practices. • Review recruitment and selection practices for senior and Board appointments to identify potential barriers for Disabled applicants. • Use workforce data to inform action to improve representation across senior leadership. • Progress the Non-Executive Director Succession Plan, which recognises WRES and WDES findings and the need to improve Board diversity, including exploring engagement of a NExT Director through the NHS England programme and developing links with the Mary Seacole Group.	• Reduction in the gap between Disabled workforce representation (9.23%) and voting Board representation (7.69%). • Executive Board representation monitored, recognising the current 0% Disabled representation. • Evidence that inclusive recruitment approaches are applied to relevant senior appointments • Progress against the Non-Executive Director Succession Plan monitored, including exploration of the NExT Director programme and engagement with the Mary Seacole Group.	Recruitment EDI

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Dorset County Hospital
Dorset HealthCare

Strategy Transformation and Partnerships Committee Assurance Report for the meeting held on Monday 28 September 2026

Chair	Andreas Haimbock-Tichy, Chair
Executive Lead	Dawn Dawson, Joint Deputy Chief Executive Officer Nicola Plumb, Joint Chief People Officer Chris Hearn , Joint 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	• A commercially confidential risk relating to EHR • Good progress on Strategic Impact Delivery and Outcome Framework • Changing focus of content of ODPC following the identification of priority areas by the Vista Health review. • Recommend to the DHC board approval of the South West Provider Collaborative Business Case • Recommend to the DCH Board approval of the Provider Capability Assessment (presented to extraordinary Board meeting on 30th September 2026) • Common theme throughout discussions around the need for the workforce to reframe the way it works
Key issues / matters discussed at the meeting	**Strategy in Action: Stroke Pathway** deferred to next meeting, with a forward plan of future presentations to be developed. **The Strategic Impact Delivery and Outcome Framework** sought to ensure that the Federation could answer whether the strategy is achieving what it intends to achieve. The evolution of the framework was set out and was linked directly to citizens. Views were sought from the committee on the framework, particularly in relation to the metrics for each strategic outcome. Discussions covered the metrics being more citizen-focussed, the specific wording of some of the statements, ensuring that engagement and co-production was centred, measuring the impact of the federation, and measuring improvements in health inequalities. **TPP Integration** BB informed the committee that she is working with the Procurement team to begin commercial discussions relating to the new EHR. **One Transformation Approach and Highlight Report and Improving Together Update** noting: • Delivery is on track for the neighbourhood programme, and peri-hospital mental health programme. Hospital at home was not as

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progressed as the others, but project documentation continued to be developed.

- It had been agreed at Joint Transformation and Improvement Board (JTIB) that four wholetime equivalent members of staff from the transformation and improvement team to support the DCH operational recovery programme. As such there will be an impact on the progress of the Improving Together Programme. This was expected to last for 12 weeks while recruitment was undertaken for fixed-term posts to support the operational recovery programme.

Focussed Review: Neighbourhood Health and Wellbeing presentation outlining the operating model of the neighbourhood programme, with a core neighbourhood team at the centre, who would be supported by a range of other health and care partner providers as needed. The presentation described how the core team would work and the tiering of patients from lowest to highest need, as a percentage of the population. The core team would need to focus on early intervention care for those with moderate needs so that they did not move in to having high needs. The committee discussed neighbourhood core teams using data insights to understand their neighbourhood population and what their health needs are. Discussions stressed the cultural shift of the programme / operating model and that the success of the model does not sit solely with the NHS.

Our Dorset Provider Collaborative (ODPC) Report incl. Priorities, Interdependencies, and Future Status noting the change of focus for ODPC following the identification of priority areas by the Vista Health review. The focus of the collaborative was now on delivering and implementing change across the system, rather than identifying opportunities. The priority areas are:

- Proactive preventative care – with a particular focus on neighbourhoods as described earlier in the meeting
- Urgent and emergency care – with a focus on developing two command centres (one in the east of the county, and one in the west) utilising urgent and emergency care services already in place
- Planned care – providing a single point of access for elective, planned care. With pathway transformation work already underway in a number of frail services at DCH
- Women and children – work in this area had not progressed to date

The ODPC NED and Chairs group had recommended a focus on updating governance, including revised Terms of Reference, ensuring the GP Alliance were included in the ODPC, and strengthening reporting mechanisms.

The committee discussed the multiple forums and programmes of work across the system at present, and the future of ODPC, with feedback that

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ODPC was an important, structured forum where executives from providers could meet, discuss and hold each other to account.

South West Provider Collaborative (SWPC) Business Case. DHC is a provider member of SWPC led by Devon Partnership NHS Trust (DPT). The SWPC oversees specialist mental health services in the region; for DHC this included CAMHS and the perinatal service line. DPT had submitted to NHS England to continue the SWPC contract under current arrangements, with providers to take the business case through their Boards as well. There were no material changes to the contract, and the committee recommended the business case to the Board for approval.

Policies
Bi-annual update on the policies in the scope of the committee. One policy overdue for DHC (AI Governance) but noting that the due date had only recently passed, and there was significant work ongoing in this field at present. As such there were no concerns re the delay. There were no overdue policies for DCH.

Provider Capability Assessment: Strategy, Leadership, and Planning for DCH only. The assessment covered six domains, each of which was assigned to a committee; for this committee the domain was "Strategy, Leadership, and Planning". The self-assessment asks trusts to consider whether they are capable of managing it's challenges in relation to each domain. The proposed rating from the review process for "Strategy, Leadership, and Planning" is 'green'. The committee recommended the outcome to the DCH board for approval.

The following escalation reports from subgroups were received for assurance by the committee members:
Joint

- Joint Transformation and Improvement Board Meeting Assurance Report
- Digital Transformation and Assurance group
- DHC New Hospitals Programme Board Assurance Report
- DHC Information Governance Group Meeting Assurance reports
- DCH New Hospitals Programme Board Assurance Report

Decisions made at the meeting

Approvals by DCH and DHC committees:

- Recommend to the DHC board approval of the South West Provider Collaborative Business Case
- Recommend to the DCH Board approval of the Provider Capability Assessment (presented to extraordinary Board meeting on 30th September 2026)

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Issues / actions referred to other committees / groups	• Nil

Quoracy and Attendance						
	28/05/26	27/07/26	29/09/26	23/11/26	25/01/27	22/03/27
Quorate?	**Y**	**Y**	**Y**			
Andreas Haimbock-Tichy	Y	A	Y			
David Clayton-Smith (to Aug 2026)	A	Y				
Dawn Dawson	Y	Y	Y			
Chris Hearn	Y	Y	Y			
Eiri Jones	Y					
Claire Lehman	Y	Y	A			
Nicola Plumb	A	Y	Y			
Kay Taylor (from Aug 2026)			Y			
Dave Underwood	Y	Y	Y			

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Dorset County Hospital
NHS Foundation Trust

DCH Charitable Funds Committee Assurance Report for the meeting held on 22.9.26

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	• None
Key issues / matters discussed at the meeting	The committee received, discussed and noted the following reports: • **CFC Minutes (21.7.26)** – Minutes approved. • **CFC Actions (21.7.26)** – All actions completed or in progress. • **Charity applications (£10K+):** - **Defence Medical Welfare Service:** committee agreed to fund the proposal for 6-month period; subject to review against agreed KPIs and DMWS seeking external funding to continue the service thereafter. • **DCH Charity Financial Reports 26/27 (M5)** – reports were received. Total income as of end August 2026 £654,237. Unrestricted funds were £237,790 with a reserves shortfall of £35,209 against the approved reserves target of £273,000. • **DCHC Annual Report & Accounts 25/26:** approved by committee. • **£2.5M Capital Appeal (ED/CrCU) report (Aug 2026)** – report received. £2.17M income and pledges received as of end Aug 2026. Buckham Fair in Aug raised £141,500. New legacy received £100K. • **ED/CrCU Appeal Fundraising costs proposal:** approved by committee. • **DCH Charity Team report** – overview of current key fundraising activities and communications. This report is available in the Board in Common (Public) document folder on AdminControl, for the October 2026 meeting – titled '*10.2b DCH Charity Team Report (September 2026)*'. • **Lillian Martin legacy** – Awaiting update from lead beneficiary re-payment of c£30K from sale of parcel of land and Knight Frank land management actions.

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	• **AOB:** Nov meeting time to be changed to 2-3.30pm.
Decisions made at the meeting	- **Charity applications (£10K+):** **Defence Medical Welfare Service:** committee agreed to fund the proposal for 6-month period; subject to review against agreed KPIs and DMWS seeking external funding to continue the service thereafter. - **DCHC Annual Report & Accounts 25/26:** approved by committee. - **ED/CrCU Appeal Fundraising costs:** approved by committee.
Issues / actions referred to other committees / groups	• None

Quoracy and Attendance						
	19.5.26	**21.7.26**	**22.9.26**			
Quorate?	Y	Y	Y			
Dave Underwood	Y	Y	Y			
Chris Hearn	N	N	Y			
Jo Howarth	N	Y	Y			
Anita Thomas	N	Y	Y			
Margaret Blankson	Y	Y	N			
Stephen Tilton	Y					

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Dorset HealthCare University
NHS Foundation Trust

Report to	Board of Directors in Common (DHC)	
Date of Meeting	13th October 2026	
Report Title	Dorset HealthCare Charitable Fund Annual Accounts	
Prepared By	Nicky Norris, Head of Financial Services	
Approved by Accountable Executive	Chris Hearn, Chief Finance 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		No
Colleagues		No
Communities	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR6 Finance	
Financial	Failure to meet statutory requirements for year end accounts.	
Statutory & Regulatory	Requirement to meet reporting requirements in year end accounts	
Equality, Diversity & Inclusion	None	
Co-production & Partnership	None	

Executive Summary

This report focuses on key matters relating to the Final Accounts for the Charitable Fund 2025/26 and the current position of the Funds.

Members are asked to:

- Approve the Final Accounts and Letter of Representation for Dorset HealthCare Charitable Funds
- Receive the update of the Dorset HealthCare Charitable Funds position

Recommendation

Members are requested to:

- **Approve** the Final Accounts and Letter of Representation for Dorset HealthCare Charitable Funds
- Receive the update of the Dorset HealthCare Charitable Funds position

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Dorset HealthCare Charitable Fund Report

1. Introduction

1.1 The Dorset HealthCare Charitable Fund has a sole Corporate Trustee, Dorset HealthCare University NHS FT. The Board of Dorset HealthCare University NHS FT are not individual trustees under Charity Law but act as agents on behalf of the Corporate Trustee

1.2 This paper is to approve the annual report and accounts for 2025/26 and to give a biannual update for the period 1 February to 31 August 2026.

2. Annual Report and Accounts for 2025/26

2.1 The Annual Report and Accounts for the year to 31st January 2026 (Appendix C) are complete. These have been subject to independent review by the external auditors, PKF Francis Clark.

2.2 PKF Francis Clark have issued a clear Independent Reviewers Examination and the letter of representation (Appendix D) and the Board is asked to approve.

3. Biannual update for the period up to 31 August 2026

3.1 The Charitable Fund exists to support Dorset HealthCare University NHS Foundation Trust. The funds can be spent on patient welfare, staff welfare, buildings and refurbishment, the purchase of new equipment or any other suitable innovative ideas fund managers can come up with. The main criteria are that the fund should be spent on items above and beyond NHS spend. The Charitable Fund's current year end is 31 January 2027. This update covers current year activity up to 31 August 2026.

3.2 Fund Movement

	2026/27 **1 Feb 2026 - 31 Aug 2026** **£'000's**
Brought Forward Fund Balance	758
Total Income	88
Total Expenditure	(100)
Closing Fund Balance	**746**

Further details and analysis are available in Appendix A.

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3.3 Income

3.3.1

Income	2026/27 1 Feb 2026 – 31 Aug 2026 £'000's
Donations	30
Direct Fundraising	9
Legacies	1
Grants	43
Other (interest etc)	5
Total income	**88**

The Charity, in conjunction with Dorset County Hospital, received £40k from NHS Charities Together for the joint Workforce Wellbeing Project to enhance staff wellbeing across both Trusts. Monies are to be spent on training, a roadshow and conference and a post to improve staff networks/staff wellbeing. A coffee tour visiting Dorset County Hospital and Dorset HealthCare Trust sites is planned in September 2026. A grant for £4k from Sport England was received by the Closer2Home service to be spent on a climbing project for young people. Day to day donations were £30k from February 2026 - August 2026 (£31k for 2025/2026). A large £10k donation to Yeatman MIU was received in August 2026.

3.3.2 A legacy was received for St Anns Hospital of £20k in 2025/2026. St Leonards Hospital received a second large legacy of £123k in 2025/2026 (£135k received in 2024/2025). It has been agreed that the £123k legacy can be varied in use.

3.3.3 £9k has been raised in 2026/2027. Staff raised £5k including for the Closer2Home Sport England Climbing project, Alderney Hospital Fete raised funds for music therapy, Westminster Memorial Hospital EOL care ongoing fundraising and Weymouth Urgent Treatment Centre for a child friendly cubicle. Members of the public raised £4k including a football day for Yeatman Hospital and a Kilimanjaro Climb in October for Hahnemann House. Staff fundraised £15k on behalf of Trust services in 2025/2026

3.3.4 £500k has been invested with Lloyds Bank in August 2026 in both short and medium terms deposits. Interest of £664 has been earned in the first month with anticipated annual interest earnings of £8k - £15k.

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3.4 Expenditure

3.4.1 Both restricted and designated expenditure has decreased. Restricted expenditure was £55k from February 2026 to August 2026 (£112k in 2025/2026). However spending is set to continue especially from the NHS Charities Together Workforce Wellbeing Project. Unrestricted expenditure was £45k in the period February 2026 to August 2026 (£85k in 2025/2026). Unrestricted expenditure has also decreased but generally picks up in the run up to the Christmas period. Wimborne Hospital has begun to make inroads into its large balance. Appendix B details full NHS Charities Together spending plans.

3.4.2 We now pay NHS Charities Together membership fees and this year the fee was £1,850. We have received £442k in all from NHS Charities Together between 2020 to 2026.

