University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET

NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 11 November 2026

9:30 – 12:30

Boardrooms at Poole Hospital

and via Microsoft Teams

(Link to join meeting can be found in Outlook Diary Appointment)

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

AGENDA – BOARD OF DIRECTORS – PART 1 HELD IN PUBLIC

09:30 on Wednesday 11 November 2026, Boardrooms at Poole Hospital and via MS Teams

If you are unable to attend please notify the Corporate Governance Team by sending an email to: uhd.company.secretary-team@nhs.net

Judy Gillow
Interim Trust Chair

Time	Item		Method	Purpose	Lead
	1	**STANDING ITEMS**			
09.30	**1.1**	Welcome, apologies and declarations of interest	**Verbal**		**Chair**
09.32	**1.2**	Notification of any urgent business	**Verbal**	**Review**	**Chair**
09.35	**1.3**	Staff story	**Verbal**	**Receive**	**CPO**
09:50	**1.4**	Minutes of the meeting held on 9 September 2026	**Paper**	**Agree**	**Chair**
09.52	**1.5**	Action log and matters arising	**Paper**	**Review**	**Chair**
	2	**TRUST CHAIR AND CHIEF EXECUTIVE OFFICER'S UPDATES**			
9:55	**2.1**	Trust Chair's report	**Paper**	**Note**	**Chair**
10:00	**2.2**	Chief Executive Officer's report	**Paper**	**Note**	**CEO**
	3	**STRATEGY**			
10:20	**3.1**	Clinical Strategy	**Paper**	**Review**	**CSTO**
10:30	**3.2**	Transforming Care Together- Phase 3 delivery plan	**Paper**	**Assure**	**COO, CSTO**
	4	**QUALITY**			
10:40	**4.1**	Thirlwall Inquiry report and recommendations, including SUDIC policy and protocol	**Paper**	**Review**	**CNO**
10:50	**BREAK**				
	5	**CULTURE**			
11:10	**5.1**	Freedom to Speak Up	**Paper^{R}**	**Assure**	**FTSUG**

	6	**PERFORMANCE, ASSURANCE AND RISK**			
11:20	**6.1**	2026/27 Board Assurance Framework Q2	**Paper**	**Assure**	**DoCG, Exec Leads**
11:25	**6.2**	Corporate risk register	**Paper**	**Review**	**CNO**
11:35	**6.3**	Audit committee assurance report (October meeting) • EPRR annual report **(COO)** • Accountability Framework review **(DoCG)**^{R}	**Paper**	**Assure**	**Committee Chair**
11:42	**6.4**	Finance and performance committee assurance report (October and November meetings) • Premises Assurance Model **(CSTO)** • Operational Plan exception report and National Oversight Framework **(COO)**	**Paper**	**Assure**	**Committee Chair**
11:55	**6.5**	Quality committee assurance report (October and November meetings) • Quality Impact Assessment Overview Report **(CNO)** • Mortality Report **(CMO)** • Martha's Rule in Emergency Departments **(CMO)** • Perinatal Quality Oversight **(DoM)**^{R}	**Paper**	**Assure**	**Committee Chair**
12:10	**6.6**	People and culture committee assurance report (November meeting) • Modern Slavery Statement **(CPO)**	**Paper**	**Assure/ approve**	**Committee Chair**
12:15	**6.7**	Transforming care together group assurance report (October meeting)	**Paper**	**Assure**	**Committee Chair**
12:20	**6.8**	Integrated Quality, Performance, Workforce, Finance and Informatics report	**Paper**	**Assure**	**COO, Exec leads**
	7	**GOVERNANCE**			
12:25	**7.1**	Trust Constitution update	**Paper**	**Approve**	**DoCG**
12:30	**7.2**	Strategy and Transformation Committee	**Paper**	**Approve**	**DoCG**
12:35	**7.3**	Board governance cycle	**Paper**	**Approve**	**DoCG**
12:40	**8.1**	Reflections on the Board Meeting	**Verbal**	**Discuss**	**Chair**
	8.2	Questions from the Council of Governors and Public arising from the agenda. Governors and Members of the public are requested to submit questions relating to the agenda by no later than 12noon on Friday 6 November 2026 to: uhd.company.secretary-team@nhs.net			
	8.3	**Date and Time of Next Board of Directors Part 1 Meeting:** Board of Directors Part 1 Meeting on Wednesday 20 January 2027 at 9:30.			

	8.4	**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 the next part of the meeting be excluded due to the confidential nature of the business to be transacted.

* Late paper
R Associated item in Reading Room

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The recording will be deleted after the minutes of the meeting have been approved.

University Hospitals Dorset
NHS Foundation Trust

AGENDA- BOARD OF DIRECTORS – PART 2 HELD IN PRIVATE

13:00 on Wednesday 11 November 2026, Boardrooms at Poole Hospital and via MS Teams

Time		Item	Method	Purpose	Lead
	9	**STANDING ITEMS**			
13:00	9.1	Welcome, apologies and declarations of interest	Verbal		Chair
13:02	9.2	Notification of Urgent Business or Confidential Escalations	Verbal	Review	Chair
13:05	9.3	Minutes of the Board Part 2 Meeting held on 14 and 28 October 2026	Paper	Approve	Chair
13:07	9.4	Action log and matters arising:	Paper	Review	Chair
	10	**CHAIR AND CHIEF EXECUTIVE OFFICER'S UPDATE**			
13:10	10.1	Chair's update: • Feedback from Board service visits	Verbal	Note	Chair/ NEDs
13:20	10.2	Chief Executive Officer's Update	Verbal	Note	CEO/ Exec Leads
	11	**GOVERNANCE AND STRATEGY**			
13:50	11.1	Partnership Board update (HealthSet)	Verbal	Assure	CDO
	12	**ITEMS FOR APPROVAL**			
14:00	12.1	Private Patients Joint Venture	Paper	Approve	CSTO
	12.2	Transforming People Services OBC	Paper	Approve	CPO
	12.3	Use of seal: Lease surrender and renewal for the office space on 3rd floor in Tringham House	Paper	Approve	CSTO
	13	**MEETING CLOSURE**			
14:30	13.1	Reflections on the Board Meeting	Verbal	Discuss	Chair
Date and Time of Next Standing Board of Directors Part 2 Meeting: Board of Directors Part 2 Meeting on Wednesday 9 December 2026 at 09.30.					
Close					

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University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS PART 1

Minutes of the Part 1 meeting of the Board of Directors held on Wednesday 9 September 2026 at 09:30am in the Boardrooms at Poole Hospital and via Microsoft Teams.

Present:	Claire Whitaker	Non-Executive Director (*meeting chair)*
	Beverley Bryant	Chief Digital Officer
	Siobhan Harrington	Chief Executive Officer
	Sarah Herbert	Chief Nursing Officer
	Femi Macaulay	Non-Executive Director
	Alastair Matthews	Non-Executive Director
	Helena McKeown	Non-Executive Director
	Mark Mould	Chief Operating Officer *(left during BoD163/26, returned during BoD164/26)*
	Pete Papworth	Chief Finance Officer and acting Chief People Officer
	Sharath Ranjan	Non-Executive Director
	Richard Renaut	Chief Strategy and Transformation
	Peter Wilson	Chief Medical Officer
In attendance:	Vivian Alividza	Deputy Chief Nursing Officer
	Andrew Doe	Associate Non-Executive Director
	Alison Honour	Associate Non-Executive Director
	Leonora May	Director of Corporate Governance
	Lorraine Tonge	Director of Midwifery and Neonatal Services
	Klaudia Zwolinska	Deputy Company Secretary
	7 Governors	
	1 member of staff	
	3 members of the public	

BoD150/26	**Welcome, apologies and declarations of interest** In Judy Gillow'a absence, Claire Whitaker Chaired the meeting and welcomed everyone. Apologies were received from: • Judy Gillow, Interim Trust Chair • Michael Marsh, Non-Executive Director Peter Wilson declared an interest relating to a new advisory role with Stalis, a data migration company. The Board was assured that appropriate safeguards were in place to prevent any involvement in related procurement or decision-making activities and was satisfied that the potential conflict of interest was appropriately managed. There were no further declarations of interest other than those recorded on the register of interests. The meeting was declared quorate.
BoD151/26	**Notification of any urgent business** There were no alerts of urgent business.
BoD152/26	**Patient story** Sarah Herbert introduced the patient story, which demonstrated the benefits of partnership working between the Trust and voluntary sector organisations in supporting prevention, rehabilitation and long-term health outcomes. The patient reflected positively on the care received following a heart attack in 2023 and

	described the significant role that cardiac rehabilitation, counselling support and participation in the Heart Club had played in his recovery and wellbeing. The Board heard how the close relationship between the Trust's cardiac rehabilitation service and the Heart Club provided a seamless transition to ongoing exercise, peer support and health improvement activities. A representative of the Heart Club outlined their wider work in supporting rehabilitation and prevention, including initiatives aimed at reducing the risk of long-term conditions. Board members reflected on the importance of prevention, community partnerships and integrated working. In response to a question from the Siobhan Harrington, the patient reported high levels of satisfaction with his care, noting only a minor technical issue relating to ECG equipment. The Board thanked the patient and Heart Club representatives for sharing their experiences**.** The Board NOTED the Patient Story.
BoD153/26	**Minutes of the meeting held on 15 July 2026** The minutes of the meeting held on 15 July 2026 were AGREED as an accurate record.
BoD154/26	**Action log and matters arising** Leonora May presented the action log and advised that: • three actions were not yet due for completion and would be reported back at future meetings, • one action remained ongoing and a written update on progress had been provided, and • seven actions had been completed and supporting updates were included within the action log. The Board NOTED the action log.
BoD155/26	**Trust Chair's report** Claire Whitaker presented the Trust Chair's report. The Board noted recent activity undertaken by Non-Executive Directors in consultant recruitment processes and reflected positively on the quality of candidates being attracted to the organisation. Members agreed that participation in recruitment activity provided valuable insight into services and strengthened engagement across the Trust. The Board NOTED the Trust Chair's report.
BoD156/26	**Chief Executive Officer's report** Siobhan Harrington presented her report and thanked staff for their continued commitment in delivering patient care during a challenging summer period. The Board noted recent national developments, including changes in political leadership, the continued focus on local healthcare delivery and social care, and an evolving approach to national oversight. An update was provided on the Trust's position within the national oversight rankings, which was thought to remain stable. It was expected that league tables would be published next week. The Board received an update on the Better Flow, Better Care programme, which will support improvements in patient flow and operational efficiency ahead of winter and the implementation of pathway changes in emergency and elective care in April 2027. Operational performance remained challenging in some areas, although improvements had been seen in cancer performance. Work continued locally and across Dorset to address system-wide pressures. The Board noted that the Trust had received regional correspondence regarding performance against the 12-hour emergency department standard and was participating in a formal assurance process. It was reported that this had resulted in increased focus within the Integrated Performance Report and across governance committees on performance areas that were off trajectory. Whilst July performance

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	had been challenging, the Board heard that performance had improved during August. The continuing challenge associated with patients who no longer met the criteria to reside in hospital was discussed. The Board noted the work being undertaken by Ian Sturgess to improve patient flow within the Trust and heard that he was also developing a wider system perspective through similar work at Dorset County Hospital. His findings would be discussed at a future Dorset Chief Executives meeting to support system-wide improvement. The Board noted that the HealthSet Programme Board had confirmed a go-live date of 28 April 2028. Progress continued across the programme and planning remained on track. The Board reviewed the Trust's financial position, noting that performance remained broadly in line with plan. Members discussed the ongoing challenge of delivering recurrent savings and reducing reliance on non-recurrent measures, with operational improvement and service transformation identified as key enablers of sustainable financial performance. Updates were also provided on a number of transformation initiatives, including the endoscopy programme and workforce initiatives, including Together Tuesday and Thrive Live events. The Board heard positive feedback regarding co-location of teams within Tringham House and recognised the contribution of the Estates team in supporting the move. The Board noted progress in recruiting to the Chief People Officer role and arrangements for interim leadership cover from the end of September. Members also recorded their thanks to Pete Papworth for his support during the transition period. An update on the forthcoming flu vaccination campaign and national uptake targets was also highlighted. During discussion, Board members reflected on the continued importance of creating an inclusive working environment. Siobhan Harrington outlined ongoing work to support colleagues who experience discrimination and reiterated the Trust's commitment to a zero-tolerance approach. The Board noted the importance of ensuring staff felt safe, supported and able to raise concerns. The Board NOTED the Chief Executive Officer's report.
BoD157/26	**Quality strategy for NHS funded care in England** Sarah Herbert presented the national Quality Strategy for NHS-funded care, published in July 2026. The Board noted that the strategy does not introduce new performance targets but provides a framework for defining, measuring and improving quality, with a continued focus on safety, effectiveness, patient experience and the patient voice. The Board discussed the implications for UHD and noted that the Trust was well placed to build on existing arrangements for quality oversight, leadership and accountability through Patient First. It was emphasised that quality remains the responsibility of all staff and that robust quality management systems and a strong organisational culture are essential to delivering high-quality care. Board members welcomed the emphasis on leadership accountability, staff development and patient feedback. Discussion highlighted the importance of embedding ownership of quality throughout the organisation, aligning quality risks with the Board Assurance Framework and ensuring quality improvement is reflected in appraisal, training and leadership development processes. The Board also noted the links between the strategy, prevention, population health management and the emerging clinical strategy. The Board NOTED the quality strategy for NHS funded care in England.
BoD158/26	**Maternity services and UHD response to Ockenden and Amos reports.**

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	Lorraine Tonge presented the report and outlined the work undertaken to benchmark maternity services against the national requirements arising from the Amos report. The Board heard that twenty-six deliverables had been identified and that action plans were in place to support ongoing implementation. The discussion focused on listening to women, families and staff, improving data collection relating to inequalities and strengthening assurance around maternity triage. Members noted the scale of work being required of maternity services nationally and recognised the significant resource implications of implementing these requirements. There would be a more detailed report on progress against the ten-point plan recommendations during part 2. The Board NOTED the maternity services and UHD response to Ockenden and Amos reports.
BoD159/26	**Racism and antisemitism and UHD response to Lord Mann review** Pete Papworth presented a report on racism, antisemitism and the Trust's response to the Lord Mann Review. The Board noted that NHS England had accepted the review's recommendations in full and heard that the findings were consistent with themes already identified through Trust feedback and workforce data. The Board discussed the importance of ensuring that implementation of the recommendations resulted in meaningful cultural change rather than a compliance-driven approach. Members emphasised that creating an inclusive organisation relied on visible leadership, personal accountability and a shared commitment to challenging discrimination and inappropriate behaviour. Siobhan Harrington highlighted the importance of speaking up and taking appropriate action when incidents occur, noting that recent cases had been addressed through formal processes where necessary. The Board also discussed the capacity required to deliver the range of national equality, diversity and inclusion (EDI) initiatives and was advised that work was underway to strengthen resource within the EDI function. Members reflected on the importance of co-production, engagement with staff networks and learning from lived experience. The positive impact of initiatives such as reverse mentoring was acknowledged, together with the need to ensure that staff experiencing discrimination feel supported, safe and able to access appropriate assistance. The Board NOTED the racism and antisemitism and UHD response to Lord Mann review and: • Supported incorporating the Lord Mann Review recommendations into the NHS Staff Standards implementation programme, • Supported the development of a single anti-racism and inclusion improvement framework as part of the Trust's emerging EDI Strategy, • Supported a review of governance, accountability arrangements and workforce data to ensure the Trust can target improvement activity effectively and measure its impact.
BoD160/26	**Corporate risk register** Sarah Herbert presented the risk register. The Board noted two new risks that met the threshold for inclusion on the Corporate Risk Register, relating to Transforming Care Together Phase 3 delivery and patient safety risks associated with the emergency department waiting area at the Royal Bournemouth Hospital. The Board received an update on the Phase 3 move and noted the robust gateway review process in place. Discussion also focused on number of patients with no criteria to reside and the importance of system readiness and support. Members were advised that discussions with the ICB regarding system responsibilities and governance arrangements were ongoing.

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	Siobhan Harrington provided an update on the ongoing changes within the ICB and the establishment of a Service and Delivery Group, chaired by a Chief Executive, to lead the system through forthcoming changes. Further clarity on these arrangements was expected in the coming weeks. The Board NOTED the risk register.
BoD161/26	**Audit Committee assurance report** Tracie Langley presented the Audit Committee assurance report. The Board heard that the Trust had received a clean and unqualified set of accounts and that internal and external auditors were satisfied with the organisation's willingness to identify areas for improvement and respond positively to recommendations. It was also noted that the Annual Report had been laid before the Parliament and had been published on the Trust's website. <u>Fit and proper persons test report</u> Leonora May presented the fit and proper persons test report. The Board was advised that all required checks had been completed in line with NHS England requirements and that all Board members had been confirmed as meeting the Fit and Proper Persons criteria. The Board NOTED: • Audit Committee assurance report • Fit and proper persons test report
BoD162/26	**Finance and Performance Committee assurance report** Alastair Matthews presented the Finance and Performance Committee assurance report. He reported that: • the Committee noted improving trajectories across several performance indicators and received early information relating to August performance. Cancer performance continued to require close attention, particularly in relation to the 62-day standard, although actions remained in place and some improvement had been observed. • the Committee discussed patient flow and no criteria to reside delays. The Committee welcomed additional investment approved to support community capacity but remained concerned about continuing pressures affecting patient discharge. • the Committee reviewed the Trust's financial position and noted the ongoing challenge of delivering recurrent savings. While plans remained in place to achieve the financial target for the year, members recognised that significant reliance remained on non-recurrent measures and future service reconfiguration. • The Committee reviewed progress with HealthSet, the Premises Assurance Model, operational performance, diagnostic waiting times, coding performance and winter planning. Coding timeliness was identified as a specific concern due to workforce shortages affecting clinical coding teams. <u>Winter plan 2026</u> Mark Mould presented the Winter Plan 2026. The Board noted that the plan had been developed to support winter resilience while preparing for the planned separation of emergency and elective care pathways in April 2027. Key initiatives included the opening of the Older Persons and Acute Medicine Same Day Emergency Care (SDEC) facility and expansion of Hospital at Home capacity, supporting improved patient flow, care closer to home and implementation of the future operating model. Members welcomed the integrated approach to winter planning and service transformation and noted that additional investment had been identified to support delivery, with a system-wide assurance process to be completed prior to final

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	submission. The Board Assurance Statement would be discussed in more detail during part 2. <u>Premises Assurance Model (PAM)</u> The Board received an update on the Premises Assurance Model. The Finance and Performance Committee had reviewed the submission process and received assurance from Internal Audit regarding the robustness of the approach being taken. Key areas requiring ongoing attention included backlog maintenance, planned preventative maintenance and the continued development of governance processes. It was noted that the submission deadline had been extended and that the final return would be submitted later in the month and presented to the Board at its meeting in November. Members were assured that a structured process was in place and that no significant unexpected issues had been identified. <u>Nursing band 5 job evaluation</u> Vivian Alividza presented the nursing band 5 job evaluation. The Board heard that the review formed part of a national programme and would involve all eligible nursing and midwifery staff over an extended implementation period. Members noted the significant scale of the exercise and the uncertainty regarding the full financial impact, although national funding had been identified and further modelling was underway. The Board recognised the opportunity to acknowledge the evolving responsibilities of nursing and midwifery staff and emphasised the importance of delivering the review through a fair, transparent and well-supported process, with appropriate equality impact monitoring and staff engagement throughout implementation. The Board NOTED: • Finance and Performance Committee assurance report. • Premises Assurance Model (PAM) • Nursing band 5 job evaluation The Board APPROVED: • Winter plan 2026 and authorised completion of the final assurance process and submission arrangements.
BoD163/26	**Quality committee assurance report** Helena McKeown presented the Quality committee assurance report. The Board received assurance regarding scrutiny of gynaecology services, operational performance, complaints, safeguarding, paediatric services and maternity oversight activity. It was also noted that immediate action had commenced in response to preliminary findings arising from a recent CQC review. <u>Kingdon report – organisational response</u> Sarah Herbert presented the Trust's response to the Kingdom Review into paediatric audiology services. The Board noted that UHD had completed a self-assessment against the review's assurance requirements and was able to demonstrate a reasonable level of assurance through existing governance and accountability arrangements. The Board heard that opportunities had been identified to strengthen oversight of healthcare science services, particularly in relation to workforce and service risks. Members supported integrating any additional assurance requirements into existing governance processes to minimise duplication and reporting burden. <u>Q1 perinatal quality oversight</u> Lorraine Tongue presented the Q1 perinatal quality oversight and maternity outcomes signal system (MOSS) submission. The Board discussed maternity staffing indicators and staff feedback relating to perceptions of staffing adequacy. Assurance was provided that further analysis was underway to understand the

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	underlying causes and that work was in progress to improve the consistency and accuracy of Birthrate Plus reporting. The Board noted that the Quality Committee had requested additional training to strengthen assurance regarding safe staffing arrangements. The Board also received an update on progress against the Maternity Incentive Scheme. Members were advised that delivery remained broadly in line with the annual compliance cycle, with continued focus on consultant attendance standards and mandatory training requirements. While some actions remained outstanding, assurance was provided that improvement plans were in place and progress was being closely monitored through established governance arrangements. <u>Maternity outcomes signal system (MOSS) submission</u> Lorraine Tonge presented the MOSS report following a safety alert triggered by four incidents in July. The Board noted that a multidisciplinary Critical Safety Review had been undertaken with executive oversight. Two of the incidents were not considered attributable to care provided by the Trust. The review identified opportunities for improvement relating to compliance with the 75-minute emergency caesarean section standard and ongoing medical staffing challenges. Members were advised that both issues were already recognised risks with established improvement plans in place. The Board noted that the Trust's overall position had been assessed as Green/Amber and was assured that the identified risks were already subject to active management and oversight. <u>Safeguarding annual report</u> Vivian Alividza presented the safeguarding report. The Board discussed the reported increase in allegations against people in positions of trust and was advised that this largely reflected greater awareness of safeguarding processes and increased confidence in reporting concerns, rather than an increase in substantiated cases. Work was underway to ensure concerns were managed through the most appropriate safeguarding or HR processes. The Board welcomed the comprehensive report and recognised the work of the safeguarding team. Members noted that increased reporting could be viewed positively as evidence of greater awareness and confidence in safeguarding processes. It was suggested that future trend analysis would help provide additional understanding of underlying patterns. <u>Infection, prevention and control annual report</u> Sarah Herbert presented the Infection Prevention and Control Annual Report. The Board noted the positive progress made during the year and recognised the significant contribution of the IPC team, particularly in supporting major transformation and service relocation programmes while maintaining patient safety and infection prevention standards. During discussion, reference was made to meningitis awareness campaigns undertaken within higher education settings. It was confirmed that whilst meningitis was managed through clinical pathways and infectious disease arrangements, it was not specifically reported through the Infection Prevention and Control Annual Report. Opportunities for further collaboration around awareness and vaccination uptake were noted. <u>Health and safety annual report</u> Richard Renaut presented the health and safety annual report. The Board welcomed the comprehensive nature of the report and recognised the significant work being undertaken by the Health and Safety team to strengthen reporting processes, learning from incidents and organisational oversight. The Board recorded its thanks to the team for their contribution and ongoing support to the Trust's wider transformation programme. It was also noted that engagement

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	with Health and Safety representatives had continued to strengthen governance and provide additional assurance regarding the management of health and safety risks. The Board NOTED: • Quality committee assurance report • Kingdon report- organisational response • Q1 perinatal quality oversight and maternity outcomes signal system (MOSS) submission • Safeguarding annual report • Infection, prevention and control annual report • Health and safety annual report The Board APPROVED: • The statement of commitment to safeguarding children, young people and vulnerable adults • Infection, prevention and control work plans for publication.
BoD164/26	**People and culture committee assurance report** Presenting the Committee's Assurance Report, Sharath Ranjan highlighted concerns regarding declining appraisal completion rates which remained below target and had declined over the previous four months, prompting further review of areas where compliance should be achievable and findings from the National Education and Training Survey indicating that sexual safety results were below the national benchmark and required further investigation. The Board noted progress in delivering the refreshed People Strategy, implementation of the NHS Staff Standards and Leadership and Management Framework, workforce risks within the Board Assurance Framework and ongoing work to strengthen leadership, culture and workforce improvement. Members also received an update on the Transforming People Services programme and were advised that staff-side representatives were engaged in the programme through regional governance arrangements. The Board welcomed the simplified structure of the refreshed People Strategy, noting that clearer priorities, accountability and delivery milestones would support effective implementation and oversight. <u>Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) annual reports</u> Pete Papworth presented the WRES and WDES reports. The Board noted that, while improvements had been made in a number of measures, inequalities remained in areas including career progression, recruitment outcomes and experiences of bullying, harassment and discrimination. Members heard that the findings were consistent with themes emerging from other workforce feedback mechanisms, including staff survey, pulse survey and Freedom to Speak Up. It was emphasised that the Trust's focus remained on achieving measurable improvements in staff experience rather than solely demonstrating compliance with national requirements. The Board supported the Trust's approach of addressing these issues through a single, integrated programme of work aligned to the People Strategy, EDI Strategy and NHS Staff Standards, rather than developing multiple standalone action plans. Discussion highlighted the importance of leadership, inclusive recruitment practices and leadership development in supporting further improvement. <u>Guardian of Safe Working annual report</u> Peter Wilson presented the Guardian of Safe Working Hours report and recognised the contribution of Rachel Ford and Julie Prince in strengthening the Trust's arrangements for supporting resident and locally employed doctors. The Board noted improvements in engagement, including the re-establishment of the doctors'

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	forum and increased opportunities for medical staff to raise concerns and contribute to workforce improvement initiatives. Members welcomed the progress made in strengthening communication and engagement with medical staff and noted the positive impact on participation and feedback. The Board also discussed the value of aligning medical, nursing and patient safety workforce information to provide a more comprehensive understanding of workforce-related risks and areas requiring attention. **ACTION:** To review opportunities to triangulate nursing, medical workforce and patient safety data within workforce reporting to strengthen oversight of workforce-related risks. **Sarah Herbert** and **Peter Wilson** <u>Safe staffing (nursing) report</u> Vivian Alividza presented the safe staffing (nursing) report. The Board was advised that compliance with workforce safeguards continued to be monitored through regular reviews and reporting mechanisms. External reviews had been undertaken and had provided positive assurance regarding the Trust's approach to safer staffing. The Board noted changes in staffing ratios within some continuing care areas, where a greater proportion of support workers were being utilised. Assurance was provided that quality indicators were being closely monitored and that staffing models would be reviewed if any deterioration in quality indicators emerged. <u>Integrated maternity workforce report</u> Lorraine Tonge presented the Integrated maternity workforce report. The Board noted improvements in a number of areas, including reduced midwifery sickness absence, lower agency expenditure, increased compliance with neonatal workforce training requirements and the appointment of additional anaesthetic support within maternity services. Members also welcomed the successful recruitment of newly qualified midwives. The Board also considered wider workforce challenges affecting maternity and other healthcare professions, including recruitment, retention and employment opportunities for newly qualified staff within constrained funding environments. Members noted the importance of long-term workforce planning to respond to increasing clinical complexity and changing patterns of demand. Assurance was provided that maternity staffing levels continued to be maintained above the Birthrate Plus establishment, reflecting the Trust's commitment to safe and sustainable maternity services. <u>Terms of Reference</u> Leonora May presented the revised Terms of Reference for the People and Culture Committee, which had been refreshed to align with the updated People Strategy, strengthen the Committee's strategic focus and align the governance cycle with the financial year. Sharath Ranjan confirmed that the Committee had reviewed and supported the proposed changes. During discussion, members noted that the governance and reporting arrangements for health and safety were not sufficiently reflected within the revised documentation. It was agreed that the reporting route and the Committee's responsibilities in relation to health and safety assurance would be clarified as part of the final revisions. **ACTION:** To review and amend the People and Culture Committee Terms of Reference and governance arrangements to ensure that health and safety reporting responsibilities and escalation routes are clearly defined. **Leonora May** The Board NOTED: • People and culture committee assurance report

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	• Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) annual reports • Guardian of Safe Working annual report • Safe staffing (nursing) report • Integrated maternity workforce report. The Board APPROVED: • People and Culture Committee Terms of Reference, subject to the inclusion of appropriate health and safety governance arrangements.
BoD165/26	**Transforming care together group assurance report** Sharath Ranjan presented the Transforming care together group assurance report. The Borad noted the revised timetable for Phase 3 moves and heard that planning continued to focus on reducing reliance on bed numbers and increasing emphasis on patient flow. Discussion highlighted ongoing work to understand the impact of programme delays on productivity, workforce planning, efficiency savings and anticipated quality benefits. The Board also heard that further work was underway to understand the financial implications of delayed activity. Members were advised that system-wide governance arrangements continued to develop and that greater involvement from system partners would support future delivery. The Committee NOTED the Transforming care together group assurance report.
BoD166/26	**Charitable funds committee assurance report** Femi Macaulay presented the Charitable funds committee assurance report. The Board noted that fundraising income was below plan due to the timing of legacy income and delays to the charity lottery relaunch, although the Committee remained confident that full-year targets would be achieved. Demand for charitable funding had increased significantly, resulting in increased expenditure against charitable objectives and a corresponding reduction in fund balances. Femi Macaulay thanked the charity team for their work. The Committee NOTED the Charitable funds committee assurance report
BoD167/26	**Integrated Quality, Performance, Workforce, Finance and Informatics report** <u>Performance</u> The Board noted continued improvement in operational performance, including 12-hour waits and elective recovery standards. However, delays associated with patients with no criteria to reside remained a significant challenge to patient flow, and members noted ongoing work with system partners, local authorities and NHS England, supported by additional system investment. The Board also received an update on the publication of the national minimum standards for patient experience and noted that a baseline assessment had been completed. Further work would be undertaken through implementation of the Epic electronic patient record system to support compliance and enhance communication with patients throughout their care journey. <u>Finance</u> Pete Papworth provided an update on the financial position, noting that the Trust remained on plan but continued to face challenges in delivering recurrent savings. While opportunities had been identified to support in-year delivery, achieving sustainable efficiencies remained a key priority, with a degree of reliance on the planned service reconfiguration and associated benefits. <u>Workforce</u> Pete Papworth reported that workforce performance remained below trajectory in a number of areas, including appraisal compliance, mandatory training, sickness

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	absence and vacancy rates. The Board noted that improvement plans were in place and being monitored through existing governance arrangements, with continued focus on delivery of the People Strategy and wider workforce improvement initiatives. <u>Quality</u> Sarah Herbert highlighted key quality indicators within the Integrated Performance Report. The Board welcomed the continued reduction in corridor care, reflecting the sustained focus on patient flow and emergency care performance, but noted ongoing concerns regarding pressure ulcer performance, with improvement actions in place to support recovery. The Board also received an update on infection prevention and control, noting an increase in E. coli cases during the summer period and the importance of maintaining a focus on hydration and infection prevention measures during periods of prolonged hot weather. The Board NOTED the Integrated Quality, Performance, Workforce, Finance and Informatics report and the 12 hour waits action plan.
BoD168/26	**Trust Constitution update** Leonora May presented the Trust Constitution update which was APPROVED by the Board.
BoD169/26	**Board meeting schedule** Leonora May presented the Board meeting schedule which was APPROVED by the Board.
BoD170/26	**Scheme of Delegation** Pete Papworth presented the updated Scheme of Delegation which was APPROVED by the Board.
BoD171/26	**Reflections on the Board Meeting** Claire Whitaker invited reflections on the meeting and thanked members for their support during her first public Board meeting. Members were invited to provide any further feedback informally outside the meeting.
BoD172/26	**Questions from the Council of Governors and Public arising from the agenda** There had been one question received from a member of the public ahead of the meeting: *The Board's September meeting pack shows that gynaecology is one of the largest groups contributing to patients waiting over 52 weeks, and that this is partially due to reduced capacity cause by clinician availability. Given that UHD provides a specialist Dorset Endometriosis Centre, can the Board provide information on:* • *Number of patients waiting specifically for endometriosis treatment and whether this backlog has increased since the lack of clinician availability was raised* • *Average (Mean/Median) waiting time for endometriosis treatment* • *What additional capacity or action has been taken to ensure patients are not experiencing unacceptable delays*. Mark Mould responded that increasing public awareness had contributed to higher referral rates and explained that the Trust continued to provide specialist endometriosis services supported by recognised clinical expertise. While challenges existed within gynaecology services more broadly, the Trust had retained specialist expertise and continued to invest in additional capacity. Members heard that average waiting times remained under active review and that further recruitment, pathway redesign and additional clinic capacity were being implemented. It was also noted that patients requiring treatment following specialist

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	assessment could often commence treatment significantly sooner than the initial outpatient waiting time. Claire Whitaker thanked Board members, governors, staff and members of the public for their attendance and contributions. The meeting was closed.
The next standing Board of Directors Part 2 meeting would be held on Wednesday 11 November 2026 at 9:30am	

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Board Part 1 Action List - November 2026						
Meeting Date	**Minute No.**	**Matter Arising / Action**	**Lead**	**Due Date**	**Progress**	**Status**
15/07/2026	**BoD123/26**	**Communication on the COAST building:** To provide regular communications and FAQs on the COAST programme and service changes to support stakeholder engagement and maintain confidence in programme delivery	Communications Team	Ongoing	**Sep-26:** We have sent regular all staff emails since March 2026. These have also been made available on the intranet (main pages and TCT page) with the latest FAQs. The latest update about our new cladding company Axis, was sent on 4 August in the staff bulletin. We also shared the Coast Building delay via email with our stakeholders and have updated the main webpage with details of the Coast Building delay, with more details to be shared as we get more information. **Nov-26:** The Communications Team will continue to provide regular staff updates on developments relating to the COAST building and associated service changes, in line with the approach taken to date.	Complete
15/07/2026	**BoD123/26**	**System delivery plan:** To develop a system delivery plan supporting 'Transforming Care Together', in partnership with system partners, setting out key actions, milestones, measures of success and reporting arrangements	Siobhan Harrington Richard Renaut	Nov-26	**Sep-26:** To be presented to the Board at its meeting in November 2026. **Nov-26:**The System Delivery Plan will be considered by the Strategy and Transformation Committee at its first meeting in November.	Complete
15/07/2026	**BoD125/26**	**Changes to discharge process:** To invite wider system colleagues to a future Board development session to provide an overview of emerging developments regarding discharge, assessment and social care services, and to explore how UHD and partner organisations can continue to support patient flow and reducing excessive hospital stays	Mark Mould	TBC	**Sep-26:** Not due yet. **Nov-26:** This will be reviewed as part of wider system work to ensure a coordinated approach to discharge, assessment and social care services, with the aim of achieving the best outcomes for patients and supporting effective patient flow. The outcome of this work will be presented at a future Board meeting.	Complete
15/07/2026	**BoD126/26**	**Baby tagging:** To complete the review of the baby tagging system and associated dependencies, and provide an update on future arrangements through the Quality Committee and Board.	Sarah Herbert	Nov-26	**Sep-26:** The review of the baby tagging system will be presented at the November 2026 Board meeting. **Nov-26:** The report in relation to the baby tagging system can be found in the reading room.	Complete
09/09/2026	**BoD164/26**	**Workforce reporting:** To review opportunities to triangulate nursing, medical workforce and patient safety data within workforce reporting to strengthen oversight of workforce-related risks.	Sarah Herbert/ Peter Wilson	Jan-27	**Nov-26:** This work remains in progress. No substantive progress is expected in the short term, and a further update will be provided once work advances.	In Progress
09/09/2026	**BoD164/26**	**PCC Terms of Reference:** To review and amend the People and Culture Committee Terms of Reference and governance arrangements to ensure that health and safety reporting responsibilities and escalation routes are clearly defined.	Leonora May	Nov-26	**Nov-26:** The People and Culture Terms of Reference have been updated to clarify reporting responsibilities and escalation arrangements for health and safety.	Complete

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **2.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Trust Chair's report
Prepared by:	Judy Gillow, interim Trust Chair
Presented by:	Judy Gillow, interim Trust Chair
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Information
Executive summary:	**National Developments** I continue to work closely with NHS Alliance regarding the Health Bill and its potential implications for Foundation Trusts and Councils of Governors. I remain engaged in national discussions concerning the future of local accountability and governance arrangements and will continue to keep governors and the Board informed of developments as further details emerge. I was pleased to note the Government's announcement on 28 October 2026 that Healthwatch England and local Healthwatch organisations will be retained and strengthened, ensuring that the experiences of patients and the public continue to play a central role in shaping and improving health and social care services. We look forward to continuing our positive relationship with Healthwatch locally and nationally. **Non-Executive Director Activities** A programme of service visits continues to support Non-Executive Directors in gaining first-hand insight into services, strengthening triangulation of assurance, organisational learning and stakeholder engagement. Since the last Board meeting, Non-Executive Directors have undertaken visits to: • Pathology • Eye Unit • Physiotherapy Services • Maternity Services

These have covered Poole, RBH and Christchurch hospitals. A quarterly report will be provided to Board on the key themes commencing in January 2027.

I would like to thank colleagues working within these services for their openness, professionalism and engagement in supporting Board visibility and assurance.

I also remain connected through the Southwest Chairs Network, providing opportunities to share learning, discuss common challenges and consider developments impacting NHS organisations across the region.

Staff Recognition and Engagement

During October, the Trust marked Black History Month through a series of events celebrating diversity, inclusion and the valuable contribution of our colleagues from Black communities. I was honoured to open one of these events and to support colleagues in recognising the importance of equality, diversity and inclusion across our organisation.

I was also pleased to support the Allied Health Professional Awards. Following review of the nominations, I had the privilege of selecting the winner of the Healthcare Science Innovation and Improvement Award and presenting the award to the Theatre AHP Team. I would like to congratulate the team on this well-deserved recognition and thank all nominees for their commitment to innovation and continuous improvement in patient care.

Council of Governors

The Council of Governors met on 30 October 2026 and considered several matters relating to governor membership and the ongoing effectiveness of the Council during a period of uncertainty regarding future legislative arrangements.

Governors agreed a range of proposals related to membership of the Council of Governors to support continuity, retaining valuable experience and ensuring the Council remains effective while national proposals relating to Foundation Trust governance continue to be considered. These arrangements including filling two vacant roles (one staff and one public) without the need for election and creating an opportunity for elected governors reaching the end of their current term to continue their involvement with the Council as co-opted governors for a transitional period. This has been recognised as good practice by NHS Alliance.

I would also like to express my sincere thanks to two Public Governors, Elizabeth McDermott and Deniz Cetinkaya, who will conclude their terms of office at the end of December. Both have made a valuable contribution to the Council of Governors and have demonstrated a strong commitment to representing members, patients and local communities.

I continue to meet regularly with the Lead Governor to discuss governor activities, membership matters and other issues relevant to the Council of Governors.

Looking ahead, we will host a Pan-Dorset Governor Development Event in December, bringing together governors from across Dorset to share best practice, build relationships and strengthen collaborative working across the system.

Partnership Working

	On 2 November 2026, we held a joint Board-to-Board meeting with Dorset County Hospital, Dorset HealthCare and Dorset General Practice Alliance. The event provided a valuable opportunity for discussion around shared priorities, partnership working and the continued development of integrated approaches to improving services for our local Dorset population. The positive and constructive discussions reflected the strength of relationships across Dorset and our collective commitment to working together in the interests of patients and communities.
ALERT:	None.
ASSURE:	I continue to work closely with NHS Alliance regarding the Health Bill and its potential implications for Foundation Trusts and Councils of Governors. The Council of Governors is actively considering arrangements to support continuity, retain valuable governor experience and ensure its ongoing effectiveness during this period of national uncertainty.
ADVISE:	The Council of Governors met on 30 October 2026 and agreed a series of measures to maintain stability and continuity of membership, including arrangements to fill governor vacancies and the introduction of transitional co-opted governor roles for governors reaching the end of their elected terms. A Pan-Dorset Governor Development Event will also be held in December, providing an opportunity for governors from across Dorset to share learning, strengthen networks and discuss emerging developments affecting healthcare governance and public engagement.
Celebrating Outstanding:	Congratulations to the Theatre Allied Health Professional Team on receiving the Healthcare Science Innovation and Improvement Award. The team's commitment to innovation and continuous improvement demonstrates the dedication of our staff to delivering high-quality care and achieving better outcomes for patients.
RECOMMENDATION:	That the Board NOTES the contents of the report.
Implications associated with this item:	Council of Governors ☒ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☐ Strategy/Transformation ☒ System ☒ Explain the impact on each selected area; positive outcomes, risks and mitigations, and any oversight needed.

CQC Assessment Framework:		
	Safe	☐
	Effective	☐
	Caring	☐
	Responsive	☐
	Well-Led	☒
	Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
NA	Please insert meeting date	Please provide outcome from committee/meeting at which item was considered. If meeting has not yet taken place at the time of submission of this item, please specify this here
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

NOVEMBER 2026 TRUST BOARD
CHIEF EXECUTIVE UPDATE

1 INTRODUCTION

The clocks have changed and we begin to experience the seasonal pressures that accompany winter. Thank you to all our teams who have been dealing with balancing operational pressures while continuing to deliver our planned service change and improvements. The coming months will undoubtedly be demanding. Sustaining operational and financial performance, delivering better flow, better care and our transformation agenda alongside maintaining patient safety and looking after our staff remain significant priorities. We enter this period with a clear focus, a strengthening improvement culture and a shared commitment to providing safe, high-quality care for our patients and communities.

October saw us celebrate Black History Month under the theme of honouring our communities, providing an important opportunity to celebrate Black heritage, share lived experiences and recognise the valuable contributions of our global majority communities. Trust-wide celebrations at Poole and Royal Bournemouth Hospital included storytelling, cultural activities and team-based conversations on inclusion and belonging, with managers supported to lead activities within their own teams. Our focus now is on turning what we have heard into action to strengthen inclusion and belonging across the Trust.

I recently made an unplanned visit to our neonatal department which gave me an opportunity to reflect on the team's positive progress following recent national reports. The conversations that I had with staff and parents demonstrated how colleagues have responded constructively and worked to improve the service. Parents spoke particularly positively about their experiences, and it was encouraging to see the confidence and sense of purpose within the team. I am so very pleased to see the progress colleagues have made and their continued commitment to providing high-quality care for babies and families.

2 NATIONAL UPDATES

2.1 Winter Urgent and Emergency Care Capacity

The Government and NHS England have announced additional investment in urgent and emergency care services ahead of winter. Nationally, the emphasis remains on improving patient flow, reducing long waits in emergency departments, expanding same day emergency care and supporting system resilience during the winter period. This continued focus reinforces the importance of effective discharge arrangements, reducing delays across pathways and ensuring patients receive care in the most appropriate setting.

https://www.gov.uk/government/news/140-million-boost-to-urgent-care-to-ease-winter-pressures-on-nhs

2.2 NHS Oversight Framework – September Segmentation Publication

NHS England published its latest provider segmentation and league table information during September. UHD was ranked 79th out of 134 providers nationally. Whilst league tables provide only one view of organisational performance, the publication reinforces the importance of maintaining our focus on delivery of our operational plan as we move into winter.

https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/

2.3 Thirlwall Inquiry report and recommendations

NHS England has issued guidance following publication of the Thirlwall Inquiry report and recommendations. The correspondence reinforces expectations around patient safety, leadership accountability, escalation processes and organisational learning. NHS organisations are expected to consider the implications of the Inquiry findings and ensure that lessons are reflected in local governance, safety and quality arrangements. The Trust's Sudden and Unexpected Death In Children (SUDIC) policy and protocol is applicable to every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably 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.

NHS England – Thirlwall Inquiry report and recommendations

2.4 Implementation of Martha's Rule in emergency departments

NHS England has announced plans to implement Martha's Rule across all emergency departments in England before the end of March 2028. The initiative will provide patients, families, carers and staff with access to a rapid review process where there are concerns about a patient's condition. The expansion builds on existing implementation within inpatient settings and aims to strengthen escalation processes and further improve patient safety.

NHS England – Implementation of Martha's Rule in emergency departments

2.5 Unauthorised access to confidential patient information

NHS England has introduced a strengthened national approach to preventing unauthorised access to patient records. Trusts have been instructed to take immediate action where inappropriate access is suspected, including removal of system access while investigations are undertaken. The measures form part of a wider national focus on information governance, maintaining public confidence and protecting patient confidentiality.

NHS England – Unauthorised, inappropriate and unjustifiable access to confidential patient information

2.6 Elective Single Point of Access

NHS England has published guidance to support development of Elective Single Points of Access across integrated care systems. The guidance promotes greater use

of Advice and Guidance services, improved digital assessment through the NHS e-Referral Service and more streamlined referral pathways. The programme is intended to support earlier clinical decision-making and improve the management of elective demand.

NHS England – Elective Single Point of Access: technical guidance and implementation considerations

2.7 Implementation of the resident doctors' deal

NHS England has issued further guidance to trusts regarding implementation of the resident doctors' deal. The correspondence sets out national expectations and next steps for NHS organisations and represents an important development in workforce policy and employment arrangements across the NHS.

NHS England – Implementation of the resident doctors' deal: latest guidance and next steps

2.8 Single-sex services, facilities and staff accommodation guidance

NHS England has published updated guidance to support NHS organisations in the provision of single-sex services and facilities, alongside guidance on NHS staff facilities. The publications set out expectations regarding privacy, dignity and safety in NHS settings and provide guidance for trusts, foundation trusts and integrated care boards in relation to patient accommodation, staff facilities and compliance with relevant legislation. Given the national profile of the issue and potential implications for provider organisations, trusts are expected to review local arrangements against the updated guidance. Our People and Culture Committee will have continued oversight of this work.

NHS England – Guidance on NHS staff facilities

NHS England – Guidance to support NHS organisations in the provision of single-sex services and facilities

2.9 Healthwatch England and local Healthwatch organisations to be retained

The Government has announced that Healthwatch England and local Healthwatch organisations will be retained and strengthened, ensuring that patients, families and communities continue to have an independent voice in health and social care. We welcome this decision. Healthwatch plays an important role in **maintaining public confidence and providing independent oversight and challenge**, as well as ensuring that the experiences of patients and communities inform the development and improvement of services

3 DORSET UPDATES

3.1 Our Dorset Provider Collaborative (ODPC)

The Our Dorset Provider Collaborative (ODPC) continues to focus on delivery of the Strategic Review of Dorset Services, with agreement to prioritise three system-wide transformation themes: Proactive and Preventative Care, Urgent and Emergency Care, and Planned Care. During September and October, work has continued to focus on these collaborative initiatives to achieve the greatest impact on patient outcomes, system sustainability and future service delivery. A fuller report was provided to all

three Trust Boards in October and will now routinely be provided to future Board meetings of University Hospitals Dorset.

3.2 Dorset Care Record development

The Dorset Care Record has joined the NHS-managed Interweave Partnership to develop its next version, DCRv2. This will support more joined-up information sharing, with future opportunities to include care planning, end-of-life care and mental health information.

3.3 Stroke Care: Pre-hospital Video Triage

On 7 September, NHS partners in Dorset and Somerset announced a phased rollout of pre-hospital video triage across Dorset and Somerset to support care for patients with suspected stroke. The system enables ambulance clinicians to consult hospital stroke specialists by video, helping teams identify the most appropriate destination for each patient and prepare diagnostic investigations ahead of arrival. Initial trials in Dorset supported patients reaching the right service first time and, in some cases where a potential stroke was ruled out, remaining at home. The initiative represents a practical example of digital innovation and partnership working to support timely access to specialist care.

Stay Well Dorset – New technology to improve care for stroke patients (7 September 2026)

3.4 Board to Board to Board Meeting

On 2 November 2026, we held a joint Board-to-Board meeting with Dorset County Hospital, Dorset HealthCare and Dorset General Practice Alliance. The event provided a valuable opportunity for discussion around shared priorities, partnership working and the continued development of integrated approaches to improving services for our local population.