3.4.3 Expenditure during the period includes but is not limited to:

- Sofa sleeper chair beds for relatives and friends to stay with patients in Shaftesbury End of Life unit;
- Christmas presents for patients in hospital over the holiday period (particularly patients who may not otherwise receive a gift);
- Sensory items and wobble boards for CAMHS;
- The creation of a child friendly cubicle at Weymouth Urgent Treatment Centre;
- The Trust's Staff Support Fund has issued £9.5k to help 18 staff in difficulty;
- And over 270 other items have been funded in period.

3.4.4 The Charitable Fund has limited unrestricted reserves; therefore, expenditure is primarily associated with designated and restricted funds.

3.5 Key Performance Indicator

3.5.1 *Number of months to spend fund balance* - Charitable funds should be utilised in a timely manner rather than accumulated without a defined purpose. This is monitored via this KPI. As restricted funds have to be retained for the purpose they were given for, we monitor unrestricted funds only. Unrestricted balances include both designated (given freely to a Ward or unit) and wholly unrestricted funds. We aim to spend funds within 18 months of receipt. The monthly KPI is broken down to reflect the rate of spend in each area:

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	Spend in year £'000's	Fund balance £'000's	No. of months to spend balance in current year	No. of months to spend balance in previous year
Unrestricted	10	4	4	71
Designated	83	607	96	70

3.5.2 The KPI for the unrestricted funds has decreased as the Fund match funded £5k to the NHS Charities Together Wellbeing Project and there was other small spend. The KPI for designated spending has increased in 2025/2026 but this is likely to decrease as the trend is that spending picks up as Christmas approaches.

4. Recommendations

4.1 It is recommended that the Board approves the following:

- Annual Report and Accounts for 2025/26 (Appendix C)
- Letter of Representation (Appendix D)

4.2 The Board is also asked to note the following:

- The biannual update of the year-to-date position of the Dorset HealthCare Charitable Fund figures.

Nicky Norris
Head of Financial Services
8 September 2026

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Appendix A

	Balance at 01/02/2026	Transfers between funds	Income	Expenditure	Balance at 31/08/2026
	£000	£000	£000	£000	£000
Unrestricted and designated funds					
Unrestricted funds	**7**	**(5)**	2	0	**4**
Designated funds					
Wimborne Hospital fund	**189**		3	(14)	**178**
Blandford Hospital	**42**		0	(7)	**35**
New Wave fund	**26**		0	(1)	**25**
St Leonards Hospital site	**252**		3	(7)	**248**
Other immaterial designated funds (43 funds)	**112**		25	(16)	**121**
Total unrestricted and designated funds	**628**	**(5)**	**33**	**(45)**	**611**
Restricted					
Buckland Fund	**6**		0	0	**6**
Swanage Hospital	**8**		0	(5)	**3**
Swanage Hospital Training LoF	**2**		3	(2)	**3**
District Nurses Bournemouth North	**2**		0	0	**2**
Dorset Working Women's Project	**4**		0	0	**4**
Willows Bullows Eyes	**2**		0	0	**2**
Kings Park Hospital	**28**		0	(1)	**27**
Oncology Service	**5**		0	0	**5**
NHS CT - Stage 3 Recovery	**21**		0	(21)	**0**
NHS CT Volunteering Partnership	**12**		0	(12)	**0**
NHS CT Workforce Well Being Project	**0**	**5**	37	(2)	**40**
Other immaterial restricted funds (47 funds)	**40**		15	(12)	**43**
Total Restricted Funds	**130**	**5**	**55**	**(55)**	**135**
Total Funds	**758**		**88**	(100)	**746**

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Appendix B

A Summary of NHS Charities Together (NHS CT) monies received and how it will be spent.

Date received	Received from NHS CT £'000's	Amount spent by 31/08/2026 £'000's	Spent on	Residue to be spent on
December 2021	143	143	Health and Wellbeing initiatives – e.g. wellness rooms at Pebble, Nightingale	Spent in full
June 2022	54	54	Volunteering partnership monies – spent on partnership with Dorset Community Action and Participation post	Spent in full
May 2023	30	30	Charity Development	Spent in full
April 2026	42	2	Workforce Wellbeing Project in conjunction with Dorset County Hospital - Trans and Nonbinary Training awareness, promotional materials and Pride	A wellness conference and stands, staff networks awareness, documentary films to promote awareness and a part-time Project Support Officer post

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Dorset Healthcare Charitable Fund

Registered in England and Wales – Charity number: 1056550

Registered Office:

Dorset Healthcare Charitable Fund
Sentinal House Nuffield Industrial Estate
4-6 Nuffield Road
POOLE
Dorset
BH17 0RB

FRANCIS CLARK LLP
Towngate House
2-8 Parkstone Road
Poole
Dorset
BH15 2PW

Dear Sirs,

Financial Statements of Dorset Healthcare Charitable Fund for the year ended 31 January 2026

The following representations are given to you in connection with your review of the charity's financial statements for the year ended 31 January 2026.

We confirm that the following representations are made on the basis of enquiries of management and staff of the charity with relevant knowledge and experience (and, where appropriate, of inspection of supporting documentation) sufficient to satisfy ourselves that we can properly make each of the following representations to you.

1. **Responsibility for the Financial Statements**

   We acknowledge as trustees our responsibility for the financial statements which we have prepared on behalf for the charity and in particular confirm that we have selected suitable accounting policies and applied them consistently and made judgements and estimates that are reasonable and prudent.

   We also acknowledge our responsibilities for:

   a. Keeping adequate accounting records which disclose with reasonable accuracy at any time the financial position of the charity and which enable us to ensure that the financial statements comply with the Charities Act 2011, UK Generally Accepted Accounting Practice (UK GAAP) and the Statement of Recommended Practice 'Accounting and Reporting by Charities' (Charities SORP (FRS 102 (1a))).

   b. Safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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2. **Assets**

   We confirm that all assets have been included in the balance sheet and exist.

   We confirm that the charity has satisfactory title to all assets, and there are no liens or encumbrances on the assets except for those disclosed in the financial statements.

   We confirm that the cost (or value) of all the assets in the balance sheet is fairly stated.

3. **Liabilities**

   All liabilities of the charity of which we have knowledge are included in the appropriate classifications and we have no knowledge of any pending litigation or other claims against the charity, or any contingent liabilities or capital commitments. No liabilities are 'secured' by reason of suppliers restricting the transfer of title to goods supplied.

   The charity has no charitable commitments at the balance sheet date, other than as included or disclosed in the financial statements.

4. **Income and expenditure**

   We confirm that all income and expenses have been fully recorded and correctly classified in the correct fund.

   We confirm that all grants, donations and other income, including those subject to special terms or conditions or received for restricted purpose, have been notified to you. There have been no breaches of terms or conditions during the period regarding the application of such income.

5. **Transactions with trustees**

   The charity has not at any time during the year had any material transactions with trustees or connected or related parties other than as disclosed in the financial statements.

   The charity has had at no time during the year any arrangement, transaction or agreement to provide credit facilities (including loans, quasi-loans or credit transactions) for trustees, nor to guarantee or provide security for such matters, except as disclosed in note to the financial statements.

6. **Related parties**

   We confirm that we are aware that a related party of the charity is a person or organisation which either (directly or indirectly) controls, has joint control of, or significantly influences the charity or vice versa and as a result will include: trustees, other key management, close family and other business interests of the previous. We confirm that we have disclosed to you the identity of all related parties and all the related party relationships and transactions of which we are aware.

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7. **Completeness of Information**

   All the accounting records have been made available to you for the purpose of preparing the financial statements and all the transactions undertaken by the charity have been properly reflected and recorded in the accounting records. All other records and related information, including minutes of all management and trustees' meetings (held during the year and up to the date of this letter) have been made available to you.

8. **Going Concern**

   We confirm that, in our considered opinion, the charity is able to continue for the foreseeable future and for at least one year from the date of this letter. In arriving at this opinion, the trustees have considered the charity's current financial position, its current level of activity and all other relevant information.

9. **Post balance sheet events**

   There has been no event since the balance sheet date which requires disclosure or which would materially affect the amounts in the accounts, other than those already disclosed or included in the financial statements.

10. **Laws and Regulations**

    We confirm that there are no Laws or Regulations that are central to the charity's ability to conduct its business that may have an impact on amounts or disclosures in the financial statements.

11. **Reporting to regulator**

    We confirm that we are not aware of any matters of material significance that should be reported to the Charity Commission.

Yours faithfully

..... [Signed on behalf of the Board]

..... [Date]

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DORSET HEALTHCARE CHARITABLE FUND

A registered charity
(Registered No. 1056550)

ANNUAL REPORT AND FINANCIAL STATEMENTS

FOR THE YEAR ENDED 31 JANUARY 2026

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Dorset HealthCare Charity

ANNUAL REPORT AND FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 JANUARY 2026

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REFERENCE AND ADMINISTRATIVE DETAILS

Charity registration number: **1056550**

Principal & Registered Office of Charity:
Trust HQ
2 Nuffield Road
Nuffield Industrial Estate
Poole
Dorset
BH17 0RB

Bankers:
Lloyds Bank PLC
45-47 Christchurch Road
Bournemouth
BH1 1ED

Independent Examiners:
PKF-Francis Clark
Towngate House
2-8 Parkstone Rd
Poole
BH15 2PW

Internal Auditors:
BDO LLP
Arcadia House, Maritime Walk
Ocean Village, Southampton
Hampshire
SO14 3TL

Dorset HealthCare University NHS Foundation Trust (the Foundation Trust) is the Corporate Trustee of Dorset HealthCare Charitable Fund governed by the laws applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011. The Foundation Trust Board has responsibility for overseeing the administration of the charity acting as the Corporate Trustee. The members of the Foundation Trust Board who served during the last two financial years were as follows:

Corporate Trustee members:

David Clayton-Smith	Joint Trust Chair
Chris Hearn	Joint Chief Financial Officer
Nicola Plumb	Joint Chief People Officer and Director of Strategy

Trust Board members current:

David Clayton-Smith	Joint Trust Chair
Matthew Bryant	Joint Chief Executive Officer
Dawn Dawson	Joint Chief Nursing Officer
Rachel Small	Chief Operating Officer
Dr Lucy Knight	Chief Medical Officer
Nicola Plumb	Joint Chief People Officer and Director of Strategy
Chris Hearn	Joint Chief Financial Officer
Jenny Horrabin	Joint Executive Director of Corporate Affairs
Andreas Haimboeck-Tichy	Non Executive Director
Suresh Ariaratnam	Non Executive Director
Eiri Jones	Joint Non Executive Director and Deputy Trust Chair
David Underwood	Joint Non Executive Director
Claire Lehman	Joint NED (from 18 May 2025)
Nikki Rowland	Deputy Chair and Chair of Audit Committee (from 09 December 2025)

Trust Board members past:

Steven Peacock	Non Executive Director
Sir David Haslam CBE	Non Executive Director
Frances West	Non Executive Director
Dr Andy Dean	Chief Medical Officer
Nick Johnson	Joint Chief Strategy, Transformation and Partnerships Officer

Executive Directors in joint posts are with Dorset County Hospital NHS Foundation Trust.

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Trustees' Annual Report

The Corporate Trustee presents the Charitable Funds Annual Report together with the Independently Examined Financial Statements for the year ended 31 January 2026. The prior year was the year to 31 January 2025. The trustees have adopted the provisions of the Statement of Recommended Practice (SORP) "Accounting and Reporting by Charities" FRS102 (1a) in preparing the annual report and financial statements of the charity.

The Charity's Annual Report and Financial Statements for the year ended 31 January 2026 have been prepared by the Corporate Trustee in accordance with the accounting policies set out in the notes to the financial statements on page 16 and comply with the charity's governing document, the Charities Act 2011 and Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their financial statements in accordance with the Financial Reporting Standard FRS102 (1a).

Trustees of the Charity

The Board of Directors of the Foundation Trust are the Charity's trustees for the purpose of charity law. The Trustees who have served during the year and since the year end are noted on page 1.

Objectives

Dorset HealthCare Charitable Fund is an independent registered charity. It exists to raise funds and receive donations for the benefit of the patients and staff of Dorset HealthCare University NHS Foundation Trust. We are a trustee body independent from the Foundation Trust but work for the benefit of the patients, their families and the staff.

The Charity's main objective is to hold the fund upon trust to apply the income for any charitable purpose or purposes relating to the provision of health and social care. This includes social care services; particularly in relation to services provided on or behalf of (but in no way limited to) Dorset HealthCare University NHS Foundation Trust.

The Charity secures funding from fundraising, donations, grants and legacies received from patients, their relatives, the general public and other organisations to be able to enhance the service provided and environment in which care is provided.

The fund benefits a wide range of patients in hospitals, day centres, clinics and within their own home including older people, children, those with mental health problems, those recovering from operations, as well as people with physical and sensory difficulties and those who have learning disabilities.

Staff also benefit from the fund which is used for staff appreciation, team building and the improvement of staff facilities and wellbeing as well as the education of staff by providing training over and above normal NHS standards. This enhanced training benefits both staff and patients. In September 2021 a Staff Support Group was created in recognition of staff hardship. Since inception it has paid out £42k to 97 staff in need.

Trustees' Annual Report continued

Public Benefit

The Charity Trustees have complied with the duty in section 4 of the Charities Act 2011 to have due regard to public benefit guidance published by the Charities Commission. The Trustees:

- must act reasonably and prudently in all matters relating to the Charity;
- must protect the Charity and act in the best interests of the Charity;
- should fully discuss and agree the annual accounts and annual report;
- ensure the income and property of the Charity is applied for the purposes set out in the Governing Document;
- ensure that good policies are in place and are followed to ensure that the systems of control are rigorous and that the systems of control are well monitored;
- annually review policies and investments and method of investment;
- take proper professional advice when necessary;
- must ensure that the way in which the Charity is administered is not open to abuse by unscrupulous persons;

Structure

Governance

Dorset HealthCare Charitable Fund was established by a Declaration of Trust dated April 1996. The objects being for any charitable purpose(s) relating to the provision of health and social care in relation to (although no way limited to) services provided by or on behalf of Dorset HealthCare University NHS Foundation Trust.