The positive and constructive discussions reflected the strength of relationships across Dorset and our collective commitment to working together in the interests of patients and communities.

4 UNIVERSITY HOSPITALS DORSET

4.1 UHD Performance Headlines

The Trust's performance in September overall showed evidence of accelerating recovery. The 4-hour standard was finalised at 71.8%, against a trajectory of 72% and an overall improvement in reducing the number of patients spending greater than 12 hours in the emergency department was maintained. Avoided admissions through SDECs has also continued to outperform the forecast and trajectory.

All 3 Referral to Treatment (RTT) operational targets were met in September showing a reduction in the number and length of time people are waiting and a greater proportion of patients being treated or discharged within 18 weeks.

Diagnostic performance demonstrated accelerated recovery at 9.1%; a 5.9% improvement on the previous month. Our new purpose built Endoscopy Unit also opened at Poole in October, which will provide further capacity to aid recovery.

This improvement was delivered whilst maintaining some of our markers of quality within expected ranges including falls, which stayed low across the month.

Patients with no criteria to reside (NCTR) remains both UHD and a system level challenge, averaging 234 in October 26 against a target of 110, largely unchanged from the last quarter and up against this time last year, driven by a shortfall in pathway 1 community capacity or patients occupying the available capacity longer than planned, alongside challenges when patients require placement outside of core funded pathways. Cancer performance continues to have management focus and has improved but has not yet met national targets, with August performance showing an above 5% improvement against the 62 day standard at 70.1% and 28-day standard is at 73.8%.

4.2 Digital Update

HealthSet remains on track for the planned 28 April 2028 go-live, with implementation now mobilised and the governance, workforce and technical foundations progressing. Third-party systems have received technical approval and are moving through the wider organisational approval process, supported by engagement with Care Groups.

Wider transformation also continues across the digital portfolio, including the successful NHS.net implementation at Dorset County Hospital. Collectively, this progress is strengthening Dorset's digital foundations and readiness for HealthSet, while supporting the longer-term ambition for a more integrated digital service across Dorset.

4.3 Finance

At the end of September, the Trust has delivered within its agreed budget, reporting a deficit of £13.9 million, which was £38,000 favourable to plan. Within this, the Trust has delivered £21 million of efficiency savings. A total of £52 million of savings opportunities has been identified through the Efficiency Improvement Programme; being £16.5m short of the full year target. A potential non-recurrent opportunity has been identified to mitigate this shortfall and is currently being worked through before being included within the savings forecast. The Trust continues to focus on the identification and delivery of recurrent savings, specifically aligned to the planned reconfiguration in April. Our focus remains on delivery but also planning for next year.

4.4 Strategy & Transformation

The Trust continues to make good progress across its major capital and transformation programmes, with several significant milestones achieved during October.

The new Endoscopy Unit at Poole Hospital went live successfully in October, with both outpatient and inpatient activity transferred into the new facilities. The move was delivered safely and represents a significant milestone within the Trust's transformation programme.

Rheumatology and Dermatology services are also relocating to their new accommodation, supporting the continued reconfiguration and modernisation of services across the Trust.

Preparations for the April 2027 Phase 3 moves continue at pace across operational, workforce, digital and estates readiness. A detailed readiness assessment was

considered by Trust Management Group on 22 October, with the programme maintaining its planned commencement of moves from 19 April 2027. Planning is progressing independently of the COAST building timetable, supported by work to implement the new operating model and improve patient flow.

The Acute Medical Unit and Older Persons Assessment Unit development at Royal Bournemouth Hospital continues to progress, supporting improvements in same day emergency care and assessment services with these fantastic new facilities opening in December.

Travel and transport improvements have also progressed, with 240 additional parking spaces at Wessex Fields and the new shuttle bus contract commencing on 1 October, including revised weekend arrangements. The new service recorded 326 passenger journeys on its first day.

Trust residences continue to perform strongly, with occupancy exceeding benchmark levels and income ahead of plan.

4.5 Our People

Consultant Industrial Action

The BMA has announced two days of industrial action by consultants in England on 25 and 26 November, as part of its ongoing dispute with the Government over pay and working conditions. Emergency cover will continue at a level similar to Christmas Day, with planned elective care expected to be most affected. Maintaining patient safety and supporting colleagues will remain central to our approach during this period.

Staff Survey

Current participation in the NHS Staff Survey stands at 44.3%, with 4,546 responses from an eligible sample of 10,262 colleagues. Our engagement campaign continues to encourage participation ahead of the survey closing on 27 November. Colleagues' feedback will help shape our organisational priorities and identify where further support and improvement are needed.

Flu Vaccination

At week 9, flu vaccination uptake among frontline staff was 41%, as recorded through the Federated Data Platform, against the NHS England target of 60%. Occupational Health continues to offer drop-in and bookable clinics across all sites, with peer vaccinators supporting areas where uptake remains low. Increasing uptake remains a priority to protect colleagues and patients over winter.

Thrive Live

Thrive Live provided three weeks of virtual and face-to-face wellbeing sessions for colleagues from 14 September to 2 October. The programme included 105 sessions and 650 bookings, with 1,740 attendees across the two Marquee days. A further 36 recordings remain available for colleagues to access. Feedback is being gathered to help shape future events and ensure our wellbeing offer continues to respond to staff needs.

Lord Mann Review

Following the Board discussion of the Lord Mann Review at its public meeting in November 2025, we have adopted both the International Holocaust Remembrance

Alliance (IHRA) working definition of antisemitism and the Government's non-statutory definition of anti-Muslim hostility. Working with staff networks and faith leaders, we will continue to listen to colleagues' experiences and strengthen a culture of belonging in which any form of discrimination is challenged, and staff feel confident to speak up.

Transforming People Services

The Board has approved the Outline Business Case in support of the South West Transforming People Services programme. Current work is focused on standardisation, benchmarking, digitalisation and automation, supporting the development of more consistent and efficient people services.

4.6 Excellence Awards

Laura Hankin, IT Projects, was recognised for championing lasting improvements and supporting colleagues with exceptional dedication, positivity and care.

Morwenna Gower, Jeremy Mashonga, Heather Exell, Joanna Rhodes and Sarah Davies, Cancer MDT, were recognised for their outstanding compassion and support for a colleague through bereavement while delivering a high-quality cancer service.

Poole Catering Team (Patient Feeding) was recognised for exceptional teamwork in transforming meal services across every Poole ward at short notice while keeping patient meals uninterrupted.

5 TRUST MANAGEMENT GROUP AAA REPORT

The Trust Management Group's Triple A (Alert, Assure, Advise) report, covering the meetings held on 24 September and 22 October 2026, is included at Appendix A. It provides the Board with an overview of the Group's work over this period.

6 BSW, DORSET AND SOMERSET CLUSTER BOARD 15 JUNE 2026

I attended the meeting held on 15 June 2026 have the final minutes are available here: 260615_Cluster-Board-Meeting-in-Public-Minutes_FINAL.pdf

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise		
Report from:	Trust Management Group (TMG)- Chair's Report	
Presented by:	Siobhan Harrington, Chief Executive Officer	
Agenda items discussed:	**24 September 2026** • Phase 3 planning and action tracker • Governance group reports • Integrated performance • Pathology digital capital bids • Clinical Strategy • Fragile Services • Winter Plan assurance • People Strategy refresh • WRES and WDES	**22 October 2026** • Phase 3 readiness and delivery • Governance group reports • Integrated performance • Freedom to Speak Up • One Dorset Provider Collaborative • EPRR Annual Report • Aseptic services options • WRES and WDES • Pathology digital capital bids • Employee relations case management • Digitised employment checks • EEMAC Phase 1 business case
ALERT	The group wishes to alert members of the Board that: • Winter resilience, urgent and emergency care and patient flow remained significant areas of focus across both meetings. In September, four components of the Winter Plan Assurance Statement were not yet assured, principally because patients with no criteria to reside remained above initial plan assumptions. In October, urgent and emergency care performance remained below trajectory, with admitted performance approximately 25% against the approximately 40% required, and cancer performance remained particularly challenged in colorectal, urology and gynaecology. • Phase 3 readiness remains a TMG priority. TMG has reconfirmed and committed to 19 April 2027 as the start date for the phase 3 move programme, and will	

	continue to monitor the consequences and risks of not proceeding. Delivery remains dependent on reducing occupied beds, translating the required reduction into clear expectations for clinical areas, maintaining people and estates readiness and establishing confidence in the deliverability of medical staffing efficiencies. • Financial sustainability remains a material focus. TMG acknowledged that the Trust would enter 2027/28 with a significant underlying deficit and has committed to first-draft efficiency plans by mid-November to support the mid-December planning submission.
ASSURE	The group wishes to assure members of the Board that: • The September meeting approved the Clinical Strategy, People Strategy refresh and Leadership and Management Framework. It also agreed the Fragile Services framework and supported further work on its governance, methodology, application and communication before wider implementation. • The September Clinical Governance update confirmed that the GP discharge communication issue had been reviewed, no patient harm had been identified and the matter was closed. • The October EPRR Annual Report was approved. UHD was reported as fully compliant with 60 of 62 core standards, with actions in hand on the two areas not yet compliant: digital requirements and Emergency Department decontamination capability and staff identification by shift. • Planned care remained a relative strength. In October, elective performance was considered capable of achieving the month-end position, diagnostic improvement was reported in echocardiography and endoscopy, and DM01 performance was expected to exceed 90% for the month.
ADVISE	The group wishes to advise the Board that: • Care Groups were asked to review their local Freedom to Speak Up data, identify changes required in response to local themes and share learning across Care Groups. TMG linked this work to the Staff Standards and Leadership and Management Framework. • TMG noted improvements in some WRES and WDES indicators, but agreed that significant further improvement is required to achieve equity. Delivery will be tracked through the People Strategy programme, with relevant staff networks involved in shaping action plans. • EEMAC (Extended Emergency Medicine Ambulatory Care) is a proposed Emergency Medicine-led, same-day service for adult ED patients needing further investigation, treatment or observation before safe discharge. Expected benefits include safer care, reduced corridor crowding, improved patient flow and fewer avoidable admissions. TMG agreed recruitment may commence, but approval remains conditional; the

	business case will return to TMG in November for further assurance on benefits, staffing and implementation, with benefits reviews at three and six months
Review of Risks	• Phase 3 delivery: the planned start date remains 19 April 2027. Principal risks are failure to achieve the required occupied-bed reduction, insufficient clarity about the consequences of delay, people and estates dependencies, and uncertainty over whether associated medical staffing efficiencies can be released. • Operational performance: cancer performance, urgent and emergency care, admitted flow and prolonged waits remained below required trajectories. TMG also noted the regulatory risk associated with significant waits for major patients in the Emergency Department. • Financial sustainability: the opening deficit for 2027/28, delivery of recurrent efficiencies, affordability of new investment and the need for timely efficiency plans remain material risks. • EEMAC: affordability, workforce assumptions, clinical support service requirements, measurable benefits, dependencies and implementation arrangements require further assurance before final approval.
Celebrating Outstanding	• TMG recognised the continued improvement in the quality and concision of the meeting minutes. • TMG recorded its thanks for the contribution made to the organisation's emergency preparedness and safety by the outgoing Head of EPRR. • Positive feedback from Freedom to Speak Up visits to clinical areas was acknowledged, and TMG emphasised the importance of sharing positive experience and improvement alongside areas of concern.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **3.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	UHD Clinical Strategy 2026–2036 – draft for discussion
Prepared by:	Richard Renaut, Chief Strategy and Transformation Officer
Presented by:	Peter Wilson (CMO), Sarah Herbert (CNO) and Richard Renaut (CSTO)
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	No specific BAF or Corporate Risk Register reference on strategy.
Purpose of paper:	For approval. To then engage partners and staff to further refine.
Executive summary:	The draft UHD Clinical Strategy 2026–2036 sets out the ambition for Dorset to become the healthiest place to live in the UK, and UHD's part in that. The three key parts are: • Prevention, • Excellent planned and emergency care, • Patient centred approach. The strategy provides the framework, with the delivery plan to follow. The Board of Directors is asked to test the ambition, including getting to a system Integrated Care Organisation (IHO). Detailed route maps, outcome measures, ownership, dependencies and resource implications will be developed through the 2027/28 planning round and existing governance.
ALERT:	The strategic direction builds on a busy two years ahead of delivery the current clinical strategy of: - Deliver the Phase 3&4 of the Transforming Care Together moves, to create the planned and emergency hospitals

	- Healthset to deliver a single digital system across Dorset and Somerset - Neighbourhood health with integrated teams - Other changes including single services The UHD ambition comes from continued listening to patients, communities, partners plus horizon scanning for innovations, policy and opportunities to deliver the objectives of the UHD and system strategic goals. Those goals aren't changing, but the clinical strategy facilities and aligns the clinical models of care with those goals.
ASSURE:	The draft builds on UHD's agreed strategic objectives and draws on patient feedback, national policy, specialty input and developing Dorset system plans. The proposed approach uses existing Patient First governance and monthly strategy deployment reviews, avoiding a separate governance structure.
ADVISE:	Further engagement is planned across the remainder of the financial year, to align with the 27/28 planning round. Clinical specialties will be asked to develop their five-year route maps setting out initiatives, priorities, ownership, dependencies, measures and resource shifting implications.
Celebrating Outstanding:	The Specialist Palliative Care service has developed a detailed plan with stretching ambition, that can fulfil one of the supporting strategy priorities of prevention, and a great end of life. Other well-developed strategies already in place include Digital, which is system wide.
RECOMMENDATION:	The Board of Directors is asked to endorse the strategic direction. Next steps are: 1. Continue the ongoing dialogue with partners, communities and our staff 2. Create the written document, including case studies and "glimpses of the future" 3. Use feedback to refine and agree final version 4. Link to 27/28 and multi-year planning process
Implications associated with this item:	Council of Governors ☒ Environmental Sustainability ☒ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☒

	Quality Regulatory Strategy/Transformation System The strategy has broad organisational and system implications. Detailed benefits, risks, mitigations, costs, workforce requirements and oversight arrangements will be defined through consultation, specialty route maps and the supporting delivery framework.	☒ ☒ ☒ ☒
CQC Assessment Framework:	Safe Effective Caring Responsive Well-Led Use of Resources	☒ ☒ ☒ ☒ ☒ ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Numerous TMGs	01/05/2026	The Group noted the progress.
Clinical Strategy workshop	16/07/2026	The workshop helped shape priorities.
Trust Management Group	22/10/2026	The Group noted the progress.
Board of Directors development session	14/10/2026	The Board supported the direction of travel.



2026—2036



UHD Clinical Strategy, and routes to delivery



Draft *for discussion – November 2026*

Feedback to: *richard.renaut@nhs.net*

An ambitious and challenging decade ahead. 3 principles to guide us....

Prevention is better than cure.

When you need care, we've excellent emergency and planned services.

That care needs to be Patient-Centred, with continuous listening, learning and improvement.

Our Dorset goal 2036:

to be the healthiest place to live in the UK



We're building on our current clinical strategy. The next two years sees:

1. Transformation: into the UKs largest planned care hospital, and our dedicated emergency hospital
2. Digital: our Electronic Healthcare Record deployment (EPIC)
3. Neighbourhood: The shift to neighbourhood health led care & integrated pathways

This is strong platform for us to be really ambitious and move to our Dorset goal....

Developing the strategy

Setting the scene

Our strategic objectives, and Trust values are already agreed



We are caring one team listening to understand open and honest always improving inclusive

to deliver our strategic goals

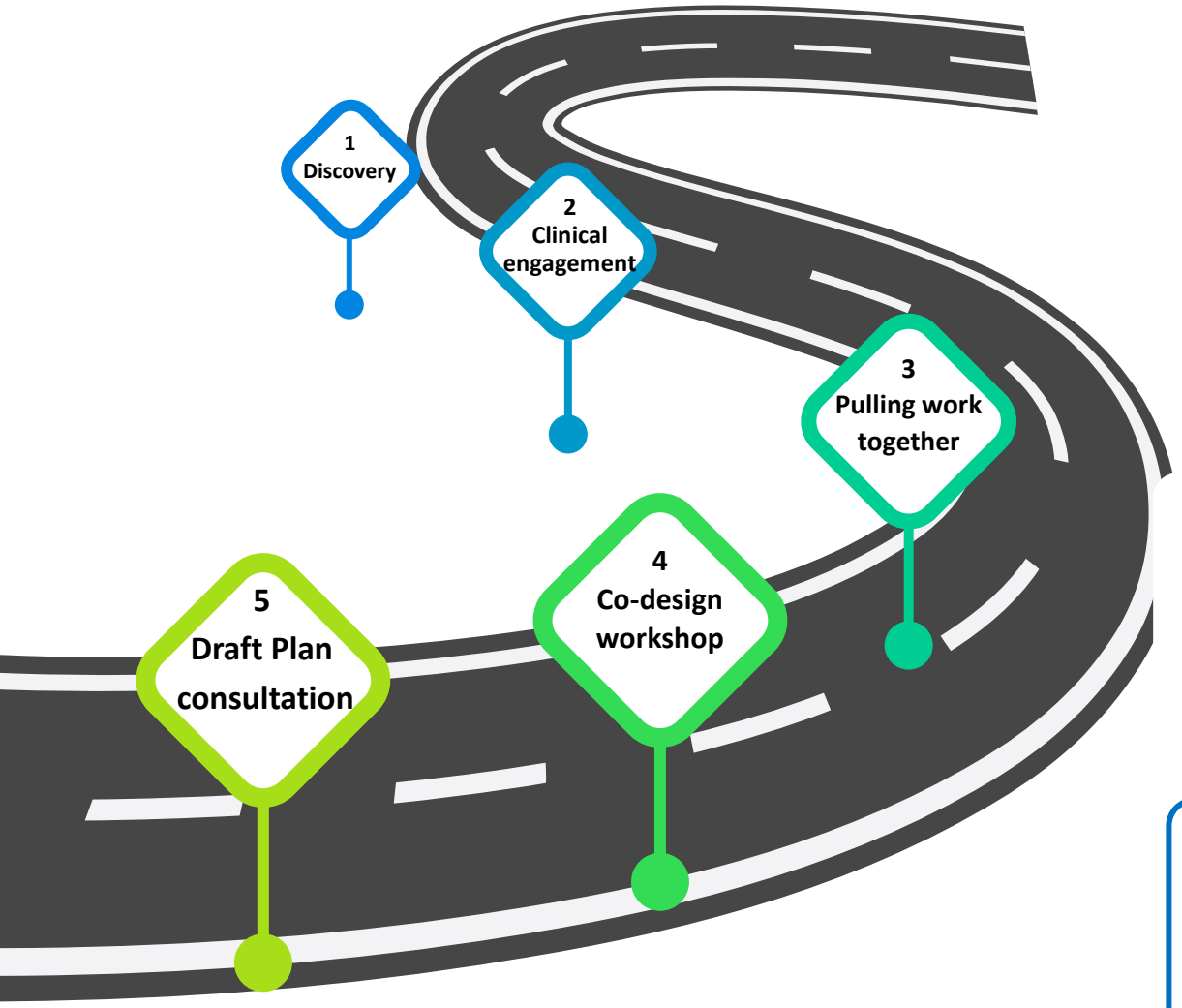
Strategies & enablers

Continuous improvement	Patient First Improvement Strategy 2023-26
Population and system	Urgent and Emergency Care Delivery Plan, Site Specific Cancer Plan, Elective Care Delivery Plan
Our people	People and Culture Strategy 2024-27
Patient experience	Patient Engagement and Experience Strategy
Quality outcomes and safety	Quality and Safety Strategy, Clinical Strategy (under development)
Sustainable services	Medium Term Financial Plan, Green Plan, Estates Masterplan

Strategic Goal	Vision *LONG TERM: 7-10 years*	Strategic Goal *MEDIUM TERM: 3 - 5 YEARS*
POPULATION AND SYSTEM *Chief Operating Officer* "See our patients sooner"	Consistently delivering timely, appropriate, acc essible care as part of a wider integrated care system for our patients.	Meeting the patient national constitutional standards for Planned and Emergency care, reducing inequalities in outcome and access and improving productivity and value
OUR PEOPLE *Chief People Officer* "Be a great place to work"	To be a great place to work, attracting and retaining the best talent, as measured by the Trust being in the upper quartile for all 7 elements of the People Promise.	• To develop a sustainable workforce measured against the 3 components of staff morale: improving retention, staff feeling supported with sufficient resources, and respected and trusted to do their work
PATIENT EXPERIENCE *Chief Nursing Officer* "Improve patient experience listen and act"	All patients at UHD receive quality care which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change.	• Rated as Outstanding by CQC as Caring • Over 80% of our employees see patient care as a top priority for UHD • In the top 20% of NHS Acute Hospital Trusts on the 'overall experience' section in all CQC national surveys
QUALITY OUTCOMES AND SAFETY *Chief Medical Officer* "Save lives, improve patient safety"	To be rated the safest Trust in the country and be seen by our staff as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios – HSMR) and patient safety (Patient Safety Incidents - PSIs).	• In the top 20% of trusts in country for Hospitalised Standard Mortality Ratios (HSMR) • Rated as Outstanding by CQC for Safety • Decrease severe/moderate harm Patient Safety Incidents (as a ratio of all incidents) by 30% • Over 80% of employees believe the Trust promotes a safety culture • Digital integration across all clinical and operational workflows
SUSTAINABLE SERVICES *Chief Finance Officer* "Use every NHS pound wisely"	To maximise value for money enabling further investment and sustainability in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.	• Return to recurrent financial surplus from 2028/29 • Rated as Outstanding by the CQC for our Use of Resources • Achieve our Green UHD goals of sustainability for people and planet, and 80% carbon reduction by 2030

But we need an upto date clinical strategy...
The "why we're here, as a set of clinical & support services."

Working Together to Develop a Clinical Strategy for UHD





Discovery Phase

01

Start with collation of all patient feedback, (see next slide). Review of all national and local strategies, to inform initial work with Trust leaders, Governors and Dorset Patient Engagement Group. Six initial themes for consideration by UHD clinical teams proposed.

Clinical Engagement

02

Each **clinical specialty** at UHD reviewed their patient and service data, NHS 10 Year Plan and the 6 initial themes to propose potential opportunities for improving services and outcomes for patients and wider population in their specialty area.

Pulling work together

03

Specialty plans and themes reviewed and collated. Dorset clinical strategy developed ("Vista") with focus on prevention/ neighbourhoods, emergency & elective.

Patient codesign workshop

04

Work with PPIE reps to co-design workshop and write up. Checking top 3 areas of focus with stakeholders. Current slide deck and paper produced.

Draft Plan, for consultation

05

- These slides –

Share at internal and external forums over September / October and gather feedback and refine.

Delivery

06

Develop delivery plan, using existing patient first governance to track progress, and adjust as needed. Keep alignment with system plans as they develop. Maintain patients & public engagement.

What are the "seeds to plant" for after TCT and EPIC?

Policy and public voice

THREE NATIONAL SHIFTS (NHS 10-year plan)

- Hospital → neighbourhoods
- Analogue → digital
- Sickness → prevention

WHAT PEOPLE TELL US, MOST OFTEN

- A future NHS should be Safe, Effective and Efficient
- Patients need to be listened to, trusted and included in discussions and decisions around care
- Services should focus on providing easier and earlier access to support
- Services need to work together so that carers don't have to keep telling the same story
- Services need to provide appropriate information, tools and techniques to empower people to self-manage their own conditions

Work needed in all areas, but our biggest changes are in UHD's effort in prevention and person-centred care

Five factors, driving why we need to update our clinical strategy now

CHILDHOOD

Affects a lifetime of health

AGEING

Dorset is 20 years ahead of the curve, but frailty can be avoided

LONG-TERM CONDITIONS & MENTAL HEALTH

Treating a person as a whole

INEQUALITY

Requires unequal efforts to get best outcomes

DETERMINANTS OF HEALTH

We recognise 80% are beyond health services

Predictable and increasing demands on healthcare services require a new response:

PREVENT EARLIER

EXCELLENCE IN CARE

PATIENTS FIRST APPROACH

The public we serve

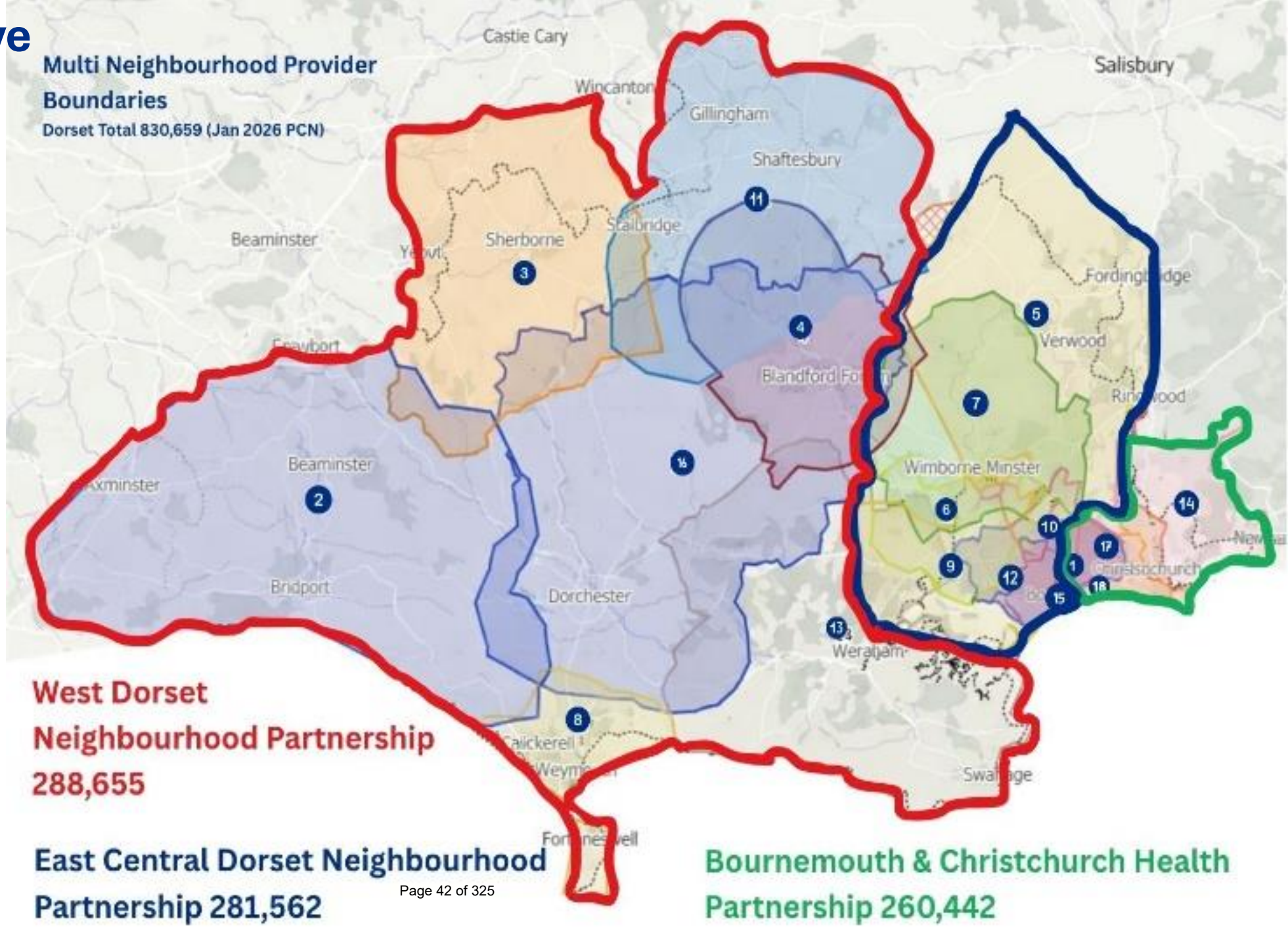
UHD “core DGH catchment” covers East Central + Bournemouth & Christchurch MNPs. 550,000 population.

UHD specialist services for West Dorset & Hants eg Oncology, Vascular etc c1m population.

Hampshire “core DGH provider” to Ringwood/ New Milton etc.

Note: Approx half of East Central is BCP, half DC.

Core demographics of total catchment: much older than rest of UK.



Proactive and preventative care

Quantifying the opportunity

Our modelling shows that proactively shifting patients from higher-need tiers into **more activated, community-managed segments** can drive substantial reductions in secondary care use, illustrating the **short- to medium-term system impact of adopting this model**.

Through P&PC, there is an opportunity to reduce the unplanned care and outpatient activity of individuals with multiple complex health needs – both physical, and mental. Through proactively managing these individuals within the community, unplanned and outpatient activity should be limited to only activity that requires hospital-based specialist input. Therefore, we would expect proactively managed patients to drop down the Tiers of healthcare need (e.g. Tier 1 → Tier 2).

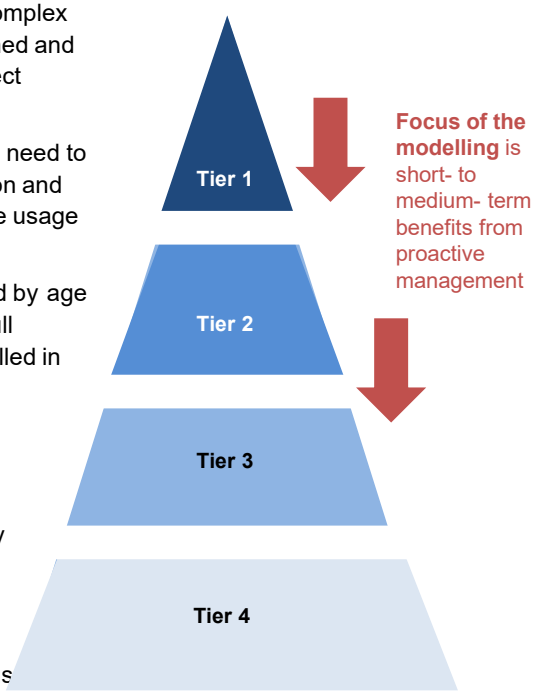
Using the population segments described previously, our modelling focused on the shift from low activation and very high need to low/moderate activation and high need (Tier 1 → Tier 2) and low/moderate activation and high need to moderate activation and moderate need (Tier 2 → Tier 3). This is where we expect **proactive** model of care would decrease secondary healthcare usage in the short-term. This modelling approach was co-developed with clinicians in the clinical workshops.

We can model the impact of this downward shift in activities using the mean healthcare resources of each group, stratified by age group. To ensure our modelling is realistic and conservative, we have assumed that 50% of this activity could shift. Our full methodology can be found within Appendix 3. Our findings include the following annual savings (excluding benefits modelled in Women and Children's Health theme).

19,674 Fewer ED attendances	**42,442** Fewer non-elective bed days	**55,238** Fewer outpatient appointments

Additional benefits may also be possible within certain groups. For example, patients in these Tiers with mental health needs may see their acute activity drop to zero if managed appropriately as community mental health settings are usually a more appropriate care setting.

Benefits are also expected through preventing individuals from moderate activation and moderate need from rising into higher need groups. These potentially significant benefits are expected due to the prevention of worsening health and therefore related secondary healthcare usage. However, these benefits will be longer-term and therefore are not the focus of this modelling.



System I&E

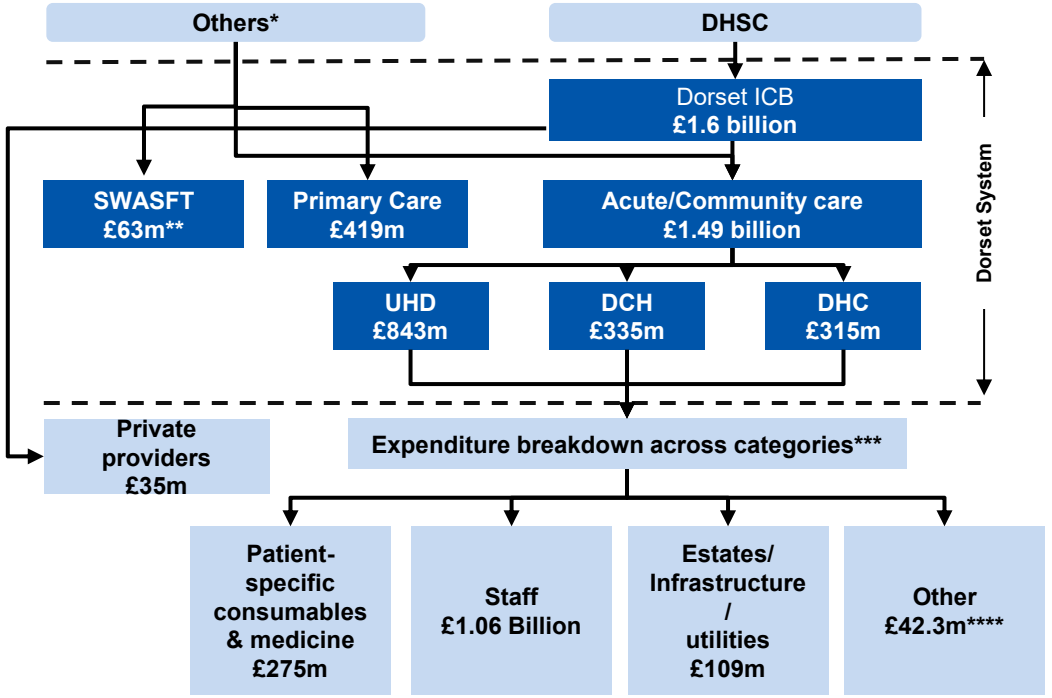
With an existing deficit of around £130 million, siloed working and isolated initiatives are not enough to close a gap of this scale. A system-wide Income & Expenditure (I&E) framework provides a single, organisation-agnostic financial view by aggregating patient-level costing into system cost lines. This allows Dorset to see where the deficit truly sits across the system, and to identify the **real, releasable cost savings that can be made**, rather than relying on tariff-based calculations

Key objective of System I&E

- Establish a single, provider-agnostic financial baseline that reflects the full Dorset system's resources & cost lines
- Align financial benefits and savings to population-level outcomes instead of organisational savings
- Enable collaboration that cuts across organisational boundaries, supported by shared principles, transparent data and joint accountability

Scope of collaboration

- Redesign services and pathways at a system-level, coordinating across providers to remove duplication and focus on population health
- Align workforce and resources around integrated models of care rather than organisational boundaries



Opportunity for high-performing NHS providers to hold the whole health budget for a defined local population as an IHO (Integrated Healthcare Organisation)

Population-based, built around place

Align with neighbourhood geographies
Align with local authority and HWBB populations
Set outcomes, payment and oversight around local need

Aligns incentives

Budget holder is responsible for delivery
Savings from prevention accrue to the investing organisation
Bind providers through clear leadership and governance

Provider-led

Engage staff in change
Understand population costs and activity
Shift resources, delivery modes and skill mix
Use real-time risk mitigation
Involve communities
Pool back-office infrastructure

Critical success factors

System partnership working
Geographic alignment
GP partnerships
Organisation capacity & ambition
Understanding current models & opportunities
Track record of delivering new models of care

Phased approach

Lead provider for defined services
Year of care payment for defined patients e.g. children
Out of hospital integrated care models
Risk sharing on services & patients e.g. end of life
Shifting from activity to outcome payments

International evidence

Germany, Israel, parts of US and New Zealand indicates potential for provider-led innovation and highlights transaction costs and information asymmetry in commissioner-led change.

A mature IHO model can integrate care around individuals and communities, and addresses “failure demand” where parts of healthcare drifts right to higher-cost, lower value-add acute care.

The strategy: framework for improving outcomes

Three ambitions, and the priorities within each

X

PREVENTION

- Great start to life
- Fighting frailty
- Living well until the end of life
- Population health

X

EXCELLENT CARE

- Planned
- Emergency
- Integrated
- Digitally enabled

X

PATIENT CENTRED

- Co-design & shared decisions
- Continuous improvement
- Research & innovation
- A learning organisation

Avoid needing care, but when needed, there is good access to excellent, patient-centred care. This requires integrated care with a learning approach to ensure the best population outcomes.

Five factors driving why we need to update our clinical strategy now

CHILDHOOD

Affects a lifetime of health

AGEING

Our population is one of the oldest population in the UK but frailty can be avoided

LONG-TERM CONDITIONS & MENTAL HEALTH

Treating a person as a whole

INEQUALITY

Requires unequal efforts to get best outcomes

DETERMINANTS OF HEALTH

We recognise 80% are beyond health services

Predictable and increasing demands on healthcare services require a new response:

PREVENT EARLIER

EXCELLENT CARE

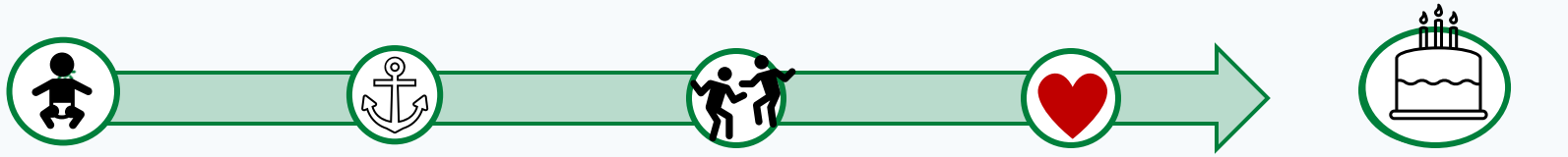
PATIENT CENTRED CARE

Ambition 1 | prevention is better than cure

3,000

births annually at UHD: every start matters. 6,000 deaths across all of Dorset: each deserves dignity.

PREVENTION THROUGH THE LIFE COURSE



Great start to life

Population health (Anchor institution for people & planet)

Fighting frailty

Dignity and comfort a the end of life

Leading to healthy, longer, purposeful lives

Make every contact count • targeting inequalities • work through neighbourhood teams and DiiS

Integrated Healthcare Organisation **(IHO) approach to support prevention and enable greater independence to allow healthy, longer, purposeful lives. So Dorset becomes the healthiest place to live in the UK.**

Ambition 2 | Excellent planned and emergency care

Poole

PLANNED CARE POWERHOUSE

- centre of excellence
- cancer outcomes
- networked services

Excellence measured

- National Outcomes Framework ("league tables")
- Getting it Right First Time

Bournemouth

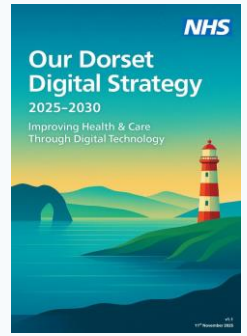
EXEMPLAR EMERGENCY HOSPITAL

- better flow, better care
- system control centre
- networked services

EXCELLENT ALSO REQUIRES:

INTEGRATED CARE: • With multi neighbourhood providers
• Supporting acute networks

DIGITAL CARE based on the single Healthset approach



Ambition 3 | "Patients Centred, continuous listening, learning, improving”



MEASURE OUTCOMES + EXPERIENCE

By 2031, patients experience is coordinated, personalised care and actively shape decisions, pathways and patient reported outcomes.

Aim for top-quartile patient survey

TIMELINE: Laying foundations, becoming a national exemplar, so we're on the right track to be the healthiest place to live



RECONFIGURATION

Planned & emergency hospitals
Neighbourhood health

DIGITAL ENABLEMENT

EPIC deployed system wide
Pathways connected

TOP QUARTILE AMBITION

Prevention "early fruits"
NOF and patient survey up

TOP DECILE AMBITION

Integrated Health Organisation
Exemplars for our 3 ambitions

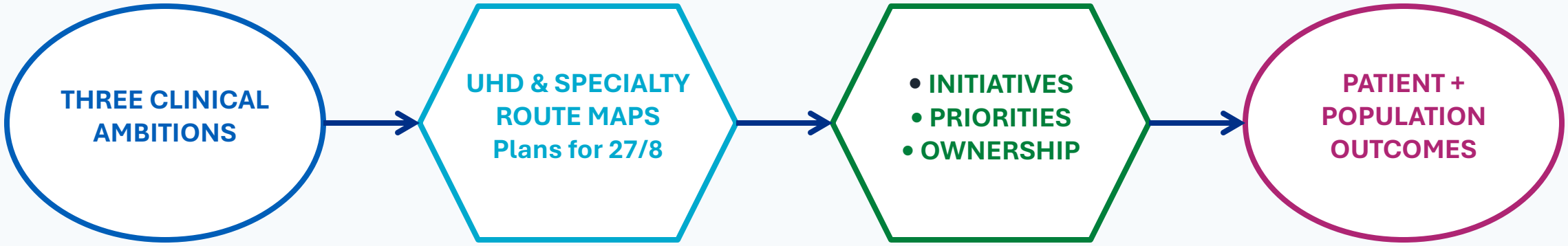
HEALTHIEST PLACE TO LIVE

Population outcomes

Prevention,
Excellent care,
Patient centred

BOARD ASSURANCE : Outcomes Framework • Patient & staff experience • Partner feedback •Strategy progress

Clinical specialties now need to turn ambitions into delivery plans…



Our 36 clinical specialties will need to define their own FIVE-YEAR plans, with dependencies and contributions to prevention, outstanding care and applying a patient-centred approach.

**Progress set and measured by UHD's 5 strategic goals,
Tracking progress with monthly strategy deployment reviews (SDRs).
These drive system/population outcome measures.**

Next Steps

- Use this framework to

1. Continue the ongoing dialogue with partners, communities and our staff
2. Create the written document, including case studies and “glimpses of the future”
3. Use feedback to refine and agree final version
4. Link to 27/28 and multi-year planning process (and life after Phase 3 moves and Healthset)

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS – PART 1

Meeting Date: 11 November 2026

Agenda item: **3.2**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Services Reconfiguration in April 2027
Prepared by:	Richard Renaut, Chief Strategy & Transformation Officer
Presented by:	Richard Renaut, Chief Strategy & Transformation Officer
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	**Risk 1053**: Inability to Reduce Medically Ready for Discharge (MRFD) / NCTR Bed Occupancy to a Safe Reconfiguration Threshold. **Risk 1460:** Inability to Meet UEC 4-Hour Safety Standard Leading to an Adverse Impact on Patient Safety and Quality. **Risk 2339:** Transforming Care Together Programme - Delays to Phase 3 Delivery. **Risk 2366:** Failure to Deliver the Planning Assumptions Underpinning the 2026/27 Operational Trajectories. **Related BAF Risk:** Delivery of Phase 3 Reconfiguration Programme, including workforce readiness, move planning and capacity assumptions.
Purpose of paper:	Assurance
Executive summary:	This report provides the Board of Directors, with an update on the Phase 3 operating model, capacity requirements, delivery plan and remaining work. It highlights the assurance work undertaken, and the approval at TMG of the move date starting on 19th April 2027. The plan is based on the improved operating modelling, which uses well-established approaches plus new and more appropriate capacity to reduce unnecessary patient stays in hospital. The 140 fewer inpatient targeted improvement is set against over 240 no criteria to reside patients currently at UHD. The improvement work uses a single indicator of occupied bed, to track progress.

	There are three themes to the improvement work: 1. minimum reduction of 85 beds currently being used for no criteria to reside, requiring internal and partner improvement work 2. a further minimum 30 gain from the Better Flow, Better Care work improvements, including expanded SDECs, use of Board rounds and admission avoidance work. 3. The third themed area is new and more appropriate capacity. This targets a minimum improvement of 25. Examples include the new expanded discharge lounge, extended ED (EEMAC), and hospital at home expansion of 25. The 140 minimum improvement results in 85 fewer beds, and a lower bed occupancy (and waits in ED) for the balancing 55.
ALERT:	The Phase 3 operating model requires a significant reduction in bed capacity while maintaining safe operational performance. Delivery is dependent upon improvements in patient flow, reductions in NCTR and long lengths of stay, expanded Hospital at Home provision and changes to clinical pathways. The financial effect of the proposed capacity changes supports the approach of living within our means, and re-investing where better models of care result in patients being in the right place. A more detailed slide presentation will be shared, and be part of a wider communications strategy. The Phase 3 move plan comprises 30 linked service moves concentrated across a Friday-to-Sunday period, with 19 moves planned for the Sunday. Four same-day vacate-and-reoccupy dependencies have been identified, and further work is required on patient flow, workforce, equipment, transport, contingencies, and interim locations to be completed over December and January.
ASSURE:	A structured delivery plan has been established, with identified actions, executive and operational leads, milestones, and timescales. This includes work to finalise the occupied bed-day and NCTR trajectory, quantify efficiency opportunities, develop detailed bed reductions and staff consultations where required. The overall move has 4 internal workstreams, with well established governance, escalation, critical paths and track record of delivery from previous phases of moves. These are: - Build ready - People ready - Service ready - Move ready An external partners action and assurance process is being re-established by the ICB cluster. A productive risk workshop was held on 28th October, with an action plan generated. The ICB

	cluster CEO chaired group to oversee the external assurance is being established. With the service ready aspect three Workstreams are progressing the new operating model: • Better Flow Better Care (CMO Leadership) • NCTR reduction (COO Leadership) • Operating Model / Building changes/ benefit realisation emergency / planned Care site (COO Leadership with Exec support) The plan brings together operational, clinical, workforce, financial and quality requirements and links the proposed operating model to the Phase 3 move programme. The intended delivery approach includes weekly review of milestones, dependencies, and risks, with unresolved matters escalated through the appropriate governance route.
ADVISE:	The Board is asked to: 1. **Note** the proposed Phase 3 operating model and the plan to progress to this by April 2027 2. **Note** the requirement to deliver the planned bed reduction and improved bed occupancy rate, based upon the 3 workstreams. 3. **Note the overall** financial model will need to live within the funding available by providing care to patients in the right place and time 4. **Note assurance in place** via the "ready groups" and Board Transforming Care Together committee, plus new ICB group 5. **Receive further updates** on delivery against milestones and trajectories via the TC committee moving to monthly
Celebrating Outstanding:	N/A
RECOMMENDATION:	The Board is asked to note the Phase 3 update and receive further updates on implementation, as the project progresses.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☒ Health Inequalities ☐ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☐ Strategy/Transformation ☐ System ☐
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒

	Well-Led	☒
	Use of Resources	☒

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Trust Management Group	24/09/2026	The Group noted the report.
Reconfiguration Ready Group		The Group noted the report.
Transforming Care Together	05/10/2026	The Group noted the report.
Finance and Performance Committee	05/10/2026	The Committee noted the report.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **4.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Review of the Thirlwall Inquiry and Recommendations
Prepared by:	Amy Stubbs, Director of Maternity and Neonatal Services
Presented by:	Sarah Herbert, Chief Nursing Officer
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☐ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Assurance
Executive summary:	**Situation** The Thirlwall Inquiry was established following the conviction of Lucy Letby for the murder of seven babies and the attempted murder of seven others whilst employed as a neonatal nurse at the Countess of Chester Hospital between 2015 and 2016. The Inquiry was not tasked with revisiting matters of criminal guilt but was asked to examine how concerns were raised, escalated and managed; whether opportunities to prevent further harm were missed; the actions of managers, boards, regulators and external bodies; and what changes are required across the NHS to prevent similar events occurring in future. The Inquiry heard evidence from 134 witnesses and reviewed events from the first neonatal deaths in 2015 through to Letby's arrest in 2018, alongside wider consideration of NHS governance, regulatory oversight and organisational culture. The final report, published on 15 September 2026, comprises more than 1,100 pages across three volumes and contains 17 recommendations directed at Government, NHS England, regulators and NHS providers. On 21 September 2026, NHS England wrote to all Trusts advising that, whilst the Government considers the recommendations in full, five actions should commence immediately. NHS England has requested that all Trust Boards formally consider the findings of the Inquiry and seek assurance that equivalent circumstances could not arise within their own organisations.

	Background The Inquiry identified a series of systemic failures that enabled patient harm to continue over a prolonged period. Whilst the actions of an individual practitioner were central to the events examined, the Inquiry concluded that failures in organisational culture, leadership, oversight and escalation arrangements significantly contributed to missed opportunities to intervene. The Inquiry's key findings were that: • Clinicians recognised emerging patterns of harm but concerns were not acted upon with sufficient urgency. • Senior leaders failed to respond appropriately to credible patient safety concerns. • Relationships became polarised between clinicians and managers, hindering effective decision-making. • Board oversight and assurance arrangements were insufficiently robust. • Organisational reputation at times appeared to be prioritised over patient safety. • Staff concerns were not consistently heard, valued or escalated effectively. • External regulatory and oversight mechanisms failed to identify or respond to emerging risks. The report concludes that patient safety must remain the overriding consideration in organisational decision making and that stronger safeguarding, whistleblowing, managerial accountability and oversight arrangements are required across the NHS.
ALERT:	Whilst many recommendations are directed nationally and will require further guidance from Government, NHS England and regulators, the report provides important learning for all NHS organisations. It reinforces the need for strong Board oversight of patient safety, effective speaking-up arrangements, robust escalation processes, a culture of professional curiosity and challenge, and clear accountability for safeguarding and quality concerns. Overall, UHD has existing governance, safeguarding, Freedom to Speak Up and patient safety arrangements in place. However, the publication of the Inquiry provides an opportunity to review these arrangements against the Inquiry findings, identify any gaps, and strengthen assurance that concerns raised by staff are heard, escalated appropriately and acted upon promptly in the interests of patient safety. It is anticipated that there will be significant nationally driven work to strengthen safeguarding frameworks across organisations in response to this report in early 2027.
ASSURE:	**Local Immediate Actions for implementation** NHS England has already identified several actions requiring immediate local implementation. University Hospitals Dorset (UHD) has commenced work in response to these requirements: Consideration of the Thirlwall Report and the immediate actions advised by NHSE is scheduled for discussion at Trust Board on 11th November 2026. The immediate actions scheduled for local implementations are:

	• SUDIC process awareness and compliance Communication issued to relevant staff and the Board on 23 September 2026. Opportunities to review local and system learning, themes and trends from SUDIC reviews will be explored through future Board reporting. • National Bereavement Care Pathway- Draft implementation arrangements based upon updated benchmarking exercise have been developed and will progress through established maternity and neonatal governance processes. • Insulin access and storage controls. Initial meeting held with Pharmacy and Security colleagues to explore implementation options and compliance with forthcoming requirements. Quotes for installation of the relevant technology have been obtained, and this is being driven through a task and finish group which is on track for the 30th November 2026. • Safeguarding assurance review underway to determine how safeguarding compliance, assurance and escalation are monitored within Care Groups and reported through governance structures.
ADVISE:	The 17 recommendations collectively seek to strengthen patient safety, safeguarding, governance, oversight and organisational culture within NHS organisations. Key themes include: • Enhanced neonatal safety measures, including CCTV monitoring, baby monitoring technology and strengthened controls over insulin storage and access. • Improved safeguarding arrangements, including mandatory safeguarding training for all staff and Board members, revised employment requirements and a national Suspicion of Deliberate Harm Protocol. • Strengthened mortality review processes through revised SUDIC requirements, enhanced medical examiner arrangements and improved pathology capacity. • Improved use of data, interoperability of systems and real-time monitoring of neonatal outcomes. • Greater managerial accountability through regulation, professional standards and a national barring system. • Stronger support for speaking up, whistleblowing and organisational learning. • Increased scrutiny of regulators and oversight bodies, including the Care Quality Commission and Parliamentary and Health Service Ombudsman. • Formal monitoring of implementation of Inquiry recommendations across the NHS.
Celebrating Outstanding:	N/A
RECOMMENDATION:	**Next Steps** A detailed Trust-wide action plan will be developed following consideration of the report and NHS England guidance. This will include a gap analysis against the seventeen Inquiry

	recommendations, identification of any additional assurance requirements, and regular progress reporting through the appropriate governance committees and Trust Board. **Key Recommendations** To note the details of this briefing summary and next steps It is recommended that all Board members read the report in full to fully understand the impact on those involved in the Review Summary of the Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Quality Committee	03/11/2026	The Committee noted the report.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

REPORT OF THE PUBLIC INQUIRY INTO EVENTS AT THE COUNTESS OF CHESTER HOSPITAL (Thirlwall Inquiry), 2015–2018 AND RECOMENDATIONS

Author: Amy Stubbs

Director of Maternity and Neonatal Services

REPORT OVERVIEW

1. Introduction

The Report of the Public Inquiry into events at the Countess of Chester Hospital, 2015 to 2018, led by The Rt Hon. Lady Justice Thirlwall DBE, was published on 15 September 2026. The Inquiry was established following the conviction of Lucy Letby, a neonatal nurse at the Countess of Chester Hospital, for the murder of seven babies and the attempted murder of seven others between 2015 and 2016. The Inquiry was not tasked with re-examining her criminal guilt. Instead, it considered:

- How concerns were raised and handled.
- Whether opportunities to prevent further harm were missed.
- The actions of managers, executives, boards, regulators and external organisations.
- What changes are required across the NHS to prevent similar events occurring again.

The Inquiry heard evidence from 134 witnesses and examined events from the first neonatal deaths in 2015 through to Letby's arrest in 2018 and the wider NHS context and regulatory framework. The report found that the collapse and deaths of some babies could have been avoided had safeguarding practices been followed. The Report found that senior nurses never accepted that the consultants' concerns were – or might be – justified, and that there was a prolonged delay by senior managers in calling the police. There is criticism of successive internal and external reviews commissioned by hospital leadership after concerns were raised about Letby. The reviews did not address whether deliberate harm was being caused or not. Rather than being believed when concerns were raised, clinicians were themselves made the subject of investigation within Letby's grievance process. The Report reflects the anger some parents feel at the way they were treated by the Hospital which was palpable during the Inquiry hearings. Thet trust was not open and transparent with families regarding the potential that their baby had suffered deliberate harm.

Their consent was not obtained before sharing their babies' medical records with external experts and other organisations; they were not informed about external reviews. Many parents took the view that protecting the reputation of the hospital was more important to senior managers than keeping them informed about what was happening. The Hospital's safeguarding policy did not mention the possibility of deliberate harm by a staff member, and there remains no NHS-wide protocol on deliberate harm.

2. How the review was conducted

The Inquiry heard evidence from 134 witnesses and examined events from the first neonatal deaths in 2015 through to Letby's arrest in 2018 and the wider NHS context and regulatory framework.

The terms of reference for the review were published on the 19th October 2023 and the final report was published on the 15th September 2026.

3. Key findings

- **Clinicians recognised a pattern of harm**

Consultant paediatricians became increasingly concerned that unexpected collapses and deaths were occurring around a single nurse. By June 2016 clinicians believed there was a possibility of deliberate harm and sought urgent action.

- **Senior leaders failed to act on credible safety concerns**

The Inquiry concluded that senior executives repeatedly failed to take adequate precautionary action despite receiving clear warnings from clinicians. This included;

• Failure to remove Letby from clinical duties when concerns became serious.

• Failure to prioritise patient safety over reputation and operational considerations.

• Delay in informing the Board fully.

• Delay in involving the police.

• Failure to consider safeguarding procedures.

• Excessive focus on alternative explanations rather than risk mitigation.

- **A culture of "doctors versus managers" developed**

The Inquiry found that concerns raised by clinicians were frequently challenged, minimised or treated as a professional dispute. Rather than seeking collaborative investigation of serious concerns, executive leaders and some nursing leaders developed a "nurses versus doctors" narrative which distracted attention from the fundamental question of whether babies were safe. The Inquiry concluded that this culture contributed directly to delays and missed opportunities to prevent further harm.

- **Board oversight was insufficient**

The Board was not promptly informed about the full nature and seriousness of the concerns. The Inquiry criticised delays in escalating concerns to Board level and found that executive leaders appeared reluctant to expose the emerging issues to wider scrutiny.

- **Organisational reputation was given undue weight**

A recurring theme throughout the Inquiry is that concern about reputational damage influenced decision-making. The Inquiry found evidence of senior discussions focusing on; reputational implications; CQC ratings; media consequences; organisational impact of police involvement. These considerations were allowed to influence decision-making before patient safety questions had been properly resolved.

- **Concerns raised by staff were not effectively heard**

Although mechanisms such as whistleblowing and Speak Out Safely existed, staff members did not experience them as effective routes for resolving serious concerns. The Inquiry found that simply having a process is insufficient if organisational culture discourages challenge or if concerns are not acted upon.

- **Regulatory and oversight systems did not identify the risk**

Multiple external organisations interacted with the Trust but none recognised the significance of emerging signals including; CQC, NHS England, Coroners offices, External reviews, Professional regulators The Inquiry concluded that information existed in different places but was not connected in a way that would identify the developing pattern quickly enough.

- **Wider NHS Findings**

The Inquiry expanded beyond Countess of Chester Hospital and examined system-wide issues. Major themes included:

Culture

The Inquiry identified persistent NHS cultural issues including; reluctance to challenge authority and organisational defesiveness.as well as prioritisation of organisational reputation over transparency in some circumstances.

Leadership and Management

The Inquiry questioned the preparation, accountability and regulation of NHS managers and highlighted the absence of equivalent professional regulation compared with clinicians.

4. Recommendations

4.1 WCCSS Care Group

Recommendation 1: CCTV and Monitoring

CCTV and Monitoring (aligned to Chapter 33) 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.

Recommendation 2: Insulin

Insulin (aligned to Chapter 34). Digital devices should be used to restrict access of insulin to authorised people and record access to insulin storage units. Immediate actions are being taken within the service to implement this by 30 November 2026 deadline.

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.

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

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. Initial engagement with pharmacy teams across UHD has taken place to consider progression of this work.

Recommendation 3: Bereavement Care

Bereavement Care (aligned to Chapter 29) The National Bereavement Care Pathway for neonatal death should be implemented nationally and in all Trusts by 31 August 2027. Initial benchmarking has taken place and is being tracked through existing improvement processes.

Recommendation 8: Sudden Unexpected Death in Infancy and Childhood (SUDIC)

Sudden Unexpected Death in Infancy and Childhood (SUDIC) (aligned to Chapters 12 and 28) NHS England have informed all Trusts with a neonatal unit that the SUDIC process applies to the sudden and unexpected deaths of babies who have never left hospital. UHD have complied with the seven-day deadline following receipt of this notification and ensured that all staff and the board were made aware of this requirement.

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

4.2 University Hospital Dorset

Recommendation 4: Safeguarding and contracts of employment

Safeguarding and contracts of employment: (aligned to Chapter 41)

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. 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.

Recommendation 7: Data reporting

Data reporting (aligned to Chapter 35). 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. 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: whether any alerts or a need for investigation have arisen and the investigation or action plan in place.

4.3 NHS England and Regulatory Bodies

Recommendation 5: Operating systems (interoperability)

Operating systems (interoperability) (aligned to Chapter 35) 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.

Recommendation 9: Suspicion of Deliberate Harm Protocol and guidance

Suspicion of Deliberate Harm Protocol and guidance (aligned to Chapter 41)

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; 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 and where concerns or suspicions of deliberate harm are being raised in good faith, they must be acted upon immediately. Only in cases where the concerns are obviously irrational or malicious (which assessment must be recorded) will no further action be justified. 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. 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. Safeguarding steps must be followed, as a result of which the police will become involved.

Recommendation 10: Panel of experts

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. Such investigations should always include safeguarding considerations (including contacting the police).

Recommendation 11: Medical examiners

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

The revised SUDIC guidelines (see Recommendation 8 above) should be set out within the good practice guidelines for medical examiners, 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. 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.

Recommendation 12: Paediatric and perinatal pathologists

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.

Recommendation 13: Accountability and regulation of managers

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.

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

- The move is not proposed because of the manager's lack of capability or misconduct.
- The manager meets the fit and proper person test.

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.

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.

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."

Recommendation 14: Care Quality Commission (CQC)

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

Inspectors and team leaders must always approach an inspection of services not as a box-ticking exercise but as a way to determine that babies in hospital are safe.

Recommendation 15: Assessment of the performance of CQC

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.

Recommendation 16: Parliamentary and Health Service Ombudsman

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:
• investigating complaints that whistleblowing in the NHS has not been dealt with adequately

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

Recommendation 17: Implementation of recommendations

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.

5. NHS England letter and immediate actions

On the 21st September 2026 Trusts received a letter from NHSE to note that: The Secretary of State had 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.

Recommendations requiring further thought and guidance from NHSE include

- 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.

The letter also highlighted actions needed now. Trusts should immediately progress the following actions in response to the Inquiry's findings:

5.1 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. Scheduled for trust Board 11th November 2026.- complete

5.2 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 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. It is important to note that SUDIC reporting runs alongside your own internal reporting processes. This has been actioned on the 23rd September 2026.- complete

5.3 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). Both maternity and neonatal services have benchmarked against the bereavement care pathway and there are ongoing improvement groups in both teams to align services against the care pathways. Progress against this work will report to the Maternity Improvement Group.

5.4 Insulin control and storage

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 (https://gettingitrightfirsttime.co.uk/wp-content/uploads/2026/04/GIRFT-guide-to-safe-insulin-use-in neonatal-services-FINAL-January-2026.pdf). 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. The service has obtained quotes for installation of the required surveillance with a plan to implement within the scheduled deadline.

5.5 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 have been 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.

6. Next Steps

A comprehensive action plan for all recommendations to be implemented by the care group and the wider organisation to be developed and presented.

7. Recommendations

The trust board is asked to note the details of this briefing summary and next steps. It is recommended that all board members read the report in full

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **5.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Freedom to Speak Up (FTSU) Bi-annual Report 2026/7
Prepared by:	Helen Martin, Freedom to Speak Up Guardian
Presented by:	Helen Martin
Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☒ Patient Experience ☐ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Assurance
Executive summary:	This report provides an overview of Freedom to Speak Up activity for Quarters 1 and 2 of 2026/27. A total of 271 concerns were raised during the period, a 13% increase on the same period in 2025/26. Referrals primarily related to processes and systems, workplace behaviours, and worker safety and wellbeing, with learning highlighting opportunities to improve organisational processes, promote respectful, inclusive and psychologically safe workplace cultures and support staff wellbeing. The report also outlines key national developments relevant to FTSU, including NHS England's revised FTSU arrangements and learning from the Thirlwall Inquiry. The report provides assurance regarding organisational culture, psychological safety and speaking up arrangements, whilst highlighting themes and risks requiring ongoing Board oversight and organisational learning
ALERT:	• Referrals increased by 13% compared with the same period in 2025/26. • Approximately a third of FTSU cases were risk assessed as complex needing senior escalation. • Patient safety concerns increased to 9% of referrals and will require ongoing monitoring for emerging themes. • Global Majority staff accounted for 15% of referrals, below both the previous year (21%) and workforce representation (26.8%), indicating a need to better understand potential barriers to speaking up in 2026.

	• Anonymous referrals remain above the national average. While there may be a range of reasons for choosing anonymity, this can include concerns about psychological safety or confidence in speaking up openly.
ASSURE:	• The Trust continues to meet NHS England requirements for Freedom to Speak Up arrangements following the transition from the National Guardian's Office. • The FTSU service remains visible and accessible through two Guardians supported by an 18-member Ambassador network. • Staff feedback about the FTSU service remains positive, with all respondents indicating they would or may speak up again.
ADVISE:	• The majority of concerns relate to processes and systems, workplace behaviours, and worker safety and wellbeing, highlighting opportunities for organisational learning and improvement. • The importance of strengthening managers' capability and confidence to listen, respond and follow up when concerns are raised. • The opportunity is presented by the Thirlwall Inquiry to strengthen organisational focus on listening, action, feedback and learning following concerns being raised.
Celebrating Outstanding:	The FTSU service continues to demonstrate strong engagement and visibility across the Trust, supported by an active Ambassador network. Speaking Up Week, staff network engagement, partnership working across southwest region, and positive feedback from service users demonstrate continued commitment to fostering an open and learning culture. The Trust also remains on track to deliver all Freedom to Speak Up priorities identified through the NHS England Board Reflection and Planning Tool.
RECOMMENDATION:	1. Note the contents of the Freedom to Speak Up Bi-Annual Report 2026/27. 2. Endorse and Renew board commitment to Sir Robert Frances principles and Annual declaration of behaviours (appendix a) 3. Receive assurance regarding the effectiveness of the Trust's Freedom to Speak Up arrangements. 4. Note the discussion and scrutiny undertaken through Trust Management Group and People & Culture Committee.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☐ Strategy/Transformation ☐

	System ☐ The report provides insight into staff experience, psychological safety, organisational culture and workforce wellbeing. It highlights speaking up experiences of Global Majority staff and supports the Trust's equality and inclusion agenda. The report contributes to quality improvement through identification of patient safety, workforce and behavioural themes, while supporting compliance with NHS England Freedom to Speak Up requirements and expectations arising from the Thirlwall Inquiry.
CQC Assessment Framework:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well-Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Trust Management Board	22/10/2026	Received and discussed
People and Culture Committee	02/11/2026	Received and scrutinised. PCC supported submission of the report to the Board for noting and assurance.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

University Hospitals Dorset
NHS Foundation Trust

Freedom to Speak Up (FTSU): Bi-Annual Report 2026/7

1.0 Introduction

1.1 NHS England published *The Future of Freedom to Speak Up* in April 2026, setting out revised national arrangements that came into effect on 1 July 2026. Responsibility for FTSU now rests with NHS commissioners and providers, with national support functions delivered through NHS England. University Hospitals Dorset (UHD) continues to meet these requirements (reading pack).

1.2 The Thirlwall Inquiry, published on 15 September 2026, made a number of significant recommendations relating to speaking up. Its findings reinforce the critical role of effective speaking up arrangements in supporting patient safety and also placed renewed emphasis on what happens after concerns are raised, including listening, action, learning and feedback (reading pack).

1.3 Speaking up, and the work of our FTSU team, remain a core pillar of our People Promise at UHD "We each have a voice that counts". FTSU is one of several routes available for staff to raise concerns at UHD.

1.4 The role of the FTSU team is to identify emerging risks and themes, provide independent insight and share organisational learning from staff experiences. In doing so, the team acts as an early warning mechanism, helping the organisation identify issues that may require further attention. FTSU does not lead operational delivery or investigations. Responsibility for investigating concerns and taking appropriate action remains with care groups and relevant organisational teams. Confidentiality is a fundamental principle of FTSU, and information is only shared with an individual's consent, unless there is a legal, safeguarding or serious safety requirement to do so.

1.5 The FTSU team comprises 2 FTSU Guardians alongside a network of 18 FTSU Ambassadors who help raise awareness and support staff in speaking up. Senior leaders demonstrate a strong and sustained commitment to speaking up, reaffirmed annually through a public statement and declaration of expected behaviours (Appendix 1).

1.6 Speaking Up Week was once again a successful campaign promoting Freedom to Speak Up across the Trust. This year's theme, "A Decade On", reflected on 10 years of FTSU, celebrating progress in strengthening speaking up cultures across the NHS while also considering current challenges and future opportunities. A range of activities was delivered to raise awareness, encourage engagement, and reinforce a positive culture in which staff feel safe and supported to speak up (reading pack).

1.7 The Trust remains on track to deliver all two-year Freedom to Speak Up priorities identified through the NHS England Board Reflection and Planning Tool in May 2025. This will return to Board in 2027 to review progress and agree refreshed priorities.

2.0 A Year at a Glance

April

- NHSE publication *The future of FTSU*. UHD contributed to engagement sessions and meets all guidance (see reading pack).
- Commenced Dorset and Somerset case modulation and audit.
- 15th April Civility Saves Lives FTSUG was an international Speaker to the programme
- 27th April - FTSU Ambassador Development

April-Sept

- UHD FTSU Network
- UHD staff Networks
- Dorset and Somerset Network
- South-west regional Networks



May

- NGO annual report laid before Parliament. The report reflects 10years of progress. (reading pack)

May UHD

- FTSU Annual report presented to May board.

June:

- Closure of NGO office. Responsibility moved to providers with national support from NHSE.
- The UHD Awards is an important way to recognise each-other. In 2026, 1200 staff and volunteers were nominated. The "Open and Honest" winner was Ben Higgins in the Finance Dept for his leadership and creating psychological safety.

July

- Presented UHD FTSU Annual report to Council of Governors, Staff side and Care Groups.
- Commenced work on pan-Dorset Healthcare guardian FTSU module with DHT and DFT.

August:

- New Data collection submitted via NHSE portal. This data will be submitted quarterly.
- Out of hours walkabout by FTSU. Themes and observations shared with care groups

Sept:

- UHD FTSUA development day on supporting staff and us through change.
- Thirlwall Inquiry published (15th September; reading pack)
- UHD Risk and safety conference

Oct:

- Civility saves lives conference
- Speak Up Week 12-16th October (reading pack)

All tables and graphs can be found in the reading pack.

Speaking up Data (Qtrs. 1 and 2; 2026/27)

3.0 FTSU Data – the Headlines

3.1 Prior to June, UHD submitted quarterly information to the NGO, enabling benchmarking against neighbouring healthcare organisations (Table 1). While referral numbers alone do not indicate the strength of a speaking up culture, trends may reflect organisational factors such as workforce change, merger activity and restructuring. Following the transition to new national arrangements, the Trust now submits quarterly FTSU data through the NHSE portal, with reporting expected to be incorporated into Model Hospital metrics.

3.2 The FTSU team received 271 referrals during the reporting period (Graph 1), averaging 45 cases per month. This represents a 13% increase compared with the same period in 2025/26, although referrals remain below 2024/25 levels. Peaks were seen in June and August, coinciding with higher numbers of concerns relating to behaviours and to processes and systems, alongside smaller increases in patient safety concerns and, in August, worker safety concerns (Graph 2).

3.3 Fifty-three percent of staff reported speaking to more than two people before approaching the FTSU team, suggesting that FTSU is frequently not the first point of contact. This is further reflected in the reasons staff gave for approaching the service, with 21% reporting that their line manager was the subject of their concern and a further 29% feeling their line manager had not addressed the concern they had raised (Table 2). Collectively, these findings reinforce the importance of concerns being heard, acted upon and followed up effectively when they are first raised, and highlight an opportunity to strengthen managers' confidence, capability and skills in responding when staff speak up. Engagement with the Listen Up and Follow Up e-learning modules for line managers and senior leaders remains low (Table 3). Strengthening uptake of these modules may support managers to better understand the barriers to speaking up and build confidence in listening and responding effectively when concerns are raised.

3.4 Approximately a third of FTSU cases (88; 32%) were risk assessed as medium to high and escalated for senior oversight, providing assurance that higher-risk concerns are identified and appropriately escalated. Trends in the number and nature of these cases will continue to be monitored during 2026/27.

3.5 Speaking up through FTSU continues to relate predominantly to working environments and relationships (Graph 3). The largest themes were processes and systems (97 cases; 44%), followed by behaviours (92 cases; 34%) and worker safety (41 cases; 15%). Patient safety concerns increased to 9%, compared with 5% during the same period in 2025/26, and this increase will continue to be monitored for any emerging themes or risks.

3.6 Process and Systems (44%). Process and systems are the largest theme within FTSU referrals during this period. Significant organisational change and changes to ways of working can generate increased uncertainty around established procedures and ways of working. Table 4 provides further analysis, with 61% of cases relating to HR and employment matters. These include navigating organisational change and agile working, as well as seeking clarity on

processes such as grievances, mediation and probation. This highlights the value of accessible HR advice, clear processes and appropriate support, particularly during periods of change or where working relationships may be under strain, helping staff navigate employment matters with confidence and enabling concerns to be addressed earlier.

3.7 Behaviours (34%). Behaviour remains a significant theme, with incivility the most frequently described behaviour, accounting for 48% of behaviour-related cases (Table 5). Poor workplace behaviours can affect staff wellbeing, team functioning and the delivery of safe, effective care. The Behaviour Charter, launched in August 2025, and the forthcoming Active Bystander Programme provide organisational mechanisms to reinforce expected standards of behaviour and support staff to challenge behaviours that fall below these expectations. FTSU intelligence will continue to provide insight into staff experience and emerging themes as these initiatives become embedded.

3.8 Worker safety and wellbeing (15%). This includes concerns relating to staffing and workload, access to equipment and resources, working conditions, and the impact of these factors on staff health, safety and wellbeing. These concerns provide valuable insight into staff experience and how the working environment may affect them.

3.9 The highest referrers to the FTSU service are nurses and midwives accounting for 31% of speaking up cases, followed by administrative staff (21%) reflecting the workforce profile (Table 6).

3.10 Anonymous referrals. Staff who are unable or unwilling to disclose their identity can raise concerns anonymously with the FTSU team through the UHD app. During the reporting period, 17% of referrals were anonymous (45 cases; Graph 4), compared with the national average of 12.2% in 2025/26. While there may be a range of reasons for choosing anonymity, this may reflect concerns about psychological safety or perceived consequences of speaking up openly. The main themes raised anonymously were processes and systems (54%; 22 cases), followed by behaviours (27%; 11 cases) (Graph 5).

3.11 Global Majority staff. Staff from Global Majority backgrounds experience greater vulnerability and potential detriment when speaking up, reinforcing the importance of monitoring demographic data. Graph 6 shows that staff accessing FTSU were predominantly female and aged 36–55. Global Majority staff accounted for 15% of referrals (41 staff), a decrease from 21% in 2025/26 and below the 26.8% representation reported in the Trust's March 2025 WRES mapping template. This is the lowest level of referrals from Global Majority staff and warrants renewed focus to better understand the reduction and ensure staff from all backgrounds feel confident and supported to speak up (Graph 7). The predominant theme raised by our Global Majority staff is behaviours (16 staff, 39%) followed by process and systems (13 staff; 32%; Graph 8).

3.12 The FTSU team continues to maintain visibility across all sites and staff groups, supported by the FTSU Ambassador network. Table 8 shows referrals across the care group structure, with Medicine and WCCSS continuing to be higher reporting areas. Targeted engagement has also

taken place over the last six months in Trauma and Orthopaedics and Facilities, with both areas seeing an increase in referrals to FTSU. Table 8 also triangulates FTSU activity with responses to question 25f of the NHS Staff Survey, providing an additional perspective on staff confidence in speaking up. Of particular interest are areas where lower FTSU reporting is seen alongside lower confidence that raising concerns will be addressed, including Head and Neck and Strategy, Transformation and Estates. These areas may benefit from further engagement to understand potential barriers to speaking up and ensure staff are aware of, and feel able to access, available routes for raising concerns.

3.13 Evaluation of the FTSU service remains an important measure of staff experience. Staff are invited to provide feedback following closure of their case; however, response rates remain low, reflecting the national experience. Since April, 100% indicating that they would, or may, speak up again (19 staff). Feedback has been positive, with respondents describing the service as supportive, responsive and non-judgemental, and reporting that they felt heard, validated and provided with a safe space to speak up. While the small number of responses limits wider conclusions, the feedback received provides a positive indication of the experience of those who responded.

4.0 Learning and Reflections

4.1 Whilst each referral provides individual opportunities for learning, recurrent broader themes provide wider insight into staff experience and can support organisational learning and the continued development of a positive speaking up culture at UHD (Graph 9).

4.2 Compassionate and inclusive leadership and management remains the most significant learning theme, identified in 54% of cases (147 referrals). Effective leadership and good management practice are fundamental to creating environments where staff feel valued, are confident to speak up and trust that concerns will be listened to and appropriately addressed.

4.3 Behaviours were identified as a learning theme in 16% of cases (43 referrals). These cases reinforce the importance of fostering healthy and respectful working relationships, alongside addressing poor behaviours promptly, consistently and compassionately. Staff frequently describe delayed or inconsistent intervention as contributing to deterioration in working relationships, with potential consequences for staff wellbeing, absence, retention and organisational reputation.

4.4 Wellbeing support was identified as a learning theme in 14% of cases (37 referrals). Referrals highlight how the workplace can affect staff wellbeing. Timely access to appropriate support, alongside compassionate management and regular communication, can help staff feel valued and supported while concerns are being considered or addressed.

5.0 Summary

5.1 Freedom to Speak Up continues to provide valuable insight into staff experience and emerging organisational themes at UHD. Referral numbers have increased by 13%, with a third of cases assessed as medium risk and over half of staff reporting that they had spoken to more than two people before approaching the FTSU team. This reinforces the importance of concerns being heard, acted upon and followed up effectively at the earliest opportunity.

5.2 Learning from FTSU referrals highlight the importance of compassionate leadership, timely management and action of concerns, workplace behaviours and staff wellbeing in creating an environment where staff feel safe and confident to speak up. The proportion of anonymous referrals, together with lower use of FTSU by staff by Global Majority staff, identifies areas where attention to psychological safety, confidence and accessibility is required.

5.3 The Thirlwall Inquiry provides an important opportunity to reflect on and strengthen UHD's approach to speaking up, reinforcing that an effective speaking up culture is more than encouraging staff to raise concerns. It requires effective listening, timely and appropriate action, learning and feedback.

Appendix A

UHD Board of Directors' Statement of Commitment to the principles of the Freedom to Speak up

Sir Robert Francis set out his vision for creating an open and honest reporting culture in the NHS in his 2015 publication Freedom to Speak Up. The Board of Directors is committed to fostering a culture of safety and learning in which all staff feel safe to raise a concern across the Trust.

Speaking up is essential in any sector where safety is an issue. Speaking up should be something that everyone does and is encouraged to do. There needs to be a shared belief at all levels of the organisation that raising concerns is a positive, not a troublesome activity, and a shared commitment to support and encourage all those who raise honestly held concerns about safety. Without a shared culture of openness and honesty in which the raising of concerns is welcomed, and the staff who raise them are valued, the barriers to speaking up will persist.

The Board supports the key principles of speaking up and is committed to leading the actions required to implement them. The Board will receive support from the Freedom to Speak up Guardian (FTSUG) who is sponsored by the Chief Executive.

The key principles the Board is committed to include:

	Principle	**Action**
1	Culture of safety	Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.
2	Culture of raising concerns	Raising concerns should be part of the normal routine business of any well led NHS organisation.
3	Culture free from bullying	Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.
4	Culture of visible leadership	All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.
5	Culture of valuing staff	Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.
6	Culture of reflective practice	There should be opportunities for all staff to engage in regular reflection of concerns in their work.
7	Raising and reporting concerns	All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.

Supporting you to raise concerns
Freedom to speak up

8	Investigations	When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.
9	Mediation and dispute resolution	Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.
10	Training	Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.
11	Support	All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality.
12	Support to find alternative employment in the NHS	Where a NHS member of staff who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.
13	Transparency	All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.
14	Accountability	Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns.
15	External Review	There should be an Independent National Officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report
16	Coordinated Regulatory Action	There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns
17	Recognition of organisations	CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.
18	Students and Trainees	All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.
19	Primary Care	All principles in this report should apply with necessary adaptations in primary care.
20	Legal protection	Should be enhanced to those who make protected disclosures.

University Hospitals Dorset
NHS Foundation Trust

Speaking up BOARD ANNUAL DECLARATION

This declaration is to be approved annually alongside our statement of commitment to the Sir Robert Francis recommendations

Declaration

I recognise that I have a responsibility for creating a safe culture and an environment which workers are able to highlight problems and make suggestions for improvement.

I will learn about the cultural background of staff within my team(s) to find creative ways to proactively address the barriers they may have to speaking up"

I understand the importance of staff feeling able to speak up and the trusts vision to achieve this

I recognise the impact of my own behaviour on the trust's culture. I will therefore reflect on my own behaviour regularly so that it does not inhibit someone speaking up*.

I have insight into how my power could silence truth

I will welcome approaches from workers and thank them for speaking up. I will ensure that I will provide feedback

I will speak up, listen and constructively challenge one another during board meetings

I will seek feedback from peers and workers and reflect on how effectively they demonstrate the trust's values and behaviours

I will accept challenging feedback constructively, publicly acknowledge mistakes and make improvements.

I will be open and transparent and see speaking up as an opportunity to learn.

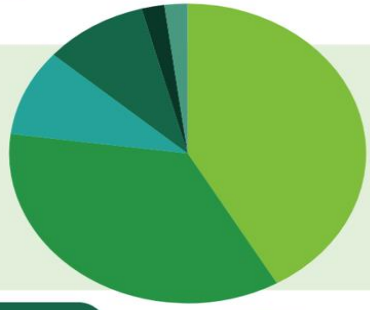
Supporting you to raise concerns
Freedom to speak up

Quarter 1 and 2; 2026/7

NHS University Hospitals Dorset NHS Foundation Trust

271 staff
came to speak to FTSU

Themes
97 referrals for 'process and systems'
92 referrals for 'attitudes and behaviours'
41 referrals for 'staff safety and wellbeing''
25 referrals for 'patient safety'
8 referrals for 'equality, diversity and belonging
8 referrals for 'sexual safety'



Behaviours
48% of concerns related to incivility
40% of concerns related to longstanding poor behaviours
6% of concerns related to toxic workspace



21% of staff came to FTSU because they felt their manager was the issue

29% of staff came to FTSU because they felt their manager knew about the issue but was not addressing it

14% of staff came to FTSU because they felt unsafe to speak up

15% of referrals came from global majority staff



45 anonymous referrals via the @UHDapp

What have we learnt?

The need for compassionate and inclusive leadership and better management skills (147 cases). The need to have respectful and civil workplaces (43 cases). The importance of health and wellbeing and looking after each other (37cases). The need to get the basics right (22 cases). The difficulties of team integration and merger (11cases).

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **6.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Board Assurance Framework (BAF) Q2 2026/27
Prepared by:	Leonora May, Director of Corporate Governance
Presented by:	Executive risk leads
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	Links to Corporate Risk Register included in the BAF.
Purpose of paper:	Assurance
Executive summary:	The Board Assurance Framework (BAF) has been reviewed and updated for Quarter 2. All strategic risks have achieved their planned Quarter 2 target risk score, demonstrating that the controls are broadly effective. Patient Experience remains above its stated risk tolerance, reflecting continued challenges in achieving complaints response standards. The Quarter 2 review has considered the effectiveness of the key controls and assurance mechanisms supporting each strategic risk. Overall, these remain established and broadly effective. Where gaps or weaknesses have been identified, these are reflected within the relevant strategic risk updates and supported by targeted actions to be delivered in the next quarter. Areas requiring continued focus include patient experience, urgent and emergency care performance and delivery of strategic transformation programmes. The Our People strategic risk has been refreshed to align with the revised People Strategy and associated programmes of work. The updated risk description and controls reflect the new strategic approach, and the changes have been reviewed and supported through the People and Culture Committee. A number of material updates have been reported during Quarter 2: • **Patient Experience:** The Trust is not currently achieving its breakthrough objective of closing 90% of complaints within 35 days. Performance has been impacted by a significant increase in complaint volumes, complaint complexity, backlog management challenges, staff

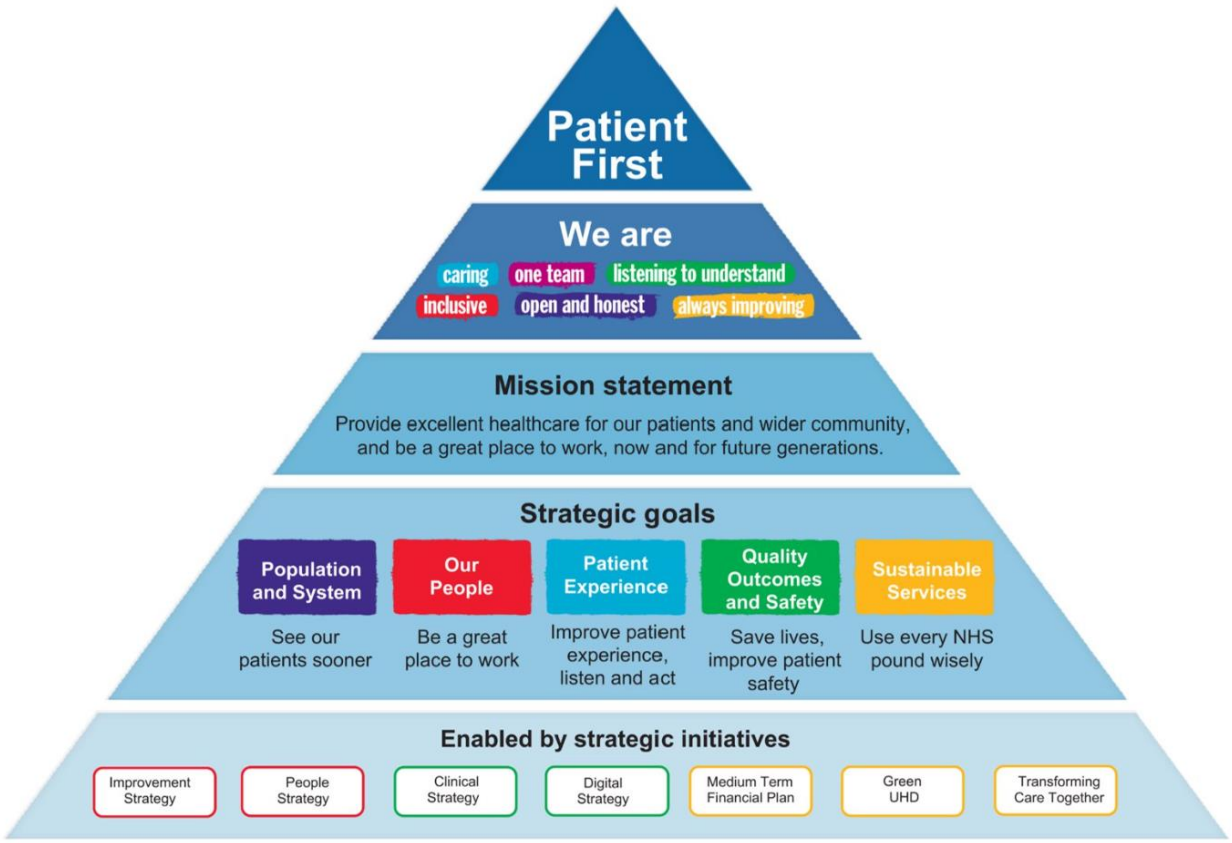
	sickness and delays in care group responses, although recovery actions are underway. • **Our People:** A full review and refresh of the People Strategy has been completed which has strenghened controls. Supporting programme governance has been strengthened, with project initiation documents developed across all People Strategy workstreams and further work underway to align workforce risks and delivery plans. • **Population and System:** While RTT performance trajectories have been met and diagnostic recovery plans are progressing, challenges remain in relation to the 4-hour emergency care standard, system flow, bed availability, no-criteria-to-reside patients and ED crowding. • **Quality Outcomes and Safety:** A CQC inspection of the surgical service identified areas for improvement including issues relating to compliance with standards. In addition, audit work and ongoing quality oversight have identified areas requiring improvement in infection prevention and control arrangements and patient safety processes. The Trust has established action plans and governance arrangements to monitor improvement. • **Sustainable Services:** Quarter 2 updates demonstrate strengthened financial controls, including enhanced drugs spend reporting, strengthened forecasting arrangements, implementation of additional grip and control measures, and ongoing review of workforce expenditure to support delivery of the Trust's financial recovery objectives. • **Transforming Care Together:** Progress continues across the programme; however, further delays to the COAST development have reduced confidence in the overall timetable. Whilst key elements of Phase 3 remain on track, significant focus is required on the People Ready workstream and critical path activities to support delivery of the April 2027 move date.
ALERT:	• **Patient Experience breakthrough objectives are not being achieved.** Performance against the complaints standard remains significantly below target, driven by a 20% increase in complaint volumes, complaint complexity, workforce capacity challenges and an historic backlog.
ASSURE:	• **All strategic risks have achieved their planned Quarter 2 target risk score**, demonstrating continued oversight and management of the Trust's principal strategic risks. • The **Our People** strategic risk has been refreshed following completion of the revised People Strategy, with updated controls, assurances and delivery arrangements supported through the People and Culture Committee.
ADVISE:	None

Celebrating Outstanding:	NA
RECOMMENDATION:	The Board is asked to note the Quarter 2 position, the updates made to the Board Assurance Framework, and the actions being progressed to strengthen assurance and reduce risk exposure across the Trust's strategic objectives.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☒ Equality, Equity, Diversity & Inclusion ☐ Financial ☒ Health Inequalities ☐ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☐ System ☒
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Audit Committee	15/10/2026	The Committee noted the report.
Finance and Performance Committee	02/11/2026	The Committee noted the report.
People and Culture Committee	02/11/2026	The Committee noted the report.
Quality Committee	03/11/2026	The Committee noted the report.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

Board Assurance Framework

Threats to the achievement of the Trusts strategic priorities and 2026/27 goals



5 strategic themes

- Population and System – see patients sooner.
- Our People – Be a great place to work.
- Patient experience – improve patient experience, listen and act.
- Quality Outcome and Safety – save lives, improve safety.
- Sustainable services – use every NHS pound wisely.

Corporate Projects 2026/27





Trust Strategic Priority: Patient Experience - *Improve patient experience, listen and act.*

Strategic risk description	
There is a risk that the Trust cannot achieve its strategic priority to focus on patient experience due to: • Increased demand due to the impact of deprivation, multi- morbidity and an ageing population, and seasonal variation • Increased demand – unplanned care, emergency department attendances, on patient flow across the system. • Significant growth in the number of patients waiting for elective treatment. • Ageing estate and building/digital infrastructure leading to poor patient experience. • Insufficient workforce due to availability • Lack of system capacity resulting in increased number of patients with NCtR awaiting discharge, increased length of stay, and increased risk of deconditioning. • Insufficient system and Trust provision for patients with a mental health disorder • Inconsistent compliance with fundamentals of care Resulting in potential harm to patients, impact on outcomes, experience and quality of care, impact on external relations, and regulatory breach (CQC).	**Lead Executive Director(s): CNO** **Date last reviewed: 30/09/26** **Strategic objective** All patients at UHD receive quality care which results in a positive experience or them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change. **Breakthrough Objectives** 90% of complaints closed within 35 days 95% of Friends and Family Test responses rated good or very good **Linked Corporate Projects** Fundamentals of Care **Links to Internal Audit Plan 26/27** Mental Health Act Consent IPC MIS

Current and Target Risk Ratings

Severity (impact)	Likelihood	Current Risk Rating	Target Risk Rating			
			Q1	Q2	Q3	Q4
3	4	12	12	12	9	6

Risk category and risk appetite statement

Risk Type and Category	Risk appetite	Risk Tolerance
Patient Experience	Minimal	6-10

Key Controls (to manage risks related to goal)	**Key assurances** (effectiveness of controls)
Prevention Controls (parts of a system of internal controls designed to prevent a risk from occurring) • Patient Experience and Engagement Strategy • People and Culture Strategy – Behaviour Charter • Fundamentals of care programme **Detection controls** (those that provide an early warning of control failure) • Quality Committee oversight of risks related to patient safety, quality and experience: risk framework (risk categories/risk appetite) • Quality Committee oversight of patient experience metrics • Patient Experience Group monitoring KPI • Finance and Performance Committee oversight of delivery against constitutional standards including in year deep dives. • CQC engagement process • Patient Champions, Patient Safety Partners **Contingency controls** (those that help prepare for an effective reaction in response to a control failure or overwhelming event. Designed to maintain resilience) • CQC action plans • Actions from complaints, claims, LERNS, Inquests • Trust Escalation process	• National Inpatient and outpatient survey • National Staff survey • PLACE Audit • Complaints report to Board • Annual Safeguarding Report • Quality Account • CQC inspection report(s) • CQC Regulation 10 – dignity and respect • CQC Regulation 12 - safe care and treatment • Internal audit programme • Patient feedback – FFT, patient surveys, focus groups, user/stakeholder engagement. • Health & Safety annual report • Healthcare Associated infection annual report. • Integrated Quality and Performance Report to the Trust Board, key metrics: Complaints responses, FFT results, Healthcare Associated Infection, maternity safety, pressure ulcers, falls, patient safety incidents. • Matron walkabouts • Clinical Accreditation Scheme (report to QC) • Quality Assurance Tool (report to CGG and QC) • Care Group SDR Reports – patient experience. • Trust annual governance statement • Learning from death reviews • TMG corporate projects and corporate SDR

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
30 September 2026	1397 Provision of 24/7 Haematology/ Transfusion Labatory Service
	2229 Obstetric Ultrasound Scanning Service
	1855 Breast Radiology Capacity and Demand
	2302 Medical Staffing Women's Health

	1460 Inability to meet UEC 4 hour standard
	1395 Lack of Capacity in Cellular Pathology
	1665 School Age Neurodevelopmental Service
	1697 Increased Waiting List for SACT Treatment
	2262 Insufficient Capacity and Lack of Specialist Staffing and Environment for Respiratory high Care Patients
	2350 RBH ED Waiting Room
	1974 Significant Time Delays for Macular Injection Treatment
	2052 Care of Patients in Non-Clinical/ Corridor areas in ED
	2362 Holding Ward Pathway: Patients Excluded from Inpatient Governance Processes

Date	**Updates (Improvement, Identified gaps in controls and/or assurances)** *(to be updated at least quarterly)*	**Actions to be taken next quarter** *(to be updated at least quarterly)*
Q1	Complaints policy and procedure aligned to PHSO/NHS complaints standards – clear SOPs. Friends and Family Test migrated from Formic to Microsoft Form – cost reduction Weekly review of complaints with Care Groups	Undertake a full audit of the complaints backlog; triage by date, complexity and risk; and implement a 6-week recovery trajectory Review PALS and Complaints staffing/capacity and triage process to reduce backlog and support earlier informal resolution
	Review of backlog and established 6-week improvement plan to address complaints backlog Patient Experience Group Agenda revised in collaboration with Care Group representatives to reflect Care Group reporting of improvements (AAA report)	Increase the number of Early resolution of complaints at a local/ward/department level Increase FFT return rates through (QR codes) across areas with low returns Review and refresh complaints handling training for care group teams, particularly early resolution at ward level, thus decrease the number of formal complaints and reduce reliance on central team Triangulate complaints, PALS, and FFT themes quarterly to identify systemic issues and inform quality improvement priorities, and ultimately increase the FFT satisfaction rate.
Q2	The trust is not meeting its breakthrough objective. The main drivers are: • Rising volume and complexity of complaints (20% increase in the number of complaints received) • the backlog of aged complaints • PALS and Complaints team sickness • Delays in Care Group investigation responses and sign-off, however notable improvements made in Q2. The 6-week recovery plan did not deliver the expected improvement because of the increase in the number of complaints and drivers identified above. Although the number of complaints closed increased from Q1-2, the percentage compliance dropped due to the increase in complaints received.	• Stabilise team capacity • Strengthen PALS early resolution. Contact every new complainant within 3 working days to agree whether the issue can be resolved informally, in line with the NHS Complaint Standards. • Early resolution – discussed at the weekly care group meetings and allocated to care group representatives. • Weekly huddles - Continue to strengthen weekly complaints meeting with the care groups, to ensure escalations are raised and addressed effectively and in a timely manner. • Care Group Response time - Review of process where delays in responses exist. Chasing of responses – strengthen the role of governance lead and matrons where chasing is required • How to write a complaints response – training in progress, to reduce the number of queries generated following inadequate responses. • Triage all new complaints on receipt by complexity (low, moderate, high), with timescales

Number of Complaints closed in Q1 & Q2

Month	Number of complaints closed (received)	% closed within 35 days
April	58 (180)	
May	70 (82)	41.4%
June	124 (103)	33%
July	122 (82)	25%
Aug.	89 (107)	16%
Sep.	114 (74)	20%

Performance is forecast to reach 90% by [month 11/Q4], subject to the actions in Q3.

proportionate to complexity. Agree extended timescales with complainants at the outset for complex, multi-directorate cases.