The Board of Directors, acting as the Corporate Trustee, review risk via the results of any audits undertaken by both the Internal Auditors and Independent Reviewers. The Internal Audit reports are presented to the Trust's Audit Committee and any significant risks are entered onto the Corporate and/or Operational Risk Registers. No significant risks were identified during the year under review. See also the Independent Examiners' Report to the Trustees of Dorset HealthCare Charitable Fund on page 12. The Trustees are satisfied that there are systems in place to reduce and mitigate the exposure of the Charity to any significant risks.

The Chair and Non-Executive Directors are appointed by the Board of Governors of the Foundation Trust.

The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objects of each fund. The authority to spend funds has been delegated to service managers within limits agreed by the Trust Board.

Management

The Corporate Trustee is responsible for overseeing the administration of the charity. The finance directorate of Dorset HealthCare University NHS Foundation Trust has been given the responsibility for the administration of the fund accounts and reports to the Board twice a year. The Joint Chief Finance Officer has responsibility for ensuring that full accounting records are maintained and that devolved decision making or delegated arrangements are in accordance with the policies and procedures governing the Charity.

Stacey Ryan
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Structure continued

Management

The charitable funds available for spending are allocated to service managers, with each allocation managed by use of a designated fund within the general unrestricted fund. This is intended to ensure funds are spent in a way which respects the wishes of our generous donors and benefactors. Where funds are received with specific restriction set by the donor, a new restricted fund is established.

Expenditure is approved by the Fund Managers. Higher levels of expenditure require the approval of the Service Directors (or nominated Deputies) or if over £50k require the approval of the Joint Chief Finance Officer and the Service Director (or nominated Deputy).

The Trustees consider themselves to be the only key management personnel.

Risk Management

Key risk areas include fraud and over commitments of funds. Procedures and policies have been established to mitigate these risks.

Dorset HealthCare Charitable Fund also engages with the internal auditor to periodically carry out reviews and report any areas of weakness. Improvements to processes are implemented as required and deemed reasonable.

Reserves Policy

The reserves policy consists of:

• an expectation that income in each individual fund will be spent within 18 months of receipt unless it is being accumulated for a specific purpose.

• no individual fund should hold a permanent balance of more than £25k during a three month consecutive period unless, as above, the funds are being accumulated for a specific project.

• funds with more than £50k require expenditure plans to be submitted to the Corporate Trustee.

The reserves in 2025/26 total £758k. There are three funds in 2025/26 over £25k. In some cases appropriate expenditure has not yet been identified. This has led to an accumulation of reserves. These reserves will be spent on future appropriate expenditure as and when it is identified.

There is a restricted fund relating to a legacy left by the Reverend Buckland to be used for any charitable purpose relating to the benefit of Occupational Therapy and the Rehabilitation Assessment units.

Amounts for Kings Park Hospital (£28k), Blandford Hospital (£42K) and New Wave (£26K) contribute to the reserves figure. Further details on these are included in note 14.

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Reserves Policy continued

There are two funds in 2025/26 with a balance over £50k. These are:

Wimborne Hospital designated fund - £189k

This is a designated pot to be used for the benefit of Wimborne Hospital. This hospital has a high level of support from the local community and is regularly in receipt of legacy donations. The staff at Wimborne regularly use this fund as and when they identify either a staff, patient or building requirement.

St Leonards site - £252k

Two large legacies were left for the St Leonards Hospital site in 2025/26. We are exploring opportunities to utilise these funds.

Treasury Management Policy

The Fund invests £100k with HM Treasury and this has realised a return of £4k (£5k 2024/25) on a rate of interest between 4.64% and 5.14%. Interest rates have reduced over the year and investment was not a full year effect.

The Charitable Fund spending principle is to spend funds within 18 months therefore only short term investments are made to maximise balances held but at low risk.

The Treasury Management policy states:

- surplus cash can be invested for a period of up to 6 months.
- potential risks to the reputation of the Trust that may come from an involvement with deposits in the commercial sector must be minimised.
- cash is only deposited in "safe harbour" deposits. These are low risk and high liquidity investments. They are deposited with permitted institutions which meet recognised rating agency criteria.

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Review of the Activities, Achievements and Performance of the Charitable Funds in 2025/26

Activities and Achievements

The Charitable Fund spent £162k on activities and purchases (excluding support costs) to meet the Charity's objectives in the year (£108k in 2024/25). A highlight of these include:

Using funding from NHS Charities Together, Bridport Hospital League of Friends and donations from the public, a wellness room and garden were created at Bridport Community Hospital. This provides a much needed space for staff to step away from their duties and take moments for reflection and relaxation.

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Review of the Activities, Achievements and Performance of the Charitable Funds in 2025/26 continued

Patient Welfare

Direct patient welfare expenditure for the period totalled £74k (£46k in 2024/25) excluding support costs. The £74k includes the purchase of equipment and/or refurbishment to Wards and Units to provide a better patient experience (note 5). Funds are mainly used to provide additional facilities, or extras, to make the patients' stay more comfortable. These funds make it possible to purchase certain special items which otherwise could not be provided from Dorset HealthCare University NHS Foundation Trust's existing revenue or capital budgets.

Staff Education and Welfare

Staff education and welfare expenditure for the year excluding support costs totalled £88k (£62k in 2024/25). These costs were incurred to improve staff facilities and for staff development and also represent NHS Charities Together monies being spent to support and thank staff. This includes funding ongoing Health and Wellbeing posts to enhance staff welfare within the Trust.

Staff were able to attend external training courses which provided higher level of teaching for the benefits of our patients. This included courses in palliative care and cancer care. Other funds were donated towards staff events and other morale and team building events.

Other charitable spend included:

- cookery groups for patients;
- Christmas gifts for patients hospitalised over Christmas;
- climbing activities for young people;
- hot food and drinks for people working in the night time economy in areas of deprivation;
- team days for staff and training courses for staff;
- a participation post to create greater partnership and volunteer working;
- medical and physio equipment;
- benches and furniture for hospital gardens;
- furniture and equipment for hospital wards;
- sensory items for Children and Young persons services;
- Bournemouth Symphony Orchestra musical care pathways for Alderney Hospital dementia patients;
- music therapy for Brain Injury patients.

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Review of the Activities, Achievements and Performance of the Charitable Funds in 2025/26

Staff took part in a plane pull on behalf of the Charity in August 2025. Two Teams raised over £4,000 by pulling a Boeing 737 for 50 metres. The monies raised were for mental health services.

Other fundraising activity included Fetes at Alderney and Forston, continued fundraising at Westmisnter Memorial Hospital for the end of life services and fundraising by members of the public. This resulted in £15k of fundraising in year.

A memorial garden tree for Westminster Hospital gardens.

Setchell,Ryan 09/10/2026 11:05:42

Our Future Plans

The Charitable Fund makes plans in line with the direction and strategy of the Foundation Trust to ensure funds are being spent effectively.

The following provides a summary of what we have spend and also the future spending plans for the NHS Charities Together funds:

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Our Future Plans continued

Future plans are financed by either fund reserves or new donations, legacies or grant income.

Future spend will be reflective of the future needs of the services provided or carried out on behalf of the Foundation Trust and the supporting community.

Spending plans are requested on a regular basis from all service managers who hold funds.

Current and ongoing spending plans include:

• Final works are being undertaken in 2026/27 to complete the Nightingale Hospital and Pebble Lodge wellness rooms.

• Further funds of £27k have been received for a Volunteers Partnership project to improve links between Dorset HealthCare Charitable Fund, Leagues of Friends and other charitable bodies. A participation post is funded from this money taking this forward in 2026/27.

Review of the Finances of the Charitable Funds in 2025/26

Total income increased by £10k to £230k in year totalling (2024/25 decrease of £30k). Realised legacy income increased with the receipt of two large legacies of £143k in 2025/26. Grant income increased with the receipt of £27k in year from NHS Charities Together. Over 150 donations were made totalling £31k (2024/25 £37k). Fundraising income increased to £15k (2024/25 £9k). Investment income decreased to £14k due to a reduction in interest rates (2024/25 £17k). Interest earned on the Fund's bank account also decreased as interest rates fell.

Total expenditure increased by £57k to £197k in year (2024/25 decrease of £52k). A total of £162k (2024/25 £108k) was spent directly on charitable activities, a breakdown of which can been seen in note 5. In order to manage the charity £34k (2024/25 £32k) was spent on support costs.

Total net gain of £33k (2024/25 gain of £80k) was added to the brought forward net assets of £725k resulting in total net assets at the end of 2025/26 of £758k. Direct expenditure increased by £54k in 2025/26 to £162k and support costs increased in 2025/26 to £34k (2024/25 £32k). This increase is due to NHS Charities Together membership fee (£2k). there was also an increase in fundraising costs (£1k). Much of the increase in expenditure was completion of NHS Charities Together funded projects with full completion in 2026/27.

The charity relies on donations, grants and legacies as its main source of income. Fundraising has recently become a valuable strand of income as staff and members of the public have kindly supported the Charity - including a plane pull event for St Anns Hospital and mental health services in 2025. Further activity and a fundraising strategy is planned for future years - the participation post which is ongoing in 2025/26 should help to link the Charity, volunteers and other charitable organisations.

In past years' funds have always more than exceeded total annual running costs.

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Statement of Trustees' Responsibilities

The Trustees are responsible for preparing the Trustees' Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England and Wales requires the Trustees to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources of the Charity for that period. In preparing these financial statements, the Trustees are required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP (FRS102);
- make judgements and estimates that are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in operation

The Trustees are responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed. They are also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

By Order of the Trustee
Signed:

..... Date

David Clayton-Smith, Joint Chair of the Corporate Trustee

Setchell,Ryan
09/10/2026 11:05:42

Independent Examiners' Report to the Trustees of Dorset HealthCare Charitable Fund

I report to the charity trustees on my examination of the accounts of the charity for the year ended 31 January 2026 which are set out on pages 1 to 25.

Responsibilities and basis of report

As the charity's trustees you are responsible for the preparation of the accounts in accordance with the requirements of the Charities Act 2011 ('the Act').

I report in respect of my examination of the charity's accounts carried out under section 145 of the Act and in carrying out my examination I have followed all the applicable Directions given by the Charity Commission under section 145(5)(b) of the Act.

Independent examiner's statement

I have completed my examination. I confirm that no material matters have come to my attention in connection with the examination giving me cause to believe that in any material respect:

1 accounting records were not kept in respect of the charity as required by section 130 of the Act; or
2 the accounts do not accord with those records; or
3 the accounts do not comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the accounts give a 'true and fair view' which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which attention should be drawn in this report in order to enable a proper understanding of the accounts to be reached.

Signed:

Date

Setchell,Ryan
09/10/2026 11:05:42

A BIG THANK YOU...

On behalf of the patients and staff who have benefited from the donations and legacies received, the Dorset HealthCare Charitable Fund would like to thank everyone who has made charitable donations.

In addition a special thanks to those individuals, both staff of Dorset HealthCare University Foundation Trust and external supporters who have invested their time to drive forward a charitable scheme.

Setchell,Ryan
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Statement of Financial Activities for the year ended 31 January 2026

	Note	Unrestricted funds	Restricted funds	**2025/26 Total funds**	2024/25 Total funds
		£000	£000	**£000**	£000
Income from:					
Donations and legacies	3	160	14	**174**	176
Fundraising	3	1	14	**15**	9
Grants	3	0	27	**27**	18
Investments	4	11	3	**14**	17
Total income		**172**	**58**	**230**	220
Expenditure from:					
Charitable activities	5	(84)	(112)	**(196)**	(140)
Cost of fundraising	6	0	(1)	**(1)**	0
Total expenditure		**(84)**	**(113)**	**(197)**	(140)
Net income/(expenditure)		**88**	**(55)**	**33**	80
Net movement in funds		**88**	**(55)**	**33**	80
Reconciliation of funds:					
Total funds brought forward	14	540	185	**725**	645
Total funds carried forward	14	**628**	**130**	**758**	725

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Statement of Financial Position for the year ended 31 January 2026

	Note	Unrestricted funds	Restricted funds	**2025/26 Total funds**	2024/25 Total funds
		£000	£000	**£000**	£000
Current assets:					
Debtors	11	0	(0)	**(0)**	138
Cash and cash equivalents	12	643	180	**823**	634
Total current assets		**643**	**180**	**823**	772
Liabilities:					
Creditors: amounts falling due within one year	13	(15)	(50)	**(65)**	(47)
Net current assets/(liabilities)		**628**	**130**	**758**	725
Total net assets/(liabilities)		**628**	**130**	**758**	725
The funds of the charity:					
Restricted Funds	14	0	130	**130**	185
Unrestricted Funds	14	628	0	**628**	540
Total charity funds		**628**	**130**	**758**	725

The notes at pages 16 to 25 form part of these accounts.

The financial statements were approved and authorised for issue by the Board on

Signed on behalf of the Board of Trustees

Signed:

David Clayton-Smith, Joint Chair of the Corporate Trustee

Date:

Charity registration number: 1056550

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Notes to the Financial Statements

1 Summary of accounting policies

1.1 General information and basis of preparation

Dorset HealthCare Charitable Fund is a charity in the United Kingdom. The address of the registered office is given in the charity information on page 1 of these financial statements. The nature of the charity's operations and principle activities are detailed in the Trustees Annual Report.

The charity constitutes a public benefit entity as defined by FRS 102. The financial statements have been prepared in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014, the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102), the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 October 2025.

The financial statements are prepared on a going concern basis under the historical cost convention. The financial statements are prepared in sterling which is the functional currency of the charity and rounded to the nearest £000.

The significant accounting policies applied in the preparation of these financial statements are set out below. These policies have been consistently applied to all years presented unless otherwise stated.

1.2 Statement of Compliance

These financial statements have been prepared in compliance with the provisions of FRS102 section 1a, 'The Financial Reporting Standard applicable in the UK and the Republic of Ireland'.

1.3 Funds

Unrestricted funds are available for use at the discretion of the Trustees in furtherance of the general objectives of the charity and which have not been designated for other purposes.

Designated funds comprise unrestricted funds which are either set aside to be used for specific purposes or which reflect non-binding wishes of donors.

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by donors or which have been raised by the charity for particular purposes. The cost of raising and administering such funds are charged against the specific fund.

The major funds held in each of these categories are disclosed in note 14.

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Notes to the Financial Statements

1.4 Income recognition

All incoming resources are included in the Statement of Financial Activities (SoFA) when the Charity is legally entitled to the income after any performance conditions have been met, the amount can be measured reliably and it is probable that the income will be received.

For donations to be recognised the Charity will have been notified of the amounts and the settlement date in writing. If there are conditions attached to the donation and this requires a level of performance before entitlement can be obtained then income is deferred until those conditions are fully met or the fulfilment of those conditions is within the control of the Charity and it is probable that they will be fulfilled.

No amount is included in the financial statements for volunteer time in line with the SORP (FRS 102).

For legacies, entitlement is the earlier of the Charity being notified of an impending distribution or the legacy being received. At this point income is recognised. On occasion legacies will be notified to the Charity, however it is not possible to measure the amount expected to be distributed. On these occasions, the legacy is treated as a contingent asset and disclosed. If the details of the amount are confirmed after the reporting period but prior to the accounts being authorised for issue then the legacy will be treated as an adjusting post reporting date event and accrued as income, if material.

In terms of the Charity accounts legacies left to hospitals or services are treated as designated (unrestricted) funds unless there is a specific restriction imposed on the Charity by the terms of the Will in which case they are treated as restricted funds.

Investment income is earned by depositing cash for investment purposes.

1.5 Expenditure recognition

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to the category. Expenditure is recognised where there is a legal or constructive obligation to make payments to third parties, it is probable that the settlement will be required and the amount of the obligation can be measured reliably. It is categorised under the following headings:

- Expenditure on charitable activities includes costs incurred in relation to the charitable operations including support and governance costs apportioned to the charitable activities.

- Fundraising expenditure is apportioned to the fund which benefitted from the fundraising income.

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Notes to the Financial Statements

1.6 Support costs allocation

Support costs are those that assist the work of the Charity but do not directly represent charitable activities and include office costs and governance costs. They are incurred directly in support of expenditure on the objects of the Charity. Where support costs cannot be directly attributed to particular headings they have been allocated to the cost of raising funds and expenditure on charitable activities on a basis consistent with use of the resources. All overheads have been allocated on an expenditure proportion basis.

Details of these costs are included in note 7.

1.7 Debtors and creditors receivable/payable within one year

Debtors and creditors with no stated interest rate and receivable or payable within one year are recorded at transaction price. Any losses arising from impairment are recognised in expenditure.

1.8 Cash and cash equivalents

Cash at bank and in hand is held to meet the day to day running costs of the charity as they fall due. Cash equivalents are short term, highly liquid investments, held in an interest bearing account.

1.9 Tax

The Charity is an exempt charity within the meaning of schedule 3 of the Charities Act 2011 and is considered to pass the tests set out in Paragraph 1 Schedule 6 Finance Act 2010 and therefore it meets the definition of a charitable company for UK corporation tax purposes.

1.10 Going concern

The financial statements have been prepared on a going concern basis as the Trustees believe that no material uncertainties exist. The Trustees have considered the level of funds held and the expected level of income and expenditure for 12 months from authorising these financial statements. The budgeted income and expenditure is sufficient with the level of reserves for the Charity to be able to continue as a going concern.

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Notes to the Financial Statements

2 Prior year comparatives by type of fund

The primary statements provide prior year comparatives in total; this note provides prior period comparatives for the Statement of Financial Activities and the Statement of Financial Position for the two types of funds the charity manages.

2.1 Statement of Financial Activities for the year ended 31 January 2025

	Unrestricted funds	Restricted funds	**2024/25 Total funds**
	£000	£000	**£000**
Income from:			
Donations and legacies	161	15	**176**
Fundraising	0	9	**9**
Grants	0	18	**18**
Investments	12	5	**17**
Total incoming resources	**173**	**47**	**220**
Expenditure on:			
Charitable activities	(73)	(67)	**(140)**
Total expenditure	**(73)**	**(67)**	**(140)**
Net movement in funds	**100**	**(20)**	**80**
Reconciliation of funds:			
Total funds brought forward	440	205	**645**
Total funds carried forward	**540**	**185**	**725**

2.2 Statement of Financial Position for the year ended 31 January 2025

	Unrestricted funds	Restricted funds	**2024/25 Total funds**
	£000	£000	**£000**
Current Assets:			
Debtors	137	1	**138**
Cash at bank and in hand	436	198	**634**
Total Current Assets	**573**	**199**	**772**
Liabilities:			
Creditors: amounts falling due within one year	(33)	(14)	**(47)**
Net current assets/(liabilities)	**540**	**185**	**725**
Total net assets/(liabilities)	**540**	**185**	**725**
The funds of the charity:			
Restricted Funds	0	185	185
Unrestricted Funds	540	0	540
	540	**185**	**725**

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Notes to the Financial Statements

3 Income from donations and legacies

	Unrestricted funds	Restricted funds	**2025/26**	2024/25
	£000	£000	**£000**	£000
Donations	17	14	**31**	37
Legacies	143	0	**143**	139
Fundraising	1	14	**15**	9
Grants	0	27	**27**	18
	161	**55**	**216**	203

4 Income from investments

	Unrestricted funds	Restricted funds	**2025/26**	2024/25
	£000	£000	**£000**	£000
Interest - deposits	11	3	**14**	17
	11	**3**	**14**	17

5 Analysis of charitable expenditure

	Charitable activity	Support costs	**2025/26**	2024/25
	£000	£000	**£000**	£000
Purchase of new equipment	30	6	**36**	18
Building and refurbishment	22	5	**27**	7
Staff education and welfare	88	18	**106**	80
Patient welfare	22	5	**27**	35
	162	**34**	**196**	140

The basis for allocating support costs is by number of transactions processed to more accurately reflect the support time and resources used.

Patient welfare has attracted proportionally higher support costs due to the amount of transactions involved but at smaller expenditure cost. Building and refurbishment expenditure is reduced in year as most major works are completed and only minor works were needed to finalise projects.

Of the above support costs £9k were attributable to restricted funds (2024/25 £11k). The decrease is due to buildings and refurbishments and purchase of new equipment transactions, many of which came from restricted funds, attracting a lower support cost as this included fewer transactions but higher amounts.

6 Cost of raising funds

	Unrestricted funds	Restricted funds	**2025/26**	2024/25
	£000	£000	**£000**	£000
Cost of raising funds	0	1	**1**	0
	0	**1**	**1**	0

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Notes to the Financial Statements

7 Allocation of support costs and governance costs

Support costs are allocated between fundraising activities and charitable activities. Governance costs are those support costs which relate to the strategic and day to day management of the Charity.

The bases of allocation used are as follows:

Support cost	Charitable activities £000	**Total 2025/26 £000**	Total 2024/25 £000
Internal Audit	1	**1**	1
External Independent Review	4	**4**	4
Governance Total	**5**	**5**	5
Financial administration	24	**24**	24
Telephone/postage/stationery	1	**1**	1
Computer expenses	2	**2**	2
Membership fees	2	**2**	0
Total	**34**	**34**	32

	Unrestricted funds	Restricted funds	**Total 2025/26**	Total 2024/25
Charitable activities	25	9	**34**	32
	25	**9**	**34**	32

8 Independent examiners remuneration

The estimated independent examiners remuneration of £4k (2024/25 £4k) relates to the independent examination of the financial statements by our external reviewers.

9 Trustees' and key management personnel remuneration and expenses

The Trustees and key management personnel neither received nor waived any remuneration during the year 2025/26 (2024/25 - £nil).

No Trustees are accruing pension arrangements (2024/25 - £nil).

The Trustees did not have any expenses reimbursed during the year (2024/25 - £nil).

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Notes to the Financial Statements

10 Staff cost and employee benefits

For the 2025/26 year the charitable fund did not employ any staff (2024/25 - nil).

Staff are not directly employed by the Charitable Fund. Staff of Dorset HealthCare University NHS Foundation Trust have responsibility for the day to day running of the Charitable Fund and the time spent on this work is recharged to the Charity on a monthly basis.

The Charity has no volunteers.

11 Debtors

	2025/26	2024/25
	£000	£000
Other debtors	0	1
Prepayments and accrued income	0	137
	0	138

The decrease in Debtors is due to the large legacy of £135k notified in 2024/25 being received in 2025/26

12 Analysis of cash and cash equivalents

	2025/26	2024/25
	£000	£000
Cash in hand	723	534
Cash on deposit	100	100
	823	634

13 Creditors: amounts falling due within one year

	2025/26	2024/25
	£000	£000
Accruals	4	47
Creditors	48	0
Other	13	0
	65	47

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Notes to the Financial Statements

14 Fund reconciliation

	Balance at start date	Transfer	Income	Expenditure	Balance at end date
	£000	£000	£000	£000	£000
Unrestricted and designated funds:					
Designated funds					
Wimborne Hospital fund	218	0	3	(32)	**189**
Blandford Hospital	48	0	1	(7)	**42**
New Wave fund	32	0	1	(7)	**26**
Other immaterial designated funds (42 funds)	95	0	43	(26)	**112**
Unrestricted funds					
St Leonards Hospital accrued legacy	135	0	124	(7)	**252**
General funds	12	0	0	(5)	**7**
Total unrestricted and designated funds	**540**	**0**	**172**	**(84)**	**628**
Restricted					
Buckland Fund	7	0	0	(1)	**6**
Swanage Hospital	9	0	0	(1)	**8**
Swanage Hospital Training LoF	2	0	0	0	**2**
Oncology Service	6	0	0	(1)	**5**
Dorset Working Women's Project	4	0	0	0	**4**
Wimborne Bullows A&E Eyes	2	0	0	0	**2**
Kings Park Hospital	29	0	1	(2)	**28**
NHS Charities Together - Recovery	52	0	0	(31)	**21**
NHS Charities Together Volunteers Partnership	14	0	27	(29)	**12**
NHS Charities Together - Development Grant	28	0	0	(28)	**0**
District Nurses Bournemouth North	3	0	0	(1)	**2**
Other immaterial restricted funds (46 funds)	29	0	30	(19)	**40**
Total Restricted Funds	**185**	**0**	**58**	**(113)**	**130**
Total Funds	**725**	0	**230**	(197)	**758**

Zero balances are included as they represent balances under £500.

Fund Descriptions

Full details of funds are shown with the Trustee Report.

a) Unrestricted and designated funds

The purpose of the unrestricted funds are to support the charitable purpose as stated in the objects of the Dorset HealthCare Charitable Fund; particular designated funds have been created to reflect the non binding wishes of donors.

The Trustees set a closing balance of £50k or above as the threshold for reporting material designated funds. In the interests of accountability a breakdown of all such funds is available upon written request. There are two designated funds with a closing balance over £50k: Wimborne Hospital at £189k and St Leonard's Hospital at £252k.

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Notes to the Financial Statements

Fund Descriptions continued

Wimborne Hospital Material Designated Fund

Wimborne Hospital has been the recipient of several legacies in the last few years. This year funds were spent on dementia training, thank yous and team building events for staff, physio gym equipment, garden furniture for Hanham Ward and newspapers for hospital patients use.

St Leonards Hospital Material Designated Fund

A legacy of £135k (accrued for in 2024/25) for St Leonard's Hospital was received 2025/26 and a further legacy of £123k was also received in 2025/26. Plans are in progress to consider varying the use of one of the legacies as general funds.

Unrestricted and designated funds under £50k

The New Wave fund is for areas of deprivation in the Boscombe/Springbourne area of Dorset and several projects have been identified for this purpose. A project commenced with the Youth Sports Trust in 2025/26.

Blandford Hospital has been the beneficiary of legacy income and is spending its funds on patient welfare and furnishings for the hospital wards. This spend is continuing into 2026/27.

b) Restricted funds

Restricted funds under £50k

NHS Charities Together - Recovery Funds

The Charity joined NHS Charities Together in 2020 and has since applied for funding for various purposes. Grants of £143k were received in previous years to support recovery. In year £26.8k was spent on finalising garden areas and Pebble Lodge and Bridport Hospital's wellness rooms. The Health and Wellbeing admin support post used the remaining £2.2k. Works have completed in 2026/27 for Nightingale Hospital and some futher items for Pebble Lodge Children's Unit.

The Charity previously received a further £27k from NHS Charities Together to improve volunteer partnership working. This is a joint project with Dorset County Hospital and £22.6k has been used to fund a participation post and £5k for project work. The Charity also received £30k in 2023 to be used to develop the Charity and this was spent in 2025/26.

Kings Park Hospital

Kings Park Hospital received a £40k legacy in July 2018. Some spending has commenced and further ideas are being sought regarding how to spend this money.

The other immaterial restricted funds relate to funds under £10k.

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Notes to the Financial Statements

15 Related party transactions

Information about related party transactions and outstanding balances is outlined below:

	Income £000	Expenditure £000	Debtors £000	Creditors £000
Dorset HealthCare University NHS Foundation Trust - Corporate Trustee To 31 January 2026	**0**	**28**	**0**	**0**
To 31 January 2025	0	28	0	0

The Trust Board of Dorset HealthCare University NHS Foundation Trust is the sole corporate trustee of the charitable fund.

Board Members of Dorset HealthCare University NHS Foundation Trust (and other senior staff) take decisions on charity matters but endeavour to keep the interests of each discrete and do not seek to benefit personally from such decisions.

Dorset HealthCare University NHS Foundation Trust on occasion will receive income or make payments on behalf of Dorset HealthCare Charitable Fund, the Charity will then refund the balance. In addition Dorset HealthCare University NHS Foundation Trust provides management and accounting support to the Charitable Fund.