Trust strategic priority: Our People - *Be a great place to work.*

Strategic risk description

There is a risk that the Trust cannot achieve its strategic priority to be a great place to work because of:

- Insufficient workforce supply, attributable to national and local workforce shortages.
- Inability to achieve all aspects of, and the metrics associated with, the NHS People Promise and the NHS Staff Standards.
- Insufficient attention to the positive impact of an attractive 'employee value proposition' (EVP) helping to attract and retain all staff groups.
- Pressures on leaders' and managers' capacity and capability, in their task to create a positive environment for all colleagues and to implement, deliver and sustain change.
- Inability to achieve an inclusive, respectful and psychologically safe culture, which addresses discrimination, inequitable experiences, unacceptable behaviours and closed cultures, and deliver workforce race, disability, and gender standards.
- Insufficient opportunities for training and development because of operational pressures, leading to diminution of skills and failure to attract and retain talent.
- Employee burnout, attributable to sustained operational pressures, and significant scale of change, leading to the potential for change-fatigue and staff turnover.
- Reduced workforce availability attributable to sickness absence (primary drivers are musculoskeletal problems and stress, anxiety, and depression) and violence and aggression towards employees.
- Scale of digital change and the requirement for workforce digital adoption and digital literacy.
- Ageing estate / extensive new estates footprint leading to poor staff experience during change processes.
- Financial and workforce controls, in line with national planning guidance, require workforce reduction targets.
- Insufficient support to the organisation from the People Directorate, given the breadth and volume of demand from the people agenda, including support for change programmes (both internal and external change programmes, such as the Transforming People Services Programme) and managing the impact of unanticipated risks (such as Industrial Action).

Lead Executive Director(s): CPO

Date last reviewed: 07/09/26

Strategic objective:

To be a great place to work, attract and retain the best talent.

Breakthrough objectives:

- Increased substantive staff availabillity measured by a reduction in temporary staffing spend
- 15% reduction in premium bank spend (compared to 2025/26)
- 30% reduction in agency spend.

Linked Corporate Projects

People Strategy and all associated projects

Links to Internal Audit Plan 26/27

Rostering

Optimising and valuing admin

Current and Target Risk Ratings

Severity (impact)	Likelihood	Current Risk Rating	Target Risk Rating			
			Q1	Q2	Q3	Q4
3	4	12	12	12	9	9

Risk category and risk appetite statement

Risk Type and Category	Risk appetite	Risk Tolerance
Staff Health, Safety and Well Being	Minimal	6-10
Knowledge and Skills	Cautious	9-15
Workforce capacity	Cautious	9-15
People Function	Open	12-20

Key Controls (to manage risks related to goal) OBJ	**Key assurances** (effectiveness of controls)
Prevention Controls (parts of a system of internal controls designed to prevent a risk from occurring) • People and Culture Strategy and projects linked to delivery of NHS People Promise and NHS Staff Standards. • Behaviour Charter. • HR Policies and Procedures • Strategic Workforce Plans – PWR return • Health and Well Being Plans - THRIVE • Equality, Diversity & Inclusion plan • Learning, Education and Training plan • Digital Strategy • Staff vaccination programme and support • Freedom to speak up policy. • Accountability Framework. • People Ready strand of Transforming Care Together programme • Workforce Operational Efficiency and Reduction Programme	• National Staff survey • People Pulse Survey results. • People and Culture Committee Annual Report • CQC inspection report(s) • CQC Regulation 18 - staffing • Internal Audit Programme • Trust Annual Governance Statement • People and Culture Group. • Chief People Officers' Report. • Transforming Care Together – People Ready Assurance Report. • Safer Staffing Reports. • Guardian of Safe Working Hours Report. • Workforce Race Equality Standard (WRES) Report. • Workforce Disability Equality Standard (WDES) Report. • Gender Pay Equality Annual Reports. • Freedom to Speak up Report. • Integrated Performance Report. • NHS Staff Standards Report. • Patient First Report. • Risk Register Report. • Care Group and Corporate SDR Reports. • Staff Partnership Forum Reports. • Workforce Operational report. • Health and Safety Committee Reports. • Violence Prevention Group Reports. • Sexual Safety Panel Reports. • UHD Equality Networks.
Detection controls (those that provide an early warning of control failure) • Escalation process from Care Group and Corporate Strategic Deployment Reviews (SDRs) to People and Culture Group • People and Culture Committee oversight of people risks. • People and Culture SDR meetings.	
Contingency controls (those that help prepare for an effective reaction in response to a control failure or overwhelming event. Designed to maintain resilience) • Bi-monthly People and Culture Group review all People Strategy programmes and projects. • Care Groups and Corporate SDR meetings • People Ready meetings.	

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
September 2026	1397 Provision of 24/7 Haematology/ Transfusion Laboratory Service
	2229 Obstetric Ultrasound Scanning Service
	1855 Lack of Breast Radiologists
	1202 Medical Staffing Women's Health
	2399 TCT Programme- Delays to Phase 3 Delivery

Date	**Updates (Improvement, Identified gaps in controls and/or assurances)** *(to be updated at least quarterly)*	**Actions to be taken next quarter** *(to be updated at least quarterly)*
Q2	Assurance/ Improvements: • Review and refresh of People Strategy.is complete • All People Strategy Projects have Project Initiation Documents (PIDs) • People and Workforce Delivery Group meetings scheduled • Gap assessment to ensure that all workforce risks are addressed in the 2026/27 Project PIDs. • Preparation for 2026 NHS Staff Survey.	• All People Strategy Project PIDs to be finalised and agreed. • Delivery of Q3 actions in each project. • Undertake NHS Staff Standards gap analysis and begin reporting. • Flu vaccinations. • Black History Month (October). • Breast Cancer Awareness Month (October). • ADHD Awareness Month (October). • Stoptober (Stop smoking). • National Work:Life Week (6 to 12 October). • Dyslexia Awareness Week (6 to 13 October). • Backcare Awareness Week (14 to 20 October). • International Infection Prevention Control Week (19 to 25 October). • World Stroke Day (29 October). • Movember (Men's Health Awareness Month) and International Men's Day (19 November). • World Diabetes Day (14 November) • Anti-Bullying Week (18 to 22 November). • Carers' Rights Day (23 November) • International Day for the Elimination of Violence Against Women (23 November). • People ready actions. • Thrive Live 2026.

Trust strategic priority: Population and System - See patients sooner

Strategic risk description	
There is a risk that the Trust cannot achieve its strategic priority to see patients sooner due to: • Delay in Phase 3 Transformation programme resulting in sub optimal pathways and processes for planned and emergency care. • Emergency department capacity and workflow pressures resulting in increased waiting times and increased corridor care. • Lack of system resilience due to workforce and funding pressures in community/primary/social care • Lack of system capacity resulting in increased number of patients with No Criteria to Reside (NCtR) awaiting discharge • Higher demand due to local patient population profiles, with high level of frailty adding to the demand for ongoing support out of hospital (linking to above bullet). • Sustained operational pressures due to capacity and demand and potential for industrial action. • Increased demand in specific specialties, due to local and national health promotion campaigns and initiatives. • Insufficient workforce supply due to national and local workforce shortages in specific areas. • Lack of sufficient capacity and resources in diagnostic services pending full completion of CDC development programme. • Ageing estate and building. • Inadequate digital infrastructure. • Capacity (workforce and physical estate) constraints creating a reliance on high-cost outsourcing / insourcing to deliver elective activity within a restricted financial allocation. • Limits on ISP elective activity contracts due to System financial plan resulting in potential further increases in demand and reduced capacity system wide. • Inefficiencies and variation in systems and processes impacting the productivity of teams to deliver elective and non-elective pathways. • Lack of unified organisational culture and ownership of the objective. Resulting in possible harm to patients due to treatment delays, poor experience, impact on external relations, failure to deliver the trust /System transformation programme and failure to meet NHS constitutional performance standards. Long-term threat to service sustainability and regulatory breach (CQC).	**Lead Executive Director(s):** Chief Operating Officer **Date last reviewed: 25/09/26** **Strategic Objective** Consistently delivering timely, appropriate, accessible care as part of a wider integrated care system for our patients. **Breakthrough Objective:** 82% of patients admitted, transferred or discharged from ED within 4 hours 7% improvement in patients waiting 18 weeks or less for elective care (RTT standard) 80% of cancer patients treated within 62 days of referral **Linked Corporate Projects** Operational Flow Outpatients **Links to Internal Audit Plan 26/27** Optimising and valuing admin Booking systems

Current and Target Risk Ratings						
Severity (impact)	**Likelihood**	**Current Risk Rating**	**Target Risk Rating**			
			Q1	**Q2**	**Q3**	**Q4**
4	**2**	**12**	**16**	**8**	**12**	**16**

Risk category and risk appetite statement		
Risk Type and Category	**Risk appetite**	**Risk Tolerance**
Flow and capacity Partnership Working	Cautious Open	9-15 12-20

Key Controls (to manage risks related to goal)	**Key assurances** (effectiveness of controls)
Prevention Controls (parts of a system of internal controls designed to prevent a risk from occurring) • Patient Access policy, Transfer policy and Repatriation Policy • Trust Interprofessional standards • Discharge policies and procedures • Internal flow & FutureCare programme in partnership with the wider Dorset system • Planned Care Improvement programme • Outpatient Improvement Corporate Project • Workforce plans • Accountability framework including enhanced support • HR Policies and Procedures • Dorset ICB Working Better Together Strategy • Trust People and Culture Strategy • ICB and Trust activity contracts • Community Diagnostic Centre Programme of works • Vista Health Strategic Review of Dorset NHS Services	• Integrated Quality and Performance Report to the Trust Board (IPR) • Finance and Performance Committee deep dive reports • Care Group SDR reports • TMG SDR breakthrough objective reporting • Efficiency Improvement Programme report • Risk heat map • Elective activity reporting • Exec Enhanced support oversight • Community Diagnostic Centre programme reporting
Detection controls (those that provide an early warning of control failure) • Escalation process from Care Group SDR to Finance and Performance Committee • Finance and Performance Committee oversight of risks related to operational performance • Operational targets: 4hr safety standard, Referral to Treatment standard, elective waits to first activity target, Cancer waiting time standards and DM01 diagnostics standard • SWASFT handover times Monitoring • Internal COSMOS and Dorset Intelligence and Insights System (DiiS) reporting suite • Elective activity tracker (Trust and System) • Workforce reports • LERNS • Planned Care /Future Care Improvement Group highlight reports • Equality, Inclusion and Diversity System • Care Group SDR Reports • Waiting list validation • Weekly operational performance huddles • Improvement of trajectory and daily reporting providing early indication of risk / threat to delivery.	
Contingency controls that help prepare for an effective reaction in response to a control failure or overwhelming event. Designed to maintain resilience) • Waiting list initiatives	

• Trust Escalation process • Outsourcing/Insourcing • Elective Recovery and Cancer Funding • System wide UEC Weekly Improvement Group • Daily system overview and action with escalation to Exec / Senior Decision-making group (SRG) by exception / escalation. • Virtual Wards / SDEC capacity • DrDoctor Patient Engagement Portal • Community Diagnostic Centre Funding • Waiting list validation • Winter plan / Surge plan • Weekly Senior Huddle to review operational Metrics	

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
September 2026	2339 Transforming Care Together Programme – Delays to Phase 3 Delivery 1202 Medical Staffing Women's Health 1460 Inability to meet UEC 4 hour safety standard 1395 Lack of Capacity in Cellular Pathology 1665 School Age Neurodevelopmental Service 1697 Increased Waiting List for SACT Treatment 2310 Theatre Staffing

Date	**Update (Improvements, identified gaps in controls and/or assurances)** *(to be updated at least quarterly)*	**Actions to be taken next quarter** *(to be updated at least quarterly)*
Q1	**Cancer 62-day standard** – Recovery plans in place for the top 3 cancer pathways Additional non –recurring investment deployed Improvement in Backlog but number of patients waiting for 62 day treatment remains Engagement of Wessex cancer alliance for additional support	(1) Continuing Delivery of the cancer recovery actions to support pathway improvement focusing initially on clearing FDS waiting time backlog. Focus on 14 days first PT.s seen (Ongoing) (2) UHD cancer Group developing a delivery role in leading Trust strategic cancer (Established and meeting) (3) Wessex cancer continues to support through their improvement team (Ongoing) with a focus on the actions agreed for the top 3 plans (4) Finalise 2nd read dermatology through governance process
Q1	1. Horizon 1 Ways of Working agreed through the Future Care Programme (now within CVF) 2.Work with system partners on System Re-Design and Re-Commissioning including improvement trajectories	(1) Clarity/Delivery plan on the proposed UHD Operating Model (2) Better flow Better Care continued testing and embedding of change (3) NCRT reduction plan and ongoing work with partners (4) Early implementation of facilities and pathways
Q1	(1) Elective RTT – Operational planning trajectories for RTT 18 week performance and 52ww as a percentage of the total waiting list, have been met in M02, whilst total waiting list and DMO1 is forecasted to be off plan for Q1agreed. (2) Visibility of the elective priorities and plan for the Trust in	(1) Documentation of actions and timescales for DMO1 recovery at modality level to achieve operational plan trajectory. Sign off to be agreed at Planned Care Improvement Group. (2) Deliver action plan to reduce the total waiting list in line with the operational plan, including validation. (3) Bring forward ERF funding to

	2026/27 has been shared with TMG in May. (3) Delay in CDC Endoscopy build will impact on DMO1 recovery plan for Endoscopy and requires specific actions at modality level to be documented and timescales for recovery	increase capacity to meet the waiting list and DMO1 recovery actions (4) Revised timeline to deliver new Endoscopy Unit to be agreed by Move Ready Group and Planned Care Hospital Oversight Group. Implement mitigation plan in intervening period.
Q2	Elective RTT – (1) Operational planning trajectories for RTT 18 week performance, and the supporting measure of waiting list size and 52ww, have been met in month 5. Diagnostic performance (DM01) is above plan. Two key contributing factors are: • Echocardiology: Capacity and higher referrals than planned • Endoscopy: Capacity following a delay to the opening of the new CDC Endoscopy Unit at Poole Hospital and staff sickness and booking team vacancies. Imaging and physiological measurement both exceeding the internal target. Visibility of the diagnostic recovery plan for Trust in 2026/27 has been shared with Finance and Performance Committee in Q2.	1. Additional Echo insourcing has been secured to align performance to the Trust's trajectory by October 2026. 2. The new CDC Endoscopy Unit is scheduled to become operational in October 2026 and the booking team have returned to capacity in August. Continuation of insourcing will support recovery in Q3. 3. Deliver focus on 1st OPA in November
	Cancer 62 Day RTT: • Delays at the diagnostic phase of the pathway impacting performance. • Capacity within Interventional Radiology and Theatres contributing to breaches • Increase in demand for treatments above expected growth levels. Cancer 28 Day FDS: • Progress - fast tack backlogs eliminated • Challenge to balance elective activity demand with cancer capacity • Investment into Histopathology to improve reporting and turnaround times. Now the most significant contributor to breaches • Improvements being realised in informing patients quickly if cancer has been ruled out. Cancer over 62D backlog: • Month on month reduction over 62D position	Lung Cancer Pathway Mapping event completed with a clear improvement action plan – to now be rolled out to all major tumour sites. Moving to Exec led weekly PTL meetings from Q3. Revising recovery trajectories Gynecology enhanced support process. Continuation of insourcing and outsourcing for Skin throughout Q3 & Q4. Additional funding agreed for diagnostic services Continued collaboration with the Wessex Cancer Alliance on Pathway Improvements The Breast Pain pathway launched in July 26 and is fully operational which streamlines the demand for fast track referrals and protects one stop capacity – ongoing monitoring throughout Q3 to measure the impact and benefits.
	UEC 4 hour standard delivery • ED crowding and exit block – constrained bed availability and rising NCtR numbers mean majors cubicles are frequently full, limiting space to	PDSA of additional RBH ACA senior decision maker in ED. Review of daily operational rhythm to support enhanced early flow.

	offload ambulance crews. Admitted flow – constrained by bed availability, attributing factor is partial reconfiguration of bed model. • Demand - afternoon and evening demand is exceeding operational capacity with breaches peaking out of hours. Predominant at RBH where exacerbated by mismatch of demand and outward flow. • Process and visibility – handover and cohorting practice varies between sites, escalation is triggered late, and ambulance arrivals are not visible in real time on the ED system. • Increasing number of NCRT patients • Winter plan requirement to address increasing demand • 12 hours in the emergency department	Developing revised medical rota's to align to site demand and support the casemix and decision making Cross-site review of the handover process and staffing incl. RBH two-holding bay model. I.e. pitstop model from Poole. NCtR delivery plan for winter and hospital moves Delivery Plan for Phase 3 moves Development of the winter plan
Q2	Projected Target risk rating achieved for Q2 • UEC delivery achieved - improving 12 hours • RTT target trajecory achieved • Cancer Improved • DMO1 Improved	Imbed improvements but recognising slippage possible in q3 but mitigations being taken

Trust strategic priority: Quality Outcomes and Safety - Saves lives, improve patient safety

Strategic risk description

There is a risk that the Trust cannot achieve its strategic priority to avoid patient harm and improve patient safety due to:

- Increased demand due to the impact of deprivation, multi-morbidity and an ageing population
- Increased demand – unplanned care, emergency department attendances, impacting on patient safety and increased use of corridor care.
- Ageing estate and building/digital infrastructure deficiencies impacting on patient safety.
- Insufficient workforce due to availability impacting on patient care and patient safety.
- Lack of system capacity resulting in increased number of patients with NCtR awaiting discharge and at risk of deconditioning and higher mortality.
- Insufficient system and Trust provision for patients with a mental health disorder
- Staff fatigue due to increased demand resulting in increased risk to patient and staff safety.
- Gaps in fundamental standards of care.
- Uncertainty around impact of abolishment of NHS England and changes to ICBs
- Inadequate business continuity arrangements in the event of unavailability of IT systems
- Inadequate IT systems
- Delays in completion of the Transforming Care Together programme (Phase 3 and 4 moves) resulting in suboptimal patient pathways.

Resulting in potential harm to patients, impact on outcomes, experience and quality of care, impact on regulatory breaches.

Lead Executive Director(s):
Chief Nursing Officer, Chief Medical Officer

Date last reviewed: 24/09/26

Strategic objective:
To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios – HSMR) and patient safety (Patient Safety Incidents - PSIs).

Breakthrough objectives:

- 95% compliance with VTE risk assessment and prescribing within 24 hours
- 20% reduction in hospital-acquired E. coli infections
- Improved ICE filing and sign-off rates, reviewed monthly

Linked Corporate Projects
Healthset

Links to Internal Audit Plan 26/27
Estates compliance
Learning from deaths
Consultant job planning
ICE programme
IPC
Consent

Current and Target Risk Ratings

Severity (impact)	Likelihood	Current Risk Rating	Target Risk Rating			
			Q1	Q2	Q3	Q4
4	3	12	12	12	9	9

Risk category and risk appetite statement

Risk Type and Category	Risk appetite	Risk Tolerance
Patient Safety	Averse	4-6
Patient Outcomes	Minimal	6-10
Infection Prevention and Control	Averse	4-6
Medicines Management	Averse	4-6

Key Controls (to manage risks related to goal)	**Key assurances** (effectiveness of controls)
Prevention Controls (parts of a system of internal controls designed to prevent a risk from occurring) • Risk Management Strategy • Annual Clinical Audit Plan • Patient First Quality Priorities • Fundamentals of Care Standards • Interprofessional Standards • Capital and Estates Plan • Clinical Strategy • Clinical Policies and Procedures • CQC Action Plans • Clinical Accreditation standards • NICE • Digital Strategy • Quality Governance Framework • Accountability Framework • Transforming Care Together Governance and Programme controls	• National Patient Survey • National Audit results to CAEG, CGG, QC and Audit committee • Local Audit results to CAEG, CGG, QC and Audit Committee • LERN Reports to CGG and QC • CQC inspection reports • Integrated performance report to QC and Board • NICE compliance reports to CGG and QC • Internal Audit Reports • External Inspection reports • ICB Quality Audits • Care groups SDR reporting. • CGG report to TMG and QC • Annual Governance Statement • Annual Quality Account • Annual Infection Prevention and Control Report • Annual Safeguarding Report • GIRFT reports • QIA reports • Ward to Board reporting on quality metrics • Mental Health Corporate Project updates to TMG SDR, CCG and QC • Programme Reports, Build Contractor Reports
Detection controls (those that provide an early warning of control failure) • LERNS • Learning from death reviews • CQC reports • Clinical audit reports • IPR Quality metrics, Ward Quality dashboards • Reports to CGG and Quality Committee • External review reports • Reporting to Transforming Care Together Group, Build, Service, Move and People Ready Groups & sub-groups	
Contingency controls that help prepare for an effective reaction in response to a control failure or overwhelming event. Designed to maintain resilience) • CQC Action plans • PSII Action plans • Clinical Audit action plans, Actions from complaints, claims, LERNS, Inquests • Actions from Service Ready escalation Reports, escalations from SRG/BRG/MRG, PRG into TMG	

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
30 Sept 26	2310 Emergency Theatre staffing supporting a second theatre out of hours 2262 Insufficient capacity and lack of specialist staffing and environment for respiratory high care 15 patients and safety impact 1974 Significant time delays for macular injection treatment 2052 Care of patients in non-clinical/corridor areas in the Emergency Department 1855 Breast radiologist provision 2302 Accuracy of clinical coding 1460 UEC 4 hour standard 1397 Provision of 24/7 Haematology/ Transfusion Laboratory Service

	2229 Obstetric ultrasound scanning service 1202 Medical staffing women's health 1697 Increased waiting list for SACT treatment 2350 RBH ED waiting room 1950 The Trust EPR will be unsupported from April 2027 2362 Holding Ward Pathway: Patients Excluded from Inpatient Governance Processes

Date	**Update (improvement, Identified gaps in controls and/or assurances)** *(to be updated at least quarterly)*	**Actions to be taken next quarter** *(to be updated at least quarterly)*
Q1	Progress against 25/26 priorities and PSIRF plan included in Quality Account report 25/26	New PSIRF priorities to be set out in PSIRF \plan. Establish new Pressure Ulcer steering group and QI programme Review PSII VTE Thematic review report and agree action plan Continue to implement WHO checklist project Report on review of LfD policy (audit and BDO reports) at MSG
Q1	New PSIRF Plan approved VTE Thematic review presented to PSIRF Oversight and action plan agreed New Audit Management System (AMaT) is now in place, Annual Audit plan approved, Audit report 25/25 approved. Harm review tool for ED waits in pilot Review of eDischarge summary breaches – project group in place and thematic review in progress. Gaps being addressed by Care Groups. Annual Safeguarding Report, Annual IPC Report and Annual Patient Experience Report completed New ToR agree for PSIRF Oversight to enhance monitoring of PSIRF principles	Develop wider Harm Review SOP Clear eDS backlog and implement new SOP Develop SOP for ED waits and Corridor care breaches Implement actions from Learning from Deaths Audit. Implement new Oversight model from 1 July 26
Q2	CQC inspection of surgical core service in July 26 identified gaps in regulatory compliance and patient safety. BDO Audit of IPC identified gaps in staff awareness of infection control policies and procedures. New Sepsis Nurse appointed and Sepsis Group to be established (reporting into the Deteriorating Patient Group)	Roll out of update Quality Governance Toolkit Implementation of CQC action plan for Surgery Implement actions from BDO audits (infection control, learning from deaths) Update Learning from Deaths policy Implement SOP for Harm Reviews Prepare for likely CQC inspections in Emergency and Acute Medicine Q3)

	Pilot of harm review tool for ED 24 hour breaches and corridor care breaches PSIIs completed for Ophthalmology never events, actions plans identified and in progress. Monitoring via Care Group and PSIRF Oversight.	Continue roll out of AMaT including ward assurance module audits for infection control, window checks and pressure ulcer skin bundle compliance Review of Sepsis policy and completion of baseline Sepsis audit.

Trust strategic priority: Sustainable Services - Use every pound wisely

Strategic risk description

There is a risk that the Trust cannot achieve its strategic priority to return to financial surplus by 2028/29, due to:

- Delay in Phase 3 Transformation programme resulting in sub optimal pathways and processes for planned and emergency care.
- Minimal growth funding within local allocations;
- Inadequate Cost Improvement Programmes
- Inflation funding below cost of inflation;
- Inability to achieve efficiency requirements due to sustained operational pressures;
- Ageing population, deprivation, morbidity and health inequalities;
- ICS budget position and poor system financial performance;
- Political and economic framework, legislation and regulatory changes;

This has the potential to result in a failure to deliver a balanced financial plan including recurrent savings targets, possible harm to patients, poor experience, and a long-term threat to service sustainability.

Lead Executive Director(s):
Chief Finance Officer

Date last reviewed: 30/09/26

Strategic Objective:
To maximise value for money enabling further investment and sustainability in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.

Breakthrough objectives:

- A favourable forecast outturn variance to budget
- 60% of EIP savings delivered recurrently

Links to Internal Audit Plan 26/27
Care Group financial governance
Key Financial Systems:
Research Finance
Stock Management
Maternity Incentive Scheme
Optimising and Valuing
Admin
Consultant Job Planning

Current and Target Risk Ratings

Severity (impact)	Likelihood	Current Risk Rating	Target Risk Rating			
			Q1	Q2	Q3	Q4
5	3	15	15	15	12	12

Risk category and risk appetite statement

Risk Type and Category	Risk appetite	Risk Tolerance
Financial Management	Cautious	9-15
Information Governance	Minimal	6-10
Medical Equipment	Cautious	9-15
Physical Assets	Cautious	9-15
Information Technology	Open	12-20

Key Controls (to manage risks related to goal)	**Key assurances** (effectiveness of controls)
Prevention Controls (parts of a system of internal controls designed to prevent a risk from occurring) • Budgets developed with directorate teams, formally accepted at Care Group level and fully devolved to named budget holders. • Dedicated financial support in place including additional variance analysis and reporting. • Scheme of delegation, Standing Financial Instructions, and other finance policies and procedures in place. • Monthly reporting to Trust Management Group, Finance and Performance Committee and Board highlighting risks and mitigating actions. • Patient First 'driver' and 'watch' metrics agreed and monitored monthly. • Alignment of approved nursing templates, e-roster templates, and budgeted establishment. • Enhanced vacancy and non pay controls implemented to support financial recovery. • Financial planning with system partners • Efficiency Improvement Programme in place with oversight by Finance and Performance Committee. • QIA policy and process in place	• Integrated Performance Report • Detailed monthly finance report • Annual Report and Accounts • Board approved Operational Plan • Trust annual governance statement • Efficiency Improvement Programme Reports • External auditors reports • Internal audit programme and reports • Oversight by Sustainable Services Group, Trust Management Group, Finance and Performance Committee and Trust Board.
Detection controls (those that provide an early warning of control failure) • Monthly finance reporting • Weekly Efficiency Improvement Programme reporting • Care Groups Strategic Deployment Review meetings • Sustainable Services Group meetings	
Contingency controls (those that help prepare for an effective reaction in response to a control failure or overwhelming event. Designed to maintain resilience) • Strengthened expenditure controls e.g. vacancy management processes. • Enhanced financial forecasting (monthly from Month 2).	

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
30 September 2026	2339 TCT Programme- Delays to Phase 3 Delivery 2302 Accuracy of Clinical Coding 1595 Medium Term Financial Sustainability 1950 The Trust EPR will be unsupported from April 2027

Date	**Update (Improvement, Identified gaps in controls and/or assurances)** *(to be updated at least quarterly)*	**Actions to be taken next quarter** *(to be updated at least quarterly)*
Q1	Internal audit has identified the need for improved internal reporting of drugs spend and a strengthened budgetary mechanism	High cost drugs. Enhanced spend reporting by specialty distributed by chief pharmacist to be in place by M3, enhanced budget approach to be embedded by Q2

	Workforce controls scoping work completed across multiple dimensions, including for enhanced VRP (Vacancy Recruitment Panel) approach, consistency across the Trust for Recruitment and Retention premia, and overtime / additional hours payments Medical Staffing Patient First project underway – medical job planning achieved in 100% of specialties, with over 6000 additional clinic slots identified Delivered 2025/26 full year position in line with forecast revenue and capital positions including actions agreed within the H2 recovery trajectory	Enhanced VRP approach for 26/27 agreed and implemented Consistent approach agreed across the Trust for Recruitment and Retention premia, and overtime / additional hours utilization, reducing spend where appropriate Job planning monitoring through MSTEG to ensure ongoing compliance with >95% job plans in place, clinic standardization reports into MSTEG and GIRFT groups 2026/27 revenue forecasting process to be undertaken alongside M2 reporting checkpoint, identification of risks and mitigations to delivery of the revenue position
Q2	High cost drugs. Drugs spend reporting at Trust and Care Group level now in place, and enhanced budget approach also completed. 2026/27 revenue forecasting process underway following M2 process and updated monthly from that checkpoint with risks and mitigations tracked monthly through the remainder of the year. Grip and Control checklist reviewed with additional actions identified from the rapid actions list. Job planning ongoing monitoring through MSTEG to ensure ongoing compliance with >95% job plans in place, clinic standardization reports into MSTEG and GIRFT groups. Review of recruitment and retention premia completed with these payments removed where appropriate. Overtime and additional hours fully reviewed with findings shared with services highlighting opportunities to reduce including replacing with substantive resource where appropriate and more cost effective.	Workforce grip and control actions to be closed down in relation to the programme agreed following the prior year review of the checklist. Review of additional lists (to include the procurement checklist leveraging the opportunity as One Dorset Procurement Service goes live) within the wider grip and control checklist to be completed with further actions agreed as appropriate. Rapid actions items to be closed down including no PO no pay policy implementation. Internal audit to be completed on key financial systems including review of VRP effectiveness, forecasting process and discretionary spend controls. Demand and capacity planning process to be refined alongside operational planning for 2027/28 enabling triangulation of Care Group budget setting outcomes to planned service changes and performance delivery in the plan year. Budget setting process for 27/28 to be completed as a key checkpoint enabling development of a robust operational plan for 27/28 with expected submission of draft operational plan to NHS England in December 2026.

Trust strategic priority/initiative: Transforming Care Together

Strategic risk description	
There is a risk that delays and interdependencies across the Transforming Care Together (TCT) programme (Build Ready, Reconfiguration/Service Ready and People Ready) result in a prolonged partial reconfiguration and impact delivery of Phase 3 of the planned and emergency care model. Delays compound operational pressures, patient flow, performance and safety. Delays impact of the delivery of programme benefits, increase costs and delay the overall reconfiguration benefits. Delays also create suboptimal clinical pathways and processes, increase pressure on staff and impact on morale, wellbeing and staff retention.	**Lead Executive Director(s):** Chief Strategy and Transformation Officer **Date last reviewed: 28/09/26** **Strategic Objective:** Separation of planned and emergency care - seamless, safe moves of services and patients into new configurations Workforce retained and service staff integrated to safely deliver services NHP and BEACH buildings delivered and space effectively utilized Benefits delivered (financial, clinical) **Breakthrough objectives:** To achieve Phase 3 separation of planned and emergency services. Measures to track this: • Number of critical path actions completed and off track • Number Service Reviews completed and rating including Go/No-Go list criteria • Number of workforce plans & consultations completed • Number of Gateway reviews completed and rating • Quality & Financial benefits as per FBCs • Delivery of build programmes on time and to budget • Number of completed service moves **Links to Internal Audit Plan 26/27**

Current and Target Risk Ratings						
Severity (impact)	**Likelihood**	**Current Risk Rating**	**Target Risk Rating**			
			Q1	**Q2**	**Q3**	**Q4**
4	**4**	**16**	**20**	**16**	**16**	**12**

Risk category and risk appetite statement		
Risk Type and Category	**Risk appetite**	**Risk Tolerance**
Flow and Capacity	Cautious	9-15
Partnership Working	Open	12-20
Financial Management	Minimal	6-10
Physical Assets	Cautious	9-15

Key Controls (to manage risks related to goal)	**Key assurances** (effectiveness of controls)
Prevention Controls (parts of a system of internal controls designed to prevent a risk from occurring) • Specialty level plans in place • Meeting structure, attendance, escalation and resolution from specialty steering groups into CG Transformation Steering Groups and then Service Ready Group (SRG) • Service Reviews and Gateway Reviews to assess readiness for moves with actions followed up by Care Groups • Robust critical path timeline that clearly articulates deliverables and interdependencies between specific deliverables • Good and effective management of individual programmes (Beach, NHP, Decants, Clinical Integration, Space) • Focus on Critical Path actions	• Monthly Meetings (RRG/BRG/PRG/MRG) that reviews and escalates any barrier and delays • Risks are on the agenda and reviewed on a quarterly basis • Gateway Reviews (inc. Go/No go process) and Service Reviews to ensure readiness • Detailed programme timeline is updated and any variance or off track issues are highlighted to BRG/RRG • Ongoing Internal Audit Reviews of Reconfiguration Programme • NHP National Team Readiness Assessment and Oversight
Detection controls (those that provide an early warning of control failure) • Monthly highlight reporting • Weekly Programme Review meetings with Contractors • Gateway Review Meetings • Care Groups Strategic Deployment Review meetings	
Contingency controls (those that help prepare for an effective reaction in response to a control failure or overwhelming event. Designed to maintain resilience) • Strengthened gateway review processes. • Enhanced reporting to ensure all critical path actions align.	

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
28 September 2026	2339 TCT Programme- Delays to Phase 3 Delivery

Date	Update (Improvement, Identified gaps in controls and/or assurances) *(to be updated at least quarterly)*	Actions to be taken next quarter *(to be updated at least quarterly)*
Q1	COAST build confidence rebuilding programme (micros milestone tracker and KPIs	NHP and delivery assurance review to complete.
Q1	Impact on Poole / Phase 4 programme	QS costings and options to mitigate to TCT
Q1	UEC readiness for Moves over winter months	System undertaking winter plan 26/7 readiness assessment and workshop early July with move option.
Q1	"Tricky issues" list being progressed	Reconfiguration Group oversight and tracking
Q1	Build Ready: the COAST delay has been confirmed, meaning Phase 3 moves will not take place in December. Darwin is being engaged to confirm confidence in the handover timeline. Alternative non-COAST move options are being explored, with the earliest planned move date now April 2027.	Ongoing scrutiny of COAST programme plan
	Service ready - the non-coast option is being developed with Care Groups, and the mock move week planning continues to test logistical aspects of the move (transfer routes, conveyances, teams and roles involved in the physical move). Unresolved issues still being tracked through relevant group	New clinical model (without COAST) option agreed at TMG on 25/6/26 - Clinical Vision of Flow to progress to support this as well as Care Groups Mock Move Week to be completed to understand impact on sequencing 3 unresolved issues continue to be progressed
	People Ready - good progress has been made on the workforce plans and consultations. Completion of the roster remains at risk, and the Workforce Systems Team is currently working through mitigations for this.	Finalise o/s workforce plans and maintain momentum with consultations.
Q2	Build Ready : AMU and OPAU remain on track for December 9th-14th, Endoscopy move rescheduled to the 5th October, Coast building has had further delays with an expected build handover in May/June and a potentially clinically live date of October. However the confidence in the build programme remains low.	Ongoing scrutiny of COAST programme plan and readiness for clinical commissioning to AMU/OPAU to ensure clinically live date is achieved for mid December
	Service Ready : A bed capacity delivery plan is in place and a readiness review scheduled for October. Developing a ward based move sequence plan is underway and is a critical path item for Phase 3 moves.	October review of the Bed capacity delivery plan to achieve an April move date without the COAST
	People Ready : This workstream requires renewed focus. If allowed to drift any further from agreed timelines, it **will** affect the critical path for an April move. A significant amount of work remains outstanding and consultations may need to be reviewed in	Finalise o/s workforce plans, review consultations in light of the bed capacity delivery plan, and maintain momentum with consultations.

	light of the bed capacity delivery plan and Phase 3 move sequencing. The timeline, given that there are fixed timings required for consultation and issuing of rosters is extremely tight.	

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: 6.2

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Risk Report – As at 02 November 2026
Prepared by:	Jo Sims – Associate Director Quality Governance and Risk
Presented by:	Sarah Herbert, Chief Nursing Officer
Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☐ Patient Experience ☐ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	This report.
Purpose of paper:	Assurance
Executive summary:	The report is provided in accordance with the UHD Risk Management Strategy. To provide details of the risks rated 15 and above on the UHD NHS Foundation Trust risk register.
ALERT:	Since the previous report (1 September 2026) 2 new corporate risk (risks rated 15-25) have been added to the risk register. **2362** Holding Ward Pathway: Patients Excluded from Inpatient Governance Processes - rated 16 **2368** Risk of patient harm due to delay in commencing first definitive cancer treatment beyond the 62-day referral-to-treatment standard – rated 15 Since the previous report (1 September 2026) the rating for 1 risk has increased from 15 to 20 **1053** Inability to Reduce Medically Ready for Discharge (MRFD) Bed Occupancy to Safe Reconfiguration Threshold – rated 20
ASSURE:	There has been a reduction in 2 previously high-scoring corporate risks: **1950** The Trust Electronic Patient Record (EPR) will be unsupported from April 2027 - has reduced from 15 to 8

	1397 Provision of 24/7 Haematology/ Transfusion Laboratory Service -has reduced from 15 to 10
ADVISE:	There are currently 206 approved risks on the Trust Risk Register, of which 18 are rated 15 or above. Of the 18 risks rated 15 or above, 11 remain outside the Trust's agreed risk tolerance, predominantly within urgent and emergency care, and service capacity.
Celebrating Outstanding:	Since the previous report (1 September 2026) the total number of approved risks on the Trust Risk Register has reduced to 206 from 210.
RECOMMENDATION:	The Board is asked to note the contents of the report.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Assessment Framework:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well-Led ☒ Use of Resources ☒

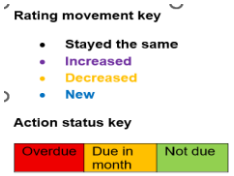
Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Risk Oversight Committee	29/10/2026	The Committee discussed and updated the risks and actions.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

Risk Register Report

Risk Register 02/11/2026

SUMMARY

The report details current (approved) risks rated 15-25. A risk rating is undertaken using an NHS standard five by five matrix according to their severity consequence and likelihood, as per the Trust's Risk Management Strategy and Risk Assessment Toolkit.



There are 206 approved risks on UHDs Risk register, of which 18 are rated as 15 and above.

Risk type – Our People Risk Category – Knowledge and Skills Appetite = Cautious Tolerance = 9-15	
Risk ID	2229
Risk Title	Obstetric Ultrasound Scanning Service
Date risk raised on the risk register	03/07/2025
Date risk approved as 15+ risk	29/09/2025
Risk Rating	15
Risk Description	If we do not improve our numbers of staff competent in delivering obstetric ultrasound imaging, we risk missing essential screening windows for our obstetric patients, delaying fetal diagnosis and treatment, impacting trust funding from MIS (maternity incentive scheme), as well as increasing rates of repetitive strain injury (RSI) in our staff.
Executive sponsor	Interim Chief People Officer
Controls in place	• Scan tracker in place to log and monitor workflow • General ultrasound examinations being conducted by outsourcing company (they do not offer obstetric services) • Substantive staff being offered bank shifts and Wait List Initiative (WLI) at weekends to increase capacity • Prioritisation of those areas measured for Maternity Incentive Scheme (MIS) audits. • Radiology management team in discussion with radiologists to look at supporting enhanced practice for sonographers to help with staff retention long term • Longer term planning completed to identify when staff/students that are currently undergoing Obstetrics training will be available to commence scanning services from Summer 2026
Gaps in controls	• Agency rate cap has meant we are unable to use agency to mitigate the risk • Limited numbers of substantive staff with obstetric competencies mean there is little appetite for more sessions in obstetrics. • Plans in place to upskill staff already in post will add limited capacity over next three months; quote requested from external insourcing company to see if the staffing issues could be addressed using them in the short term. • Prioritisation of those areas measured for MIS audit may reduce risk of losing this funding but will not necessarily help most urgent patients and so will not mitigate risk of loss of reputation

Action plan(s)	**Action**	**Due date**
	Insourcing support for obstetrics	Completed
	Align Preceptorship SOP	Completed
	Sonographer enhanced practice.	20/11/2026
	Upskilling of substantive staff	30/01/2027
Tolerance breach?	No	
Target risk rating	6	
Progress update	Interviewed and appointed 2 staff into student sonographers post last week . For update of start date and impact on the service to be discussed at RQSM 22/10/26	

Risk type – Our People **Risk Category – Workforce Capacity** **Appetite = Cautious** **Tolerance = 9-15**	
Risk ID	1855
Risk Title	DBSU Capacity and Demand for screening and assessment
Date risk raised on the risk register	23/02/2023
Date risk approved as 15+ risk	21/11/2024
Risk Rating	15 ⟷
Risk Description	If we do not increase the number of breast radiologists we will be unable to sustain the demands of the service.
Executive sponsor	Interim Chief People Officer
Controls in place	• Review of Incidents and complaints reported • Weekly planning meeting to discuss previous week and week going forward • Meticulous rota planning • Robust and ongoing Recruitment/retention processes • Creation of new post to support consultant radiographers and promote succession planning • Review of pressures in both clinic pathways to ensure priorities are addressed • Weekend working and extra clinic in RBH • Waiting list to record backlog • Staff in post spreadsheet to document staff in post. • Staff supporting HSU training in own time to maximise future opportunities for joint working and new staff joining the service • Staff working as single practitioner in clinics where two are required
Gaps in controls	• Lack of radiology capacity to sustain service. • Lack of suitable applicant for both substantive and locum positions - 2 WTE breast radiologists for which service is funded have not been filled, nor has the WTE consultant radiographer post. • Reliance on staff who are already working extra shifts • Radiologist on call rota and time off in lieu reduces available staff for sessions • Inability to provide legislative axilla scanning of Melanoma patients

Action plan(s)	**Action**	**Due date**
	Increase Radiology capacity DBSU	Completed
	Reduce Symptomatic Patient Backlog (Jigsaw/LBU)	Completed
	Review of radiology on call rota	Completed
	Update Risk weekly with numbers of cancelled clinics/slots/uncovered	Completed
	Completion of monthly data summary report	Completed
	Review SBARN and create a business case	Completed
	Implement a monthly Quality and Safety Meeting	Completed
	Develop and embed monitoring matrix	09/11/2026
	Monthly Review of Mitigating Actions already in place	30/11/2026
Tolerance breach?	No	
Target risk rating	2	
Progress update	Discussed with Head of Imaging, following discussion at RQSM. Team requesting potential increase to return of rating of 20,due to vacancies and added issues related to air con. Not agreed currently as agreement reached for LOCUM Breast radiologist, one substantive breast radiology and two Mammographer posts. Air con escalated via Care Group and awaiting feedback from last weeks meeting from DD OPS. The impact for patients and staff in the unit is significant. To continue to review through DBSU governance meeting and update following outcome of estates escalation meeting.	

Risk type – Our People **Risk Category – Workforce Capacity** **Appetite = Cautious** **Tolerance = 9-15**	
Risk ID	1202
Risk Title	Medical Staffing Women's Health
Date risk raised on the risk register	20/07/2017
Date risk approved as 15+ risk	29/07/2026
Risk Rating	15 
Risk Description	If the Obstetrics Medical staffing rota remains understaffed then patients will not be treated within the required timeframe, both in the elective and emergency setting. The service will be impacted by a delay in responding to the Labour Ward and being able to carry out elective C-sections as well as affecting elective list cancellation due to medical staff being required to move to cover non-elective services. A prolonged short staffed working environment will impact on the remaining medical staff as they continue to sustain their increased workload. A delay in responding to the labour ward could have significant and serious effects on the safety of the patients, with potential for clinical signs not being spotted and dealt with in an appropriate time.
Executive sponsor	Interim Chief People Officer
Controls in place	• Safe staffing standards • Rota management • Locum shifts procedures • 2WW compliance • RTT compliance

	• Theatre utilization standards • LMNS • CQC,RCOG standards • Senior clinical and ops manager oversight of roster management • Weekly review meeting for Gaps in obstetric rosters take place- senior decision making on prioritisation of activity across Obstetrics and Gynaecology where there are gaps.
Gaps in controls	• New trainee rotation gaps- within the first 4 months, 4 are leaving our rota • 1 unfilled clinical fellow post • Any unfilled shifts (including locum) are requiring Obstetric consultants to act down as resident, leaving a backfill gap for the Consultant on call
Action plan(s)	

Action	Due date
Close management of patient pathways.	Completed
Substantive workforce are covering rota gaps.	Completed
Patient long waiters booked to protected theatre lists.	Completed
Utilise weekly afternoon elective c-section lists.	Completed
Locum recruitment.	Completed
Theatre sessions booked after staffing confirmed when possible.	Completed
Business case to increase Obstetric Registrar Grade Staffing	Completed
Business plan to increase number of Obs & Gynae Consultants	Completed
work towards 2 handovers at weekends with ward rounds	Completed
MIS actions	Completed
Approval and implementation of the 2 tier on-call rota	Completed
Recruitment of Obstetric Registrars	Completed
Recruitment of Obstetric and Gynaecology Consultants	Completed
Create JD for substantive Obs Cons 1x wte and put out to advert	Completed
Management of middle grade rota	Completed
Locum Middle Grade Employment	Completed
Appoint Consultant Obstetrician into post	Completed
Recruit 2 specialist grade doctors into substantive posts	18/12/2026
Recruit replacement of Obstetric fetal medicine Consultant	29/01/2027

Tolerance breach?	No
Target risk rating	6
Progress update	Risk reviewed and updated with GM for Women and children: Grading to remain the same. New rotation of doctors in training has increased our numbers in out T1 & T2 roster, but there are still some gaps remaining. Senior clinical and ops manager oversight of roster management, to mitigate risk. There is a new gap in Obstetric fetal medicine consultant post (1wte) following resignation. Specialist work reallocated within existing fetal medicine team and locum obstetric job out to advert. This is in addition to the substantive obstetric fetal medicine post which is out to advert.