During the period none of the Trustees or members of the key management staff or parties related to them has undertaken any material transactions with the Dorset HealthCare Charitable Fund or received any benefit from the Charity through payment or in kind.

16 Contingent Assets

A legacy of £2k for Yeatman Hospital has been identified.

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Dorset County Hospital
Dorset HealthCare

Report to	Board in Common	
Date of Meeting	13 October 2026	
Report Title	DHC & DCH Premises Assurance Model	
Prepared By	Andrew Kersley – Compliance & Asset Officer	
Approved by Accountable Executive	Chris Hearn - Chief Financial Officer	
Previously Considered By	Finance and Performance Committee in Common 30/09/2026	
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 Quality and Safety SR5 Estates	
Financial	Financial input required	
Statutory & Regulatory	Upgrades statutory compliance	
Equality, Diversity & Inclusion	No Implication	
Co-production & Partnership	No Implication	

Executive Summary

This paper shows the Premises Assurance Model (PAM) submission for both Dorset County Hospital NHS Foundation Trust (DCH) and Dorset Healthcare University NHS Foundation Trust (DHC).

The 2026 PAM assessment represents the first year of reporting under the new binary scoring methodology, making direct comparison with previous years difficult. However, the results provide a strong baseline for both DCH and DHC and demonstrate generally good levels of compliance across the majority of assessed areas.

Key Messages

- DCH performed strongly across all domains, achieving particularly high scores in Safety Hard (88.7%) and a perfect score in Patient Experience (100%).
- DHC also demonstrated a solid baseline, with positive scores exceeding 77% in all assessed domains, although Patient Experience (70.6%) presents the greatest opportunity for improvement.
- The assessment identified no major systemic compliance concerns, with most gaps relating to documentation, governance, policy harmonisation, assurance processes and workforce capacity.
- A significant proportion of identified actions can be addressed through federated working, enabling each Trust to benefit from shared expertise, standardised policies and pooled specialist resources.

Areas Requiring Focus

The main improvement themes across both Trusts are:

- Strengthening Estates governance, risk assessments and audit processes.
- Improving Authorised Person (AP) capacity, particularly for High Voltage and Pressure Systems.
- Updating infrastructure drawings and asset information within DHC.
- Harmonising policies and procedures across both organisations.

Gettnellayan 09/10/2026 11:05:02

- Improving food safety training, decontamination assurance, and portering governance.
- Delivering Net Zero objectives through the forthcoming joint Green Plan.
- Addressing patient experience challenges within DHC, particularly around car parking, transport accessibility and accommodation standards.

Strategic Opportunities
The assessment highlights considerable opportunities to leverage the developing federated Estates and Facilities model. Shared resources, common Authorising Engineers, cross-Trust policy development and the adoption of established best practice from either organisation will enable many identified gaps to be addressed efficiently.

Both DCH and DHC have achieved a strong baseline position under the revised PAM framework. While a number of improvement actions have been identified, these are largely manageable and many are already underway. The continued development of federated working provides a clear route to improving compliance, resilience, efficiency and service quality across both organisations, supporting progression towards consistently high performance in future PAM submissions.

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

Setchell,Ryan
09/10/2026 11:05:42

Premises Assurance Model 2026

1.0 Overall, this has been a good year for the PAM submission for both trusts, Dorset County Hospital (DCH) and Dorset HealthCare (DHC).

1.1 This year has been the first with the new way of answering the questionnaire. Instead of a graduated score from 1 to 5 we have a binary choice of Yes or No.
It is difficult to compare the scores from previous years due to the change, however this does provide a good baseline going forward.

- PAM is scored over 5 separate areas:
  - Safety Hard
  - Safety Soft
  - Estate Competency
  - Helipad
  - Patient Experience

As neither of the trusts currently uses a helipad on their own sites this is not measured during the assessment.

2.0 Safety Hard

This looks at mostly Estates areas and safety within those sectors.

2.1 DCH scores 90.32% positive responses and 5.16% negative responses with a miscellaneous score of 4.52%.
DHC scores 82.26% positive responses and 8.71% negative responses, with a miscellaneous score of 9.03%.

2.2 The miscellaneous score changes considerably as DHC does not contain a mortuary so these are marked as NA.

2.3 Control of asbestos is maturing within the DHC area. However, the department is now working with an asbestos consultancy. This is the same consultancy that works with DCH.

2.4 One challenge with the DHC complex estate is that there are not up to dates plans of a number of different areas including Natural Gas, Water Systems, Wet Heating Systems, Ventilation, Air Conditioning, Refrigeration and Pressure Systems. While this seems to be a large intractable issue it is a relatively simple one to close. We have a CAD officer within DCH so we are looking to share the resource to create up to date plans of the DHC sites. This measure will take time to implement due to the sheer size of the portfolio.

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2.5 There are also several safety groups suggested, these are being closed out by merging them into the safety groups that are already in place. A food safety group will need to be created but this can be picked up within the current governance for food nutrition and strategy.

2.6 The mortuary door required “swipe to exit” and this has been considered and it is felt that this is not workable for the department. However, if we change 4 doors on the body store to swipe in and swipe out then we will have the security recommended by the Fuller Inquiry and still retain the departments working environment and protocols, so this is something we will add to the Capital list for 27/28.

2.7 DHC should appoint an AE for Fire Safey. It would be better if they appointed the same AE as DCH currently use. This would give conformity over both trusts and should also give some savings. An annual audit can then be carried out by the AE highlighting any areas that may have not been considered by the team.

2.8 Authorised Persons resource capacity is lacking individually at both Trust’s, however, if we were to continue with a federated approach this could resolve the issue. If we familiarise the AP’s with the other trusts systems and properties, then they can be appointed for those sites. This however will not be a viable option for either HV Electrical Systems or Pressure systems. In these areas there are not enough AP capacity even when combined so training of new AP’s must be prioritised.

2.9 There are several risk assessments that need to be undertaken. These are overall Risk Assessments for various Estates areas and are something that were not previously undertaken. These areas include Wet heating Systems, Ventilation, Air Conditioning, Refrigeration Systems and Lifting equipment. These will be closed out shortly for both Trusts.

2.91 Wet heating systems are a new area within PAM and have generally not been considered separately. Therefore, we do not carry out an annual audit on our systems, this will need to be audited and then an action plan for each trust can be produced.

2.92 There are some missing Business Continuity Plans that can be back filled by drawing on the expertise and experience of the other trust.

2.93 Missing policies and procedures will be dealt with by rewriting the other trusts paperwork to cover both. This will instil good resilience and team working.

2.94 Medical devices in DCH need to ensure that they undergo an annual audit. This will result in an action plan that can improve the service and delivery.

2.95 Reporting of safety related issues is an area that was not considered by either trust it just happened. This needs to have a properly documented process for this now. DCH has introduced this and it now needs to be mirrored across DHC. This is relatively easy change to make and hope to quickly embed within the second trust quickly.

Setchell Green
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2.96 There are a couple of minor issues in the Mental Health area with regards to DCH. Currently there is no asset register for equipment related to mental health services. This then leads into the lack of recording / maintenance on this equipment. While there is little

equipment of this type in DCH there needs to be a way of getting this onto the asset register and then onto a PPM schedule.

2.97 IT has not yet finished the changeover to the digital phonelines but this is currently about 70% completed and will be completed by the deadline.

3.0 Safety Soft

3.1 DCH scores 82.64% positive responses and 14.58% negative responses, with a miscellaneous score of 2.78%.
DHC scores 78.47% positive responses and 13.89% negative responses, with a miscellaneous score of 7.64%.

3.2 There is not a specific process for near misses or incidents in catering. These are added to the normal Datix systems that is in use within DCH and this can be filtered to give a breakdown of all of the catering issues. While it may be worthwhile to consider a separate system, the current system does seem to give a fully joined up approach.

3.3 We need to have a link on the intranet/internet to the public food and drink strategy. This is the same for both trusts and the paperwork / formatting can show this.

3.4 Ward level staff need further training in both food safety and allergen awareness. This is something that will take time to complete. Suggest identifying key staff to train first and then fellow afterwards with others for resilience.

3.5 24hr provision of food in DCH remains a major issue. This needs to be addressed in a substantive way.

3.6 There is currently a decontamination Policy but this has not been reviewed in the last 2 years, if we add an annual agenda item to the decontamination meeting to review the policy then this can be closed and should not continue to be an issue.

3.7 There was a minor lapse in DHC for decontamination where BCP has not been tested in the last 12 months. There is another lapse in testing the BCP in the Portering in the trust.

3.8 Maintenance of cleaning equipment within DHC is done on an ad hoc basis and this needs to be looked at as this may shorten the lifespan of the equipment. Putting a contract in place may be a bonus to improve this.
3.9 Efficacy audits in DHC require to be fully embedded for the DHC estate. There needs be an efficacy audit schedule within the trust and who and where these are being completed.
Portering training in DCH needs to be looked at and how the training can be delivered to the teams.
3.91 There are issues with Portering Policy for both trusts. As this is like this it can be closed by a single policy being produced to cover both trusts.

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4.0 Estate Competency

DCH scores 85.12% positive responses and 10.71% negative responses, with a miscellaneous score of 4.17%.
DHC scores 82.74% positive responses and 13.10% negative responses, with a miscellaneous score of 4.17%.

4.1 Both trusts have some challenges with Capital procurement, refurbishment and land management.

4.2Within DCH there is an issue with demonstratable project governance tracking. There needs a better tracking system to be put in place. This includes the ongoing review of costs and ensuring there is a consistent baseline in place.

4.3 Both trusts require to take flexibility into account when capital projects are being planned. Looking towards further changes to service provision in the future the trusts need to ensure that their designs incorporate the possibility of flexibility and this needs to be demonstrated going forward.

4.4 When identifying surplus land DHC needs to look to benchmark using metrics and KPI's to ensure that this is not misidentified.

4.5 Net Zero Carbon requires a full decarbonising plan for both Trusts. When the Green Plan is published this will cover both trusts and encapsulates the full Net Zero vision and how this is embedded in the organisations.

4.6 The estates strategy is not currently known and understood by staff. As this has now been approved by the board it can be presented to the workforce. A staff version of the strategy has been requested from the strategic department to ensure that all staff are informed and knowledgeable on this subject.

4.7 While there are a number of areas of property and land that are not positive for either trusts, this is already in progress to resolve. A handbook for the property and land department is currently being developed. This will cover all of the points within this area to ensure that both trusts are fully covered. To ensure counter any criminal activity in relation to land registry and our property, both Trusts have registered with the land registry to ensure alerts are sent if anyone attempts searches on the estate properties.

4.8 Water / utilities management improvements required in both trusts. Utilising our Help Desk System to schedule planned maintenance and allow EFM to track data trends will close this out.

5.0 Patient Experience

DCH scores 100% positive responses and 0% negative responses.
DHC scores 70.59% positive responses and 29.41% negative responses.

5.1 Areas for improvement

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1. Car parking systems
2. Accommodation Standards
3. All-encompassing Green Travel Plan

6.0 Conclusion

Overall, both trusts have a very good baseline and even though some of the questions have not been asked in previous submissions. There is some work to be done, as is evidenced above, but federated working means that best practice that occurs in one trust can be applied to the other trust.

7.0 Recommendations

The Board / Committee is recommended to:

- Receive the report for **assurance**

Name and Title of Author: **Andrew Kersley**
Compliance & Asset Officer
Date **03/09/2026**

Appendices

1. **Dorset HealthCare and Dorset County Hospital Premises Assurance Model** – The appendices for this report are available in the Board in Common document folder on AdminControl, for the October 2026 meeting – titled '*10.3a. Action Plan - PAM Board Report 2026' and '10.3b. PAM 2026 - Data Collection - Check Doc Matrix'*.

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Dorset County Hospital
NHS Foundation Trust

DCH SubCo Ltd Assurance Report
for the meeting held on 04 September 2026

Chair	Jonty McNuff, Chair
Executive Lead	Anita Thomas, Claire Abraham, Nick Jones (DCH SubCo Directors)
Quoracy met?	Yes
Purpose of the report	To provide assurance on the main items discussed and, if necessary, escalate any matter(s) of concern or urgent business.
Recommendation	To receive the report for **assurance**

Significant matters for assurance or escalation, including any implications for the Corporate Risk Register or Board Assurance Framework

- The SLA work remained ongoing as it was more complex than initially expected, alongside workforce availability pressures. An action tracker was being developed to keep track of and ensure completion of the various elements to bring this to a conclusion.
- Finances were off plan as a result of this, but not significantly so and were expected to improve.
- New KPIs had been drafted, though to flag not all can be reported against currently - ensuring reporting against all proposed new KPIs is under development.
- Roll out expansion had paused but was expected to resume in mid-September, with full expansion reached in late October/November should all progress as planned.
- One dispensing error in the reporting period, with no patient harm reported.
- Approval of the Annual Report and Accounts with a clean audit from KPMG.

Key issues / matters discussed at the meeting

The DCH SubCo board received, discussed and noted the following reports:

Finance Report at end of June, with a verbal update on July and August performance, noting that the budget did not include all of the final new activity the pharmacy was taking on.

- For June, a surplus of £25,000 was planned, but a loss of £7,000 was achieved. A number of factors contributed to this position, with overspend on employee benefit expenses being the biggest contributor.
- Work continued to develop and confirm the SLA with the Trust with negotiations ongoing.
- Cash position is favourable at present with no concerns.
- Financial performance in July and August was close to plan.
- Discussions around the importance of the company being explicit with the Trust about what was needed in the SLA and contract negotiations. The SLA work remained ongoing as it was more complex than initially expected, alongside workforce availability pressures. An action tracker

Setchell Ryan
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was being developed to keep track of and ensure completion of the various elements to bring this to a conclusion.

Performance Report and Review of Risk Register, Incidents and Complaints and Mitigating Actions noting:

- Significant movement in activity from the Trust to the company. The second pharmacist had been recruited to and was supporting on the onward transition of activity.
- The majority of KPIs were green. A new set of KPIs had been developed and discussed at Management Group. Some data for those KPIs was still being developed; new KPIs would be circulated, with feedback welcomed.
- One dispensing error in the reporting period, with no patient harm reported. Following the expansion of the pharmacy more incidents were expected and the maturity of reporting was still developing.
- Three risks were reported to the Board (with two verbally noted as now appropriately mitigated), with work ongoing to improve this data and to develop an escalation route from pharmacy to Management Group.
- Consideration was being given to setting a launch day to promote the new activity transfer and to help educate trust colleagues about the distinction between the trust and the company.

Fortuneswell Management Group Assurance report from the inaugural June and July meetings

- The company was working with the Trust to be added to the Home Office licence for visa sponsorship as there is a member of staff who requires a work visa.
- There is limited checking capacity in the pharmacy with only one individual able to provide this function. In the short term the Trust has agreed to provide checking support.
- Near misses are now being recorded, with the number of new staff felt to be contributing to the number of reported near misses.

Pharmacy Director Report

- National changes to visa rules meant that the pharmacy dispenser role was no longer applicable for a work visa. Pharmacist roles were applicable for work visas.
- The board heard and approved a number of proposals put forward in the report relating to staff salary, weekend working, and appraisals.
- Consideration was being given to jointly recruiting with the Trust a Business and Performance Manager, who would support the company with performance oversight.
- Discussion about how the trust's aseptic unit could be supposed by the company and the regulatory registration that would be required if this was pursued.

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	DCH SubCo Annual Report and Accounts 2025/26 which were produced in line with accounting guidance. Profit at year end was £64,000. The Board approved the Annual Report and Accounts and received: • The Management Representation Letter • KPMG Audit Report • Tax provision report and computations **Review of DCH SubCo Directors and Officers Liability Insurance** for assurance. Assurance that the **Confirmation Statements** had been submitted to Companies House on time and in line with requirements. Under 'any other business' the board: • Discussed a need to focus on strategy and the future of the company at the November meeting, and • Heard about a positive visit by HMRC with no particular concerns raised. The only caveat is that they may need further information about the lease arrangements from the Trust to the company.
Decisions made at the meeting	• Approval of a number of proposals put forward in the pharmacy director report relating to staff salary, weekend working, and appraisals • Pharmacy Director Report approvals • Approval of the Annual Report and Accounts
Issues / actions referred to other committees / groups	• Nil

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Report to	DCH Board of Directors	
Date of Meeting	13 October 2026	
Report Title	DCH SubCo Ltd Performance Report	
Prepared By	Andrew Harris, SubCo Superintendent Pharmacist	
Accountable Executive	Anita Thomas, SubCo Director	
Previously Considered By	DCH SubCo Ltd. Board, 04 September 2026 Finance and Performance Committee in Common 30 September 2026	
Action Required	**Approval**	N
	Assurance	Y
	Information	N

Executive Summary

Activity transfer from DCH Pharmacy has now begun, and activity has increased from approximately 70 dispensed items per day to 110 dispensed items per day. This represents about 25% of the total planned activity transfer, but further roll out has been paused pending the commencement of a second pharmacist.

Apart from the second pharmacist (starting Monday 3rd August) all other posts are now filled.

With new staff members and increased workload, the detected near miss rate increased in April and is beginning to drop in response to additional staff training.

Waiting times have also increased, but 86% of patients are still receiving their prescription within 30 minutes.

All other KPIs are green.

Recommendation

Members are requested to:

- Receive the report for **assurance**

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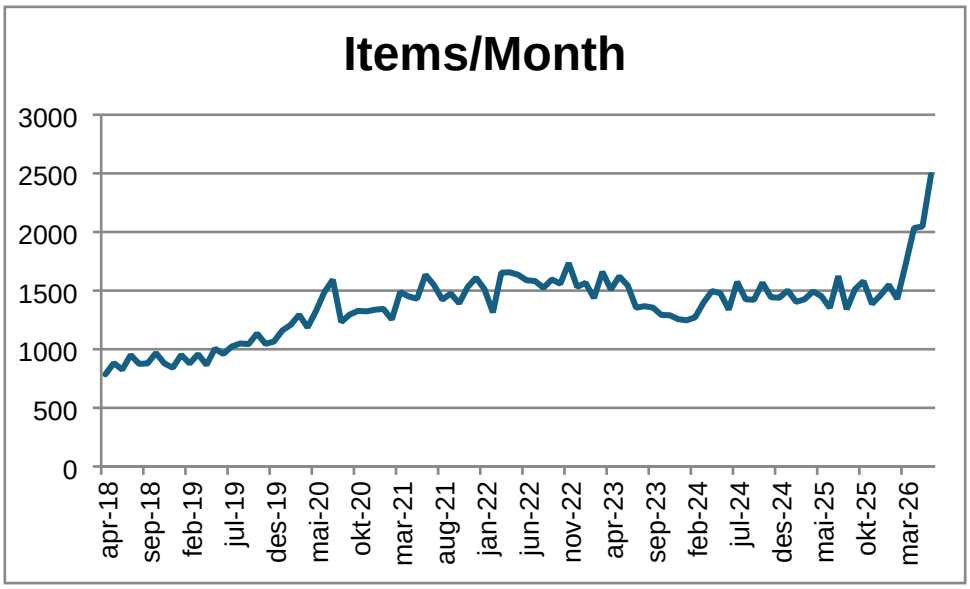
Performance Report

Andrew Harris
Superintendent Pharmacist
August 2026

Key Performance Indicators (KPIs)

	Apr-26	May-26	Jun-26
Total Items Dispensed	2034	2047	2485
Average Items/day	113.0	102.4	113.0
No. of same day Prescriptions	304	483	522
No. of Advance Prescriptions	443	523	711

Activity levels from April 2018 to current:



The transfer of additional activity from the Trust Pharmacy to Fortuneswell Pharmacy began in April 2026, and as the above graph demonstrates, during Q1 we have increased from approximately 1,500 dispensed items per month to nearing 2,500 items per month. This represents about 25% of the projected total activity to be transferred.
Capacity for transfer of workload has been reached whilst the Pharmacy continues to only employ 1 pharmacist. The second pharmacist is due to start in August.

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All contractual KPIs year to date are green with exceptions for dispensing errors, near miss rates and patient waiting times:

Performance measure	Key Performance Indicator	Target performance	Green	Amber	Red	Apr-26	May-26	Jun-26
Rate of dispensing errors detected post issue	Number of errors made per total volume of prescriptions dispensed that have LEFT the department	<0.02%	<0.05%	0.05-0.1%	>0.1%	0.00%	0.05%	0.22%
Near Miss Monitoring	Number of errors made per total volume of prescriptions dispensed that have NOT LEFT the department	<0.08%	<0.11%	0.11%-0.16%	>0.16%	5.7%	2.8%	1.7%
Availability of service	Responsible Pharmacist Availability	0	0 to 45 mins	45 to 90 mins	> 90 mins	0	0	0
Availability of service	Service downtime due to service failure					0	0	0
Availability of medicines	The % of prescription items dispensed in full at the first time of presentation excluding manufacturer can't supply	98%	100% - 99%	98.9% - 97.5%	< 97.5%	99.8%	99.0%	99.2%
MHRA Recall Assurance	100% of all SABs alerts, MHRA and Company-Led recalls are managed in accordance with Class status	100%				100%	100%	100%
All Mosaiq advance prescription preparedthe day in advance of collection	The completion time should bethe day in advance of collection/ delivery to chemotherapy nurses.	>90%	100% - 90%	89.9% - 80%	<80%	93.4%	91.0%	97.4%

The waiting time for dispensing prescriptions, during a monthly period shall be:
 	
(i) 30 minutes or less in respect of 95% of all prescriptions; and
 	
(ii) 20 minutes or less in respect of 80% of all prescriptions
	The time taken for a patient to wait for their prescription from the time they present it to the Pharmacy.	(i) 30 minutes or less in respect of 95% of all prescriptions
		
		(ii) 20 minutes or less in respect of 80% of all prescriptions
			For (i) Greater than or equal to 95%
			
			For (ii) Greater than or equal to 80%
				For (i) 80% - 94.9%
				
				For (ii) 65% - 79.9%
					For (i) Less than 80%
					
					For (ii) Less than 65%
						(i) 95.4%
						
						(ii) 89.2%
							(i) 86.7%
							
							(ii) 69.3%
								(i) 86.5%
								
								(ii) 68.1%

Index of customer satisfaction	The patient overall satisfaction level		100% of Customers to be offered Customer Feedback Survey Monthly Reporting on KPIs to record;			100%	100%	100%

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			Total Number of Customers per Month Completion / Uptake Rate (%)					
Number of complaints	The number of upheld complaints		1 or fewer complaints per quarter	0	0	0	0	0
Number of non-agreed non-formulary items supplied	Number of items that appear on total non-formulary supply report	0%	0% - 0.049%	0	0	0	0	0
Controlled drug management	Correct procedure against SOPs followed at all times	100%	No Tolerance			100%	100%	100%
Provision of financial, clinical and management information	financial, clinical and management information to be provided within 5 working days following the end of the previous month	100%	100% - 99%	98.9% - 97.5%	< 97.5%	100%	100%	100%
Waste/Expiry management*	Waste Costs below £200 per month - Stock waste to be managed	<£200	<£200			£16.51	£114.84	£70.72

Near misses have been higher than previously due to the combination of new staff and new prescription types coming through the dispensary. Additional training needs have been identified, and the trend is falling in response to this.

The increase in waiting time is a result of increased activity, and a need to purchase stock from the Trust Pharmacy to fulfil some of the prescripitions.

	Apr-26	May-26	Jun-26
Month End Stock Value £k	585	692	592

Incidents

1 dispensing error left the department in May. Moviprep and Picolax were both prescribed, notes stated for extended bowel preparation with no further detail and the prescriber was non-contactable. Patient was safety netted to check with endoscopy exactly what he was required to take, and to return anything not used. No harm to patient, but resulted in approximately £50 of stock being returned unused.

Complaints

Nil

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Dorset County Hospital
Dorset HealthCare

Report to	Board in Common	
Date of Meeting	13 October 2026	
Report Title	Proposal to create a Remuneration Committee in Common	
Prepared By	Abi Baker, Corporate Governance Manager	
Approved by Accountable Executive	Jenny Horrabin, Joint Executive Director of Corporate Affairs	
Previously Considered By	DCH and DHC Remuneration Committees, 27 August 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	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	SR7 Partnerships and Transformation – a Remuneration Committee in common would expand the established federated working relationship between DCH and DHC.	
Financial	No specific implications arising from this report	
Statutory & Regulatory	Remuneration Committees are a statutory committee of the Board. Under the proposed arrangements each Trust's Remuneration Committee would retain its responsibility as a statutory committee.	
Equality, Diversity & Inclusion	No specific implications arising from this report	
Co-production & Partnership	A Remuneration Committee in common would expand the established federated working relationship between DCH and DHC.	

Executive Summary

- As part of the agreed federated arrangements DCH and DHC operate a number of committees in common (Strategy, Transformation and Partnership; Quality; People and Culture; Finance and Performance; and Mental Health Legislation), as well as a Board in Common. To date, DCH and DHC have each retained separate Remuneration Committees.

- The Remuneration Committees are responsible for agreeing the remuneration and terms of service of Executive Directors and for reviewing the composition of the Board. With the exception of the Chief Medical Officers and Chief Operating Officers, all of the Executive Directors are now joint across DCH and DHC and the Boards of DCH and DHC predominantly operate as a federated Board.

- In August 2025, in recognition of the significant overlap of topics considered, the terms of reference for each trust's Remuneration Committee were aligned to ensure that each committee was working in the same way, with the same remit as the other.

- Given the federated working of the Trusts and the overlap of Executive Directors on each Trust Board, the committees have been meeting jointly since November 2024. Since that time the committee has met jointly seven times (in that same time the DCH and DHC committees have each met separately only once), but a formal decision to operate as a committee in common has not been made.

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- It is proposed that the current de facto arrangements are formalised and that the Remuneration Committees agree to formally operate as a committee in common, to support good governance practices. In line with the practice of other committees in common, if a trust-specific item needs to be considered the corresponding trust's committee can meet without the other committee.

- Under the proposed committee in common arrangements there would be no change in scope or remit of the committees, and each committee would retain its responsibility as a statutory committee of the corresponding Trust.

- The Terms of Reference for each Trust's committee were already aligned but have further been updated to reflect the proposed committee in common arrangements and are presented for approval.

- It is further proposed that committee membership be updated. Currently all Non-Executive Directors (NEDs) are members of the committee, but recent appointments have increased NED membership across the federation from nine to 15. A Remuneration Committee in Common meeting comprising of 15 members could be unwieldy and inhibit effective decision making. It is therefore recommended that the membership for each Trusts' committee is set at six NEDs (including the Chair and including one NED with a clinical background and one NED with a finance background), with a mix of Trust-specific NEDs and joint NEDs comprising the membership, and for membership to be refreshed on an annual basis.

Recommendation

The DCH and DHC Boards of Directors are requested to:

- Approve the proposal for the DCH and DHC Remuneration Committees to formally operate as a committee in common.

- Approve the updated Terms of Reference reflecting committee in common arrangements and updated membership.

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Proposal to create a Remuneration Committee in Common

1. Overview

As part of the agreed federated arrangements DCH and DHC operate a number of committees in common (Strategy, Transformation and Partnership; Quality; People and Culture; Finance and Performance; and Mental Health Legislation), as well as a Board in Common. To date, DCH and DHC have each formally retained separate Remuneration Committees.

The committees are responsible for agreeing the remuneration and terms of service of Executive Directors and for reviewing the composition of the Board. With the exception of the Chief Medical Officers and Chief Operating Officers all of the Executive Directors are now joint across DCH and DHC and the Boards of each Trust predominantly operate as a federated Board.

In August 2025 the terms of reference for each trust's Remuneration Committee were aligned to ensure that each committee was working in the same way, with the same remit as the other, in recognition of the significant overlap of topics considered and a concerted effort to align ways of working across the trusts.