Risk Type - Population & System **Risk Category - Flow and Capacity**	**Appetite = Cautious** **Tolerance = 9-15**
Risk ID	1053
Risk Title	Inability to Reduce Medically Ready for Discharge (MRFD) Bed Occupancy to Safe Reconfiguration Threshold
Date risk raised on the risk register	29/01/2015

Date risk approved as 15+ risk	31/03/2026
Risk Rating	**20**
Risk Description	There is a risk that patients occupy acute beds for longer than clinically necessary, driven by both internal (Trust-controlled) and external (system-wide) factors. This increases the risk of patient deconditioning, hospital-acquired harm, reduced flow and capacity for new admissions, and elective/ED pressure.
Executive sponsor	Chief Operating Officer - Mark Mould
Controls in place	UHD controls • Admitted Flow Programme. • Horizon 1/FutureCare transformation programme and sustainability arrangements through programme closure. • Continued focus on admission avoidance/criteria and appropriate use of acute beds. • Pathway 0 discharge improvement. • Strengthened board-round and ward discharge practice. • Model Ward Discharge Standard and ward-level accountability. • Routine identification and review of NCTR patients and reasons for delay. • Executive oversight of NCTR performance and delivery.
Gaps in controls	There is currently no fully funded and quantified system demand and capacity plan capable of demonstrating delivery of the 110 NCTR operating threshold. Commissioned pathway capacity remains insufficient, with outstanding gaps in intermediate care, CHC/end-of-life provision and support for patients who fall outside existing eligibility thresholds. Discharge to Assess is not yet fully operationalised and required improvements in Adult Social Care responsiveness and ICB commissioning decisions remain outstanding. Internally, further improvement is required in admission criteria, Pathway 0, board-round practice and the sustainability of transformation gains. UHD has limited direct control over several of the external dependencies and therefore cannot currently provide assurance that the overall reduction trajectory will be delivered.
Action plan(s)	

Action	Due date
24/7 consistent referral and use of criteria to admit	30/11/2026
Upload Trust action plan in relation to discharge.	30/11/2026
Review P1 pathway and decommissioning	01/12/2026
Outline the Care Group process and effectiveness of Long Length of Stay reviews.	11/12/2026
Full rollout of board blueprint across UHD	30/12/2026
First 72 hr discharge planning as a contributor to reducing the number of patient with LLOS who go on to become NCTR	31/12/2026
Optica Mobilisation	31/12/2026
Complete hospital-based readiness actions within 48 hours	29/01/2027

Tolerance breach?	Yes
Target Risk Rating	9
Progress update	Risk increase to 20 approved at Risk Oversight Committee 29/10/2026 NCTR remains a key organisational priority with ongoing Executive oversight. Work is progressing to strengthen the understanding of Care Group-level performance and to assess the effectiveness and consistency of current discharge processes and interventions. A consolidated action plan is being established to address identified internal control gaps, including ward and board round practice, training and education, and consistent use of EDR. In parallel, clinical oversight and accountability arrangements are being reviewed to ensure improvements are fully embedded into operational practice and deliver sustainable change

Risk Type - Population & System Risk Category - Flow and Capacity	Appetite = Cautious Tolerance = 9-15
Risk ID	1460
Risk Title	Inability to meet UEC 4-hour safety standard leading to an adverse impact on patient safety and quality in the ED
Date risk raised on the risk register	05/02/2021
Date risk approved as 15+ risk	22/02/2021
Risk Rating	16 
Risk Description	There is a potential risk of harm and impact on quality of care to patients waiting in excess of 4 hours in ED and being cared for in an inappropriate setting.
Executive sponsor	Chief Operating Officer
Controls in place	Compliance with National 4 hr performance Standard • Performance review against metrics • Daily breach validation • Efficient patient pathways and streaming process to SDEC's and UTC • Patient safety checklist in place • TAD Process • Trust and ED Escalation plans/SOPs • Avoidable lost time and patient delay • IPS optimisation • All elements of initial assessment: TTT, TT first clinician and TT decision are all within 3 hrs of arrival • Diagnostic reporting standards (blood tests/x-ray and CT) • Surge Management' criteria and plan • External transfers procedures compliant with patient category • Implementation of 4 and 12 hour escalation process and UHD ambulance divert policy. • 4 hour performance metrics linked to ED escalation • Corridor SOP • Escalation email/text process along with ED shift report template improvement
Gaps in controls	Gaps in assurance for sustainable delivery of 4-hour standard • SDEC pathways not in place 12 hours a day 7 days a week across all services. • Revised Escalation processes (ED and wider organisation) not yet embedded. • Gaps in recruitment remain a key challenge. • Capacity across the organisation to respond to the issues and take necessary action, including change management capacity. • UEC growth, MRTL numbers and industrial action could expose the Trust to reduced patient flow and performance • Type 3 data from MIU and UTC remains a manual process needs to be automated for new standards • Executive Enhanced support meeting has been put in place for the emergency department (Chief Medical Officer/Chief Nursing Officer & Chief Operating Officer). • ED Action plan to be reviewed and recast to reduce to a smaller number of actions over 30/60/90 days.

	• Clinical Engagement on supporting the Trust 4hour safety standard and further work on ensuring the Interprofessional standards are being followed. • Revised structure, focus and workplan for the Improving Hospital Flow Group developed for TMG review on 12th September. • IT ED System: Review of the operational configuration to ensure it supports the operational flow. • Staff compliance with ongoing observations and completion of SHINE assessments due to capacity constraints within the department
Action plan(s)	

Action	Due date
System Exec meeting to review pressures, agree action and implementation plans	Completed
Revise and implement ED Action Plan (attached)	Completed
Improving Hospital Flow Programme report and actions	Completed
ED 4 Hour Safety Standard Implementation Plan	Completed
4-hour standard 60 day plan	Completed
Flow Program launch	Completed
ED performance dashboard with case mix adjustment	Completed
Changes to clinical leadership portfolios and governance to drive greater consultant engagement	27/11/26
Improvement to Agyle to make visible any referral delays	30/11/26
ED Recovery and Improvement Plan	30/11/26
Corridor care National reporting	30/11/26
Create a process for 24 hour RCA and thematic governance	30/11/26
Review Majors and ACCA space to ensure fit for purpose and demand	31/12/26
Better care better Flow Programme Workstream1	31/12/26
Development of EEMAC service – business case and pathways	28/02/27
Demand and capacity modelling driven redesign of workforce	01/04/27

Tolerance breach?	Yes
Target Risk Rating	6
Progress update	Risk discussed at Risk Oversight Committee 29/10/26. Agreed risk rating remains at 16. Action plan to be updated to reflect longer term actions, RCRP work and BFBC workstreams

Risk Type - Population & System **Risk Category - Flow and Capacity** **Appetite = Cautious** **Tolerance = 9-15**	
Risk ID	2339
Risk Title	Risk of delays to the April 2027 planned reconfiguration date and creation of the Planned and Emergency Hospitals
Date risk raised on the risk register	09/06/2026
Date risk approved as 15+ risk	06/07/2026
Risk Rating	16 
Risk Description	There is a risk that delays to the April 2027 Phase 3 move date and programme interdependencies across the Transforming Care Together programme (Build Ready, Reconfiguration/Service Ready and People Ready) result in a prolonged partial reconfiguration and impact delivery of Phase 3 of the planned and emergency care model.

	Delays compound operational pressures, patient flow, performance and safety. Delays impact of the delivery of programme benefits, increase costs and delay the overall reconfiguration benefits. Delays also create suboptimal clinical pathways and processes, increase pressure on staff and impact on morale, wellbeing and staff retention.
Executive sponsor	Chief Strategy and Transformation Officer
Controls in place	Programme governance and oversight • Regular oversight through Build Ready, Reconfiguration Ready and People Ready Groups, with escalation to Programme Board and Risk Oversight Committee • Monthly portfolio risk and issue log review with alignment to the corporate risk register and BAF • Internal and external comms including patient and public engagement plans Critical path and build programme management • Ongoing monitoring of Coast building delivery and confidence reporting, with revised Phase 3 timelines and re-profiling as required • Close working with Capital and external partners (e.g. Darwin) to improve tracking, Reporting and recovery planning • Monitoring of Building Safety Act compliance • Cross site transport and transfer plans Service readiness and move planning • Detailed Phase 3 move planning in place (ward-level plans, equipment lists, move simulations and move protocols) • Regular review of clinical design, pathway development and unresolved complex issues through Planned Care and Emergency Care Oversight Groups Operational risk management during transition • Monitoring of operational pressures (e.g. ED flow, capacity and demand) with escalation through oversight groups • Alignment with system demand and capacity planning (e.g. CSR workshops, winter planning, system actions) Workforce readiness and consultation • Ongoing workforce planning, triangulation and consultation activity through People Ready programme • Ongoing integration of teams • Office accommodation and space utilisation group plans e.g. Tringham house • Active management of workforce risks (e.g. recruitment, rosters, HR support) with escalation to Care Groups and Executive review Integrated programme alignment • Continued alignment of Build Ready, Service Ready and People Ready plans against the overall critical path • Mapping of interdependencies and impact of Phase 3 delays on other programmes and services
Gaps in controls	• Strengthened Gateway review process required - to ensure leads have clarity on roles for different elements of the gateway process • Better reporting of coast build delivery reporting to RRG and TMG • Better links between Flow Programme and Reconfiguration Programme to understand operational pressures and system demand and capacity on proposed move date
Action plan(s)	

Action	Due date
Demonstrate evidence of good and strengthened governance and a robust gateway process covering all element of build, service and people readiness	Completed
Service Readiness and Move Planning	31/12/2026
Workforce Readiness	31/12/2026
Programme Control and Operational Risk Management	31/12/2026
Coast Building Delivery	31/01/2027

Tolerance breach?	Yes
Target risk rating	6
Progress update	Update from Update from the Strategy & Transformation Portfolio Risk Report: 26/10/2026: Delays to any element of the programme could impact delivery of Phase 3 implementation in April 2027, increase risks associated with UHD's partially reconfigured state and delay delivery of benefits. The October Phase 3 readiness review (TMG Oct 22) and supporting risk assessment considered both the risks of moving and the risks of delaying implementation beyond April 2027. A prolonged delay carries increasing patient safety, operational, workforce, estate and financial risks, with continued reliance on split-site services, interim pathways, temporary controls and duplicated processes becoming progressively more difficult and costly to sustain. Review of transformation-affected risks across the corporate risk register identified a number of risks where delayed implementation would increase risk exposure or defer planned mitigations and benefits realisation. From a Build Ready perspective, AMU and OPAU remain on track for December, Coast building has had further delays with an expected handover in June and a potentially clinically live date of October/November. Poole site schemes continue to be impacted by BSA impacting confidence in completion and go-live dates. St Marys CDC build due to commence Mid November. Planning continues on the basis of a Phase 3 move commencing in April 2027 independent of Coast availability. From a Service Ready perspective, a bed capacity delivery plan is in place and readiness review completed. Delivery of operational improvements, patient flow initiatives and the ward-based move sequence plan remain critical path activities for Phase 3. From a People Ready perspective, risks remain around consultation sequencing, workforce planning, rosters and workforce systems. A number of key workforce planning milestones must be achieved over the coming weeks to enable consultations to conclude on time and maintain readiness for April 2027 implementation, with delays creating a direct risk to delivery of the planned operating model.

Risk Type - Population & System **Risk Category - Flow and Capacity**	**Appetite = Cautious** **Tolerance = 9-15**
Risk ID	1395
Risk Title	Lack of Capacity in Cellular Pathology Causing a Delay in Processing and Reporting
Date risk raised on the risk register	13/11/2020
Date risk approved as 15+ risk	23/07/2025
Risk Rating	16 
Risk Description	Very significant demand and capacity gap exacerbated further by additional elective recovery activity. IF this is not addressed this may result in breaches to national TAT targets, delays in MDT reviews, diagnosis /treatment and ability to deliver on cancer pathways. Alongside staff wellbeing issues.
Executive sponsor	Chief Operating Officer
Controls in place	• Digital program on track nearing completion for both sites and NHSE target met. • Automation project verification initiated with Steering & Implementation groups in place • Outsourcing reporting, if breaching TAT • Job planning senior, BMS time is on hold, appraising extended day • Active sickness management in place • Recruiting to template

	• Detailed Action Plan included in this risk to maintain BAU
Gaps in controls	• Business case for additional staff has not yet been approved • significant gaps in staff structure • Not meeting TAT's, has a significant impact on the rest of the hospital, patient waiting times and potential clinical impact.
Action plan(s)	

Action	Due date
Monitor TATs	Completed
Report for Finance committee	Completed
Trust to support demand management initiative	Completed
Trust to review MDT requirement to reduce commitment from pathology and radiology	Completed
Funding Stream	Completed
Report delays in recruitment	Completed
Trust to initiate cultural review with a view to optimising productivity in consultant body	30/11/2026
Department to implement AI	30/12/2026
Department to accelerate BMS cut up training programmes	31/12/2026
Department to accelerate BMS reporting training programmes	31/12/2026
Department to implement digital pathology	31/12/2026
Address demand and capacity staffing issues in Cellular Pathology	28/02/2027
Department to implement order comms	28/02/2027
Automation project	30/03/2027

Tolerance breach?	Yes
Target Risk Rating	4
Progress update	Staffing: Stabilisation plan submitted to CIG – Band 5 and Band 3 navigator approved (Band 5 appointed to , Band 3 in flight) Recovery plan formulated and reviewed by CD, clinical HoD and Head of Pathology Ops on weekly basis. Awaiting care group approval to utilise 0.57 wte Bd 7 funding Trajectory and modelling paper to support request for a further 2 x Band 5s and a Band 3 MLA has been presented to CIG Department has met with HR 13/10/26 to review staff on workplace adjustments and LTS. Digital : Interfacing for outsourcing awaiting trust to sign SLA, in interim sending both slides and digital. Digital licences available from 19/10 to save MDT prep time . Actively seeking funding for gastric AI scheme The department is in line to receive a revenue funding grant from NHSE to help with service re-design and optimisation within cellular pathology (pan ODP, but primarily UHD) The automation element of the DDCP is being progressed - the department is working up an internal BC to cover the revenue costs Automation: Automation delays due to lack of clinical capacity to sign off validation - slides ready for review. Automation element includes slide and block tracking system, biopsy transfer stations x 2 and a rough trimmer , also cassette printers

Risk Type - Population & System **Risk Category - Flow and Capacity** **Appetite = Cautious** **Tolerance = 9-15**	
Risk ID	1665
Risk Title	School age Neurodevelopmental service
Date risk raised on the risk register	03/09/2021

Date risk approved as 15+ risk	15/08/2023
Risk Rating	15 ⟷
Risk Description	The school age neuro-developmental service does not have enough capacity to meet demand for children aged 5-16 yr olds who are: - medicated and monitored to manage neurodevelopment issues - referred to the school age Neurodevelopmental service for advice, guidance and treatment
Executive sponsor	Chief Operating Officer
Controls in place	• Regular oversight within UHD with Exec team support alongside the bi-weekly ND Operational group chaired by the ICB. Action log in draft for some short-term improvements related to referral triage and increased exclusion criteria. • National targets in place-RTT zero tolerance 78 week waits, 65-week target from March 2024 • Local contractual expectation (provision of service and rejection of referrals) in place • Monitor of patient satisfaction via Complaints and claims • Escalation process in place and compliance monitored • Dorset Pathway in place and compliance monitored • Workforce template agreed • Monitoring of staff wellbeing through Absence, sickness & turnover • Triage of referrals being received to ensure visibility of activity on eCamis & effective management of the waiting list.
Gaps in controls	• National target achievement • Local contractual expectation (provision of service and rejection of referrals) • Poor patient satisfaction • Poor staff wellbeing • Lack of capacity to triage referrals in a timely fashion.
Action plan(s)	

Action	Due date
Dedicated admin support for referral screening process	Completed
Reduce backlog of un-triaged referrals	Completed
Listening events & senior leadership visibility	Completed
Recruitment of nurse specialist to support workforce	Completed
Supporting SENCo's with regards to referrals	Completed
Medical recruitment	Completed
Process mapping exercise	Completed
To monitor the CDC School age service transformation plan	Completed
Engagement with ICB All Age Autism Pathway review	Completed
Medical / AHP recruitment	Completed
Review delay in uploading referrals to eCamis	Completed
Medical / AHP recruitment	Completed
Engagement with ICB All Age Autism Pathway review	Completed
Reduction in backlog of referral triage	Completed
Monitor backlogs of referrals	Completed
IPT of patients to Haven	31/12/26
Improve communications with families RE waiting times	31/12/26

Tolerance breach?	No

Target risk rating	3
Progress update	Risk remains - working through IPT to Haven. Review of GIRFT report and working through recommendations. Further work ongoing re transition arrangements for 16-18yr olds. Backlog of long waits continues to exceed 3.5years.

Risk Type - Population & System **Risk Category - Flow and Capacity** **Appetite = Cautious** **Tolerance = 9-15**	
Risk ID	1697
Risk Title	Increased waiting list for SACT treatment/ Capacity on Day units
Date risk raised on the risk register	14/12/2021
Date risk approved as 15+ risk	27/05/2026
Risk Rating	15 
Risk Description	The waiting list to commence Systemic Anti-Cancer Therapies on our SACT day units has a target of 2 weeks from diagnosis to treatment, but this target is frequently not achieved. The SACT units are highly dependent on aseptic pharmacy abilities, which currently have a cap of 67 treatments per day across UHD.
Executive sponsor	Chief Operating Officer
Controls in place	• Collaborative working with Aseptic Pharmacy, HODU and DCC to ensure patients prioritised appropriately and team working approach to limited services • Buying in all possible treatments which reduces the aseptic pharmacy time to make treatments in house • Enabling all treatments that can be administered at home or through community teams which don't impact on day units or pharmacy aseptic cap • Increase Cap on SACT capacity in day case unit, and reviewed what treatments are including in their cap on treatments. • Weekly MDT meeting to review progress and updates • Exploring future options of private sector making and delivering SACT treatments, and ambulatory care input for urgent treatments
Gaps in controls	• No flexibility in cap on treatments provided from aseptic team, limiting patients that can be treated on day units. Despite buying in treatments, these still need to be screened. • Not consistently meeting 2 week local targets and 31 day national target, and any spike in referrals means the waiting list increases • Despite controls in place, increasing numbers of patients receiving SACT and increasing NICE TAs meaning more patients coming through system • Awaiting agreement on policies and procedures to move SACT into the community. Community capacity is a limiting factor with a very small team only providing haematology treatments for patients at home. CFA being discussed to bring additional nurse in for oncology treatments at home.

Action plan(s)

Action	Due date
Meet with Pharmacy	Completed
engage with outsourced service	Completed
Weekly SACT meetings	Completed
SACT business case	Completed
Training	Completed
Review 'bought in' chemo	Completed
Regular review to ensure waiting list reduced	01/12/2026
Staffing review	11/12/2026

	Weekly operational meetings	24/09/2027
Tolerance breach?	No	
Target risk rating	4	
Progress update	Wait times currently remain at approximately three weeks in DCC and five to six weeks in HODU. Ongoing collaboration between the two units continues to support the sharing of patient waits and help manage demand. Recruitment into vacant roles, including NCIE TA BC positions, has been successful. However, HODU has experienced further staffing pressures, with three members of staff leaving to take up specialist roles, creating additional vacancies. Nursing workforce challenges within HODU have been mitigated through support from ward teams while recruitment to substantive posts continues. Despite these improvements, pharmacy capacity remains the primary limiting factor affecting treatment delivery and service throughput at present.	

Risk Type – Quality and Safety **Risk Category – Patient Outcome (Clinical effectiveness) Appetite = Minimal Tolerance = 6-10**	
Risk ID	2362
Risk Title	Holding Ward Pathway: Patients Excluded from Inpatient Governance Processes
Date risk raised on the risk register	18/08/2026
Date risk approved as 15+ risk	29/09/2026
Risk Rating	16
Risk Description	There is a risk that patients who receive inpatient specialty assessment, treatment and discharge whilst recorded within the Holding Ward pathway are not consistently identified within standard inpatient governance, discharge and follow-up processes. Patients may remain administratively classified as Emergency Department patients despite receiving inpatient care, creating reduced visibility, unclear ownership and reliance on manual workarounds. As a result, electronic discharge summaries may remain incomplete, unlocked or not transmitted to GPs and other care providers, and patients may not consistently enter established specialty administrative and governance pathways. Failure to complete and transmit discharge communications may result in delays to continuity of care, missed medication and follow-up information, increased risk of patient harm, complaints and readmissions, reduced organisational assurance, and failure to meet national discharge communication requirements.
Executive sponsor	Chief Operating Officer
Controls in place	• Weekly reporting and review of unlocked discharge summaries. • Discharge Summary Task and Finish Group established to oversee improvement work. • Backlog reduction programme and corporate discharge summary improvement work. • Clinical Coding and Data Quality support to identify and resolve unlocked eDischarges. • Local escalation processes for patients managed within Holding areas. • Specialty team review, prescribing and discharge planning for patients awaiting admission. • Medical Examiner scrutiny of all deaths. • Existing Emergency Department mortality review processes. • LERN reporting, PSIRF and patient safety investigation processes.

	• Structured Judgement Reviews for patients experiencing the longest ED waits. • Development and use of reporting tools to identify Holding Ward discharge activity and monitor performance.
Gaps in controls	• No reliable mechanism to identify the full cohort of patients receiving inpatient care whilst remaining administratively classified as Holding Ward patients, limiting governance oversight, monitoring and assurance • Patients do not routinely appear on specialty ward lists or consultant inpatient worklists, reducing visibility and oversight. • No formal mechanism to ensure inclusion within specialty mortality review processes when patients die before reaching an inpatient ward. • No consistent mechanism to ensure follow-up appointments, investigations and administrative actions are completed for patients discharged directly from Holding. • Reliance on manual identification of patients across multiple electronic systems • No formalised and approved Holding Ward discharge process with clear clinical ownership and accountability. • No automated identification or reporting of all patients discharged from the Holding Ward. • No failsafe process to ensure completion and locking of discharge summaries before case closure.
Action plan(s)	

Action	Due date
Multidisciplinary review of the pathway	Completed
Review mortality governance arrangements	30/11/26
Review follow-up and investigation booking processes	30/11/26
Evaluate virtual specialty holding ward model	30/11/26
Governance and Board-level assurance	30/11/26
Quantify and monitor the Holding Ward cohort	30/11/26

Tolerance breach?	Yes
Target Risk Rating	8
Progress update	Risk approved at Risk Oversight Committee 29/09/2026. Executive Sponsor agreed as Chief Operating Officer. Action plans due date and owners to be reviewed and amended.

Risk Type – Quality and Safety **Risk Category – Patient Outcome (Clinical effectiveness) Appetite = Minimal Tolerance = 6-10**	
Risk ID	2310
Risk Title	Theatre staffing - ability to support a second CEPOD theatre out of hours
Date risk raised on the risk register	29/01/2026
Date risk approved as 15+ risk	31/03/2026
Risk Rating	16 ⟷
Risk Description	Current out-of-hours staffing levels in emergency theatres do not allow UHD to open a second emergency theatre when a simultaneous ‘life or limb’ case arises. The inability to open a second emergency theatre due to current staffing levels creates a significant life threatening clinical patient safety risk.
Executive sponsor	Chief Medical Officer

Controls in place	• From the beginning of February, there will be additional staff on shift overnight and across the weekend. • 1 x AP • 2 x Scrub - 1 with core obstetric skills • Emergency theatres (EMT) policy reviewed and sent for approval • EMT booking processes (Golden patient, bookings) reviewed and documented - communicated to teams • Funding to Obstetrics has been approved to provide 3 additional elective afternoon sessions (3 all days lists 2 half day lists) these lists are fully operational. Additional capacity is also requested on top on the funded activity • Weekly EMT meeting of MDT stakeholders to discuss EMT activity
Gaps in controls	• Requires Bank/overtime cover • WFP is underway and is part of our proposal and transformation • Core emergency team
Action plan(s)	

Action	Due date
BEACH simulation training - theatre staff to complete	Completed
Create UHD emergency theatre forum/working group	Completed
Advertising for bank shifts - ongoing	Completed
Review staffing for EMT theatres	Completed
Emergency theatre policy	Completed
WFP is underway and is part of our proposal and transformation	Completed
To create a core Emergency theatre team	11/12/2026
Promote theatres recruitment	25/12/2026
To monitor the number of incidents and patient impact - ongoing review via PSIRF process	30/09/2027

Tolerance breach?	Yes
Target Risk Rating	6
Progress update	General Manager Theatres and SSD and Senior Matron Theatres to present risk in Nov with proposal to reduce due to ongoing recruitment and hybrid cover by current substantive staff.

Risk Type – Quality and Safety **Risk Category – Patient Outcome (Clinical effectiveness) Appetite = Minimal Tolerance = 6-10**	
Risk ID	2262
Risk Title	Insufficient capacity and lack of specialist staffing and environment for respiratory high care patients and safety impact
Date risk raised on the risk register	18/11/2025
Date risk approved as 15+ risk	31/03/2026
Risk Rating	15 
Risk Description	If we do not address the insufficient capacity and lack of specialist staffing for acute NIV, then patient safety will be compromised through increased risk of harm or death, staff wellbeing will be impacted by unsustainable workload pressures, and critical care services will remain overburdened, leading to failure to meet national clinical standards and poorer patient outcomes.

	The requirement for ward nursing staff to provide Level 2 respiratory care significantly reduces the capacity available for the remaining patients on the ward. While nurses are delivering high-intensity monitoring, interventions, and escalation management for Level 2 patients, the rest of the ward is at risk of delayed assessments, reduced observation frequency, slower response to deterioration, and delays in routine care activities such as medications, hygiene needs, and mobilisation. This reduction in available nursing time increases the likelihood of avoidable harm occurring in the wider patient cohort, including missed or late medications, increased risk of falls or pressure damage, delayed recognition of clinical deterioration, prolonged length of stay, and reduced patient experience.
Executive sponsor	Chief Medical Officer
Controls in place	• If there is insufficient capacity on the respiratory ward, the patient is managed in Critical Care. • Continued review of staffing and skill mix to ensure safety of all patients on the wards and ratio of 2:1 for level 2 patients. Staffing flexed dependent on acuity - additional bank or agency requested when higher acuity. 1 RN approved by CG Finance for 4 wards during winter pressures. • Reporting of concerns via the LERN process. • Additional capacity being identified to support winter pressures..
Gaps in controls	• Additional burden placed on ITU. • Dependent on available critical care capacity and staffing. • Inability to ensure safe staffing numbers to provide care to all patients. • Ensuring required skill mix of staff may not always possible due to ward acuity, level 2 requirements etc. • Inability to provide appropriate therapy support services.
Action plan(s)	**Action** / **Due date** Review of staffing ratios and skill mix – Completed SOP to be created – Completed Respiratory High care unit – 31/12/2026
Tolerance breach?	Yes
Target Risk Rating	3
Progress update	Risk discussed at Risk Oversight Committee 29/10/26. Consideration to be given to reducing the risk rating and including additional actions to mitigate the risk.

Risk Type – Quality and Safety Risk Category – Patient Outcome (Clinical effectiveness) Appetite = Minimal Tolerance = 6-10	
Risk ID	2368
Risk Title	Risk of patient harm due to delay in commencing first definitive cancer treatment beyond the 62-day referral-to-treatment standard
Date risk raised on the risk register	08/09/2026
Date risk approved as 15+ risk	29/10/2026
Risk Rating	**15** 
Risk Description	If we do not improve our cancer capacity for treatments and our patient pathways across all of our hospital sites and care groups, then we risk causing patients harm by causing delay to their treatment options and clinical outcomes.

Executive sponsor	Chief Medical Officer - Peter Wilson
Controls in place	• Weekly patient-level Patient Tracking List (PTL) management across all tumour sites • Clinical escalation processes for patients approaching or exceeding 62 days on an open pathway • Targeted improvement support for the most challenged tumour groups (currently Gynaecology, Colorectal, Urology, Skin) • Trust Cancer Improvement Group providing cross-specialty oversight of capacity and demand • Enhanced recovery support in place for Gynaecology and Colorectal • Weekly reporting and challenge of recovery trajectories at [Trust Cancer Improvement Group / Cancer Strategy Group] • Benchmarking against peer trusts • Additional target funding for performance recovery • Harm reviews under taken for all patients over 104 days.
Gaps in controls	• No fully standardised, trust-wide harm review process specifically for patients whose treatment did not commence within 62 days (in development — see actions) • Reliance on insourcing providers (notably Skin) whose performance has been inconsistent, with limited direct control over their capacity delivery • Backlog clearance in one pathway is generating new breaches elsewhere (e.g. 28-day breaches emerging in Colorectal, Skin and Gynaecology following backlog clearance) • Theatre and Interventional Radiology capacity constraints sit outside direct control of the Cancer Services team • Limited forward visibility/trajectory modelling to confirm when sustained recovery will be achieved • Clinical visibility and ownership of patients on a 62D pathway
Action plan(s)	**Action** / **Due date** Risk Mitigation Action Plan (full details attached to risk register) / 30/11/2026
Tolerance breach?	Yes
Target Risk Rating	9
Progress update	Risk approved at 15 at Risk Oversight Committee 29/10/2026, CMO agreed as Exec lead, action plan discussed and supported. Monitoring via Cancer group.

Risk Type – Quality (Outcome and Safety) **Risk Category – Patient Safety Appetite = Cautious Tolerance = 4-6**	
Risk ID	2350
Risk Title	RBH Adult ED Waiting Room
Date risk raised on the risk register	14/07/2026
Date risk approved as 15+ risk	26/08/2026
Risk Rating	16 
Risk Description	If adult patients continue to wait in an overcrowded Emergency Department waiting room due to demand exceeding capacity, then there is an increased risk of delayed assessment, unrecognised deterioration, avoidable patient harm, poor patient experience, and failure to meet national quality and performance standards.

<table>
<tr><td>Executive sponsor</td><td>Chief Nursing Officer</td></tr>
<tr><td>Controls in place</td><td>

Nurse-led initial assessment streaming and triage to identify patients requiring urgent assessment.
Escalation of crowding through the Trust's Operational Pressure Escalation Level (OPEL) framework and internal escalation processes.
Daily operational and site flow meetings to support patient flow and reduce ED crowding.
Use of Same Day Emergency Care (SDEC), Urgent Treatment Centre (UTC) and specialty pathways to reduce demand within the Emergency Department.
Incident reporting (LERN) and review of patient safety events, complaints and serious incidents to identify learning and improvement opportunities.
Continuous monitoring of Emergency Department performance, including waiting times, patients leaving before treatment is complete, and crowding metrics.
HCA 1200-0000 has been approved 7 days a week.

</td></tr>
<tr><td>Gaps in controls</td><td>

Regular waiting room clinical reviews, observations and re-triage for patients with prolonged waits or changes in condition- unable to consistently provide this due to nursing template (related to phased move and increased attendances).
Senior clinical oversight through the Emergency Physician in Charge (EPIC), and Nurse in Charge (NIC)- unable to consistently provide due to both SDM and band 6/7 template. (related to phased move and increased attendances)
Clinical prioritisation using recognised triage processes (NAS) and NEWS2 to identify deteriorating patients- unable to meet initial assessment KPI or first NEWS 2/ECG timing safety measures due to waiting room oversight and staffing levels.
The physical size and layout of the Emergency Department waiting room are insufficient to safely accommodate periods of sustained high demand.
Limited capacity for continuous observation and monitoring of patients waiting for prolonged periods before assessment and treatment.
Current escalation processes cannot consistently reduce waiting room occupancy when inpatient flow is constrained.
Limited ability to separate vulnerable, infectious, behavioural or high-risk patients within the waiting area.
Variable frequency of clinical reassessment during periods of extreme crowding.
Reliance on system-wide flow improvements outside the direct control of the Emergency Department to reduce overcrowding.
Lack of defined waiting room capacity thresholds linked to mandatory organisational response.
Environmental constraints affecting patient privacy, dignity, comfort and infection prevention during prolonged waits.
HCA 1200-0000 is a bank role and fill rate is very low.

</td></tr>
<tr><td>Action plan(s)</td><td>
<table>
<tr><th>Action</th><th>Due date</th></tr>
<tr><td>Provide additional nursing cover for waiting room</td><td>Completed</td></tr>
<tr><td>Ongoing education</td><td>Completed</td></tr>
<tr><td>Define queues</td><td>Completed</td></tr>
<tr><td>Waiting room occupancy</td><td>Completed</td></tr>
<tr><td>Named registered nurse responsibility for the waiting room</td><td>16/11/2026</td></tr>
<tr><td>Patient communication and essential care during long waits</td><td>16/11/2026</td></tr>
<tr><td>Test emergency response from this physically separate area</td><td>16/11/2026</td></tr>
<tr><td>Reconcile people physically waiting</td><td>16/11/2026</td></tr>
<tr><td>Criteria for patients who cannot safely remain in the waiting room</td><td>16/11/2026</td></tr>
<tr><td>Update ED SOP</td><td>16/11/2026</td></tr>
<tr><td>Band 7 Guidance on front door staffing mitigation actions</td><td>16/11/2026</td></tr>
</table>
</td></tr>
<tr><td>Tolerance breach?</td><td>Yes</td></tr>
<tr><td>Target risk rating</td><td>6</td></tr>
<tr><td>Progress update</td><td>Discussed at Risk Oversight Committee 29/10/26. Action plan to be reviewed to amend timescales and longer term mitigations, risk to include details of actions taken and not recorded. Consideration to be given as to whether mitigations have reduced the current risk rating.</td></tr>
</table>

Risk Type – Quality (Outcome and Safety) Risk Category – Patient Safety Appetite = Cautious Tolerance = 4-6	
Risk ID	1974
Risk Title	Significant time delays for macular injection treatment
Date risk raised on the risk register	05/10/2023
Date risk approved as 15+ risk	01/07/2024
Risk Rating	16 ⟷
Risk Description	If patients do not receive their macular injection within 2 weeks (NICE guidance), then they may have a deterioration in their vision. The reasons patients are not receiving their appointments in the recommended timeframe include; increased demand, lack of staffing (nursing and medical), lack of suitable environment space
Executive sponsor	Chief Nursing Officer
Controls in place	• The team have identified Theatre 3, in Eye Outpatients, to undertake Macular injection lists as required. • Appointed a fourth Macular Nurse Practitioner (training and education will be required to ensure competencies are met and signed off). • Additional lists added, when staffing allows • Ophthalmology ED for emergency cases • An email account has been set up for the consultants to review referrals from Opticians, to ensure that only appropriate patients are seen by the macular team. • First appointments are being triaged out to the Health Village where they are seen by an Ophthalmic Technician for imaging and other diagnostic tests, not a clinician. Patients then await virtual review from a clinician. • 2 x macular coordinators reviewing patient wait times and prioritising • Direct line to macular coordinators who can escalate to Clinicians • Spreadsheet available for range of clinicians to review for oversight. • Regular Macular meeting to focus on long waiters and agree actions required (monthly and weekly meetings) • Creating a 'core team' within outpatients to work in macular • training needs identified and started to roll out. This will also support retention • Contacted reps to identify if they can support training and funding
Gaps in controls	• Additional sites to be identified to undertake additional lists/ full lists that has a 'clean' space, accessible (for staff and patients) and large enough waiting area • Budget to be identified to enable estates work to be completed and training to be given • The 4th Macular Nurse Practitioner will require a full training program. • Recruitment for replacement consultant needs to be undertaken (finance agreed)
Action plan(s)	

	Action	Due date
	Recruitment of consultant	Completed
	Identify space for macular service	Completed
	Recruit additional Health Care Support Workers	Completed
	Daily review of the waiting lists for macular appointments, undertaken by the Macular coordinators	Completed
	Weekly Macular Time Table Meeting	Completed
	Digital improvements in macular	Completed
	Submit A3 for Macular Workforce	Completed
	Weekend Nurse Injection Clinics to run if required	Completed
	Standardisation of macular clinics	Completed
	Recruit into 0.6WTE Macular Consultant post	30/11/2026
	Ensure all clinics are fully booked	30/11/2026
	Identify additional space to provide macular assessments and treatments	30/11/2026
	POD virtual review clinic model	30/11/2026
	Absence Management	01/12/2026
	Ophthalmology Practitioner Training (OPT) - macular module, for all Macular Nurse Specialists	01/12/2026
	Monitor number of patients waiting for appointment	31/12/2026
	Increase number of patients in macular One Stop clinics	08/01/2027
Tolerance breach?	Yes	
Target risk rating	9	
Progress update	Update documented to action about under booking clinics due to new issues raised with the process.	

Risk Type – Quality (Outcome and Safety) **Risk Category – Patient Safety Appetite = Cautious Tolerance = 4-6**	
Risk ID	2052
Risk Title	Care of patients in non-clinical/corridor areas in the Emergency Department
Date risk raised on the risk register	10/04/2024
Date risk approved as 15+ risk	24/11/2025
Risk Rating	15 
Risk Description	A lack of capacity in the hospital and a requirement to release ambulance crews in a timely manner has led to an increase in the use of non-clinical areas, particularly corridors for patients awaiting a trolley/chair space in both Emergency Departments. This creates a risk of harm to patients, a compromise to privacy and dignity and an increased risk of obstruction of thoroughfares and escape routes.
Executive sponsor	Chief Nursing Officer
Controls in place	• SOP on corridor use • Ambulance handover SOP • Divert procedures including dynamic conveyancing • Escalation process

	• Privacy screens in place to protect privacy and dignity at RBH
Gaps in controls	• Staffing is reliant on bank and agency and therefore levels not always met. • Non-compliance with corridor SOP requirements e.g. dementia patients, falls risks, mental health presentation should not be in the corridor • Lack of oxygen supply - use of oxygen cylinders • Observations not being completed, patients not being reviewed within a recommended timeframe, NEWS escalations not being addressed • Lack of call bells at RBH and non-compliance with responding to them at PH. • Additionally where the corridor is under the care of [redacted], there is the risk of a lack of clinical oversight from UHD. • Increase in complaints and LERNs related to unsafe care or poor experience. Fire safety LERNs also received
Action plan(s)	

Action	Due date
Improve the facilities for patient privacy and dignity in Bournemouth corridor	Completed
Demand and capacity forecasting model	Completed
MDT approach with acute medicine & OPS	Completed
Matching consultant rota capacity to demand	Completed
Strengthen patient selection and management of exceptions	16/11/2026
Address call bells and emergency response as separate problems	30/11/2026
Make the staffing contingency explicit	30/11/2026
Safe management of waiting rooms	31/12/2026
Supervision of waiting rooms	31/12/2026
Better Care Better Flow Program Workstream 1	31/12/2026
Define conditions for opening and continuing to use each area	31/12/2026
Decompress the Emergency Department to prevent crowding	28/02/2027
Extended Emergency Medicine Ambulatory Care	28/02/2027

Tolerance breach?	Yes
Target risk rating	3
Progress update	Discussed at Risk Oversight Committee 29/10/26. Action plan to be reviewed to amend timescales and longer term mitigations, risk to include details of actions taken and not recorded. CIO and CTSO to urgently review call bell issue.

Risk Type - Sustainable Services Risk **Risk Category - Financial Management Risk Appetite = Cautious Tolerance = 9-15**	
Risk ID	2302
Risk Title	Accuracy of Clinical Coding
Date risk raised on the risk register	05/01/2026
Date risk approved as 15+ risk	26/01/2026
Risk Rating	16

Risk Description	There is a risk that clinical coding especially fails to adhere to national coding standards and contains significant data analysis errors. Inadequate coding may impact on the Trust HSMR data. Poor standards of coding may also impact on financial income, other patient safety and quality metrics, and the wider national NHS benchmarking and league tables, all of which also rely heavily on coded data.
Executive sponsor	Chief Finance Officer
Controls in place	• Oversight by Mortality Surveillance Group • HR processes • Local Policies and SOP's • Internal Qualified Auditor • Coding software • HED • National Clinical Coding Qualification (NCCQ) • NHSE - National Clinical Coding Standards
Gaps in controls	• Lack of completion of e-Discharge forms • Agreed SOP for palliative care coding is not being followed • Weak leadership structure within the service • Predominately remote workforce • Majority of the team do not hold the NCCQ • Consistent breach of clinical coding standards during the coding process • Overly stretched clinical coding auditor
Action plan(s)	
Tolerance breach?	Yes
Target risk rating	4
Progress update	Quality and capability controls established through the Clinical Coding transformation programme have moved from development into implementation. An onsite practical coding competency assessment has been undertaken to establish an objective baseline of individual coding capability. Assessment outcomes are being reviewed alongside individual coding audit results, with feedback being provided through the appraisal process. Where required, individual competency improvement plans will be developed with the coder, Service Manager and Trust Clinical Coding Auditors and formally monitored through the appropriate capability arrangements. Recruitment to the revised Clinical Coding structure has now commenced and additional quality assurance has been incorporated into the recruitment governance process. Clinical engagement and validation activity has continued to expand. The Head of Clinical Coding and senior coding leadership team have also completed enhanced HED training, strengthening capability to proactively review HSMR intelligence and coding associated with mortality indicators and to support the developing Clinical Validation Plan. A Head of Data Assurance and Clinical Coding Training Lead has now been successfully recruited and is expected to commence in mid November. Recruitment of novice Clinical Coders is planned for early October, alongside development of the Clinical Coding apprenticeship pathway. Work is also progressing on a structured accelerated training route for eligible candidates who demonstrate the appropriate capability and potential, enabling suitable individuals to progress towards accredited Clinical Coder status at an accelerated pace where competency and national training requirements permit. AI supported clinical coding is also progressing through the formal implementation pathway. Appropriate coding quality assurance, validation and monitoring will form an important component of implementation to ensure that AI supported coding is subject to the same standards of accuracy, governance and assurance

Action	Due date
Present Audit results to Mortality Group	Completed
Palliative care coding standard operating procedure	Completed
Clinical Coding Consultation - Service Transformation	Completed
External Audit of Clinical Coding	Completed
Palliative Care Coding SOP	Completed
Competency framework for coders	30/11/2026
Implementation of new Clinical Validation Plan	30/11/2026

	expected of manually coded activity. Overall, material progress has been made in strengthening the controls around coding competency, recruitment, contractor assurance, clinical engagement and future training capability. However, these controls are still being embedded and there is not yet sufficient objective evidence of sustained improvement to reduce the risk. The significant capacity and submission pressures currently affecting the service also continue to present a threat to coding depth and quality. The risk should therefore remain at its current level pending demonstrable improvement through competency outcomes, coding audit results and wider quality assurance.

Risk Type - Sustainable Services Risk **Risk Category - Financial Management Risk Appetite = Cautious Tolerance = 9-15**	
Risk ID	1595
Risk Title	Medium Term Financial Sustainability
Date risk raised on the risk register	27/05/2021
Date risk approved as 15+ risk	28/06/2021
Risk Rating	15 ⟺
Risk Description	There is a risk that the Trust cannot achieve its strategic priority to return to a financial surplus by 2028/29 Failing to deliver a financial break-even position would result in regulatory intervention, an unplanned reduction in cash and the inability to afford the medium term capital programme.
Executive sponsor	Chief Finance Officer
Controls in place	• Budgets developed with directorate teams, formally accepted at Care Group level and fully devolved to named budget holders. • Dedicated financial support in place including additional variance analysis and reporting. • Scheme of delegation, Standing Financial Instructions, and other finance policies and procedures in place. • Monthly reporting to Trust Management Group, Finance and Performance Committee and Board highlighting risks and mitigating actions. • Patient First 'driver' and 'watch' metrics agreed and monitored monthly. • Alignment of approved nursing templates, e-roster templates, and budgeted establishment. • Enhanced vacancy and non pay controls implemented to support financial recovery. • Financial planning with system partners • Efficiency Improvement Programme in place with oversight by Finance and Performance Committee. • QIA policy and process in place
Gaps in controls	• Internal audit has identified the need for improved internal reporting of drugs spend and a strengthened budgetary mechanism. • Workforce controls scoping work completed across multiple dimensions, including for enhanced VRP (Vacancy Recruitment Panel) approach, consistency across the Trust for Recruitment and Retention premia, and overtime / additional hours payments. • Medical Staffing Patient First project underway – medical job planning achieved in 100% of specialties, with over 6000 additional clinic slots identified. • Delivered 2025/26 full year position in line with forecast revenue and capital positions including actions agreed within the H2 recovery trajectory.
Action plan(s)	**Action** / **Due date** Medium Term Financial Sustainability / 31/03/2027
Tolerance breach?	No
Target Risk Rating	8
Progress update	The Risk was reviewed by FPC as part the financial report, no changes to the risk grading were noted.

Risk Heat Map

Consequence						
Current Risk Grading		No Harm (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Likelihood	Almost Certain (5)	0	9	6	1	0
	Likely (4)	1	27	18	8	0
	Possible (3)	2	26	41	10	3
	Unlikely (2)	0	10	28	8	5
	Rare (1)	0	1	1	1	0

Current Risk score by month – rolling year (at the point of report date)

Current Risk Score	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26
Very Low (1-3)	4	5	6	6	6	7	7	5	3	4	4	4
Low (4-6)	72	70	64	68	69	71	73	72	70	70	66	66
Moderate (8-10)	90	86	86	84	81	75	78	81	82	92	90	90
Moderate (12)	33	31	34	39	36	34	35	29	26	28	28	28
High (15 -25)	15	15	16	16	19	19	16	14	16	16	16	18
Total number of risks under review	214	207	206	213	211	206	209	201	197	210	204	206

Appendix A
Risk types & categories, appetite scales and tolerances and aligned Executive sponsor

Risk Type	Risk Category	Risk Appetite Scale	Risk Appetite score	Risk tolerance	Executive sponsor 15 + risks
People Risk	Staff Health, Safety and Wellbeing	Minimal	1-5	6-10	Chief People Officer
People Risk	Knowledge and Skills	Cautious	1-8	9-15	Chief People Officer
People Risk	Workforce Capacity	Cautious	1-8	9-15	Chief People Officer
People Risk	People Function	Open	1-10	12-20	Chief People Officer
Population and System Risk	Flow and Capacity	Cautious	1-8	9-15	Chief Operating Officer
Population and System Risk	Partnership Working	Open	1-10	12-20	Chief Strategy and Transformation Officer
Quality (Outcome and Safety) Risk	Infection Prevention and Control	Averse	1-3	4-6	Chief Nursing Officer
Quality (Outcome and Safety) Risk	Patient Safety	Averse	1-3	4-6	Chief Nursing Officer
Quality (Outcome and Safety) Risk	Patient Outcomes (Clinical Effectiveness)	Minimal	1-5	6-10	Chief Medical Officer
Quality (Outcome and Safety) Risk	Medicines Management	Averse	1-3	4-6	Chief Medical Officer
Sustainable Services Risk	Financial Management	Cautious	1-8	9-15	Chief Finance Officer
Sustainable Services Risk	Information Governance (including information security)	Minimal	1-5	6-10	Chief Informatics Officer
Sustainable Services Risk	Medical Equipment	Cautious	1-8	9-15	Chief Strategy and Transformation Officer
Sustainable Services Risk	Physical Assets Risk	Cautious	1-8	9-15	Chief Strategy and Transformation Officer
Sustainable Services Risk	Information Technology	Open	1-10	12-20	Chief Informatics Officer
Patient Experience Risk	Patient Experience	Minimal	1-5	6-10	Chief Nursing Officer

Risk Appetite Scales



Risk type and category definitions

Risk type	Risk Category	Definition
Our People Risk The risk of unsafe or ineffective patient care resulting from inadequate systems and processes associated with the Trust's workforce supply, skills & capacity, performance and retention, within an appropriate culture.	Staff Health, Safety and Wellbeing Risk	To ensure that processes and safe systems are work are in place to meet statutory and regulatory requirements for staff safety. To ensure the Trust provides an environment for staff where all feel respected, valued, supported and included at work
	Knowledge and Skills Risk	To ensure that the Trust has processes to ensure staff develop the knowledge and skills required to support the needs of our patients and the organisation.
	Workforce Capacity Risk	To ensure that the Trust maintains a sustainable workforce capacity to meet the needs of our patients
	People Function Risk	To ensure that there are people processes and systems in place to support care groups and corporate directorates to deliver their priorities
Population and System Working Risk The risk of direct or indirect loss resulting from inadequate or failed internal processes and systems or from external healthcare system process or events.	Flow and Capacity Risk	To ensure the Trust has effective processes in place for planning and providing capacity to treat elective, non-elective, and clinically urgent patients to meet constitutional standards.
	Partnership Working Risk	To ensure the Trust has effective partnership working arrangements in place, working in conjunction with health, social care, voluntary and private sectors.
Quality (Outcome and Safety) Risk The risk of poor patient outcomes and/or patient harm resulting from inadequate systems and processes associated with the Trust's infection prevention & control, safeguarding, medicines	Infection Prevention and Control Risk	To ensure the Trust has effective processes in place for the management of infection prevention and control to reduce the transmission of infection in hospital and maintain patient safety
	Patient Safety Risk	To ensure the Trust has effective systems and processes in place for high standards of patient safety

Risk type	Risk Category	Definition
management, patient safety, clinical effectiveness and research & development. The risks of harm to staff as a result of inadequate safe systems of work and compliance with legal requirements for health and safety at work.	Patient Outcome (Clinical Effectiveness) Risk	To ensure the Trust has effective processes in place to meet best practice guidance on clinical effectiveness including compliance with national and professional standards.
	Medicines Management	To ensure that the Trust has effective processes in place for the management of medicines, including medicines optimisation and compliance with statutory and regulatory standards for prescribing, administration, storage and disposal.
Sustainable Services Risk The risk of direct or indirect loss resulting from inadequate systems and processes to the Trust's management of its estate, infrastructure, finances, financial reporting, funding and cash management.	Financial Management Risk	To ensure that financial information reported internally and externally is accurate and complete, including efficiency improvement programme, and enables the Trust to manage its financial position appropriately, on an ongoing basis. To ensure that the Trust's Systems and Controls are designed to detect, prevent and deter organisations and individuals (internal and external) from committing acts of fraud against the Trust and its patients.
	Information Governance (including information Security)	To ensure that the Trust has the right processes and systems for collecting, storing, managing and maintaining information (includes archiving and deletion) in all its forms in order to support business needs and comply with regulations. To ensure that the management of information security is designed to protect confidential, private and sensitive information or data from unauthorised access, use, misuse, disclosure, destruction, modification, or disruption.
	Medical Equipment Risk	To ensure that the management of the Trust's medical equipment is designed to prevent harm to patients, staff, visitors, and meets the needs of the organisation.
	Physical Assets Risk	To ensure that the management of the Trust's physical assets related to buildings and infrastructure is designed to prevent harm to patients, staff, visitors, volunteers and property.
	Information Technology Risk	To ensure the Trust has appropriate processes in place to manage the use, ownership, operation, involvement, development and adoption of IT to prevent unplanned business disruption
Patient experience Risk The risk of poor patient experience resulting from inadequate systems and processes associated with the fundamentals of care.	Patient Experience Risk	To ensure the Trust has effective processes in place to monitor feedback from patients and use this to improve services and patient experience.