Given the federated working of the Trusts and the number of Joint Executive Directors on each Trust Board, the committees have been meeting jointly since November 2024. Since that time the committee has met jointly seven times (in that same time the DCH and DHC committees have each met separately only once), but a formal decision to operate as a committee in common has not been made.

It is proposed that the current de facto arrangements are formalised and that the Remuneration Committees agree to formally operate as a committee in common, to support good governance practices. In line with the practice of other committees in common, if a trust-specific item needs to be considered the corresponding trust's committee can meet without the other committee present. This might be required when considering the remuneration of a Trust-specific Executive Director. Equally, the committees may choose to meet in common, if the nature of the discussions have implications for the other Trust. Such decisions can be made on a case-by-case basis.

Under the proposed committee in common arrangements there would be no change in scope or remit of the committees, and each committee would retain its responsibility as a statutory committee of the corresponding Trust.

2. Transition plan

It is good practice to develop a transition plan to support the committee in common arrangements. However, given the way in which the committees have been meeting in recent years, and the ad-hoc nature of the meetings, there is little that needs to be actioned. The below matters have been considered:

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- Action trackers – given the de facto functioning of the committee there is already one action tracker covering both DCH and DHC items. No further work is needed to align this.
- Workplan – there is no workplan of future agenda items for the committee to consider as the committee meets on an ad-hoc basis as the need arises. Items that have needed to be considered at future meetings have typically been recorded in the minutes and action tracker.
- Future meeting dates – these are arranged on an ad-hoc basis as required and will continue to be arranged as such.

3. Terms of Reference

The Terms of Reference for each Trust's committee were already aligned, as previously described. However, they have further been updated to reflect the proposed committee in common arrangements and are presented for approval. The committee in common arrangements of the terms of reference follow those used in other committees, where legal advice from Hill Dickinson LLP was sought to ensure that the technical aspects of operating a Committee in Common are adhered to.

Beyond this, the current Terms of Reference provides that all Non-Executive Directors (NEDs) are members of the committee, stating that "*membership of the committee will comprise the Non-Executive members of the Board of Directors*". However, recent appointments have increased NED membership across the federation from nine to 15. A Remuneration Committee in Common meeting comprising of 15 members could be unwieldy and inhibit effective decision making, and there is no national requirement for all NEDs to be members of Remuneration Committee. It is therefore recommended that the membership for each Trusts' committee is set at six NEDs (including the Chair and including one NED with a clinical background and one NED with a finance background), with a mix of Trust-specific NEDs and joint NEDs comprising the membership. These arrangements are comparable to other committees in common. Depending on the proportion of Trust-specific to joint NEDs, the Remuneration Committee in Common will comprise between seven and 11 people (including the Chair) attending meetings. Associate and Appointed NEDs are not eligible to be members. It is further recommended that the membership is refreshed each year to ensure a range of views are heard and all NEDs are given the opportunity be a member of the committee.

The assurance report provided to Board after each meeting will be important in providing assurance to the non-member NEDs regarding the discussions and decisions made.

4. Recommendation

The DCH and DHC Boards of Directors are requested to:

- Approve the proposal for the DCH and DHC Remuneration Committees to formally operate as a committee in common.
- Approve the updated Terms of Reference reflecting committee in common arrangements and updated membership.

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Dorset HealthCare University NHS Foundation Trust
Remuneration Committee in Common

TERMS OF REFERENCE

1. Constitution	The board hereby resolves to establish a committee of the board to be known **as the Remuneration Committee (the committee)**. The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.
2. Committees in Common	The Dorset HealthCare University NHS Foundation Trust has put in place a governance structure, which will enable it to work together with the Dorset County Hospita; NHS Foundation Trust. Each Trust has agreed to establish a committee which shall work in common with the other (**Committee in Common** or **CiC**), but which will each take its decisions independently on behalf of its own Trust. Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. The CiC shall meet together with the associated committee from Dorset County Hospital NHS Foundation Trust as the **Dorset Remuneration Committee in Common.**
3. Authority	The committee in common is authorised by the board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to cooperate with any request made by the committee. The committee in common is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.
4. Role and Purpose	The Committee in common provides the Board with a means of independent review of remuneration and executive director appointments in accordance with relevant laws, regulation and Trust policies. The Committee in common is responsible for appointing and determining the starting salaries of the Chief Executive[1] and Executive Directors[2] and to review and make recommendations to the Board on its Executive composition, balance and skill mix, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise that are required within the Board to meet them. The committee in common is responsible for: • Determining the remuneration packages for the Chief Executive and the Executive Directors and ensuring that adequate executive succession planning arrangements are in place. • Determining the remuneration package for all staff who are not Executive Directors but are on Very Senior Manager (VSM) terms and conditions. • Scrutinising non-contractual termination and special payment packages for the Chief Executive and Executive Directors, ensuring that these represent value for money.
5. Responsibilities	**Appointments**

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[1] Health and Social Care Act 2012

[2] Executive Directors includes non-voting members of the Board of Directors.

	The committee in common will**:** • regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the Board evaluation process as appropriate, and make recommendations thereon. • give full consideration to and make plans for succession planning for the executive directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future. • approve a description of the role and capabilities required for the appointment of Executive Directors, taking into account the views of the Board of Directors on the qualifications, skills and experience required for each position. • ensure that a robust appropriate process is in place for the appointment of the Chief Executive and Executive Directors. • recommend the appointment of the Chief Executive to the Council of Governors. **Remuneration** The Committee in common will: • Ensure that the starting salary and remuneration of the Chief Executive and Executive Directors are sufficient to attract, retain and motivate high calibre individuals whilst ensuring that it is not more than necessary for this purpose. • ensure that appraisals are undertaken for Executive members of the Board in their capacity as Board members. • determine the appropriate remuneration and terms of service of the Chief Executive and Executive Directors including: o All aspects of salary (including any performance related element/bonuses). o Provisions for other benefits, including pensions and cars. o Agreement of contracts of employment and if applicable terms of office. o Arrangements for termination of employment and other contractual terms, including the proper calculation and scrutiny of termination payments taking account of such national guidelines as appropriate. o Consider any matter relating to the continuation of office of any Executive Director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract. • Approve **all** non-contractual termination payment in excess of a monetary level to be agreed by the Committee. **Policies, Guidance and Regulation** The Committee in common will • adhere to all relevant laws, regulations and Trust policies and give due regard to all relevant guidance, recognise those areas that apply on a 'comply or explain' basis. • establish and keep under review a remuneration policy or principles in respect of executive directors
6. Accountability Arrangements	The committee in common shall report to the board on how it discharges its responsibilities. The minutes of the committee in common's meetings shall be formally recorded by the secretary and available for the board, with an assurance report from the Committee in common provided to the Board. The chair of the

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	committee in common shall draw to the attention of the board any issues that require disclosure to the full board or require executive action. The committee in common will report to the board at least annually on its work in support of the annual governance statement and annual report. An annual committee effectiveness evaluation will be undertaken and reported to the committee and the board.
7. Membership / Attendance	**Membership** Membership of the committee will comprise six Non-Executive members of the Board of Directors including a mix of Trust-specific, and Joint Non-Executive Directors, and including one NED with a clinical background and one NED with a finance background. The Chair of the Board shall be the Chair of the committee; the Senior Independent Director may chair the meeting in his/her absence. **Attendance** Only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis: • Chief Executive Officer • Chief People Officer • Director of Corporate Affairs Other trust officers will attend as required by the committee, at the request of the Chair. Any attendee will be asked to leave the meeting when the Committee is dealing with matters concerning their appointment or removal, remuneration or terms of service.
8. Quorum	A quorum shall be made up of four members. No business shall be conducted unless a quorum is present.
9. Administrative Support	The committee in common shall be supported administratively by its secretary. Their duties in this respect will include: • agreement of agendas with the chair and attendees • preparation, collation and circulation of papers in good time • inviting additional attendees to meetings as required • taking the minutes and helping the chair to prepare reports to the board • keeping a record of matters arising and issues to be carried forward
10. Frequency of Meeting	Meetings shall be held at least twice a year but may be held more frequently should circumstances require (to be determined by the Committee Chair).
11. Date Approved	These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Remuneration Committee • Approved by the Remuneration Committee 27 August 2026 • Approved by the DHC Board of Directors xxxx

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Dorset County Hospital NHS Foundation Trust
Remuneration Committee in Common

TERMS OF REFERENCE

1. Constitution	The board hereby resolves to establish a committee of the board to be known **as the Remuneration Committee (the committee)**. The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.
2. Committees in Common	The Dorset County Hospital NHS Foundation Trust has put in place a governance structure, which will enable it to work together with the Dorset HealthCare University NHS Foundation Trust. Each Trust has agreed to establish a committee which shall work in common with the other (**Committee in Common** or **CiC**), but which will each take its decisions independently on behalf of its own Trust. Each Trust has decided to adopt terms of reference in substantially the same form, except that the membership of each CiC will be different. The CiC shall meet together with the associated committee from Dorset HealthCare University NHS Foundation Trust as the **Dorset Remuneration Committee in Common.**
3. Authority	The committee in common is authorised by the board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to cooperate with any request made by the committee. The committee in common is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.
4. Role and Purpose	The Committee in common provides the Board with a means of independent review of remuneration and executive director appointments in accordance with relevant laws, regulation and Trust policies. The Committee in common is responsible for appointing and determining the starting salaries of the Chief Executive[1] and Executive Directors[2] and to review and make recommendations to the Board on its Executive composition, balance and skill mix, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise that are required within the Board to meet them. The committee in common is responsible for: • Determining the remuneration packages for the Chief Executive and the Executive Directors and ensuring that adequate executive succession planning arrangements are in place. • Determining the remuneration package for all staff who are not Executive Directors but are on Very Senior Manager (VSM) terms and conditions. • Scrutinising non-contractual termination and special payment packages for the Chief Executive and Executive Directors, ensuring that these represent value for money.
5. Responsibilities	**Appointments**

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[1] Health and Social Care Act 2012

[2] Executive Directors includes non-voting members of the Board of Directors.

	The committee in common will**:** • regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the Board evaluation process as appropriate, and make recommendations thereon. • give full consideration to and make plans for succession planning for the executive directors, taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future. • approve a description of the role and capabilities required for the appointment of Executive Directors, taking into account the views of the Board of Directors on the qualifications, skills and experience required for each position. • ensure that a robust appropriate process is in place for the appointment of the Chief Executive and Executive Directors. • recommend the appointment of the Chief Executive to the Council of Governors. **Remuneration** The Committee in common will: • Ensure that the starting salary and remuneration of the Chief Executive and Executive Directors are sufficient to attract, retain and motivate high calibre individuals whilst ensuring that it is not more than necessary for this purpose. • ensure that appraisals are undertaken for Executive members of the Board in their capacity as Board members. • determine the appropriate remuneration and terms of service of the Chief Executive and Executive Directors including: o All aspects of salary (including any performance related element/bonuses). o Provisions for other benefits, including pensions and cars. o Agreement of contracts of employment and if applicable terms of office. o Arrangements for termination of employment and other contractual terms, including the proper calculation and scrutiny of termination payments taking account of such national guidelines as appropriate. o Consider any matter relating to the continuation of office of any Executive Director including the suspension or termination of service of an individual as an employee of the trust, subject to the provisions of the law and their service contract. • Approve **all** non-contractual termination payment in excess of a monetary level to be agreed by the Committee. **Policies, Guidance and Regulation** The Committee in common will • adhere to all relevant laws, regulations and Trust policies and give due regard to all relevant guidance, recognise those areas that apply on a 'comply or explain' basis. • establish and keep under review a remuneration policy or principles in respect of executive directors
6. Accountability Arrangements	The committee in common shall report to the board on how it discharges its responsibilities. The minutes of the committee in common's meetings shall be formally recorded by the secretary and available for the board, with an assurance report from the Committee in common provided to the Board. The chair of the

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	committee in common shall draw to the attention of the board any issues that require disclosure to the full board or require executive action. The committee in common will report to the board at least annually on its work in support of the annual governance statement and annual report. An annual committee effectiveness evaluation will be undertaken and reported to the committee and the board.
7. Membership / Attendance	**Membership** Membership of the committee will comprise six Non-Executive members of the Board of Directors, including a mix of Trust-specific, and Joint Non-Executive Directors, and including one NED with a clinical background and one NED with a finance background. The Chair of the Board shall be the Chair of the committee; the Senior Independent Director may chair the meeting in his/her absence. **Attendance** Only members of the Committee have the right to attend and vote at Committee meetings. However, the following will be invited to attend meetings of the Committee on a regular basis: • Chief Executive Officer • Chief People Officer • Director of Corporate Affairs Other trust officers will attend as required by the committee, at the request of the Chair. Any attendee will be asked to leave the meeting when the Committee is dealing with matters concerning their appointment or removal, remuneration or terms of service.
8. Quorum	A quorum shall be made up of four members. No business shall be conducted unless a quorum is present.
9. Administrative Support	The committee in common shall be supported administratively by its secretary. Their duties in this respect will include: • agreement of agendas with the chair and attendees • preparation, collation and circulation of papers in good time • inviting additional attendees to meetings as required • taking the minutes and helping the chair to prepare reports to the board • keeping a record of matters arising and issues to be carried forward
10. Frequency of Meeting	Meetings shall be held at least twice a year but may be held more frequently should circumstances require (to be determined by the Committee Chair).
11. Date Approved	These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the Remuneration Committee • Approved by the Remuneration Committee 27 August 2026 • Approved by the DCH Board of Directors xxx

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Dorset HealthCare University
NHS Foundation Trust

Report to	Board of Directors (DHC)	
Date of Meeting	13 October 2026	
Report Title	Governor Term Extensions	
Prepared By	Sarah Anton, Governor and Membership Manager	
Approved by Accountable Executive	Jenny Horrabin, Joint Executive Director of Corporate Affairs	
Previously Considered By	Council of Governors 23 September 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	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	No specific implications for the Board Assurance Framework	
Financial	No implication.	
Statutory & Regulatory	Maintaining a quorate Council of Governors supports effective governance arrangements and compliance with current statutory requirements.	
Equality, Diversity & Inclusion	The Trust's commitment to EDI is strengthened by an inclusive Council of Governors	
Co-production & Partnership	None	

Executive Summary

In 2026, an amendment was made to the Trust Constitution through the introduction of Clause 16.4 of Annex 4, Paragraph 16. This clause allows, in exceptional circumstances and with the agreement of both the Board of Directors and the Council of Governors, for expiring Governor terms to be extended by up to 12 months. The constitutional amendment was approved by the Council of Governors in March 2026 and subsequently approved by the Board of Directors in April 2026.