Appendix B: Matrix and descriptors for Risk Register Assessment

Risk Grading	Likelihood x Consequence		Summary Descriptor (reference to patient safety domain only)
1	1	1	Less than annual occurrence of minimal injury that requires minimal intervention
2	1	2	Less than annual occurrence of evidence that overall treatment or service is suboptimal with minor implications for patient safety
	2	1	May occur annually but less than monthly - minimal injury that requires minimal intervention
3	1	3	Less than annual occurrence of evidence of significant harm to more than 50% of the patient cohort
	3	1	Every month there is evidence of minimal injury that requires minimal intervention
4	1	4	Less than annual occurrence of evidenced major injury leading to long-term incapacity/disability
	2	2	May occur annually but less than monthly and result in evidence that overall treatment or service is suboptimal with minor implications for patient safety
	4	1	Evidence of weekly occurrence that a treatment/service has significantly reduced resulting minimal injury that requires minimal intervention
5	1	5	Less than annual occurrence of evidenced issues that impacts on a large number of patients, increased probability of death or irreversible health effects occurring
	5	1	Daily evidence of minimal injury that requires minimal intervention
6	2	3	Less than annual occurrence of evidence of significant harm to more than 50% of the patient cohort
	3	2	Every month there is evidence that overall treatment or service is suboptimal with minor implications for patient safety
8	2	4	May occur annually but less than monthly and result in evidenced major injury leading to long-term incapacity/disability
	4	2	Evidence of weekly occurrence that a treatment/service has significantly reduced resulting in evidence that overall treatment or service is suboptimal with minor implications for patient safety
9	3	3	Every month there is evidence of significant harm to more than 50% of the patient cohort
10	2	5	May occur annually but less than monthly and impacts on a large number of patients, increased probability of death or irreversible health effects occurring
	5	2	Evidence of daily occurrence that overall treatment or service is suboptimal with minor implications for patient safety
12	4	3	Evidence of weekly occurrence that a treatment/service has significantly reduced resulting in significant harm to more than 50% of the patient cohort
	3	4	Every month there is evidence of major injury leading to long-term incapacity/disability
15	5	3	Evidence of daily occurrence that a treatment/service has significantly reduced with resulting harm to more than 50% of patient cohort
	3	5	An issue which impacts on a large number of patients, increased probability of death or irreversible health effects occurring and evidenced monthly
16	4	4	Weekly evidence of major injury leading to long-term incapacity/disability
20	5	4	Daily evidence of major injury leading to long-term incapacity/disability
	4	5	An issue which impacts on a large number of patients, increased probability of death or irreversible health effects occurring and evidenced weekly
25	5	5	An issue which impacts on a large number of patients, increased probability of death or irreversible health effects occurring and evidenced daily

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

Consequence score (severity levels) and examples of descriptors

1	2	3	4	5
Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
• Minimal injury requiring no/minimal intervention or treatment. • Peripheral element of treatment or service suboptimal • Informal complaint/inquiry	• Overall treatment or service suboptimal • Single failure to meet internal standards • Minor implications for patient safety if unresolved • Reduced performance rating if unresolved • Breech of statutory legislation • Elements of public expectation not being met • Loss of 0.1–0.25 per cent of budget • Claim less than £10,000 • Loss/interruption of >8 hours • Minor impact on environment	• Treatment or service has significantly reduced effectiveness • Repeated failure to meet statutory or contractual standards • Major patient safety implications if findings are not acted on • Challenging external recommendations/ improvement notice • 5–10 per cent over project budget • Local media coverage – long-term reduction in public confidence • Loss of 0.25–0.5 per cent of budget	• Major injury leading to long-term incapacity/disability • Non-compliance with national standards with significant risk to patients if unresolved • Multiple complaints/ independent review • Low performance rating • Uncertain delivery of key objective/service due to lack of staff • Enforcement action • Multiple breeches in statutory duty • Improvement notices • National media coverage with <3 days service well below reasonable public expectation • Non-compliance with national 10–25 per cent over project budget • Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget • Claim(s) between £100,000 and £1 million	• An issue which impacts on a large number of patients, increased probability of death of irreversible health effects • Gross failure to meet national standards • Multiple breeches in statutory or regulatory duty • Prosecution • National media coverage with >3 days service well below reasonable public expectation. • Incident leading >25 per cent over project budget • Non-delivery of key objective/ Loss of >1 per cent of budget • Loss of contract / payment by results • Claim(s) >£1 million • Permanent loss of service or facility • Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring? The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
	Not expected to occur for years	Expected to occur at least annually	Expected to Occur monthly	Expected to occur weekly	Expected to occur daily

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Audit Committee – Chair's Report
Presented by:	Tracie Langley, Chair of the Audit Committee

Agenda items discussed:	At its meeting held on **15 October 2026** the Committee received the following:
	• Internal Audit:
	  ○ Progress Report
	  ○ Follow-Up Report
	  ○ Internal Audit Standards Essential Conditions
	• External Audit Report
	• Anti-Crime Report
	• Risk register
	• 2026/27 Board Assurance Framework Q2
	• Information Governance Q2, including DSPT recovery plan
	• Commercial Compliance Report Q2
	• Emergency Preparedness, Resilience and Response
	• Freedom to Speak Up report
	• Review of Losses and Special Payments >£15k
	• Fit and Proper Persons Test
	• Accountability Framework review
	• Review of Effectiveness:
	  ○ Internal Audit
	  ○ External Audit
	  ○ Anti-crime

ALERT	The Committee wishes to alert members of the Board that: • There are no alerts
ASSURE	The Committee wishes to assure members of the Board that: • Positive assurance was gained that the routes for matters concerning Health & Safety risks were now in place. • The Committee continues to be assured that the culture and processes around the framework for Freedom to Speak Up are improving however note the increasing complexity of the cases.
ADVISE	The Committee wishes to advise the Board that: • There is an apparent difference between the levels of assurance from Internal Audit and emerging findings from the CQC report in surgery, particularly in relation to

	medical device management. The Committee agreed that the apparent difference in assurance should be reconciled rather than accepting the two positions without further examination. Internal Audit will complete further work and report back to the Committee.
Review of Risks	• The Committee undertook a detailed review of each of the high-rated corporate risks. A recurring concern throughout the discussion was that, although significant improvement and mitigation activity was taking place operationally, a number of risk action plans did not reflect the current position. Members emphasised that an out-of-date risk register weakened the assurance available to the Committee and could present an inaccurate picture to external reviewers. The Committee accepted that timing of risks reports to the various committees meant that sometimes the action plans did not always keep up with the reports but agreed to think about how this could be improved.
Celebrating Outstanding	• All auditors are required to complete and report on their meeting of the Global Auditing Quality Standards. All of the three groups of auditors who support UHD reported a high standard of quality in the delivery of their work.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **6.3.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	**Annual Emergency Preparedness, Resilience and Response (EPRR) Update Report for 2025-26**
Prepared by:	Mark Taylor MSc, Head of Emergency Preparedness, Resilience, and Response
Presented by:	Mark Mould, Chief Operating Officer / Accountable Emergency Officer (AEO)
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	Two EPRR risks are managed through the Emergency Planning Group: Business Continuity Planning and Preparedness (Moderate, 8-12) and Key Staff to be trained in Incident Response (Low, 4-6).
Purpose of paper:	Assurance
Executive summary:	This Annual EPRR report provides an update on the current status and activities of EPRR within the Trust. It provides an update on NHSE EPRR Core Standards 2025-26; CBRN/HAZMAT Assurance process for 2025-26; EPRR Response Plans; the UHD Business Continuity Management System (BCMS); Martyn's Law; Business Continuity Plans; Training; Exercising; Organisational Learning; and the Next Steps Work Plan for 2026-27.
ALERT:	None
ASSURE:	Following UHD's evidence submission against the 62 NHSE EPRR Assurance Standards (including CBRN/HAZMAT Assurance), UHD is Fully Compliant across 60 of the 62 standards assessed. Consequently, there is a recommendation from Dorset ICB that UHD is **SUBSTANTIALLY COMPLIANT** with the NHSE EPRR Assurance Process. The formal ICB led 'Confirm and Challenge' meeting took place on 1 October 2026. Final NHSE agreement and sign off is pending.
ADVISE:	UHD was found to be partially compliant in the following two areas of assurance:

	• **Data Security and Protection Toolkit (DSPT):** UHD had not fully met the required standard on the Data Security and Protection Toolkit (DSPT). **Response:** At the current time, there is a revised target date of December 2026 for the attainment of the DSPT audit standard. • **Decontamination capability availability 24/7:** a. UHD EDs could not evidence a shift rota planning process that ensured a minimum required number of Pressurised Respiratory Protective Suits (PRPS) trained ED staff are on duty per shift; b. There was no system to ensure that ED NiCs could readily identify which of their shift staff were PRPS trained in the event of an emergency. **Response:** • Current ED shift planning processes are under review to ensure that a minimum number of PRPS trained ED nursing staff are available per shift. • Delivery of PRPS training is being accelerated to further increase the numbers of ED nursing staff who are PRPS trained. The former system of PRPS trained staff identification was via the ESR system, however, UHD wide changes to the system during 2025-26 removed staff training designations from the system, effectively removing the system used for ED staff skills identification in an emergency. A review is currently in progress to identify an alternative system to address this gap.
Celebrating Outstanding:	UHD is Fully Compliant in 60 of the 62 NHSE EPRR Core Standards. Live exercises were delivered in partnership with Dorset & Wiltshire Fire & Rescue Service, UHD Fire Safety Advisors, the Simulation Team and the Children's Health Nursing Team, alongside a Cyber Incident Response tabletop exercise
RECOMMENDATION:	The Board is asked to note the report.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☒ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☐ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒ **Environmental Sustainability**: The report includes reference to work that the EPRR Team is conducting in conjunction with

	the UHD Sustainability Manager regarding the need for Climate Change Adaptation projects to be identified and completed e.g. in relation to the UHD Heatwave and Adverse Weather Plans. **Equality, Equity, Diversity & Inclusion:** That all aspects of EPRR related delivery are cognisant of these critical areas of consideration, and that no-one is less favourably treated because of the implementation of EPRR related measures. **Financial:** The implementation of EPRR related measures comes at a cost which are not always readily identifiable in advance but are identified / become apparent as incidents unfold / planning is undertaken for planned incident response / service disruption events. The requirement to align Climate Change Adaptation with the work of EPRR will also come with potential high levels of financial impact / consideration. **Operational Performance:** The EPRR programme is inextricably linked to the effective delivery of operational performance in circumstances of BAU; Incident Response; and Business Continuity Incidents resulting in disruption / potential disruption to effective service delivery. **People (incl. Staff, Patients):** At its core, EPRR is concerned directly with ensuring that UHD has the ability and capability to continue operating through any incident causing disruption / potential disruption whilst keeping patients / staff / visitors / contractors safe; continuing to deliver safe & effective critical care; and effecting recovery as quickly as possible in the circumstances. **Quality:** Closely aligned to considerations of Operational Performance and People, effective delivery of EPRR is critical for the delivery of a high-quality service. **Regulatory:** The EPRR work programme is driven in part by the: HSWA 1974; Civil Contingencies Act 2004; NHSE EPRR Core Standards / Assurance process; and NHSE Standard Contract Service Conditions. **Strategy / Transformation:** The EPRR work programme provides critical support to the Strategy / Transformation programme in ensuring that their work accords with the EPRR related regulatory requirements. **System:** UHD EPRR is a fundamental element of the wider NHS Dorset Integrated Care System; Dorset Local Health Resilience Partnership (LHRP); and Dorset Local Resilience Forum (LRF). Within these systems, UHD plays an integral and active part.
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-Led ☒

	Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Audit Committee	15/10/2026	The Committee noted the report.
TMG	29/10/2026	The Group noted the report.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

University Hospitals Dorset NHS Foundation Trust

APPENDIX A

ANNUAL EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) UPDATE REPORT FOR 2025-26

Report to the Audit Committee

Report author	Mark Taylor MSc, Head of Emergency Preparedness, Resilience and Response	**Version**	Draft v. 1.0

Executive Summary

Purpose: To provide the Audit Committee with annual assurance on the Trust's Emergency Preparedness, Resilience and Response (EPRR) arrangements for 2025-26, as required by the NHSE EPRR Core Standards annual assurance process.

- **Assurance position:** Dorset ICB has recommended that UHD is Substantially Compliant, being Fully Compliant in 60 of the 62 NHSE EPRR Core Standards. Final NHSE sign off is pending.
- **Partial compliance:** Two areas, namely the Data Security and Protection Toolkit (revised target date December 2026) and 24/7 decontamination capability in the Emergency Departments (PRPS trained staffing and identification, with remedial actions in progress).
- **Risks:** Two EPRR risks are managed through the Emergency Planning Group: Business Continuity Planning and Preparedness (Moderate, 8-12) and Key Staff to be trained in Incident Response (Low, 4-6).
- **Organisational learning:** Appendix One records 29 actions across four incidents and exercises, of which 19 are complete and 10 are in progress.
- **Forward plan:** A 17 point work plan for 2026-27 (section 7), including the review of the EPRR and Business Continuity policies, Martyn's Law preparedness and improved training and exercise compliance.

Recommendation: The Audit Committee is asked to note the content of this report and the Substantially Compliant assurance position, and to note the actions in hand to address the two areas of partial compliance.

1. Purpose and Background

To comply with the Civil Contingencies Act 2004 (CCA) as a category one responder, UHD is required to demonstrate its ability to deal with a variety of significant and potentially disruptive incidents whilst maintaining safe and effective levels of service delivery to its patients. This programme of work is referred to as Emergency Preparedness, Resilience and Response (EPRR).

This annual Emergency Preparedness, Resilience, and Response (EPRR) report considers various areas of EPRR concern for the past year and outlines proposed EPRR related work activity for the next 12 months.

An annual EPRR Report to the Board is a requirement of the NHSE EPRR Core Standards annual assurance process.

2. Strategic Governance

The delivery of effective Emergency Preparedness, Resilience, and Response (EPRR) is a key priority for the NHS and the requirements for EPRR are set out in the NHS England planning framework; the NHS standard contract; and through the NHS England Emergency Planning Framework. These responsibilities are detailed in the '*NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)*'.

The core standards require a structure in place for the effective management of the EPRR agenda. To meet these requirements, the Trust has the following structure in place:

- **Board Lead for Emergency Preparedness, Resilience, and Response matters:** This role is carried out by Mark Mould – Chief Operating Officer / Accountable Emergency Officer (AEO).
- **Head of Emergency Preparedness, Resilience, and Response:** This role is carried out by Mark Taylor MSc, Head of Emergency Preparedness, Resilience, and Response.
- **Emergency Planning Group (EPG):** meets monthly under the Chairmanship of the Chief Operating Officer / Deputy Chief Operating Officer and oversees the implementation and oversight of matters related to EPRR.
- **External Assurance Process:** NHSE EPRR Core Standards annual assurance process (September) and CBRN / HAZMAT Assurance Process.
- **Internal Audit Process:** Elements of UHD Business Continuity Management System are regularly audited by external auditors. The latest audit was completed by BDO in 2025.

The Annual NHSE EPRR Assurance process for Acute Trusts assesses against 62 Core Standards aligned with ten Domain areas (Governance; Duty to Risk Assess; Duty to Maintain Plans; Command & Control; Training & Exercising; Response; Warning & Informing; Cooperation; Business Continuity; CBRN / HAZMAT). The Trust's position against each Domain is set out in section 3.2.

3. Updates

3.1 EPRR Risk Management

EPRR currently has two identified risks managed through the EPG:

1. **Business Continuity Planning and Preparedness** – Moderate Risk Rating (8-12).

   Please see para 3.5 below (Business Continuity Management System) and sections 4-6 below (Training / Exercises / Organisational Learning), for details on how this risk is being managed.

2. **Key Staff to be trained in Incident Response** – Low Risk Rating (4-6).

   Please see sections 4-6 below (Training / Exercises / Organisational Learning), for details on how this risk is being managed.

3.2 NHSE EPRR Core Standards Assurance 2025-26 (See table below)

The NHSE EPRR Core Standards Assurance process for 2025-26 is pending the confirmed submission of the NHS Dorset ICB assurance evidence to NHSE for final NHSE agreement and sign off.

The formal ICB led EPRR Assurance 'Confirm and Challenge' meeting took place on 1st October 2026.

> Following our evidence submission against the 62 NHSE EPRR Assurance Standards (including CBRN/HAZMAT Assurance) there was an agreed recommendation from Dorset ICB that UHD is **SUBSTANTIALLY COMPLIANT** on the basis that it is Fully Compliant in 60 of the 62 standards.

NHSE EPRR Core Standards Assurance 2025-26

No.	Domain	Number of Standards	Fully Compliant	Partially Compliant	Non-Compliant
1	Governance	6	6	0	0
2	Duty to Risk Assess	2	2	0	0
3	Duty to Maintain Plans	11	11	0	0
4	Command & Control	2	2	0	0
5	Training & Exercising	4	4	0	0
6	Response	7	7	0	0
7	Warning & Informing	4	4	0	0
8	Cooperation	4	4	0	0
9	Business Continuity	10	9	**1**	0
10	CBRN / HAZMAT	12	11	**1**	0
	Total Standards	**62**	**60**	**2**	**0**

However, UHD was found to be partially compliant in the following two areas of assurance:

1. **Data Security and Protection Toolkit (DSPT):** UHD had not fully met the required standard on the Data Security and Protection Toolkit (DSPT).

   Response:

   At the current time, there is a revised target date of December 2026 for the attainment of the DSPT audit standard.

2. **Decontamination capability availability 24/7:**
   a. UHD EDs could not evidence a shift rota planning process that ensured a minimum required number of Pressurised Respiratory Protective Suits (PRPS) trained ED staff are on duty per shift;
   b. There was no system to ensure that ED NiCs could readily identify which of their shift staff were PRPS trained in the event of an emergency.

   Response:

   - Current ED shift planning processes are under review to ensure that a minimum number of PRPS trained ED nursing staff are available per shift.
   - Delivery of PRPS training is being accelerated to further increase the numbers of ED nursing staff who are PRPS trained.
   - The former system of PRPS trained staff identification was via the ESR system, however, UHD wide changes to the system during 2025-26 removed staff training designations from the system, effectively removing the system used for ED staff skills identification in an emergency. A review is currently in progress to identify an alternative system to address this gap.

There was no 'Deep Dive Investigation' element to the 2025-26 EPRR Assurance Process.

Chemical, Biological, Radiological and Nuclear (CBRN) / Hazardous Materials (HAZMAT) Response Plan Assurance 2025-26

This element of the wider NHSE EPRR Core Standards Assurance process was overseen by SWAST and included site visits to observe Decontamination equipment set up as per Decontamination footprints, and interviews of duty ED staff with decontamination-related roles e.g. Receptionists / ED Nurse in Charge.

3.3 EPRR Policies

There are two EPRR related policies in place guiding EPRR delivery:

- **Emergency Preparedness, Resilience, and Response Policy**
- **Business Continuity Policy**

Both policies are due their three yearly reviews in 2026, which are currently in progress.

3.4 EPRR Response Plans

UHD EPRR response plans are now written into the IIMARCH (Information / Intention / Method / Administration / Risk assessment / Communications / Human Rights) Plan format as they are reviewed and updated.

The following indicative plans are in place having been signed off by the Emergency Planning Group (EPG):

- Command, Control, Coordination, and Communication (C4) Plan
- Major Incident Plan
- Strategic / Tactical Business Continuity / Critical Incident Plan
- CBRN / HAZMAT Decontamination / Response Plans
- VIP Plan
- Cold Weather Plan
- Adverse Weather Plan
- Heatwave Plan
- Mass Casualty Plan
- Lockdown Plan
- Evacuation and Shelter Plan

3.5 Business Continuity Management System (BCMS)

The new Operational (Bronze) Level Business Continuity Plans (BCP) continue to be rolled out across all UHD Wards and Departments with a continued focus on critical areas and clinical areas subject to Transformation-related moves.

Business Impact Analysis (BIA): In addition to the high-level Strategic BIA which has identified a prioritised list of UHD critical services, Operational (Ward / Department) level BIA continues to be conducted as an element of each new operational (Ward / Department) level business Continuity planning process.

3.6 Martyn's Law

The EPRR Team are currently working closely with the UHD Security Managers (Accredited Security Management Specialists (ASMS)) in conducting a Security Threat and Vulnerability Assessment in advance of the introduction of Martyn's Law (The Terrorism (Protection of Premises) Act 2025) in Spring 2027.

The Act identifies four key types of procedures to be considered:

- **Evacuation** – Safely moving people out of the premises
- **Invacuation** – Moving people into the premises or to safer internal areas
- **Lockdown** – Securing the premises to prevent entry or exit (e.g. locking doors, deploying barriers)
- **Communication** – Alerting individuals and directing them away from danger

The current NHS England EPRR Core Standards includes standards relevant to these subjects, and UHD already has plans in place that are relevant to these procedures, however, ahead of the likely implementation date, it is proposed that all plans relevant to the above identified procedures will be subject to further review and revision as required.

3.7 BEACH Building (RBH)

The EPRR Team continues to be heavily engaged in the review and subsequent implementation of the HUGS Baby Tagging alarm and lockdown processes and the writing of the supporting response plan /

SOP. A recent EPRR Team instigated baby abduction exercise identified previously unknown weaknesses in the HUGS Baby Tagging System resulting in the protracted deployment of security contractors on BEACH building levels 2 and 3 whilst the identified issues were remedied. Linked to this work is the ongoing review of the wider BEACH lockdown footprints activated by buttons located behind the main BEACH Reception Desk; the ED UTC Reception Desk, and in the RBH Operations / CCTV room.

In September 2026, in conjunction with UHD Fire Safety Advisors; Simulation Team; Children's Health Nursing Team; and Dorset & Wiltshire Fire & Rescue Service; the EPRR team instigated a live Fire Evacuation Exercise on the 4th Floor of the BEACH Building. The learning outcomes from the exercise are still being worked through but gave an opportunity to test revised Fire Response action cards and identified the challenges of coordinating and managing the evacuation of a ward of patients and the subsequent issues arising concerning tracing patients and ensuring ongoing appropriate care based upon individual patient acuity.

4. Training

Whilst access to external LRF / CCU delivered training courses remains and has recently been re-publicised, the current focus remains on the delivery of internally delivered bespoke training packages directed primarily towards On-Call Managers, On-Call Directors, Clinical Site Managers, the newly appointed UHD Duty Managers, and Loggists (please see Appendix Two: Table of Training Courses / Exercises delivered to date).

An EPRR Induction package continues to be delivered twice a month on alternate Poole / RBH sites.

Ad hoc training and support continues to be rolled out for staff responsible for writing the new format Operational Level BCPs.

As the new Operational Level BCPs are being introduced, training for the staff responsible for implementing BCPs at a Ward / Department level is also available with a proposed move towards basic BCP training / exercise delivery by Ward leads following training by the EPRR Team.

On-Call Managers / Directors and CSMT are now supported in their role by an EPRR aide-memoire which assists in guiding the appropriate response to incidents. These will support and be supported by the roll out of the training currently being delivered.

The EPRR team are moving towards supporting the ED PRPS trainers in the delivery of PRPS training to support the delivery of such training to larger cohorts of ED Nursing staff thereby speeding up rate of training delivery and increasing the numbers of ED Nursing staff trained. The training delivered on PRPS training days will also be wider in scope to widen the skills base of staff attending the training.

5. Exercises

(Please see Appendix Two: Table of Training Courses / Exercises delivered to date).

Tabletop exercises continue to be delivered as a supporting element of the current Loggist / Working with your Loggist; Initial Incident Management; and Principles of Health Command Training Courses.

The UHD Cyber Security Manager led a Tabletop exercise (20/05/26) to test UHD response to a Cyber incident.

The number of tabletop exercises delivered in 2025-26 has been reduced due to capacity pressures, and several live incidents which have made it difficult to release staff from duties for the purposes of exercise attendance. However, in the absence of exercises to test plans and procedures, it is recognised that the management of live incidents equate to the delivery of exercise scenarios. UHD has experienced several incidents throughout the 2025-26 assurance period including several Fire related incidents, Heatwave events, and losses of power, water, and IT systems. These have all variously tested our response plans, ICC, and Command and control arrangements.

A number of lower-level Decontamination Footprint Exercises have been conducted at RBH to further test and fine tune the new RBH ED Decontamination Footprint.

Two live CBRNe / HAZMAT Decontamination Training sessions are to be held by the end of 2026. These will be run in conjunction with established PRPS training dates. They will entail the establishment of full decontamination footprints by portering teams; the deployment of ED staff in Chemical suits; the subsequent management of contaminated casualties through the disrobe / wet decontamination / re-robe process; followed by the decontamination of the staff deployed in chemical suits; and their eventual disrobe.

The EPRR Team has also been instrumental in the delivery of live baby abduction and Fire Evacuation exercises in the BEACH Building.

6. Organisational Learning

The current UHD Organisational Learning Table is attached (Appendix One) detailing some of the more significant incidents experienced / exercises participated in by UHD and the organisational learning identified from them.

7. Next Steps Work Plan 2026-27

Ref	Action Required	Owner	Quarter
1	Ongoing work to create / enhance UHD culture of organisational resilience	AEO/Head of EPRR	2027 Q4
2	Ongoing review of UHD Command & Control / ICC arrangements.	Head of EPRR	2026 Q3
3	Maintenance of UHD Business Continuity Management System.	Head of EPRR	2027 Q4
4	Continued roll out of new format Operational level BCPs.	Head of EPRR	2027 Q4
5	Continued work with Informatics Team re: ongoing development of IT System related BCPs.	Head of EPRR / Informatics	2027 Q4
6	Continued work with Estates Team re: ongoing development of high-level resilience measures.	Head of EPRR / Estates	2027 Q4
7	Continued work with Transformation Team re: ongoing alignment of project delivery with incorporation of EPRR related considerations for emergency preparedness, service resilience, training, and exercising.	Head of EPRR / Director of I&I	2027 Q4
8	Ongoing support to UHD Fire Safety Group re: review of Fire Response Plan and implementation of new Action Cards in response to organisational learning identified from UHD live fire incidents.	Head of EPRR / Estates	2026 Q4
9	Ongoing support to IPC Team re: review and revision of HCID Action cards and supporting action plan.	Head of EPRR / IPC	2026 Q3
10	Continued work with RBH Helipad T&F group to support delivery of long-term plans for RBH Helipad safety and operations.	Head of EPRR / AD Operations	2027 Q4
11	Continued work with UHD Climate Change Adaptation lead to bring work under the umbrella of EPRR Policy in alignment with NHSE EPRR Assurance process.	Head of EPRR / Sustainability Officer	2026 Q3
12	Ongoing review and iterative development of UHD Response / Business Continuity Plans.	Head of EPRR	Ongoing
13	Ongoing review and introduction of additional EPRR related training to reflect introduction of new and revised response plans / lessons identified re: organisational learning.	Head of EPRR	Ongoing
14	Ongoing review of UHD EPRR related induction / mandatory training delivery.	Head of EPRR	Ongoing
15	Review delivery of scheduled programme of EPRR related exercises in line with requirements of NHS EPRR assurance process.	Head of EPRR	2026 Q3
16	Increased focus on further improved EPRR related training / exercise compliance.	Head of EPRR	2026 Q4
17	Ongoing review of EPRR related debrief / post incident review / organisational learning processes to ensure culture of continuous development and improvement is fostered. Including establishment of EPG role in signing off on identified organisational learning requirements / options / completion.	Head of EPRR / DCOO	2026 Q4

Mark Taylor MSc
UHD Head of Emergency Preparedness, Resilience, and Response (EPRR)

APPENDIX ONE

UHD ORGANISATIONAL LEARNING TABLE: JUNE 2025 TO JUNE 2026

Appendix to the Annual EPRR Update Report 2025-26 (section 6)

This table details some of the more significant incidents experienced and exercises participated in by UHD during the period, and the organisational learning identified from them.

Summary

Incident / Exercise	Date	Type	Actions	Complete	In progress
CBRNe / HAZMAT Decontamination Footprint Exercise	10 June 2025	Exercise	5	2	3
Hospital Plant Room Fire (RBH)	7 July 2025	Incident	14	13	1
Hospital Plant Room Flooding (PGH)	Date not stated	Incident	2	2	0
Loss of Power / ICC Exercise	12 August 2025	Exercise	8	2	6
Theatres Fire Evacuation (RBH)	18 March 2026	Incident	6	2	4
Power Outage (RBH)	3 May 2026	Incident	31	11	20
Cyber Incident Response Exercise	20 May 2026	Exercise	4	4	0
Live Fire Incident Response Exercise (PGH)	18 June 2026	Exercise	9	2	7
Red Heat Health Alert	June 2026	Incident	10	9	1
Total recorded actions			**89**	**47**	**42**

Status key (as colour coded in the original table): **Complete** action closed or noted. **In progress** action open or under review.

APPENDIX TWO

Appendix to the Annual EPRR Update Report 2025-26 (sections 4 and 5)

Consolidated record of training courses, resources and exercises delivered, ongoing or planned, drawn from sections 4 and 5 of this report and Appendix One.

Summary: 16 entries (7 training courses and resources, 9 exercises). 9 delivered, 6 ongoing, 1 planned.

Status key: **Delivered** completed. **Ongoing** rolling programme. **Planned** scheduled, not yet delivered.

No.	Course / Exercise	Type	Date / frequency	Target audience	Status	Attendance	Notes
Training courses and resources							
2.1	**Bespoke internal EPRR training packages**	Training	Ongoing, 2025-26	On-Call Managers, On-Call Directors, Clinical Site Managers, UHD Duty Managers, Loggists	**Ongoing**		Current focus of the training programme. External LRF / CCU courses remain available and were recently re-publicised.
2.2	**EPRR Induction package**	Training	Twice monthly, alternating Poole and RBH sites	Ongoing	**Ongoing**		
2.3	**Loggist / Working with your Loggist; Initial Incident Management; Principles of Health Command**	Training	Ongoing	Ongoing	**Ongoing**		Courses include a tabletop exercise element.
2.4	**Operational Level BCP writing: training and support**	Training	Ad hoc, ongoing	Staff responsible for writing the new format Operational Level BCPs	**Ongoing**		
2.5	**Operational Level BCP implementation training**	Training	Available, ongoing	Staff implementing BCPs at Ward / Department level	**Ongoing**		Proposed move towards basic BCP training and exercise delivery by Ward leads, following training by the EPRR Team.
2.6	**PRPS (Pressurised Respiratory Protective Suits) training days**	Training	Ongoing, being accelerated	ED nursing staff	**Ongoing**		EPRR Team moving towards supporting ED PRPS trainers to reach larger cohorts, with wider scope. Linked to the partial compliance on 24/7 decontamination capability.
2.7	**EPRR aide-memoire for incident response**	Resource	Issued	On-Call Managers, On-Call Directors and CSMT	**Delivered**		Guides the appropriate response to incidents; supports and is supported by the training roll out.
Exercises							
2.8	**CBRNe / HAZMAT Decontamination Footprint Exercise (RBH)**	Exercise	10 June 2025	Portering staff	**Delivered**		Ended early due to a Loss of IT BC incident. Five actions logged (Appendix One).
2.9	**Loss of Power / ICC Exercise**	Exercise	12 August 2025		**Delivered**		Tested C4 / ICC alignment. Eight actions logged (Appendix One).
2.10	**Lower-level Decontamination Footprint Exercises (RBH ED)**	Exercise	2025-26		**Delivered**		To test and fine tune the new RBH ED Decontamination Footprint.
2.11	**Baby abduction exercise (BEACH Building)**	Exercise	Ongoing		**Delivered**		EPRR Team instigated. Identified previously unknown weaknesses in the HUGS Baby Tagging System.
2.12	**Cyber Incident Response tabletop exercise**	Exercise	20 May 2026		**Delivered**		Led by the UHD Cyber Security Manager. See Debrief Report.
2.13	**Live Fire Incident Response Exercise (PGH)**	Exercise	18 June 2026		**Delivered**		With DWFRS. See Debrief Report.
2.14	**Live Fire Evacuation Exercise, BEACH Building 4th Floor**	Exercise	September 2026		**Delivered**		With UHD Fire Safety Advisors, Simulation Team, Children's Health Nursing Team and DWFRS. Learning outcomes still being worked through.
2.15	**Tabletop exercises within training courses**	Exercise	2025-26, number reduced		**Delivered**		Reduced due to capacity pressures and live incidents. Live incidents are recognised as equivalent to exercise scenarios.
2.16	**Two live CBRNe / HAZMAT Decontamination training sessions**	Exercise	By end of 2026	Portering teams and ED staff in chemical suits	**Planned**		Run with established PRPS training dates. Full decontamination footprints, disrobe, wet decontamination and re-robe.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **6.3.2**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Review of embedding and effectiveness of the Accountability Framework
Prepared by:	Leonora May, Director of Corporate Governance
Presented by:	Leonora May, Director of Corporate Governance Mark Mould, Chief Operating Officer
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Assurance
Executive summary:	The current accountability-framework was approved by the Board in March 2026 and establishes the Trust's arrangements for governance, accountability, performance management, escalation, oversight, intervention and support. Following implementation of the revised Framework, and in line with an action arising from the Trust's 12-hour Emergency Department Safety Recovery Plan, a review was undertaken to assess the extent to which the Framework has been embedded across the organisation. The review found that the Accountability Framework is largely embedded across the Trust and is operating as intended. Governance structures required by the Framework have been established across all Care Groups, with clear lines of accountability, structured performance management arrangements and defined escalation routes from operational services through to the Board. Strategy Deployment Reviews (SDRs), Care Group Boards, integrated performance reporting and Board Committee assurance processes are all operating in accordance with the principles set out within the Framework. Monthly Care Group and Directorate SDRs are taking place consistently, supported by Patient First scorecards and business rules, with increasing focus on recovery of performance trajectories, management of delivery risks and implementation of mitigating actions. Executive oversight and Board assurance arrangements have also matured through

	enhanced integrated performance reporting, strengthened committee scrutiny and improved escalation processes. The review found the Accountability Framework to be strongly aligned with both the Trust's Well-Led arrangements and Risk Management Strategy. The review also considered the actions implemented following the Trust's 12-hour Emergency Department Safety Recovery Plan and associated governance improvements. This confirmed that the Accountability Framework continues to provide an appropriate governance structure for the oversight of operational performance and delivery of the operational plan. The Framework clearly defines governance, escalation and assurance arrangements and appropriately describes the role of Board Committees and sub-committees in providing scrutiny, challenge and assurance in relation to operational performance. As a result, no changes to the Accountability Framework are considered necessary at this time. The priority remains the consistent application and embedding of the Framework across all parts of the organisation. Whilst some variation remains in the maturity of governance arrangements below Care Group level, particularly in relation to governance documentation, governance cycles and the implementation of specialty-level arrangements, these areas are being progressed through the Organising for Success programme and do not represent a significant control concern. The review has identified a small number of opportunities to further strengthen organisational maturity, including completion of governance arrangements below Care Group level and Tier 4 governance arrangements, full implementation of specialty and sub-specialty SDRs, strengthening alignment between Trust Management Group and Board assurance arrangements, continued development of integrated performance and risk reporting, and strengthening accountability and leadership capability at frontline management level. The review also identified an opportunity to strengthen understanding of accountability, governance and decision-making responsibilities below Care Group level. Continued development of Tier 4 governance arrangements will strengthen accountability, ownership and escalation at ward, department and specialty level. This aligns with actions arising from the Trust's Well-Led improvement plan, particularly in relation to middle management capability. A planned culture assessment will provide further insight into how consistently accountability, empowerment and escalation arrangements are understood and applied across the organisation and will help inform development of a Trust-wide Leadership and Management Framework. Overall, it is evident that the Accountability Framework has been successfully embedded and is making a positive contribution to governance, accountability, performance management, risk oversight and Board assurance across the Trust. The Framework has become an established component of the Trust's governance architecture and is supporting delivery of effective oversight, challenge and assurance from operational services through to the Board.

	The review has been undertaken within the context of the current NHS Foundation Trust governance arrangements. The Government's proposed Health Bill is expected to result in significant changes to provider accountability arrangements, including the potential removal of current Foundation Trust membership and Council of Governors arrangements. Should the legislation be enacted, a further review of the Accountability Framework will be required to ensure continued alignment with the revised statutory, regulatory and governance requirements. The Accountability Framework is **available in the reading room**.
ALERT:	The review has identified a small number of opportunities to further strengthen organisational maturity, including: • completion of governance arrangements below Care Group level and at tier 4 (by April 2027) • full implementation of specialty and sub-specialty SDRs (by April 2027) • strengthening alignment between Trust Management Group and Board assurance arrangements through a formal Alert, Assure and Advise reporting mechanism (by November 2026) • continued development of integrated performance and risk reporting (ongoing) • strengthen understanding of accountability, governance and decision-making responsibilities at ward, department and clinical area level through the continued development of Tier 4 governance arrangements and a Trust-wide Leadership and Management Framework. Embedding of the Accountability Framework remains the responsibility of Care Groups, supported through the Organising for Success programme. (ongoing)
ASSURE:	The review concluded that the Accountability Framework is largely embedded across the Trust and is operating effectively. Governance structures, performance management arrangements, risk management processes and Board assurance mechanisms are established and functioning in line with the principles set out within the Framework. Ongoing development of Tier 4 governance arrangements will strengthen links between frontline services and organisational governance structures, improving ward-to-board information flow and accountability. There is clear evidence that the Framework has strengthened accountability for delivery, improved escalation and oversight arrangements, and enhanced the link between operational performance, executive challenge and Board assurance. Strategy Deployment Reviews, integrated performance reporting, Board Committee scrutiny and risk management arrangements are increasingly supporting a proactive approach to identifying and managing risks to delivery.
ADVISE:	The successful embedding of the Accountability Framework is dependent upon a governance structure that supports clear lines of accountability, effective oversight and timely escalation of risks and issues. The Trust's *Organising for Success* programme continues to play a key role in strengthening operational governance arrangements at both organisational and

	Care Group level, with a particular focus on ensuring that the structures defined within the Accountability Framework are consistently implemented across the organisation.
Celebrating Outstanding:	The GGI well led review described the Trust's Accountability Framework as 'unusually clear for an NHS governance document'.
RECOMMENDATION:	The Board is asked to: • Note the outcome of the review • Take assurance regarding the implementation and embedding of the Accountability Framework
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☒ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Audit Committee	15/10/2026	The Committee noted the report.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

Review of embedding and effectiveness of the Accountability Framework

1. Review methodology

The review assessed the extent to which the Accountability Framework has been embedded across the Trust since its approval by the Board in March 2026. The review was undertaken by the Director of Corporate Governance and focused on whether the governance, accountability, escalation and assurance arrangements described within the Framework are operating in practice as intended.

The review included:

- Review of governance documentation, including Care Group governance structures, Terms of Reference and governance cycles.
- Review of Board, Committee, Trust Management Group, Care Group Board and Directorate governance arrangements and supporting documentation.
- Review of Strategy Deployment Review (SDR) processes at Care Group and Directorate level.
- Review of Integrated Performance Reporting, Counter Measure Summaries and performance management arrangements.
- Review of escalation, oversight, intervention and support processes.
- Review of the alignment between the Accountability Framework, Risk Management Strategy and Well-Led arrangements.
- Consideration of evidence arising from the Organising for Success programme.

The review considered the extent to which:

1. Governance structures are operating as defined within the Accountability Framework.
2. Accountability arrangements are understood and being applied.
3. Performance management processes, including SDRs, are operating effectively.
4. Escalation and assurance processes are functioning as intended.

2. Findings

a. Governance

The successful embedding of the Accountability Framework is dependent upon a governance structure that supports clear lines of accountability, effective oversight and timely escalation of risks and issues. The Trust's *Organising for Success* programme continues to play a key role in strengthening operational governance arrangements at both organisational and Care Group level, with a particular focus on ensuring that the structures defined within the Accountability Framework are consistently implemented across the organisation.

At Committee level, oversight and assurance have been strengthened through the use of integrated reporting and enhanced scrutiny of areas that are not delivering to plan. The Finance and Performance Committee receives the Integrated Performance Report each month and undertakes focused scrutiny of areas of concern or where additional assurance is required. The Committee considers the reasons for underperformance, the effectiveness of recovery actions, delivery risks and the adequacy of executive oversight arrangements. The Committee

Chair reports directly to the Board, providing visibility of performance risks and a clear assessment of the assurance available in relation to recovery plans and delivery trajectories. Similarly, the Quality Committee receives the Integrated Performance Report each month and considers the quality and patient safety implications associated with areas of operational underperformance. This provides an additional layer of scrutiny and assurance, ensuring that the impact of delivery challenges on patient outcomes and safety is fully understood. Reporting from the Committee Chair enables the Board to consider quality, safety and operational performance in the round and supports effective challenge where concerns are identified.

The Board receives the Integrated Performance Report at each meeting, together with assurance reports from Committee Chairs. The report uses Statistical Process Control methodology and measures performance against the targets and trajectories agreed within the Trust's operational plan. The review found that the Board has continued to strengthen its oversight arrangements in response to previous self-assessment findings and emerging organisational priorities. In particular, enhancements have been made to the Integrated Performance Report to improve the visibility of oversight metrics, plan status and breakthrough objectives, with a more consistent approach adopted throughout the report. A particular strength identified through the review is the increased focus on exception reporting and oversight of areas that are off plan. Enhanced reporting arrangements now provide greater transparency regarding the impact of emerging risks on delivery, supporting earlier Board discussion of mitigations, recovery actions and delivery risks. Recovery action plans are routinely incorporated within committee and Board reporting, enabling progress to be tracked and scrutinised through established governance arrangements.

As part of this review, consideration was given to the governance improvements introduced following the Trust's 12-hour Emergency Department Safety Recovery Plan. This included reviewing whether the Accountability Framework continued to provide an adequate basis for operational performance oversight and assurance. The review concluded that the Framework remains fit for purpose and does not require amendment as a consequence of the actions arising from the 12-hour waits improvement programme. Whilst the Framework does not prescribe the detailed content of the Integrated Performance Report, it clearly establishes the governance and accountability arrangements through which organisational performance is monitored, challenged and escalated. The respective roles of Board Committees and supporting governance forums in scrutinising operational delivery and performance against plan are also clearly described and are operating as intended.

The Framework sets out a number of minimum governance requirements for Care Groups. These include defined lines of accountability to Executive Directors through the Care Group Strategy Deployment Review (SDR) process, the establishment of a Care Group Board, and supporting governance forums for quality and safety, transformation, finance and workforce. In addition, Care Groups are expected to maintain documented Terms of Reference for governance forums, operate a weekly patient safety review process, and ensure that Directorate SDRs are aligned to the Trust's performance management framework and provide an effective mechanism for escalation into Care Group governance arrangements.

The review found that Care Group Strategy Deployment Reviews (SDRs) are taking place monthly across all Care Groups in line with the requirements of the Accountability Framework. These meetings are supported by the Patient First performance management framework, including the use of agreed scorecards, performance measures and business rules, which provide a consistent and structured approach to performance review and escalation. Evidence from the review demonstrated that the SDR process has matured since implementation of the Framework and is increasingly focused on areas where performance trajectories are not being achieved. Discussions are characterised by greater challenge and scrutiny of underlying

causes, recovery actions, delivery milestones and executive support requirements. Where trajectories remain off track, there is a clear focus on the actions required to recover performance, the risks to delivery and the mitigations in place to address those risks. In line with the Trust's performance management framework, enhanced support and intervention arrangements are deployed where required, ensuring that Care Groups receive appropriate executive oversight and assistance to achieve improvement. This provides a clear demonstration of the Accountability Framework operating as intended, with structured challenge, escalation and support mechanisms reinforcing accountability for delivery at all levels of the organisation.

A review of compliance against these minimum expectations found that all Care Groups have established the required governance structures and forums. There is clear evidence that the core governance architecture described within the Accountability Framework is in place across the organisation and is supporting the flow of information, oversight and escalation between operational services, Care Groups and the Executive Team.

The review also found that Directorate SDRs are now taking place consistently across all Care Groups on a monthly basis and are being used to support performance oversight and escalation ahead of Care Group SDRs. In line with the Accountability Framework, Care Groups are currently progressing the introduction of specialty and sub-specialty SDRs to strengthen accountability further and support the escalation of issues from service level through to directorate and Care Group governance structures. Whilst implementation is at varying stages of maturity, this programme of work continues to progress across all Care Groups and is expected to further strengthen the operation of the Framework over time.

Whilst the required structures are in place, the review identified some variability in the maturity of supporting governance arrangements within Care Groups. In particular, a number of governance groups operating below Care Group level are still developing key governance disciplines, including formal Terms of Reference, annual governance cycles and the consistent application of Triple A reporting. This work is being progressed through the *Organising for Success* programme, with implementation monitored through regular reporting to the Patient First Steering Group.

Whilst the review found that governance, assurance and accountability arrangements are operating effectively, it is considered that alignment between Executive and Board oversight could be further strengthened through the introduction of a regular *Alert, Assure and Advise* report from the Trust Management Group to the Board as part of the Chief Executive's report. This would provide a structured mechanism for highlighting emerging issues, communicating executive assurance and identifying areas where Board awareness, support or direction may be beneficial, further strengthening accountability and line of sight across the organisation.

b. Well led

The review considered the extent to which the Accountability Framework supports the Trust's Well-Led arrangements. The Framework was developed in alignment with the CQC Single Assessment Framework and provides a clear structure for governance, accountability, performance management and assurance.The review found that the Framework has become an established component of the Trust's governance architecture and is supporting delivery of the Trust's strategic priorities through clear accountability arrangements and structured governance processes. Strategy Deployment Reviews (SDRs) provide a clear line of sight between organisational objectives and operational delivery, with Executive Directors, Care Group leadership teams and Directorate leaders held to account through defined performance management arrangements.

The review found particularly strong evidence against the Well-Led quality statements relating to governance, accountability and the use of information. Integrated performance reporting, SDRs, Board Assurance Framework processes, risk management arrangements and Board Committee oversight provide effective mechanisms for monitoring performance, identifying emerging risks and escalating concerns appropriately. Recent enhancements to integrated performance reporting have further strengthened Board oversight and assurance.

The Framework also supports a culture of challenge, transparency, continuous improvement and organisational learning. Accountability discussions are increasingly focused on recovery of performance trajectories, management of risks and delivery of improvement actions, supported by structured escalation and intervention arrangements where required.

The review identified an opportunity to strengthen organisational understanding of accountability, governance and decision-making responsibilities below Care Group level. Whilst accountability arrangements are well established at Board, Executive, Care Group and Directorate level, further work is required to understand how consistently the principles of the Accountability Framework have been embedded within ward, department and clinical area leadership arrangements. Effective accountability is dependent not only on governance structures and reporting arrangements, but also on the behaviours, culture and leadership practices that support ownership, decision-making and escalation.

This finding aligns with actions arising from the Trust's Well-Led Leadership and Governance Review and subsequent improvement plan, which identified the need to strengthen leadership and management capability, particularly amongst middle managers who play a critical role in translating organisational strategy, governance and accountability arrangements into day-to-day operational practice. It also aligns with the Organising for Success programme and the continued development of Tier 4 governance arrangements, which are intended to strengthen accountability, ownership and escalation from ward, department and specialty level through to Directorate, Care Group and Trust governance structures. A planned culture assessment will provide further insight into staff understanding of accountability, empowerment, decision-making and escalation, and help identify any additional actions required to strengthen embedding of the Accountability Framework at frontline leadership level. These findings also support the development of a Trust-wide Leadership and Management Framework to provide greater clarity regarding leadership expectations, governance responsibilities and accountability arrangements, and to support the consistent development of management capability across the organisation.

Overall, the review concluded that the Accountability Framework is supporting the Trust's Well-Led arrangements as intended. Clear governance structures, defined accountabilities and effective assurance processes are in place and operating effectively, providing assurance that the principles and requirements of the Well-Led framework are embedded across the organisation.

c. Risk management and assurance

The review considered the extent to which the Accountability Framework has been embedded in support of the Trust's Risk Management Strategy. The review found strong alignment between the two documents, both of which promote devolved accountability, clear ownership of risks, and structured escalation and assurance arrangements from operational services through to the Board.

Risk management responsibilities are clearly defined throughout the organisation. Individuals are accountable for identifying, assessing and managing risks within their areas of responsi-

bility, with risks escalated through established governance structures where additional oversight, support or intervention is required. The review found evidence that these arrangements are understood and operating as intended.

The risk escalation process is closely aligned to the governance arrangements set out within the Accountability Framework. Risks are reviewed through Directorate governance meetings, Care Group Boards, the Risk Oversight Committee, Board Committees and the Board, ensuring that risks receive scrutiny and oversight at an appropriate level. This provides a clear and auditable route for escalation and supports effective executive and Board assurance.

The review also found that risk management is increasingly integrated with performance management. Strategy Deployment Reviews (SDRs), Care Group governance arrangements and integrated performance reporting are being used to identify risks to delivery, monitor mitigating actions and hold leaders to account for the management of risks and recovery plans. This supports earlier identification of emerging issues and strengthens organisational accountability.

Overall, the review concluded that the Risk Management Strategy and Accountability Framework are aligned and mutually reinforcing. Clear arrangements are in place for risk ownership, escalation and assurance, and there is evidence that these have been embedded across the organisation and are operating effectively.

3. Overall assessment

The review has been undertaken within the context of the current NHS Foundation Trust governance and accountability framework. However, the Government's proposed Health Bill is expected to introduce significant changes to NHS provider accountability arrangements, including the role of NHS England, Integrated Care Boards and provider organisations. The proposed reforms are also expected to remove the current statutory governance arrangements relating to Foundation Trust membership and Councils of Governors, fundamentally changing existing accountability mechanisms. Should the legislation be enacted, the Trust will undertake a review of the Accountability Framework to ensure that it remains aligned to the revised statutory, regulatory and governance requirements and continues to provide a clear and effective framework for accountability, oversight and assurance across the organisation.

The review concluded that the Accountability Framework is largely embedded across the Trust and is operating effectively. Governance structures, performance management arrangements, risk management processes and Board assurance mechanisms are established and functioning in line with the principles set out within the Framework.

There is clear evidence that the Framework has strengthened accountability for delivery, improved escalation and oversight arrangements, and enhanced the link between operational performance, executive challenge and Board assurance. Strategy Deployment Reviews, integrated performance reporting, Board Committee scrutiny and risk management arrangements are increasingly supporting a proactive approach to identifying and managing risks to delivery.

The review confirms that the principal opportunity for improvement relates to the consistency of implementation rather than the design of the Framework itself. The Accountability Framework remains fit for purpose and provides a sufficiently clear structure for accountability, escalation, performance oversight and assurance. Continued focus should therefore be directed towards embedding the Framework at all levels of the organisation, with Care Groups retaining responsibility for ensuring that its requirements are applied consistently in practice.

Whilst some governance arrangements below Care Group level continue to mature, these areas are being progressed through the Organising for Success programme and do not represent a significant control concern.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Finance and Performance Committee – Chair's Report
Presented by:	Alastair Matthews, Chair of the Finance and Performance Committee.

Agenda items discussed:	At its meeting held on **5 October 2026**, the Committee received reports on the following:
	• 2026/27 Financial Performance Month 5, including forecast
	• Efficiency Improvement Programme
	• New Hospitals Programme: Cashflow and Contract
	• 2026/27 Operational Performance Month 5
	  ○ 12 hour waits- action plan (Final letter)
	  ○ Operational Plan exception report
	  ○ NHS Oversight Framework
	• Winter Plan 2026 (final)
	• Services Reconfiguration in April 2027
	• HealthSet Programme update
	• Estates Compliance Report
	• Private Patients – exception reporting
	• Risk Register: review of significant risks; new risks rated 12 and above (Finance and Performance)
	
	The Committee recommended to Board to approve:
	• Implantable Cardioverter Defibs (ICD's) and Cardiac Rhythm Management
	• Pathology Managed Service Contract for Microbiology
	• The Redevelopment of St Mary's Site
	The Committee approved:
	• DrDoctor Consumables

ALERT	1. Cancer performance remains behind trajectory with some slippage in the anticipated timing for recovery of the FDS standard which had been expected by the end of Q2. The expectation remains that the 62 day standard will be achieved by the end of Q4. The Committee reviewed the recovery actions and improved governance arrangements. (Partially Assured) 2. The No Criteria to Reside levels remain well above 200 - in percentage terms the Trust has one of the highest levels in England. The Committee reviewed the various actions the Trust is taking around better flow better care and noted that there was a new system level oversight board now in place to oversee a system wide

	improvement response. Whilst there have been important actions already taken to close commissioning gaps and develop systemwide improvements these are not yet being reflected in reduced NCTR levels. (Not Assured) 3. The Trust continues to forecast a full year breakeven financial outturn. The forecast assumes a significant improvement in risk adjusted EIP delivery by the year end and progress continues to be positive in this respect. The forecast also includes a significant non-recurrent mitigation that has yet to be delivered, with positive progress continuing. (Partially Assured) 4. The Committee has continued to seek assurance on the delivery of recurrent savings which are currently forecast to deliver c50% of the recurrent level assumed in the medium term financial plan. Failure to improve this significantly will put extreme pressure on the Trust's financial position next year. Management have been increasing the focus on this but there has been little improvement over recent months. The Committee will be requiring Care Groups to attend F&PC over the next couple of meetings to set out their plans to improve. (Not Assured)
ASSURE	1. The improved IPR and other reporting to F&PC is enabling a clear focus on in-year trajectories, recovery actions and their timescales. 2. The Trust has delivered a financial deficit of £11.7m which is marginally better than plan at the end of August. 3. RTT performance continues to be good and 4hr and 12hr performance shows ongoing improvement. The Committee did, however, note that the trajectory for 4hr performance improves by c10% by March 2027 and that delivering this will require significant ongoing improvements in both organisational actions and system actions (NB item (2) above). 4. The Heathset Programme is progressing well with the overall Programme status moving from Watch to Good. There is particular emphasis being placed on legacy systems identification as a significant element of financial benefit depends on many of these being replaced by the EPIC system. 5. The Winter Plan had been submitted following further scrutiny at an extraordinary Board in mid-September.
ADVISE	1. Whilst the diagnostic performance improved slightly it remains behind trajectory. Actions are in place to improve the performance in Echocardiogram and the recent opening of the new Endoscopy unit provides assurance that available capacity should facilitate reduced endoscopy waits. 2. The Trust continues to struggle with the number of patients waiting more than 52 weeks for Community Health (Neurodevelopmental) services. The Trust and ICB are looking at actions to help address what is a national challenge with the situation in Dorset particularly difficult. Currently there is no identified solution and it is

	expected that the revised NHS NOF will mean the Trust is particularly impacted by the performance of this service. 3. The Committee reviewed the quarterly estates compliance report and noted that timebound actions are generally in place to address highlighted issues with key issues continuing around theatre ventilation, statutory/reactive maintenance and staffing and the recent power outages in the BEACH Building. 4. Good progress was demonstrated regarding the Services Reconfiguration April 2027 programme. F&PC focussed on the financial/operational impacts. The changes required to the Operating Model to achieve the reconfiguration independent of the availability of the COAST building becoming available are substantial and require significant change both internal to UHD and system wide. The financial impact has yet to be firmly identified as it depends on how the improvements in occupied bed days are achieved – there is the potential for a significant recurrent financial benefit and this will need to be firmed up early in the 2027/8 planning process 5. The Committee were supportive of adjusting the scopes of F&PC and TCT to move digital and estates to TCT with TCT then meeting monthly with an agreement to review the change shortly after the main April 2027 moves.
Review of Risks	The Committee reviewed the risk register and discussed the new risks.
Celebrating Outstanding	The work done by the COO team and Care Groups together with other colleagues to develop the proposal to achieve the April moves independent of the availability of the COAST building was recognised as outstanding given the timeframe, complexity, attendant constraints and the need to effectively articulate a new operating model.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Finance and Performance Committee – Chair's Report
Presented by:	Alastair Matthews, Chair of the Finance and Performance Committee.
Agenda items discussed:	At its meeting held on **2 November 2026**, the Committee received reports on the following: • 2026/27 Board Assurance Framework Q2 • Risk Register: review of significant risks; new risks rated 12 and above (Finance and Performance) • 2026/27 Financial Performance Month 6, including forecast • Efficiency Improvement Programme • National Cost Collection 2025/26: post-submission report • EIP recurrent position: Surgical Care Group and WCCSS Care Group • 2026/27 Operational Performance Month 5 • Operational Plan exception report • Update on Private Patients • Committee's Terms of Reference • Committee's governance cycle The Committee recommended to Board to approve: • Use of seal: Lease surrender and renewal for the office space on 3rd floor in Tringham House The Committee approved: • Digital Diagnostics Capability Programme • Integrated Drug Database - EHR HealthSet • HealthSet – Wider Area Network (WAN) Links • Delegated authority to the CEO to approve an EEMAC capital accelerated delivery contract within agreed parameters
ALERT	1. In September No Criteria to Reside ("NCTR") levels averaged 240 and this continued very high level has continued through October and represents 23.5% of occupied beds – one of the worst levels in the country. The Committee reviewed the actions and noted the more active oversight beginning to be undertaken by the ICB with all system partners, with the most recent meeting identifying trajectories individual organisations will be

	held to account against. It was recognised that was challenging for our Local Authority which is dealing with significant financial pressures. System working and accountability appears to be improving but as yet this is not translating into reduced levels of NCTR. (Not Assured) 2. The Recurrent EIP forecast at 30 September indicates a shortfall of £19m (£21m at 31 August) against the 60% breakthrough objective in the Plan. Management have been increasing focus on these over recent months and the Surgical and WCCSS Care Groups attended F&PC as an escalation to provide the Committee with the opportunity to better understand progress and plans to further improve the situation. The Care groups were clearly well engaged in improving the recurrent delivery and identification for 2026/7 albeit there remains significant work to be done to identify and realise material improvement. This remains a significant concern with the underlying financial deficit being £57m. (Non Assured) 3. The Trust continues to forecast a full year break even financial outturn. This relies upon an £8.9m improvement in EIP delivery against the current risk adjusted EIP programme by firming up delivery of identified projects - this is subject to clearly evidenced management engagement and oversight and a significant non-recurrent mitigation which continues to progress but has yet to de delivered. Management are currently undertaking a full forecast update. (Partially Assured) 4. Cancer Performance remains behind trajectory for all 3 main indicators; the Committee reviewed the action plans presented and noted that performance was broadly stable with an expectation of improvements in 28- and 31-day standards but a recognition that achieving the 62 day trajectory by March would remain challenging. (Partially Assured)
ASSURE	1. The Trust has delivered H1 financial performance in line with the planned £13.9m deficit. 2. RTT performance continues to be good with all 3 RTT trajectories achieved in September. 3. Despite a scanner outage for a week, 6-week diagnostic performance continued on an improvement trajectory in September albeit it fell 2.1% short of the 93% trajectory.
ADVISE	1. ED 4-hour performance in September fell just 0.15% behind the 72% trajectory, however, the trajectory for October required an improvement to 74% and it is anticipated actual performance based on early information will not show improvement in September – given that the trajectory expected 94% in October and improvement to 80% by March it is clear this will need substantial further improvement from the many actions highlighted to the Committee. The Trust exceeded its 12-hour ED wait trajectory by 95 patients (albeit this performance would likely place the Trust in the top quartile of performance against other acute providers),

	with ongoing actions to improve ED waits likely to impact both measures. 2. The timeliness of clinical coding has been identified as a significant risk throughout the year and for the first time, at the National Freeze date (when further activity/coding is not accepted) 45 patients remained uncoded. The Committee noted that additional Managed Service Provider resource was now being utilised and considered the actions underway to move to the new improvement trajectory provided as an action from the previous F&PC meeting. The Committee was informed the income position would not be impacted from this missed coding occurrence. 3. The level of Operating Cash (ie; after capital payables) has reduced to 19 days when it has generally been significantly higher, this may indicate that a greater proportion of EIP is not being delivered by cash backed improvements and given the likelihood that a significant proportion of the H2 EIP is also likely to be non-cash it was recognised that a more detailed review of cash forecasting will be required going forward. 4. The Trust continues to perform poorly in terms of the number of patients waiting over 52 weeks for Community Health (neurodevelopmental) services. There is no identified plan to materially reduce this backlog of patients, this being recognised as a national as well as local challenge.
Review of Risks	The Committee reviewed the relevant BAF and Risk Register entries relevant to its terms of reference. Actions were taken for future meetings to (i) look at the timing of the risk register extract as it did not reflect the latest updates about to go in the report to the Board; and (ii) consider the format of the extracted data for each risk as it does not include actions undertaken/planned to mitigate risks.
Celebrating outstanding	N/A

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **6.4.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Premises Assurance Model
Prepared by:	Bernard Bhukal, Associate Director of Estates
Presented by:	Richard Renaut, Chief Strategy and Transformation Officer
Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	Risk Register: Risks 2017 (statutory compliance), 2093 (staffing capacity), 2355 (theatre ventilation) and 1260 (fire safety compliance).
Purpose of paper:	Information
Executive summary:	**The final version of the PAM has been uploaded, and the full submission is in the Reading room.** This is in line with the delegated authority agreed at the September Board. Good controls and governance routes are in place for Estates and Facilities Management, as scored against the new Yes/No criteria used in the PAM. Overall compliance is high, but No to assurance questions are covered in this paper. Internal Audit independently reviewed the process and was positive about the approach taken. Governance is strong overall and, where there are gaps, the appropriate groups have developed oversight and action plans are in place. The higher-impact gaps are consistent with those previously reported to the Trust Management Group and Finance and Performance Committee and through the risk register. These are • statutory planned preventative maintenance, particularly at Poole and linked to staffing; • ventilation for procedures; • aspects of fire safety requiring major investment. Other gaps highlighted by PAM relate to asset information registers and access to supporting governance evidence.

	Risk 2355, theatre ventilation, remains rated 16, with an estimated £6 million required to achieve compliance. Risk 1260 covers the fire safety assurance position, with £3 million of priority work, particularly fire doors and compartmentation. Risks 2017, overall compliance indicators, and 2093, staffing, are mainly revenue and recruitment related. The overall Estates backlog is estimated at approximately £204 million against an annual capital programme of approximately £10 million, only part of which reduces backlog. The need for increased capital expenditure will feed into UHD's annual capital planning process and be shared with regional colleagues. Bid-ready work packages will continue to be developed. The Board is asked to note the PAM final submission, support the prioritisation of capital and maintain oversight of Risks 2355, 1260, 2017 and 2093 and their mitigations.
ALERT:	The Board is alerted to the following: • **Statutory PPM and technical compliance** PAM remains rated "No" where statutory planned preventative maintenance is not fully current. Staffing constraints and operational demand continue to affect compliance. Risks 2017 and 2093 relate to statutory compliance and staffing capacity. **Action:** Work is being prioritised by risk, contractor support is used where required, recruitment to vacancies continues and oversight is maintained through operational governance groups. Purchase of the PLANET replacement is required to improve reporting. Operational Estates and Clinical Engineering review recovery monthly. **The Board is asked to support capital plan prioritisation for backlog, maintain an agile approach to bid-ready priority works and support procurement of the new Estates management system.** • **Theatre ventilation** Risk 2355 is rated 16 and remains the highest-rated Operational Estates risk. Ageing or inadequate ventilation may disrupt theatre activity and service continuity. **Action:** Senior oversight and clinical controls remain in place while verification is completed, and priorities are agreed within a funded mitigation plan. £750K has been identified for 26/7. All care groups and outpatient departments are to complete ventilation reviews, with the Ventilation Safety Group prioritising the programme. The position remains under monthly review until a funded plan is agreed. **The Board is asked to note the estimated £6 million multi-year programme is under development.** • **Fire safety** Risk 1260 covers fire risk assessment actions, fire door repairs and wider fire safety compliance improvements. **Action:** Fire Safety Group oversight and independent Fire Authorising Engineer assurance continue while a defined remediation programme is developed. The programme is monitored monthly. Good progress has been made and sustained on delivery of all fire precautions, including training, wardens, safety returns, alarm systems, exercises and internal (secondary) fire risk assessments.

	The Board is asked to support prioritisation of the approximately £3 million multi-year fire safety investment requirement
ASSURE:	• **Risk visibility and governance** The Board is assured that there was good engagement and independent verification of the PAM assessments. A working group tracks progress against the action plan and accountable groups continue oversight of their areas. Evidence includes the PAM action plans, accountable group reporting through Alert, Assure and Advise reports to the Estates, Infection Prevention and Control and Health and Safety groups, and continued oversight through the Risk Oversight Group. The risk references have been verified against the live Estates Risk Register and PAM action plans.
ADVISE:	• **Health and Safety governance** Annual H&S audits were marked as "no" as these are not soley Estates based. However, BDO, the Trust's independent auditor, is commissioned annually to undertake a targeted Health and Safety audit. The audit programme is informed by identified assurance gaps and provides independent scrutiny of the effectiveness of the Trust's Health and Safety governance arrangements. **Action:** The annual audit scope will be agreed with BDO and will include identified assurance gaps. Recommendations will be recorded in the Trust's Health and Safety improvement plan and monitored through the established governance route. If other Trusts are approaching this differently, we will learn and standardise with others. Lead: Trust Health and Safety governance team. Timescale: annual audit cycle. **The Board is asked to note the annual independent assurance arrangement and receive assurance on the audit findings, management response and progress against agreed actions.** • **Asset information and document control** Gaps in asset information, document control and computer-aided facilities management capability account for a large number of the "No" responses. **Action:** Replacement planning, targeted surveys and governance improvements are being progressed. Leads: Christopher Green and Martin Nash. Timescale: programme milestones to be confirmed. **The Board is asked to support prioritisation of the system replacement and asset verification programme.** • **Medical gas governance** PAM governance and training actions remain outstanding. **Action:** Complete the gas-testing programme and establish the Medical Gas Safety Group within two months, by December 2026. Lead: Medical Gas Safety Group. **The Board is asked to note the gap and require a dated completion plan.** • **Pest control** Risk assessment and contract actions remain outstanding.

	Action: Complete the action plan. Lead: Martin Lovell. Timescale: December 2026. **The Board is asked to note the position and require confirmation of completion evidence.** • **Fire risk assessment programme** All secondary fire risk assessments covering internal areas and the primary fire risk assessment for new buildings have been completed. Primary fire risk assessments for the Trust's older buildings have been commissioned. **Action:** Existing information is held but requires a small, targeted exercise to place it into the new required format. Any new findings and remedial work will be incorporated into the fire safety improvement plan. Lead: Fire Safety Group. Timescale: December 2026. Final programme cost: to be confirmed. **The Board is asked to note the completed assessments and receive assurance on delivery of the remaining programme, including confirmation of final cost, findings and resulting actions at the end of Q4.** • **Linen and Laundry** The lowest scoring area for "Yes" results reflects the need for policy and practice to be documented. **Action:** To facilitate stakeholders to evidence the requirements across Housekeeping, material management and IPC. Lead: Martin Nash. Timescale: December 2026 **The Board is asked to note the work to evidence in this service area.** • **Investment context** Verified requirements include approximately £3 million for fire safety and £6 million for ventilation within an Estates backlog of approximately £204 million. **Action:** Verified figures and tender responses will inform prioritisation and investment planning. Leads and delivery timescales are subject to capital governance and Board approval. **The Board is asked to note the scale of the requirement and consider the affordability and prioritisation implications.**
Celebrating Outstanding:	• The PAM review brought together verified risk references, accountable governance routes and investment requirements in one evidence-based assurance position. This provides a clearer basis for prioritisation, escalation and future monitoring. Based on our lead for this work being on the national reference group, we may be more advanced than many Trusts in the depth of evidence, and assurance processes. • Progress has been made in 2026/27 in a number of high-risk areas, including fire safety works, electrical resilience, medical equipment and use of external assurance sources. UHD's relative compliance levels will be benchmarked when NHS England shares the results of the nationwide exercise.
RECOMMENDATION:	The Board is asked to: • Endorse the PAM assessment. • Support the prioritisation of capital plan works to reduce backlog.

	• Maintain oversight of Risks 2355, 1260, 2017 and 2093 and their mitigations.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☒ Health Inequalities ☐ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☐
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☐ Responsive ☒ Well-Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Estates Group	03/08/2026	The Group noted the report.
Finance and Performance Committee	07/09/2026	The Committee noted the progress.
Finance and Performance Committee	05/10/2026	The Committee noted the final report.
Audit Committee	15/10/2026	The Committee noted the outcome of the internal audit

OPERATIONAL PERFORMANCE – Exception Reports



Population and System
Performance against Annual Plan 26/27 trajectories

University Hospitals Dorset NHS Foundation Trust

		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 % within 18 weeks	plan trajectory	66.26%	66.82%	66.22%	65.22%	65.22%	66.63%	68.23%	69.82%	70.05%	70.55%	71.46%	73.10%
	actual	66.50%	66.90%	67.62%	66.80%	65.97%	67.32%						
	var	0.24%	0.08%	1.40%	1.58%	0.75%	0.69%						
Number of 52+ week RTT waits	plan trajectory	631	602	642	664	661	587	423	315	267	202	154	0
	actual	619	672	672	773	657	582						
	var	-12	70	30	109	-4	-5						
RTT waiting list – total	plan trajectory	66,552	66,447	66,647	67,367	67,305	67,015	66,840	66,618	66,713	66,671	66,523	66,485
	actual	67800	67497	67378	67365	67260	66984						
	var	1248	1050	731	-2	-45	-31						
Childrens community WL % within 18 wks	plan trajectory	3.6%	3.7%	3.7%	3.8%	3.8%	3.9%	3.9%	3.9%	4.0%	4.1%	4.1%	4.2%
	actual	6.5%	6.4%	6.4%	5.9%	8.9%	7.5%						
	var	2.9%	2.7%	2.7%	2.2%	5.1%	3.6%						
DM01 - % waiting over 6 weeks	plan trajectory	7.5%	7.4%	7.4%	7.7%	7.5%	7.0%	6.4%	5.5%	5.2%	5.2%	4.9%	4.4%
	actual	12.1%	13.7%	13.3%	15.0%	13.2%	9.1%						
	var	4.6%	6.3%	5.9%	7.3%	5.7%	2.1%						
cancer 28 day FDS standard *	plan trajectory	78.4%	79.3%	79.3%	78.3%	78.9%	80.0%	82.1%	82.2%	80.5%	79.4%	80.5%	81.8%
	actual	67.2%	75.5%	71.5%	75.3%	73.8%	*73.3%*						
	var	-11.2%	-3.8%	-7.8%	-3.0%	-5.1%	*-6.7%*						
cancer 31 day standard *	plan trajectory	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%
	actual	91.0%	93.6%	93.2%	93.6%	95.8%	*91.2%*						
	var	-5.0%	-2.4%	-2.8%	-2.4%	-0.2%	*-4.8%*						
cancer 62 day standard *	plan trajectory	75.0%	75.2%	75.4%	75.6%	75.8%	76.0%	76.5%	77.0%	77.5%	78.0%	79.0%	80.0%
	actual	65.8%	69.1%	61.2%	64.7%	70.1%	*64.5%*						
	var	-9.2%	-6.1%	-14.2%	-10.9%	-5.7%	*-11.5%*						
4 hour safety standard	plan trajectory	70.0%	70.0%	70.0%	68.0%	70.0%	72.0%	74.0%	76.0%	76.0%	77.0%	79.0%	82.0%
	actual	68.5%	70.2%	70.2%	72.2%	70.9%	71.8%						
	var	-1.5%	0.2%	0.2%	4.2%	0.9%	-0.2%						
Patients >12hrs in dept	plan trajectory	1,015	1,049	1,015	1,049	1,049	1,015	1,049	1,015	1,072	1,072	948	1,049
	actual	1815	1542	1472	1189	881	1110						
	var	800	493	457	140	-168	95						
Overnight total general and acute bed occupancy %	plan trajectory	96.37%	95.89%	95.89%	100.40%	101.11%	95.91%	96.41%	96.16%	97.24%	97.24%	96.29%	94.24%
	actual	94.40%	93.30%	93.20%	93.10%	91.90%	93.80%						
	var	-1.97%	-2.59%	-2.69%	-7.30%	-9.21%	-2.11%						
Average handover time (Total Handover time (ED and non ED) / No of handovers (ED and non-ED)	plan trajectory	00:28:00	00:28:00	00:29:00	00:28:00	00:25:00	00:25:00	00:26:00	00:26:00	00:28:00	00:28:00	00:27:00	00:26:00
	actual	00:33:20	00:32:40	00:33:55	00:32:24	00:32:23	00:30:50						
	var	00:05:20	00:04:40	00:04:55	00:04:24	00:07:23	00:05:50						

** performance in italics is provisional as at 06/10/26*

12 hour Emergency Department Patient Safety Recovery Plan (1)

University Hospitals Dorset NHS Foundation Trust

Note on interdependency. The actions below are framed against the 12hour operational Indicator, but each also directly supports delivery of the 4 hour organisational standard and the reduction of ambulance handovers. Reporting and oversight of these three operational metrics are triangulated rather than managed as separate piece of work.

Action to recover agreed plan	Description	Responsible officer / Forum	Actions completed	Ongoing actions *incl. due date and milestones to year end*
1. Immediate actions to improve pace of delivery and oversight and safety of the 12 hour Operational Indicator, with learning applied across other operational metrics	To provide the Board and executive team with improved visibility and to drive the day to day actions required to recover delivery against the agreed operational trajectories, with particular focus on the 12 hour position. *Note: given the shared drivers of front door flow, this action is also the primary lever for recovery of the 4 hour standard and for reducing 30 minute ambulance handover delays.*	UHD Chief Operating Officer (COO) Trust Management Group	• Implemented changes to the Trust Integrated Performance Report (IPR) for the July report • Improved operational daily visibility of the 12 hour position • Escalation SOP implemented across both sites including ambulance handovers • Weekly multidisciplinary review meeting established to examine all patients identified on the 12 hour ED report • Counter Measure Summaries completed outside business rules • Daily 12 hour, 4 hour and ambulance handover data triangulated into a single daily report • Weekly triangulated performance meeting for operational standards, chaired by the COO • Develop a draft revised 12 hour trajectory to year end, with monthly milestones to monitor against • New Risk added to the risk register on 'planning assumptions underpinning the 2026/27 operational trajectories	• Review embedding of the Accountability Framework, (Oct/Nov 2026)
2. Holding UHD improvements already in place, transferred to the Better Flow, Better Care programme	The ways of working established through our Dorset system Future Care programme, including the transfer of care hub referral discipline and Same Day Emergency Care streaming and utilisation, are now embedded within the Better Flow, Better Care programme. *Note: These embedded gains directly reduce the pool of patients waiting over 12 hours and lower ambulance conveyance where SDEC streaming diverts appropriate patients away from the ED front door.*	UHD COO Trust Management Group via Better Flow Better Care Steering Group	• Internal element of the Future Care work programme transferred to Better Flow, Better Care • Daily SDEC utilisation and conversion data monitored, showing improved performance against pre Future Care levels (ongoing) • Flow Improvement dashboard developed to support oversight of patient flow across the Trust • SDEC access gap analysis completed against the NHS England SDEC service specification • Gap analysis completed against the Model Emergency Department standards for high performing urgent and emergency care pathways • Review completed against the Model Acute Pathway standards for care of acutely unwell patients in their first 72 hours • Future Care closure report shared with Trust Board, with agreement on next steps (9th Sept 26)	• Work through the gaps in the Model Emergency Department standards for high performing urgent and emergency care pathways (Currently meet 25 of 33 criteria set out as key requirements in the Model ED guidance, submitted to NHSE in May 2026) Nov 26
3. Delivering the Trust Better Flow, Better Care Programme, a structured, multi workstream change programme	An executive-sponsored programme '***Better Flow Better Care' (BFBC)*** delivers improvement through four clinical workstreams: Emergency Department, Same Day Emergency Care, Sick Specialty and Sick Frail, each with an executive sponsor, clinical lead and SRO.	UHD Deputy Chief Executive Officer Trust Management Group via Better Flow Better Care Steering Group	• Appointment of an external Clinical Advisor for Urgent & Emergency Care (BFBC) • Initial set of PDSA's have been agreed • Communications plan has been deployed / The strategy document developed by 30 clinical leaders has now been socialised. • Inaugural steering group held, 29 June 2026, group to continue meet monthly for programme oversight, with individual workstream meetings fortnightly • Workstreams reporting PDSA outcomes to Steering group	• Programme level milestone and benefits review to be presented to Trust Management Group (Oct 26) • 2nd trust BFBC Workshop to be held 'Big Room Event' to review progress and further organisational engagement (Oct 26) • National Discharge model to be folded into the BFBC work programme (Oct 26) and implemented Q3/Q4

12 hour Emergency Department Safety Recovery Plan (2)

Action to recover agreed plan	Description	Responsible officer / Forum	Actions completed	Ongoing actions *incl. due date and milestones to year end*
4. Hospital emergency flow redesign and optimisation	Sustained focus on delivering the emergency and planned care split ahead of the Phase 3 timeline, through optimised Same Day Emergency Care, Call Before Convey, expansion of Hospital at Home and a Command Centre view of patient flow.	UHD COO Trust Management Group via Reconfiguration Ready Steering Group	• High Impact Changes agreed through an organisational innovation event • SROs for each high impact change agreed and progress tracked through the Emergency Hospital Oversight Group, with key deliverables aligned to wider Better Flow, Better Care metrics • Agreement on plans to enhance UHD Operating Model 'Opportunities for Our Patients' agreed through the UHD Trust Management Group • System wide meeting mobilised and meeting weekly to inform the design plan for Urgent Care Command Centres/ SPOA	• System wide Command centre proposal to be developed with a focus on frail elderly for a minimum of 12 hours a day (Oct 2026) • System wide offer to be in place for enhanced SPOA for Winter (Nov 2026) • Hospital at Home business case expansion trajectory, with bed equivalent capacity by month, agreed (by Oct 2026) • EMAC proposal to be drafted including the capital & revenue implications (Oct 2026) • Delivery plan for new operating model to be developed (Oct 2026)
5. NCRT reduction, system redesign and recommissioning	Around 50 acute beds are occupied by patients whose needs exceed Local Authority commissioning thresholds. Four conditions to reach the 110 no criteria to reside target; progress being tracked jointly with the ICB, BCP Council and system partners and shared with the Trust Board monthly. Current position: no criteria to reside numbers are averaging around 230, against the 110 target. **Four Conditions** 1. Close commissioning gaps (ring-fenced placement budget, delirium in-reach 2. Discharge-to-Assess operationalisation 3. Right-size community P1 and P2 commissioning 4. Optimise BCP Adult Social Care response times	System Partners through Dorset Recovery and Delivery Board UHD Trust Management Group via Reconfiguration Ready Steering Group	• A new Dorset wide Recovery and Delivery Board has been established which will oversee delivery of these plans. This is Chaired by the ICB Chief Executive. • £1.8m additional intermediate care investment through the Discharge to Assess Partnership supported by the ICB and Investment Panel, July 2026 (Condition 1) Partnership agreement signed off (Condition 2) • Patients have started to leave UHD on the agreed pathway • ICB to oversee delivery through the Discharge to Assess Partnership, with impact on no criteria to reside levels, discharge performance and system capacity monitored monthly (ongoing). • ICB, via Dorset HealthCare, to progress the Dorset Transfer of Care Operating Model to strengthen Home First decision-making and Pathway 1/2 flow, overseen through the pan-Dorset senior leadership group and Weekly Improvement Group (ongoing). • ICB to align system partners, investment and oversight behind the factors with the greatest impact on emergency admissions and patient flow, in support of sustained 12-hour ED performance improvement (ongoing).	• ICB/Local Authority/ UHD to set a Monthly no criteria to reside trajectory, current ask 110 with milestones to March 2027, published (by Oct 2026) • ICB to finalise Tier 1 cohort plans and improvement trajectory through the Neighbourhood and Wellbeing Programme Board, supported by Macmillan Social Investment funding, with targeted interventions mobilised ahead of winter (by end Sept 2026) • ICB to mobilise a targeted demand management programme for the Tier 1 cohort — 1.2% of the population but 16.5% of ED attendances and 21.3% of emergency admissions — aimed at reducing avoidable attendances and admissions through earlier intervention and coordinated care. Trajectory and impact measures to be agreed through the Neighbourhood and Wellbeing Programme Board, supported by Macmillan Social Investment funding, (by end September 2026), with interventions mobilised ahead of winter.

UEC - Patients Over 12 Hours

Time in department | September 2026 Performance Exec Lead | Mark Mould Owner | Leanna Rathbone

Off plan but Improved

1,096

Patients spent over 12 hours in the Emergency Department against a trajectory of 1,015

27th

National ranking of 117 trusts. Since April, UHD have improved from 9.7% in April to 5.9% in September, while the national average went from 9.3% to 10.1% over the same period.

Recovery Trajectory

12 hr breaches Annual Plan	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
2025/26 actuals	870	684	686	657	565	874	1,365	1,243	1,390	2,003	1528	1,571	13,436
Annual Plan trajectory	1,015	1,049	1,015	1,049	1,049	1,015	1,049	1,015	1,072	1,072	948	1,049	12,397
26/27 actuals	1,806	1,537	1,468	1,202	881	1,110							
Proposed trajectory (20% improvement vs 25/26)							1,092	994	1,112	1,602	1,222	1,257	15,189

12 hr % breach (NOF)	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
2026/27 Annual plan attendances	19,429	20,366	20,198	20,676	20,352	19,181	19,631	19,613	18,801	18,581	17,686	20,987	235,501
2026/27 actual attendances	20,142	20,918	20,377	21,011	20,734	20,486							
2026/27 12 hr % breaches	9.0%	7.3%	7.2%	5.7%	4.2%	5.4%							

Reasons for variance

- Demand - afternoon and evening demand is exceeding operational capacity with breaches peaking out of hours. Predominant at RBH where exacerbated by mismatch of demand and outward flow.
- Admitted flow – constrained by bed availability reflecting wider system pressures including NCtR as well as well as overnight availability of admission avoidance pathways.
- Specialty delay- inefficient specialty referral process is adding delay before patients are seen or accepted by the right team.
- Casemix- patients requiring extended observation or longer periods of assessment and observation before decision making and/or transfer.

KEY ACTIONS: Trust / ICB / Partner-Owned Actions

Focus	Actions Taken	Owner	Due	Progress
Earlier streaming and diagnostics	- PDSA of additional RBH ACA senior decision maker in ED - Flagging more complex patients within waiting room on ED EPR system for earlier senior review (RAT)	ED	October 26.	Digital go live delay- October completion.
Aligning demand across the day and case mix with workforce.	- Develop Revised Medical rota's to align to site demand and support casemix and decision making - Progress agreed changes in the ED rota - Scoping of EEMAC/CDU and MH crisis spaces /facilities - Agree Route through EMAC revenue investment	MCG	Complete Oct/Nov Sept 2026 Oct	Medical rotas agreed EMAC proceeding to BC Oct 26.
Referral Process	- Updates to the ED EPR system (Agyle) will track referral delays to allow earlier / live resolution of IPS issues - Pilot evening huddles with key specialties, enabling better out of hour decision making.	ED	Oct 2026 Complete	Come online in Nov 26.
Optimes escalation and organisational role card.	- Increase visibility of daily reporting of 12 hours - OP written for 12 hour escalation, with improved daily visibility	COO	Complete	On-going daily

Recovery / Oversight: Oversight: IPR through weekly meeting / SDR / TMG / FPG /QC / Board.)
Request to region to reset the trajectory for 12 hours

Delivery Risks: (1)Flat trajectory despite sustained National position. (2)Winter pressures reduced flow. (3) Site Separation not happening July /dec 26 (4) Increasing NcRT numbers

Quality Oversight & Impact: Weekly meeting focusing on 12/24+ hours waits with RCA.

Patients UEC Standards – Ambulance Handover

Average Ambulance Handover| September 2026 position | Exec Lead Mark Mould | Owners: Sean Kedzia

Off plan but improving

32 minutes

Average ambulance handover against trajectory 25 minutes. Sustained 32 minutes from July and August while occupancy worsened with increased admissions.

Handovers within 15 minutes have improved for five consecutive months, from c.12% in April to c.16% in September

Recovery Trajectory

Mins	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan		Feb	Mar
Plan trajectory	28	28	29	28	25	25	26	26	28	28		27	26
26/27 actual	33	33	34	32	32	32							

Reasons for variance

- **ED crowding and exit block –** constrained bed availability and rising NCtR numbers mean majors cubicles are frequently full, limiting space to offload ambulance crews.
- **Clustering of arrivals –** peak surges and overlapping arrivals exceed rapid assessment (RAT) capacity; staffing is not consistently aligned to these peaks, including HALO cover and overnight triage.
- **Process and visibility –** handover and cohorting practice varies between sites, escalation is triggered late, and ambulance arrivals are not visible in real time on the ED system.

KEY ACTIONS: Trust / ICB / Partner-Owned Actions

Focus	Milestone	Owner	Due	Progress
Front-door workforce	- Employing newly qualified paramedics to act as HALO within the trust given inconsistent coverage - Additional reception staff in RATs to release nursing capacity to support clinical v administrative handovers and support fast registration	GDO	Oct 2026 Sep 2026	• JD s going through internal approval process. • Reception staff supporting as of 17th Sept
Standardised handover and escalation	- Cross-site review of handover process and staffing, incl. RBH two-holding-bay model (pitstop model from Poole)	GDO	Sep 2026	• Complete
Real-time visibility of arrivals	- Reviewing geofencing for ambulance arrivals at RBH - Audit of handover clock-stop times to assure data accuracy - Development of iPAD fast registration for crews at the ambulance front door	DCOO / SWASFT	Sep 2026 Oct 2026 Jan 2027	• Engaged in regional improvement meeting with SWAFT • Commissioned EPR developer to design
Alternatives to ED conveyance	- Reduce declined direct conveyances to SDEC via Better Flow, Better Care programme, as well as expansion of targeted Care home (OPS) and stroke direct conveyance trials	COO/ SYSTEM	Nov 2026	• Ongoing reviewing SDEC opportunities /command centre
ED capacity and onward flow	- EPIC & NIC escalation for rapid assessment on ambulance trolleys when RATs are full & regular huddles enforcing use of ACA over majors to protect capacity - EEMAC pilot adding majors and ACA capacity, releasing RAT space for handover	GDO	Oct 2026 Feb 2027	• Complete and ongoing (August onwards) • Business case to Oct 2026, then move to recruitment and detailed pathway devt.

Recovery / Oversight: Oversight: IPR through weekly meeting / SDR / TMG / FPG /QC / Board.

Delivery Risks: (1)Winter pressures reduced flow. (2) Site Separation not happening July /Dec 26 (3) Increasing NcRT numbers impacting on flow out

Quality Oversight & Impact: Review of outcomes and patient experience, monitored and reviewed through care group governance, trust SDR processes and via SWASFT partnership review

Patients UEC Standards – 4 Hours

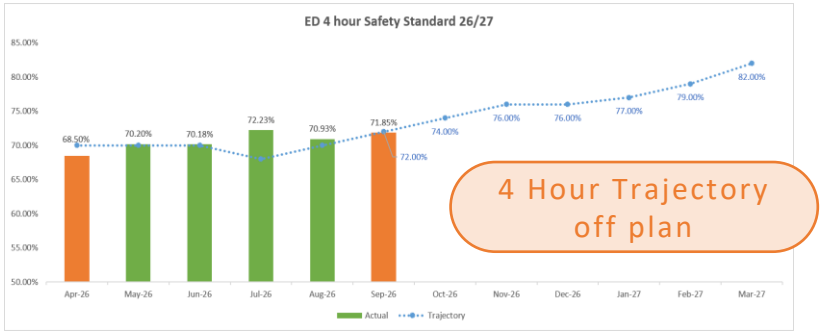
Type 1 & 3 combined | September 2026 position | Exec Lead Mark Mould | Owners: Leanna Rathbone

71.85%

Overall 4hr performance, Type 1 & 3 September (Trajectory 72%). Non-admitted best performance in over 18 months at 82.3%, including referred non-admitted patients.

Between April to September, o**f the 108 larger type 1 departments in the NHS, UHD was the fourth most improved in the country** (+3.7%)
While August was a challenging month for UHD, with record attendances, **we recovered the position in September through targeted improvements in staffing rotas in ED, as well as revised streaming criteria and processes working with SDECs.**

Recovery Trajectory



Reasons for variance

- Mismatch of demand and operational flow- the South West and UHD in particularly continue to see one of the largest rates of growth in emergency presentations (+12% in Type 1 in 8 years)
- Admitted flow – constrained by bed availability, attributing factor is partial reconfiguration of bed model.
- System level constraints- commissioning gaps in NCtR and restricted D2A pathway access reducing discharge efficiency, increasing bed occupancy and impacting ED outflow.
- High volumes of complex patients requiring extended observation- case – mix is shifting toward high acuity presentations at RBH requiring longer ED stays, increasing congestion and reducing flexibility.

KEY ACTIONS: Trust / ICB / Partner-Owned Actions

Focus	Milestone	Owner	Due	Progress
Strengthening whole system flow	- Mobilisation of the Flow Stream Work programme - Working with external partners to navigate through a reduction in NCRt in hospital beds	COO /System	Complete On-going	PDSA's mobilised with outcomes to be reviewed in Oct.
Improved Admitted Flow through enhanced bed availability	- Referral process are being strengthen through digital tracking and clearer escalation routes - Enhanced Command Centre	Exec Leads /System	Oct 2026	Reduced Bed occupancy in July. Frailty pathway online via Command Centre
Emergency hospital flow redesign and optimisation	- Work Programme defining 'High Impact' changes, specific focus on admission avoidance. - Key areas include Call before Convey /Hospital at Home and optimised SDEC.	COO	Ongoing	Stroke online Oct. Confirmed increase in H@H capacity.
Optimising ED Operational Performance	- Continuous improvement in non-admitted performance - Focus on clinical oversight and escalation process including revised THP SOP- improving throughput and reduced corridor care. - Reviewing of staffing capacity to better align to demand profile.	CGGDO OO/CMO	On Track and Improving	Recovery trajectory for 12 hours as well as reduction in corridor related care.

Recovery / Oversight: Oversight: IPR Through Weekly Meet/ SDR/ TMG/ QC /FPG /Board

Delivery Risks: (1) Sustained improvement in Non-Admitted, all Admitted delivery is within realms of normal variation. (2)Winter pressures reduced flow. (3)Site Separation not happening July /Dec 26 (4) Increasing NcRT numbers

Quality Oversight & Impact: Logged on organisational risk register including oversight of care in non-clinical areas.

Patients Standards NcRT

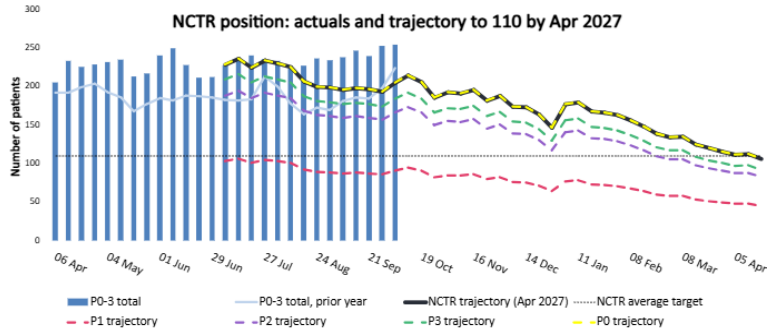
NcRT Standards | September 2026 | Exec Lead: Mark Mould | Owner: Sean Kedzia

Off plan

23.5% / 240 Delays
September Month average

21% / 219 Pts.
Pathway 1-3

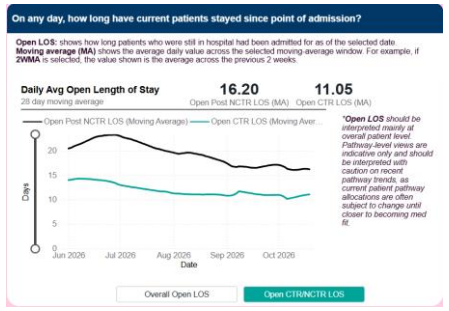
2% / 21
Pathway 0



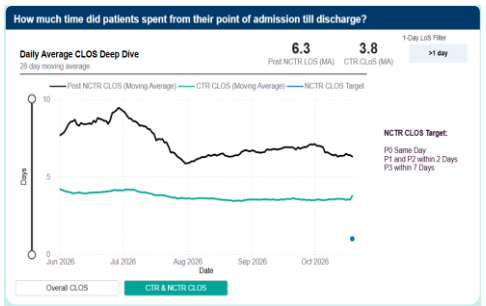
Reasons for variance

- **Demand** – Increased referrals through the Transfer of Care Hub for Pathway 1. Throughput through Pathway 1 providers is not meeting increased demand.
- **Backlog** – NCTR P1-3 in Acutes building whilst focus and resource is deployed to community.
- **System level constraints-** increasing complexity of need and dependency combined with restrictive D2A pathway is reducing discharge efficiency.
- **Commissioning challenges-** Gaps between health and social care commissioning is leading to extraordinary length of stay.