Following this constitutional change and in view of current Governor vacancies and the need to maintain a quorate Council of Governors during July 2026, four Governors whose terms were due to expire in September and October 2026 were approached to ascertain whether they would be willing to extend their terms of office by a further 12 months.

Two Governors Hattie Taylor and Anoop Bains confirmed their willingness to continue in their roles for 12 months. This paper therefore seeks approval of those individual term extensions in accordance with Clause 16.4 of the Constitution.

- The Staff Governor term of Hattie Taylor, Staff Governor due to expire on the 31 October 2026 will be extended until 31 October 2027.

- The Staff Governor term of Anoop Bains, Staff Governor due to expire on the 23 September 2026 will be extended until 23 September 2027.

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Andy Burgen declined the opportunity to extend his term of office, while Tilak Ginige did not respond to the invitation to indicate whether they wished to extend their term. Consequently, the terms of office of Andy Burgen and Tilak Ginige will end on their scheduled expiry dates of 23 September 2026 and 31 October 2026 respectively.

Following approval by the Council of Governors on 23 September 2026, the proposed extensions to the Governor terms are now presented to the Board of Directors for final approval.

Recommendation

The Board of Directors is requested to:

- **Approve** the extension of the Staff Governor term of Hattie Taylor from the 1 November 2026 to the 31 October 2027, in accordance with Clause 16.4 of Annex 4, Paragraph 16 of the Trust Constitution.
- **Approve** the extension of the Staff Governor term of Anoop Bains from the 24 September 2026 to the 23 September 2027, in accordance with Clause 16.4 of Annex 4, Paragraph 16 of the Trust Constitution.

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Governor Term Extension

1. Introduction

1.1. In 2026, an amendment was made to the Trust Constitution through the introduction of Clause 16.4 of Annex 4, Paragraph 16. This clause allows, in exceptional circumstances and with the agreement of both the Board of Directors and the Council of Governors, for expiring Governor terms to be extended by up to 12 months. The constitutional amendment was approved by the Council of Governors in March 2026 and subsequently approved by the Board of Directors in April 2026.

1.2. In July 2026, four Governors whose terms were due to expire on 23 September 2026 or the 31 October 2026 were approached to ascertain whether they would be willing to extend their terms of office by a further 12 months. Hattie Taylor and Anoop Bains confirmed their willingness to continue in their roles for 12 months.

1.3. Andy Burgen declined the opportunity to extend his term of office, while Tilak Ginige did not respond to the invitation to indicate whether they wished to extend their term. Consequently, the terms of office of Andy Burgen and Tilak Ginige will end on their scheduled expiry dates of 23 September 2026 and 31 October 2026 respectively.

1.4. The following Governors have agreed to extend their terms of office by 12 months, subject to approval by the Council of Governors and the Board of Directors:

a. The Staff Governor term of Hattie Taylor will be extended until 31 October 2027.
b. The Staff Governor term of Anoop Bains be extended until 23 September 2027.

1.5. Following approval by the Council of Governors on 23 September 2026, the proposed extensions to these Governor terms are now presented to the Board of Directors for final approval.

2. Risks of not extending the Governor terms

1.1. To ensure compliance with the Constitution, the Council of Governors must remain quorate until the anticipated legislative changes take effect in April 2027.

1.2. Without the proposed term extensions, the Council would be at increased risk of becoming inquorate due to the number of existing vacancies and expiring Governor terms, reducing its ability to discharge its statutory responsibilities effectively.

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1.3. **Table 1,** Current Elected Governor's Constituencies, names and terms

Constituency	Governors Name	Term Due to end	Number of Terms served
Dorset & RoEW	Andy Burgen	23/09/2026	1
Dorset & RoEW	David Dickson	25/09/2027	2
Dorset & RoEW	Caroline Harris-Birtles	25/09/2027	1
Dorset & RoEW	Andy Mercer	23/09/2028	1
Dorset & RoEW	Steve Clark	23/09/2028	1
Dorset & RoEW	Adrian Yule	25/09/2027	1
Dorset & RoEW	Amy Roff	23/09/2028	1
BCP	Amanda Gavin	23/09/2028	1
BCP	Keith Standish	23/09/2028	1
BCP	Tilak Ginige	31/10/2026	1
BCP	Jacqueline Wilson	25/09/2027	2
BCP	3 x Vacancy	N/A	N/A
Staff	Gary Wong	25/09/2027	1
Staff	Maria Hayward	23/09/2028	1
Staff	Anoop Bains	23/09/2026	2
Staff	Hattie Taylor	31/10/2026	2
Staff	Matt Hay	23/09/2028	1

1.4. **Table 2** - Current Partner Governors representing partner organisations

Partner Organisation	Name of Appointed Governor	Term due to end	Number of Terms served
Dorset Council	Will Chakawhata	25/09/2027	1
BCP Council	Vacant	N/A	N/A
Bournemouth University	Vacant	N/A	N/A
Dorset Network of Friends of Community Hospitals	Jane Ashworth	07/07/2029	1
Dorset Mental Health Forum	Sarah Rose	18/11/2028	1
People First Forum	Amanda Frost	22/09/2029	1

3. Recommendations

The Board of Directors is requested to -

- **Approve** the extension of the Staff Governor term of Hattie Taylor from the 1 November 2026 to the 31 October 2027, in accordance with Clause 16.4 of Annex 4, Paragraph 16 of the Trust Constitution.

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- **Approve** the extension of the Staff Governor term of Anoop Bains from the 24 September 2026 to the 23 September 2027, in accordance with Clause 16.4 of Annex 4, Paragraph 16 of the Trust Constitution.

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Report to	Board of Directors (DCH)	
Date of Meeting	13 October 2026	
Report Title	Governor Term Extensions	
Prepared By	Sarah Anton, Joint Governor and Membership Manager	
Approved by Accountable Executive	Jenny Horrabin, Joint Executive Director of Corporate Affairs	
Previously Considered By	Council of Governors 21 September 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	Yes	
Sustainability	Yes	
Implications	Describe the implications of this paper for the areas below.	
Board Assurance Framework	No implications	
Financial	No implication.	
Statutory & Regulatory	Maintaining a quorate Council of Governors supports effective governance arrangements and compliance with current statutory and regulatory requirements.	
Equality, Diversity & Inclusion	The Trust's commitment to EDI is strengthened by an inclusive Council of Governors	
Co-production & Partnership	None	

Executive Summary

In 2026, an amendment was made to the Trust Constitution through the introduction of Clause 16.4 of Annex 4, Paragraph 16. This clause allows, in exceptional circumstances and with the agreement of both the Board of Directors and the Council of Governors, for expiring Governor terms to be extended by up to 12 months. The constitutional amendment was approved by the Council of Governors in March 2026 and subsequently approved by the Board of Directors in April 2026.

Following this constitutional change and in view of current Governor vacancies and the need to maintain a quorate Council of Governors during July 2026, five Governors whose terms were due to expire on 30 September 2026 were approached to ascertain whether they would be willing to extend their terms of office by a further 12 months.

Three Governors Kathryn Harrison, Jean-Pierre Lambert and Midhun Paul confirmed their willingness to continue in their roles for 12 months. This paper therefore seeks approval of those individual term extensions in accordance with Clause 16.4 of the Constitution.

Whilst not part of the proposed term extensions, David Taylor will conclude his Public Governor term on 30 September 2026 and, subject to Dorset Council's appointment process, will take up the position of Appointed Governor representing Dorset Council from 1 October 2026. This arrangement will provide continuity within the Council of Governors and further strengthen the partnership between Dorset County Hospital and Dorset Council. As an experienced Governor, David Taylor is already familiar with the Trust and the responsibilities of the role.

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Simon Bishop declined the opportunity to extend his term and will therefore cease to hold office on 30 September 2026.

The following Governors have agreed to extend their terms of office by 12 months, subject to approval by the Council of Governors and the Board of Directors:

- The Public Governor term of Kathryn Harrison, due to expire on 30 September 2026, will be extended until 30 September 2027.
- The Public Governor term of Jean-Pierre Lambert, due to expire on 30 September 2026, will be extended until 30 September 2027.
- The Staff Governor term of Midhun Paul, due to expire on 30 September 2026, will be extended until 30 September 2027.

Following approval by the Council of Governors on 21 September 2026, the proposed extensions to the Governor terms are now presented to the Board of Directors for final approval.

Recommendation

The Board of Directors are asked to –

- **Approve** the extension of the Public Governor term of Kathryn Harrison from 1 October 2026 to the 30 September 2027, in accordance with Clause 16.4 of Annex 4, Paragraph 16 of the Trust Constitution.
- **Approve** the extension of the Public Governor term of Jean-Pierre Lambert from the 1 October 2026 to the 30 September 2027, in accordance with Clause 16.4 of Annex 4, Paragraph 16 of the Trust Constitution.
- **Approve** the extension of the Staff Governor term of Midhun Paul from the 1 October 2026 to the 30 September 2027, in accordance with Clause 16.4 of Annex 4, Paragraph 16 of the Trust Constitution.

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Governor Term Extension

1. Introduction

1.1. In 2026, an amendment was made to the Trust Constitution through the introduction of Clause 16.4 of Annex 4, Paragraph 16. This clause allows, in exceptional circumstances and with the agreement of both the Board of Directors and the Council of Governors, for expiring Governor terms to be extended by up to 12 months. The constitutional amendment was approved by the Council of Governors in March 2026 and subsequently approved by the Board of Directors in April 2026.

1.2. In July 2026, five Governors whose terms were due to expire on 30 September 2026 were approached to ascertain whether they would be willing to extend their terms of office by a further 12 months. Kathryn Harrison, Jean-Pierre Lambert and Midhun Paul confirmed their willingness to continue in their roles for 12 months.

1.3. Following discussions with Dorset Council, David Taylor will conclude his term as a Public Governor on 30 September 2026 and, from 1 October 2026, will take up the position of Appointed Governor representing Dorset Council. This arrangement will provide continuity within the Council of Governors and further strengthen the partnership between Dorset County Hospital and Dorset Council. As an experienced Governor, David is already familiar with the Trust and the responsibilities of the role.

1.4. Simon Bishop declined the opportunity to extend his term and will therefore cease to hold office on 30 September 2026.

1.5. The following Governors have agreed to extend their terms of office by 12 months, subject to approval by the Council of Governors and the Board of Directors:

a. The Public Governor term of Kathryn Harrisonwill be extended until 30 September 2027.
b. The Public Governor term of Jean-Pierre Lambert be extended until 30 September 2027.
c. The Staff Governor term of Midhun Paul will be extended until 30 September 2027.

1.6. Following approval by the Council of Governors on 21 September 2026, the proposed extensions to the Governor terms are now presented to the Board of Directors for final approval.

2. Risks of not extending the Governor terms

2.1. To ensure compliance with the Constitution, the Council of Governors must remain quorate until the anticipated legislative changes take effect in April 2027.

2.2. Without the proposed term extensions, the Council would be at increased risk of becoming inquorate due to the number of existing vacancies and expiring Governor terms, reducing its ability to discharge its statutory responsibilities effectively.

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2.3. **Table 1,** Current Elected Governor's Constituencies, names and terms

Constituency	Governors Name	Term Due to end	Number of Terms served
West and South Dorset	Jean-Pierre Lambert	30/09/2026	1
West and South Dorset	Kathryn Harrison	30/09/2026	1
West and South Dorset	David Taylor	30/09/2026	1
West and South Dorset	Mike Byatt	08/07/2027	2
West and South Dorset	Alan Clark	08/07/2027	1
West and South Dorset	Anne Link	08/07/2027	1
West and South Dorset	Judy Crabb	08/07/2027	2
West and South Dorset	4 x Vacancies	N/A	N/A
North and East Dorset	Simon Bishop	30/09/2026	3
North and East Dorset	Maurice Perks	08/07/2027	3
North and East Dorset	Carol Manton	08/07/2027	1
North and East Dorset	Lynn Taylor	08/07/2027	2
South Somerset & Rest of England & Wales	1 x Vacancy	N/A	N/A
Staff	Midhun Paul	30/09/2026	1
Staff	Max Deighton	08/07/2027	1
Staff	Jan Wagnar	08/07/2027	1
Staff	1 x Vacancy	N/A	

2.4. **Table 2,** Appointed Governors to represent partner organisations

Partner Organisation	Name of Appointed Governor	Term due to end	Number of Terms served
Coastlands College	Kate Wills	30/06/2028	1
People First Dorset	Laura Kerr	31/07/2028	1
Dorset Mental Health Forum	Becky Aldridge	17/11/2028	1
Two Harbours Healthcare	Sharlina Sallehuddin	07/03/2029	1
Dorset Council	David Taylor from 1 October 2026	30/09/2029	2
Organisation to represent older people	Vacancy	N/A	N/A
Organisation to represent the spectrum of palliative and hospice care	Vacancy	N/A	N/A

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3. Recommendations

The Board of Directors are asked to –

- **Approve** the extension of the Public Governor term of Kathryn Harrison from 1 October 2026 to the 30 September 2027, in accordance with Clause 16.4 of Annex 4, Paragraph 16 of the Trust Constitution.
- **Approve** the extension of the Public Governor term of Jean-Pierre Lambert from the 1 October 2026 to the 30 September 2027, in accordance with Clause 16.4 of Annex 4, Paragraph 16 of the Trust Constitution.
- **Approve** the extension of the Staff Governor term of Midhun Paul from the 1 October 2026 to the 30 September 2027, in accordance with Clause 16.4 of Annex 4, Paragraph 16 of the Trust Constitution.

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