Open Length of Stay



Closed Length of Stay



KEY ACTIONS: Trust / ICB / Partner-Owned Actions

Focus	Actions Taken	Owner	Due	Progress
Demand	**Pathway 1** has been identified as the immediate operational pressure point; additional capacity has been brought online by system partners at start of October. Pathway escalation process in place if trajectory is not recovered. **Pathway 0** will be reviewed by each care group daily using improvement cycle methodology.	System/COO COO	Mid October 26	Early indications of improvement in P1 delays. Daily P0 data circulated
Backlog	Recovery trajectory: **≤180 Nov → ≤150 Dec → ≤140 Jan → ≤120 Feb → ≤110 Mar 2027.** Trigger based recovery plan and framework drafted	System/COO	Oct 26 - delivery April 27	Trajectory needs system agreement
System level constraints	Partnership agreement Signed off by System to support patients with specialist or non-core commissioned care needs	System/COO	Complete	Review outcome
Commissioning challenges	Interim CHC discharge pathway for individuals with significant health needs from the acute hospitals in Dorset SOP drafted	System/COO	Nov 26	Dorset SOP drafted

Recovery Oversight: Oversight: IPR through weekly meeting / SDR / TMG / FPG /QC / Board. with trigger-based escalation where milestones are missed.
System ownership of Pathway 1 flow and backlog recovery

Delivery Risks: Insufficient P1 throughput, workforce/capacity constraints and variation in D2A pathways may slow recovery. Delivery remains dependent on timely partner action

Quality Oversight & Impact: Maintain safe discharge while reducing NCRT and length of stay. Monitor pathway outcomes and unintended consequences via TOC governance and internal reporting mechanisms

Patients Access to Diagnostics (DM01)

Diagnostics| September 2026 position | Exec Lead Mark Mould | Owner Darren Jose

Off plan–Limited to 2 Modalities & improving

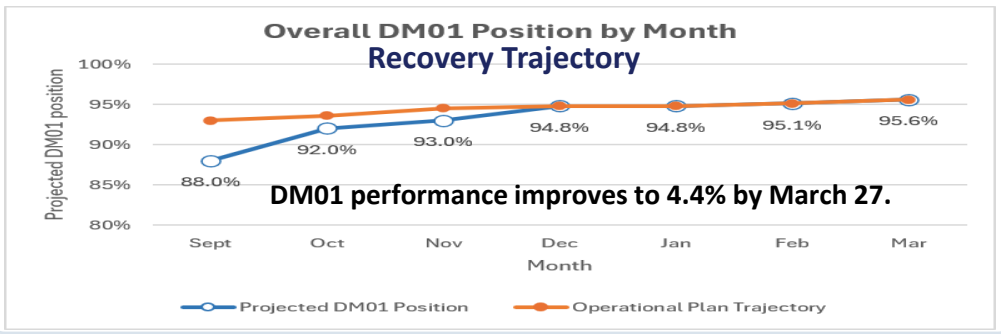
9.1% (90.9%)

National DM01 standard <1%

+2.1% adverse to trajectory. Improvement in September better than recovery trajectory. NOF metric score 2.1

78.7% Endoscopy
81.7% Echo

Modalities of Concern



Reasons for variance

Echocardiogram and Endoscopy waits are above the operational plan trajectory.

- **Echocardiogram performance** has been driven by rising demand (Y on Y 7%) above planned levels, workforce shortages (cardiac physiologists with Echo skillset) and limited availability of insourcing capacity. **22.3% improvement in September and full recovery expected October 26.**
- **Endoscopy performance** has been impacted by workforce factors including combined high sickness absence and booking capacity. This has influenced our ability to fully utilise available capacity.
- The delay to the opening of the new purpose-built CDC Endoscopy Unit and therefore delay to additional capacity coming online has also hampered the pace of the planned improvement.
- Booking team capacity has now improved following successful recruitment and the new Endoscopy unit opened in October. 2.2% improvement in September. **Recovery >96% expected by March 2027**

KEY ACTIONS: Trust / ICB / Partner-Owned Actions

Milestones	Owner	Due	Progress
Robust recovery plans and trajectories in place with revised implementation plans to better align performance delivery to shift in demand and utilisation.	Modality leads	Aug 2026	Complete
Echo/Endo: optimised use of outsourcing capacity commissioned, additional in/outsourcing capacity scoped and sourced including new insourcing provider for Echo commencing September. Additional c1200 tests agreed for Echo	GM	Aug 2026	Complete
Echo: Full recruitment and revised job planning complete - weighted towards elective delivery without compromising inpatient review. Demand & Capacity to be reviewed including future establishment requirements.	GM	Sept 2026	Complete
Endoscopy: recruitment and sickness management in place to support staff and mitigate utilisation impact.	GM	Sept 2026	Ongoing
Endoscopy: Go- live of CDC scheduled for October, outsourcing arrangements and additional elective rooms to remain online to support backlog reduction	GM	Dec 2026	Complete
Deliver St Mary's CDC/OAC transformation following successfully securing national CDC funding	DOPO	Mar 2027	On track

Recovery & Oversight: Endoscopy: return to over 90% trajectory by end Q3 and >96% by March 2027. Echocardiography: >95% by October 2026. DM01 performance improves to 4.4% by March 2027. Oversight via Planned Care Improvement Group.

Delivery Risks: (1) Capacity and reliability within in/outsourcing providers (2) Site separation delayed until April 2027

Quality Oversight & Impact: LERNs & Harm reviews completed in line with Trust policy. There were none reported through September Q&S / governance meetings.

Patient Cancer Standards (1)

National Cancer Waiting Times Standards | July 2026 | Exec Lead Mark Mould | Owner Sean Kedzia

Off plan – Partially improving

73.8%

28 Day Faster Diagnosis Standard

1.5% deterioration from July. September currently = 73.3%

95.8%

31 Day Standard

+2.2% improvement from July. September currently = 92.6%

Reasons for variance

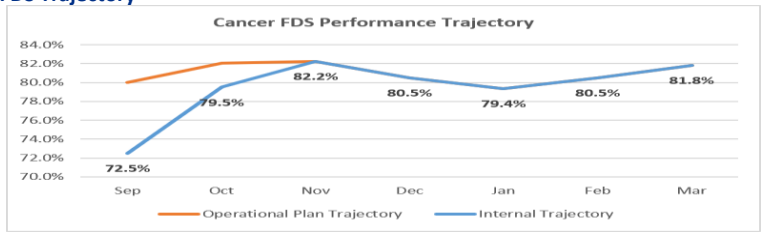
Capacity:

- First appointment timeliness is at its best this year, but sites are being impacted by admin delays in pathways with regards to informing patients that cancer has been ruled out.
- Histopathology capacity and reliance on insourcing providers remain constraints, alongside workforce sickness and administrative capacity.
- Surgical, theatre and interventional radiology access constrain 31 Day performance.

Referral demand:

- Demand remains high and above expected growth, particularly in Dermatology.
- Sustainable recovery depends on aligning capacity to demand across the major tumour sites whilst protecting the capacity from any last minute impact e.g operational pressures.

28-Day FDS Trajectory



KEY ACTIONS: Trust / ICB / Partner-Owned Actions

Milestone	Owner	Due	Progress
Tumour sites to have A3 recovery plans in place and trajectories they are being managed to	COO	July 2026	Complete
Weekly enhanced cancer oversight meetings to be established alongside elective recovery	COO	June 2026	Complete and ongoing
Implementation of national best practice timed pathways across major tumour sites	COO/MD	March 2027	In progress
Histopathology recovery plan to improve turnaround delays with agreed funding support	COO	September 2026	On track
Additional funding to be agreed for additional capacity across major specialties to clear fast track backlogs.	COO	August 2026	Complete
Breast Pain Pathway to go live to stream low risk patients, protecting one stop capacity.	COO	August 2026	Complete

Recovery & Oversight: Oversight via Planned Care Improvement Group, the Weekly Cancer Improvement Group and the new Trust Strategic Cancer Group

Delivery Risks: Histopathology TATs, reliance on insourcing providers who often do not deliver on commitments, high staff sickness levels.

Quality Oversight & Impact: Daily reviews of PTL, decision to treat dates and 2WW performance.

Patient Cancer Standards (2)

National Cancer Waiting Times Standards | July 2026 | Exec Lead Mark Mould | Owner Sean Kedzia

Off plan – Improving

70.1%

62 Day Standard

5.4% improvement from July. September currently = 67.7%

179

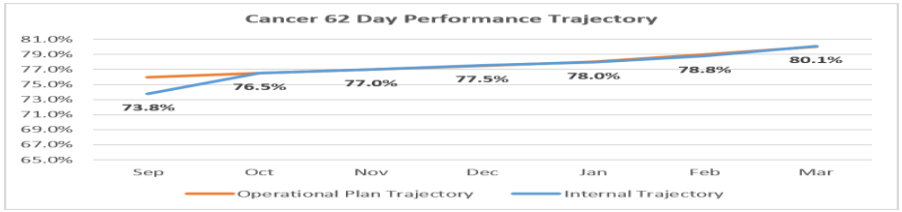
Over 62 day PTL

10 patient increase since July.

Reasons for variance

•Delays at the front end of the pathway continue to affect 62 Day performance, which improved to 70.1% but remains below the 80% recovery target.
•62 day performance is also constrained by theatre capacity and diagnostic turnaround times, balanced against backlog recovery. All sites have recovery plans for Q3 & Q4.
•Recovery is uneven: Colorectal and Gynaecology remain the most challenged sites, while Skin has met the target.
•Balancing the capacity requirements for managing both elective RTT priorities and cancer demand.

62D RTT Trajectory



KEY ACTIONS: Trust / ICB / Partner-Owned Actions

Milestone	Exec Owner	Due	Progress
Tumour sites to have A3 recovery plans in place and trajectories they are being managed to	COO	July 2026	Complete
Engagement of Wessex Cancer to work through the top 3 Challenged cancer sites (Colorectal – complete, Urology ongoing, Gynae started)	COO	August 2026	Complete
Trust Cancer Forum established to lead enhanced strategic oversight	COO /MD	June 2026	Complete
Continue clinical escalation and validation for patients >62 days, prioritising highest-volume tumour sites. Aiming for a 120 position by March 27.	COO	March 2027	On track
Weekly enhanced cancer oversight meetings to be established alongside elective recovery	COO	June 2026	Complete and ongoing
Agree recovery plan and funding to improve access to Interventional Radiology	COO	September 2026	On track
Launch FIT100 pathway in Colorectal to stream high risk patients for earlier diagnostics and treatment.	COO	February 2026	On track

Recovery & Oversight: Oversight via Planned Care Improvement Group, the Weekly Cancer Improvement Group and the new Trust Strategic Cancer Group

Delivery Risks: Knock on impact of delays at the front end of the pathway. Delays in Histopathology TAT, Interventional Radiology Capacity.

Quality Oversight & Impact: Clinical Harm Reviews undertaken for all patients over 104 days. No harm identified in 2025 or 2026 YTD.

Patient RTT Waiting Times

RTT, Waiting list and 52ww trajectories met

Elective care | September 2026 position | Exec Lead Mark Mould | Owner Judith May

66,984

Total waiting list (target 67,015)

September trajectory met

582 (0.87%)

Patients waiting over 52 weeks +NOF metric

September trajectories met (587 & 0.88%) and scored 2.89 in NOF

67.3%

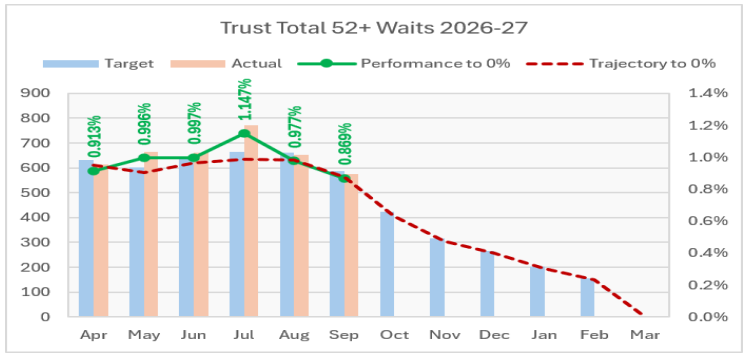
18 week standard performance (target 66.6%) + NOF metric

0.7% ahead of Trajectory plan and score 2.15 in NOF

Reasons for variance

- **No variance from plan.** Specialties - Gynecology, T&O, Surgery and Dermatology are the largest contributors on >52+ww.
- Challenges being managed:
  - Demand higher than planned
  - Prioritisation of cancer backlog reduction due to cancer performance - variance from plan
  - In month peaks in 52ww cohort drop ins
- Pre-op assessment and theatre capacity are constrained - limiting how much of the backlog can be cleared each month
- Fully optimising referral management and capacity utilisation across care groups – incl. WHH, SPOA, Outpatients

Recovery Trajectory



KEY ACTIONS: Trust /ICB / Partner-Owned Actions

Milestones	Owner	Due	Progress
Gynecology to have an activity recovery plan in place linked to an improvement trajectory for Q3	Lisa Clarke (GDO)	August 2026	Plan in place and improvement evidenced
Engagement with HR to develop Admin & clerical resource plan agreed for all 3 Care Groups that supports robust booking processes	GDOs	August 2026	Task and finish group established. Successful recruitment evidenced
Theatre capacity plan including pre-op capacity to be agreed across Surgical / WCCSS Care Group	Abigail Daughters/ Lisa Clarke (GDOs)	October 2026	Initial outcome to be revisited. Gynae theatre efficiency actions – on track
St Mary's to support further release of theatre and outpatient capacity	GDOs	Q2-Q3	Currently in flow and CDC decant plan to maintain current state
Single Points of Access delivered in 10 priority specialties. Incl 3 system-wide SPOA	DOPO/ICB/One Dorset Prov. Collab.	October 2026	On track for 10 Provider SPOA. System SPOA to align to single services programme – April 2027
Demand and Capacity training for clinical and operational leads leading to full D&C analysis.	DOPO	October 2026	Training complete. Full D&C analysis now underway.

Recovery Oversight: On Plan
Oversight delivered through the Planned Care Improvement Group

Delivery Risks: (1) Mutual aid request received from DCH (2) Capacity and reliability within in/outsourcing providers (3) Booking capacity – admissions and outpatients (4) Site Separation not happening July /Dec 26 (4) Increasing NcRT numbers

Quality Oversight & Impact: LERNs & Harm reviews completed in line with Trust policy. There were none reported through September Q&S / governance meetings.

National Oversight Framework

University Hospitals Dorset
NHS Foundation Trust

UHD has been placed into **segment 3** of the NHS Oversight Framework (NOF) in **Quarter 1, 2026/27** (published September 2026), with a rank of #79/134 acute and specialist providers and an average metric score of 2.49 (previous quarter 2.34).

Scores and ranks are refreshed quarterly (Segment 1 is best , representing the highest scoring 25%)

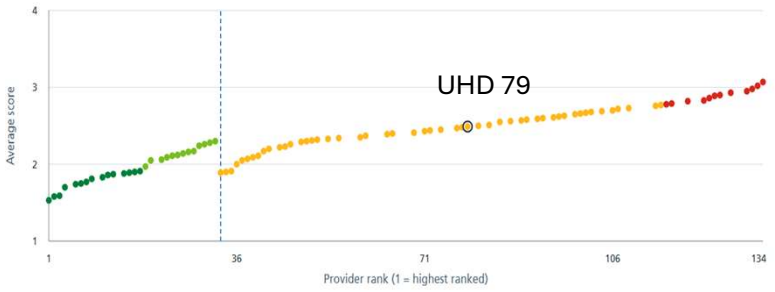
Domain	Domain Score June 2026	Segment (1 is best - higehst scoring 25%)	Direction of Travel since last segmentation	Previous score March 2026
Access to services	3.09	4	↓	Domain score 2.57 / Segment 3
Patient safety	1.87	2	↓	Domain score 1.78 / Segment 1
Finance, productivity and innovation	2.12	2	↔	Domain score 1.95 / Segment 2 *(previously Finance and Productivity)*
People	2.06	2	↔	Domain score 2.17 / Segment 2 *(previously People and Workforce)*
Experience of Care	2.13	2	↑	Domain score 2.49 / Segment 3 *(previously Effectiveness and Experience of Care)*
Effectiveness of care and population health	2.79	4	↓	

Trust Overview

Average score	Financial deficit	Overall segment
2.49 — Below Average and/or Financial Deficit. Likely range: 2.15 to 2.83	No	3 — Below Average and/or Financial Deficit. Based on average metric score

Capability rating	Provider rank
Amber/Green	79 out of 134 providers. Likely range: 26 to 116

Average score by provider rank placement



We are caring one team listening to understand open and honest always improving inclusive

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 6 October 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Quality Committee – Chair's Report
Presented by:	Michael Marsh, Chair of the Quality Committee

Agenda items discussed:	At its meeting held on **6 October 2026**, the Committee received the following:
	• Risk Register: risks rated 12 – 25 (Quality & Safety)
	• Integrated Performance Report
	  ○ Operational Plan exception report
	  ○ NHS Oversight Framework
	• Equality & Quality Impact Assessment Report
	• Perinatal Quality Oversight:
	  ○ Maternity and Neonatal Quality and Safety Report
	  ○ Delivery exceptions Re Amose and ten-point plan
	  ○ Triage benchmarking tool
	• Mortality Report
	• Electronic Results Acknowledgement Process
	• Annual Radiation Safety Report
	• National Standards for Healthcare Food & Drink
	• Report from Clinical Governance Group

ALERT	The Committee wishes to alert members of the Board that: • The Annual Radiation Safety Report was presented and highlights good compliance in radiology. There however areas outside of radiology where compliance with requirements is poor (within theatres and endoscopy) and work is required to address the issues. A centralised website on the Intranet is needed for the relevant radiation safety documents. The Chief Medical Officer will support addressing the block in achieving this requirement. **The Committee requested feedback on progress prior to the next annual report**. • NCTR numbers remain a significant threat to delivering high-quality care and performance of key national targets. • An incident relating to sending of discharge letters to GPs out of UHD area was identified as an issue with the cause relating to technology fault. This has been rectified.

ASSURE	The Committee wishes to assure members of the Board that: • The Integrated Performance Report shows No Criteria to Reside (NCTR above trajectory at 237 (177 same time last year). Cancer operational performance shows some improvement. An improvement approach is being taken to pressure ulcers by a working group. An increase in bacteraemia cases was seen during the heat wave period. **The Committee was Assured**. • The Equality and Quality Impact Assessment was presented and shows a robust system and process for assessing schemes. There is no evidence of negative impact on quality or equality. **The Committee was Assured**. • The maternity and neonatal quality and safety report was reviewed. Neonatal nurse sickness remains elevated at 8.1%, the shortage of middle grade obstetric staff continues. Post partum haemorrhage rate was 29/100 and remains an area of focused work. Many quality indicators are positive. **The Committee was Assured.** • The Mortality Surveillance Group Report shows a rolling HSMR 99.38 and SHMI 0.87. The HSMR has increased over recent period as was expect and highlighted to the Board previously. The Medical Examiner Service has workforce pressures with 6PA per week uncovered leading to delays in case reviews of between 3-10 days. **The Committee was Assured.** • Substantial progress has been made on electronic results acknowledgement supporting the move to a paperless requesting and acknowledgement of test results. There is still further work to be done. **The Committee was Assured** on the process and progress of the work. • The National Standards for Healthcare Food and Drink were reviewed and 3 of the 8 key standards are not yet achieved (a food service dietician, training for all staff involved in food service and 24/7 food service provision). Work is underway to address and mitigate these areas. T**he Committee was Assured**. • The report form the Clinical Governance Group provides clear assurance that it is undertaking appropriate work
ADVISE	The Committee wishes to advise the Board that: • The CQC visit report has been received for review of factual accuracy. Additional information will be submitted back to CQC in addition.
Review of Risks	• New risks were noted 2350 Royal Bournemouth ED waiting room relating to concerns of overcrowding, patient observations and clinical oversight of patients that may deteriorate.
Celebrating Outstanding	• Work of staff leading on radiation safety and protection both Radiation Protection Advisors (RPA) and Medical Physics Experts (MPE). • Progress on Electronic requesting and acknowledgement.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Quality Committee – Chair's Report
Presented by:	Michael Marsh, Chair of the Quality Committee

Agenda items discussed:	At its meeting held on **3 November 2026**, the Committee received the following:
	• Deep dive: Neck of Femur (#NOF) pathway
	• 2026/27 Board Assurance Framework Q2
	• Risk Register: risks rated 12 – 25 (Quality & Safety)
	• Integrated Performance Report
	  ○ Operational Plan exception report
	• CQC report
	• Thirlwall Inquiry report
	• Martha's Rule in Emergency Departments
	• Perinatal Quality Oversight:
	• Clinical Audit & Effectiveness Report
	• Medical Device Replacement Programme
	• Falls report
	• Annual End of Life Care Report and Care of Dying Audit
	• Report from Clinical Governance Group
	  ○ Patient Safety Report

ALERT	The Committee wishes to alert members of the Board that: • A deep dive into fractured neck of femur (#NOF) pathway shows opportunities for improvement exist in achieving the national standard for operation within 36 hours (standard 85%). Work needs to consider systems, processes and resources to treat this condition whilst delivering all orthopaedic services. Over the last 4 years there has been significant improvement from a low base, however the % achieved has been static for 2 years with significant fluctuations. • A verbal updated was provided on the 6 month trial of implementing Martha's Rule in the Emergency Department. It is recognised that it will not work as originally described for a ward setting. A new methodology will be required, and it is expected there will be a similar challenge implementing it in Maternity Services.

ASSURE	The Committee wishes to assure members of the Board that: • The Board Assurance Framework was reviewed to inform considerations of the committee. **The committee is Assured** that it is focusing appropriately on the quality aspects of the Trust's Strategic Priorities. • The Integrated Performance Report (IPR) was considered. There is continuing work required in relation to Infection Prevention Control with staff to ensure correct practice in hand hygiene for different infections. There have been 2 MRSA cases and normal review of the cases is underway. The Committee noted that No Criteria to Reside (NCTR) remains stubbornly above trajectory and significantly higher than the same time last year. There have been improvements in emergency access in ED, some elements of cancer performance and Access to diagnostics (DMO1) though these are still not reaching national standards. Despite the challenges **the Committee was Assured**. • The Trust's response to the Thirlwell Inquiry recommendations was reviewed and the 5 immediate actions have been completed. It is becoming clear that clinicians believe some of the recommendations are not practical and we await the formal National Response. In discussion it was noted that safeguarding training needs to be focused on to improve numbers of staff undertaking it. • Perinatal Quality Oversight shows that neonatal nurse sickness remains higher than target at 8.2% with work continuing to address it. Work also continues on Post Partum Haemorrhage (PPH) with the 3 month rolling rate at 33/100 which is above the national target of 30/1000. **The Committee was Assured**. • The clinical Audit and Effectiveness report provides strong assurance of audit and review of practice being embedded in normal operational practice. There was a discussion on the areas not taking part in national audits with description of local audits with robust local oversight of findings. The ambition remains to take part in all national audits applicable to UHD. The management team will discuss some of the audit findings relating to Metastatic Breast Cancer to understand where significantly below national figures. **The Committee was Assured**. • An update was provided on Medical Devices Programme with the previous outstanding actions being part of business as usual. The group has also picked up the issues identified by CGQ in terms of oversight of some external managed contracts. **The Committee was Assured**. • The Falls Report was considered and there is evidence of significant progress in relation to oversight, governance, accountability and management of cases. Monthly Steering Groups continue as further

	improvement is required. T**he Committee was Partially Assured**. • **The Committee was Assured** by the Clinical Governance Report.
ADVISE	The Committee wishes to advise the Board that: • The CQC report has still not been received fallowing the Trust sending back factual accuracy points. However, actions have already been taken in several areas based on the verbal feedback. • The Annual End of Life Care Report was deferred to the December Committee.
Review of Risks	• The Risk Register was reviewed; a new risk (2362) Holding Ward Pathway was discussed confirming that works has taken place to improve governance and oversight of patients cared for in 'Holding Wards' (e.g. Virtual Wards, Corridor Care areas). Full assurance is not yet possible in relation to this risk.
Celebrating Outstanding	N/A

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **6.5.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Equality and Quality Impact Assessment Report
Prepared by:	Sarah Herbert CNO, Judith May, Director of Performance and Oversight, Trudi Ellis, Transformation Lead Nurse
Presented by:	Sarah Herbert CNO
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	Relevant to all elements of the BAF
Purpose of paper:	Assurance
Executive summary:	A standard EQIA form has been produced for use in UHD and should be completed for: • Efficiency Improvement Projects • Workforce plans • Service change and service development proposals. The UHD EQIA Policy provides a framework for the Quality Impact Assessment (EQIA) process within UHD for the 3 workstreams above. This report provides a summary of Equality & Quality Impact Assessments (EQIAs) completed and reviewed across both Productivity & Efficiency schemes and Transformation programmes during panel review on 23 September 2026. The Group received assurance that governance arrangements remain effective, with 19 EQIAs completed since the previous reporting period and no assessments requiring escalation. Whilst 56 schemes remain in draft and 60 have yet to commence, there is no evidence that current delays are adversely affecting delivery of planned efficiencies, quality or patient safety outcomes.

	The Group identified areas requiring ongoing oversight, including the Winter Pressure Plan risk assessment, the proposed out-of-hours biochemistry service model and workforce pressures within therapies services. In each case, appropriate challenge was provided and additional mitigations or amendments were requested where necessary to strengthen quality and safety assurance. The Committee is advised that the Winter Pressure Plan, interim Endoscopy pathway and Therapies workforce EQIA were supported, with approvals subject to specified actions and final signatories. The proposed out-of-hours biochemistry arrangements were supported in principle pending further engagement with paediatric, emergency and critical care services and revision of risk assessments to reflect the acute service profile at Poole Hospital.
ALERT:	**Winter Pressure Plan 2025/26** • The Group identified that infection prevention and operational flow risks associated with winter pressures were understated within the EQIA. • Members agreed that the pre-mitigation infection prevention risk should be increased and that operational flow risks remain significant despite planned mitigations. • Approval was therefore conditional upon revision of risk ratings to better reflect the anticipated pressures across the organisation and wider system. **Out of Hours Biochemistry Service** • Concerns were raised regarding the description of Poole Hospital as a predominantly elective site, as acute, paediatric and trauma services continue to operate overnight. • Further assurance was requested regarding potential impacts on emergency, paediatric and critical care pathways arising from the proposed overnight sample transfer arrangements. • Clinical outcome and patient safety risk assessments require revision before final sign-off.

	Workforce Pressures • The therapies workforce EQIA highlights continuing staffing capacity pressures and vacancy-related challenges associated with delivery of the 2% efficiency programme. • While risks remain assessed as moderate, there is potential for increased length of stay and reduced service responsiveness if vacancies cannot be sustainably managed.
ASSURE:	**Governance and Equality Impact Assessment Oversight** • The Group received assurance that all completed EQIAs since the previous meeting have been appropriately reviewed, with no issues requiring escalation. • No emerging equality, quality or safety concerns were identified from the portfolio of completed assessments. • 490 EQIAs have been completed for 26/27; an additional 19 EQIAs since August 2026. None of these 19 EQIAs have raised a risk score of above an 8. **Winter Pressure Planning** • Subject to amendment of risk ratings, the Group was satisfied that the Winter Pressure Plan includes appropriate mitigations covering workforce resilience, admission avoidance, discharge planning, infection prevention and system-wide coordination. **Out of Hours Biochemistry** • Assurance was provided that the proposed overnight transfer arrangements have already operated on multiple occasions during staffing shortages without reported clinical harm. • Final sign-off will be undertaken once additional clinical engagement and amendments to the EQIA have been completed.

	Endoscopy Services • The Group was assured that appropriate clinical, operational and infection prevention controls are in place to support the interim service model. • The EQIA was approved. **Therapies Workforce Scheme** • The Group was assured that the workforce reduction proposals relate primarily to vacancy management and workforce changes already occurring within services. • The EQIA was approved subject to completion of the HR signatory process.
ADVISE:	**EQIA Programme Delivery** • Nineteen transformation-related EQIAs have been completed since the previous report, with no assessments requiring escalation. • Fifty-six schemes remain in draft and sixty EQIAs have yet to commence. • Delays in EQIA completion are not currently expected to compromise delivery of planned efficiency savings, as schemes can progress through governance gateways pending final EQIA approval and can be withdrawn if approval is not subsequently obtained. **Endoscopy Reconfiguration** • The Group reviewed the interim inpatient and complex endoscopy arrangements required because of delays to Phase 3 reconfiguration. • Risks relating to staff unfamiliarity, service transition and satellite-site working have been mitigated through simulation training, revised SOPs, staffing plans, IPC review and performance monitoring. • External review by JAG has indicated that the proposed arrangements are acceptable pending further review in December.

	Governance Arrangements • Given the anticipated increase in transformation activity associated with Phase 3 implementation, the Group recommended returning to monthly meetings from January 2027 to maintain oversight of EQIA development and approvals.
Celebrating Outstanding:	**Strong EQIA Delivery for 2025/26** • Since the previous report, 19 EQIAs have been completed without requiring escalation and no significant equality, quality or safety concerns have been identified. The Group has provided constructive challenge to major transformation programmes, strengthening risk management and supporting safe implementation.
RECOMMENDATION:	The Board is asked to: • Note the current EQIA position and key risks • To note the EQIA Oversight Group remains assured that transformation and efficiency schemes continue to be subject to appropriate equality, quality and safety scrutiny, with no significant unmitigated risks requiring escalation to the Quality Committee at this time.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☐ Strategy/Transformation ☒ System ☒
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☐ Responsive ☐ Well-Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Equality and Quality Impact Assessment Panel	26/06/2026	AAA escalation to Quality Committee on current EQIA position across Trust
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **6.6.2**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Mortality Report
Prepared by:	Jessica Wiggins
Presented by:	Peter Wilson, Chief Medical Officer
Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☐ Patient Experience ☐ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Assurance
Executive summary:	This paper provides an update from the Mortality Surveillance Group (MSG), including review of national mortality indicators, Learning from Deaths processes, care group mortality reporting, Medical Examiner report and LeDeR input. Mortality indicators remain broadly favourable. The Trust's rolling HSMR has increased to 99.38 but remains below the national average and SHMI remains lower than expected at 0.87. Mortality alerts relating to cancer diagnostic groupings, secondary malignancies and neurodegenerative conditions remain under review. Trust-wide Learning from Death compliance was 87% for May 2026 and 34% of deaths were sent for review for this month. During this reporting period MSG undertook a detailed review of the elevated maternity and neonatal HSMR. Coding quality and methodological factors were identified as likely contributors and no new patient safety concerns were identified.

ALERT:	The Medical Examiner Service continues to experience workforce and capacity pressures, particularly due to increasing community referrals, fluctuating seasonal demand and sickness absence with the loss of 6PA each week. Waiting times for review have risen from approximately 3 days to up to 10 days. Elevated Maternity and Neonatal HSMR was reviewed through a dedicated multidisciplinary deep dive. Coding depth within neonatal services, delayed post-mortem outcomes and limitations of HSMR methodology were identified as contributing factors. No new patient safety concerns were identified. Mortality alerts relating to cancer and neurological diagnostic groupings remain under review. Initial review has not identified any systemic quality concerns and work continues to validate coding, understand case mix and undertake patient-level review where indicated. The impact of hospice inclusion in UHD SHMI data has again been questioned with HED. Ongoing issues have been reported by the MEO with identifying Consultants to support Residents with MCCD completion and coroner referral and an SOP to clarify this escalation route is underway.
ASSURE:	**Mortality indicators remain stable and within expected limits** • HSMR (rolling 12 months): **99.38** • HSMR (in-month): **107.5** • SHMI: **0.87 (lower than expected, top 14 nationally)** The rolling 12-month HSMR remains below the national position at 99.38. Although the May in-month HSMR increased to 107.5, the rebased SPC chart remains within control limits and a single month does not demonstrate a sustained change. SHMI remains lower than expected at 0.87, with all reported diagnosis groups either as expected or lower than expected **Learning from Deaths – completion performance** • eLFD completion remains at **87% within 3 months** • Medical care groups continue to perform strongly, with improving consistency across other areas Learning from Deaths compliance for May 2026 was 87% Trust-wide, comprising 86% for Medical, 89% for Surgical and 86% for WCCSS. Care group reporting continues to provide evidence that deaths are being reviewed and learning identified. The WCCSS submission was notably more detailed than a year earlier, and weekly neonatal grand-round attendance by Clinical Coding is supporting more accurate and granular coding. PMRT, MBRRACE, MNSI and mortality review processes continue to provide assurance regarding maternity and neonatal services.

ADVISE:	Work continues to strengthen mortality governance through standardised morbidity and mortality meeting outputs, thematic reporting and future use of automated reporting tools. MSG is considering whether Learning from Deaths review should be expanded to all deaths other than OPS and palliative deaths. While this could increase learning, the group was clear that any change must be aligned with simplification and standardisation of M&M processes, with sufficient support to avoid reducing the quality or timeliness of reviews. Mortality leads will be consulted before any change is made. The tighter application of palliative care coding criteria is expected to increase HSMR because Z51.5 will be used only where the full criteria are met. The mortality position will therefore be monitored over the next few months and interpreted alongside coding changes and the rolling 12-month position. The names of Forest Holme and the Macmillan Unit do not currently identify them as hospices within ODS data, so these deaths have not been excluded from SHMI as intended. A request has been made to amend the ODS names. While formal LeDeR reviews remain paused regionally, local review processes continue to identify important learning relating to Mental Capacity Act assessments, Best Interest decision-making, reasonable adjustments and personalised end-of-life planning. MSG welcomed ongoing work from the Learning Disability and Autism Team to strengthen practice in these areas and noted that these themes align closely with wider Trust learning and forthcoming education initiatives around Mental Capacity Act training and simulation. ED Holding Patients and Mortality Governance: MSG continues to review governance arrangements for patients managed by specialty teams within ED holding areas. Current processes may result in deaths being reviewed through ED pathways without entering specialty mortality review processes, limiting opportunities for specialty learning. The issue has been escalated for organisational review and digital solutions are being developed to improve visibility, discharge governance and mortality oversight. The risk will be detailed on the Trust Risk Register.
Celebrating Outstanding:	Continued improvement in Learning from Deaths compliance, strong multidisciplinary engagement in mortality review processes, development of standardised Trust-wide mortality governance arrangements, and implementation of targeted improvement initiatives arising directly from mortality review learning, including Mental Capacity Act simulation training and end of life escalation support.
RECOMMENDATION:	The Board is asked to:

	1. Note the current mortality position and assurance provided by HSMR, SHMI and care group mortality review processes. 2. Support HR changes required to improve availability of additional ME sessions. 3. Support continued work to standardise M&M reporting and consider expansion of Learning from Deaths review when the process and required support have been agreed.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Assessment Framework:	Safe ☒ Effective ☐ Caring ☐ Responsive ☐ Well-Led ☐ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Quality Committee	06/10/2026	The Committee noted the report.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

Executive Summary

This report provides an update from the Mortality Surveillance Group (MSG) following its meeting on 10 September 2026 but also includes information from the report submitted in August to cover Q2. Mortality indicators remain broadly favourable. The rolling 12-month HSMR has increased to 99.38 but remains below the national position. The latest fully coded in-month HSMR for May 2026 is 107.5 and remains within expected statistical variation. SHMI remains lower than expected at 0.87.

Learning from Deaths review compliance was 87% Trust-wide for May 2026. MSG discussed a proposal to expand review to all deaths other than OPS and palliative deaths. The group agreed that any change must be aligned with work to simplify and standardise M&M processes and supported appropriately, so that a higher volume of reviews does not reduce their quality or timeliness.

The group noted that tighter application of palliative care coding criteria is expected to increase HSMR. The next few months will therefore require careful interpretation of the in-month and rolling positions alongside coding changes. Work continues to improve mortality governance through standardised M&M reporting, clearer accountability for actions and better capture of deaths occurring in ED and other non-clinical areas.

Introduction

The learning from deaths report sets out to satisfy the requirements within the NHS Learning from Deaths Framework. Data is presented from UHD data sources, NHS England and data collected by the Medical Examiners in UHD.

1. Analysis and discussion

1.1 Inpatient Deaths at UHD

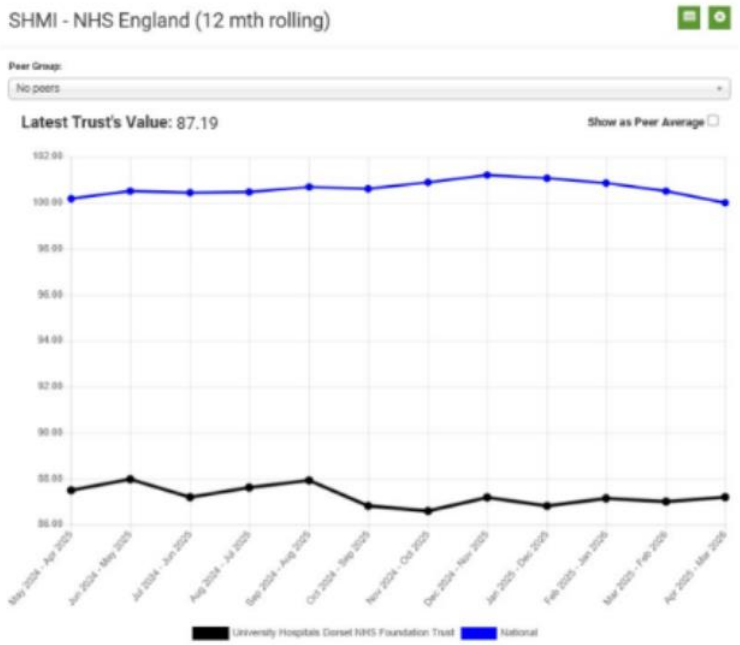
Quarter	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26	2026-27
Q1	548	522	675	681	682	645	515
Q2	575	658	685	623	622	594	
Q3	761	708	807	765	693	639	
Q4	989	715	749	693	741	617	
Total	2873	2603	2916	2762	2738	2495	

Data source is Camis.

Q1 of 2026-27 saw 515 inpatient deaths at UHD sites, compared to 645 in Q1 of 2025-26.

1.2 SHMI

SHMI (Summary of Hospital Level Mortality Indicator) is the ratio between the number of patients who die up to 30 days following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated here. Data is provided for rolling 12 months and is always in arrears. Covid-19 related activity is included in if the discharge data is on or after 1st September 2021. Hospices are excluded. The national average is 1.
UHD's SHMI is in the 'lower than expected' range at 0.87 for the 12 months to March 2026. NHS England's published position places UHD close to the lower control limit of the 'as expected' range and within the top 14 of the 119 trusts included.



Site level breakdown;

Site level breakdown
(official statistics in development)

Table notes

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
R0D02	Royal Bournemouth Hospital	60,470	1,885	2,305	0.8165	Lower than expected SHMI
R0D01	Poole Hospital	41,840	1,330	1,635	0.8137	Lower than expected SHMI

NHS England calculates SHMI values and bandings for 10 SHMI diagnosis groups. The latest available breakdown is for the rolling 12-month period to March 2026.

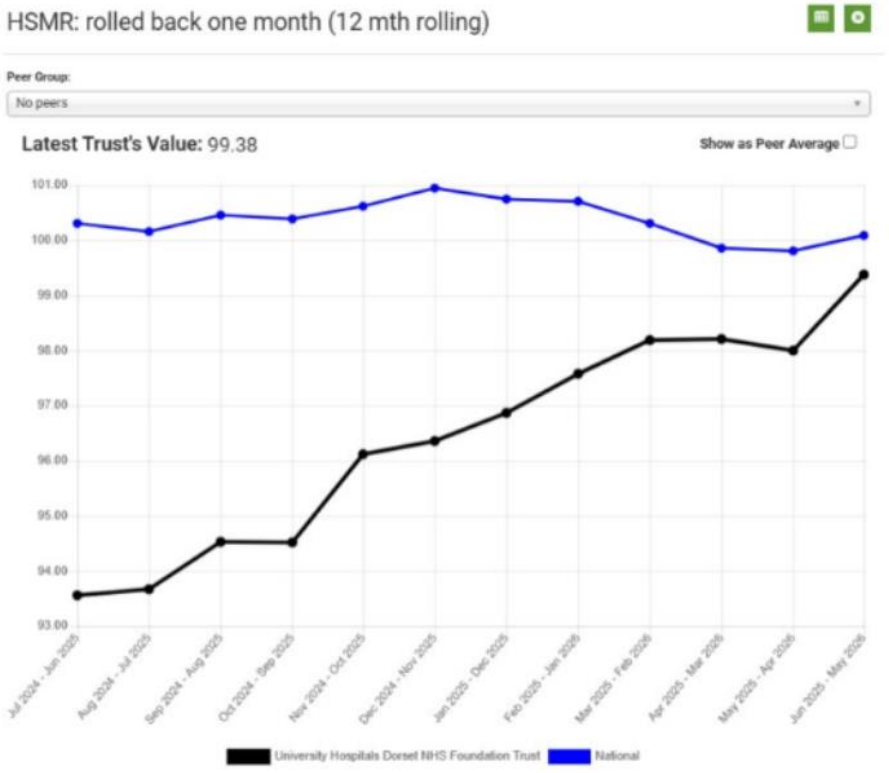
Diagnosis group description	Diagnosis group number	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
Cancer of bronchus; lung	15	330	105	95	1.1553	As expected SHMI
Secondary malignancies	30	790	130	125	1.0378	As expected SHMI
Fluid and electrolyte disorders	37	840	50	55	0.9325	As expected SHMI
Septicaemia (except in labour), Shock	2	660	160	175	0.9177	As expected SHMI
Acute myocardial infarction	57	945	65	75	0.8707	As expected SHMI
Pneumonia (excluding TB/STD)	73	2,990	410	475	0.8665	As expected SHMI
Urinary tract infections	101	1,950	80	95	0.8480	As expected SHMI
Gastrointestinal hemorrhage	96	700	35	45	0.8461	As expected SHMI
Fracture of neck of femur (hip)	120	935	60	80	0.7418	Lower than expected SHMI
Acute bronchitis	74	2,005	55	80	0.6987	Lower than expected SHMI

For the 12 months to March 2026, all diagnosis level values are either as expected or lower than expected.

1.3 HSMR

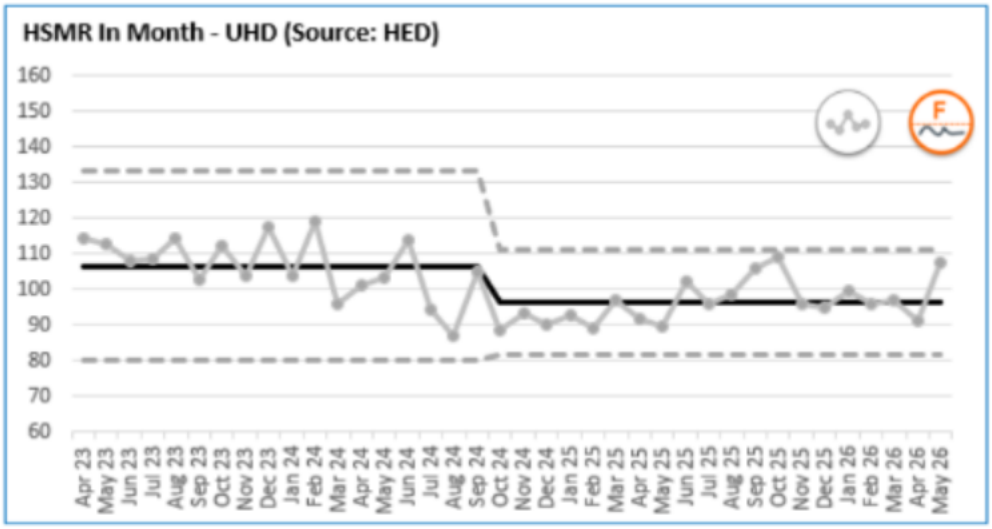
HSMR (Hospital Standardised Mortality Ratio) is the ratio of observed number of in-hospital inpatient deaths compared to the expected* number of in-hospital deaths. UHD report both the in-month and rolling 12-month positions and data is usually a few months in arrears. Data is extracted from HED (Healthcare Evaluation Data) and excludes the latest month which is not yet fully coded. The national average is 100.

HSMR Rolling 12 Month: June 2025 to May 2026 is 99.38. The chart below displays UHD against the national position.



HSMR In Month: The latest fully coded position is May 2026 at 107.5. This is above the national average of 100 but remains within expected statistical variation. The SPC chart has been rebased and the latest point remains within the control limits.

HSMR In Month - Latest fully coded position is May 2026 at 107.5, which is above the national average of 10 remains within expected variation.



Each month UHD receives mortality alerts from HED. These are triggered when there is a higher than expected value above a defined threshold; for red alerts, this threshold is the upper control limit. UHD received the following red alerts in August 2026:

Rolling 12-month SHMI position for the latest data period (June 2025 – May 2026) for the following diagnostic groups:

- Cancer of bone and connective tissue, Cancer of thyroid, Malignant neoplasm without specification of site
- Multiple sclerosis, Other hereditary and degenerative nervous system conditions

The alerts remain under review using the agreed approach of HED data analysis, coding validation, consideration of case mix and patient-level clinical review where indicated.

2. Care Group Morbidity & Mortality Learning

One of the Patient First driver metrics for 25/26 is eMortality Consultant Review Compliance. This is reported monthly on the Patient First scorecard, showing deaths up to 3 months ago. The target is 100% to be reviewed within 3 months.

Trustwide position is 87% complete for May 2026 (as at 2nd September)



By Care Group

(blank indicates there were no deaths requiring review in that month)

Care Group	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Total
⊟ **Medical**	**92%**	**87%**	**100%**	**97%**	**98%**	**100%**	**100%**	**100%**	**100%**	**86%**	**96%**
⊞ Emergency & Urgent Care	0%	0%								0%	**0%**
⊞ Networked Medicine	100%	95%	100%	100%	100%	100%	100%	100%	100%	96%	**99%**
⊞ OPS and Acute Care	100%	100%	100%	100%	93%	100%	100%	100%	100%	86%	**98%**
⊞ Specialist Medicine	92%	78%	100%	83%	100%	100%	100%	100%	100%	77%	**92%**
⊟ **Surgical**	**100%**	**78%**	**100%**	**100%**	**100%**	**80%**	**100%**	**100%**	**57%**	**89%**	**89%**
⊞ Head and Neck						0%					**0%**
⊞ Surgery	100%	86%	100%	100%	100%	100%	100%	100%	100%	100%	**98%**
⊞ Trauma & Orthopaedics	100%	50%	100%	100%		100%	100%	100%	25%	67%	**79%**
⊟ **WCCSS**	**100%**	**50%**	**100%**	**67%**	**100%**	**92%**	**100%**	**83%**	**88%**	**86%**	**87%**
⊞ Cancer Care	100%	50%	100%	67%	100%	92%	100%	83%	88%	86%	**86%**
⊞ Gynaecology					100%						**100%**
Total	**93%**	**83%**	**100%**	**95%**	**98%**	**98%**	**100%**	**98%**	**93%**	**87%**	**95%**

Trust-wide Learning from Deaths review compliance was 87% for May 2026 as at 2 September. This comprised 86% for Medical, 89% for Surgical and 86% for WCCSS. Thirty-four per cent of deaths in May had been sent for review.

Care Group mortality reporting continues to improve in both quality and consistency. There is evidence of strengthened governance structures, clearer escalation of themes, and improved multidisciplinary engagement. Work within the Medical Care Group to streamline governance processes is expected to further enhance alignment and reporting. WCCSS reporting now contains substantially more clinical detail than a year earlier and provides greater assurance that deaths are being reviewed and learning identified. Surgical reporting was limited during the summer, with no directorate M&M reports received.

Learning identified at specialty level is increasingly being incorporated into local action plans, providing assurance that mortality review is supporting quality improvement across the organisation.

Themes identified from Learning from Deaths (LfD) reviews and care group reporting remain consistent and include:

- delays with verification of death
- delays with Medical Examiner review
- delays in recognition and escalation of deterioration
- variability in treatment escalation planning
- communication challenges, particularly at end of life
- issues at transitions of care (e.g. ITU step-down)

These themes reflect wider system pressures rather than isolated issues. Actions continue to be progressed within care groups, with increasing focus on system-level solutions.

In response to concerns about compliance with the Learning from Deaths policy, further external audit work is underway to review both compliance with policy requirements and the quality of learning and actions arising from eLFD and morbidity and mortality (M&M) processes. This is providing a more detailed understanding of how deaths are reviewed in practice and will inform improvements to case selection criteria and overall process design.

3. Medical Examiner Service update

The East Dorset Medical Examiner Service continues to experience significant operational pressure. At the September MSG meeting, waiting time for Medical Examiner review had increased from approximately three days at the end of quarter one to up to ten days for acute and community deaths. This followed sickness absence and the loss of at least six planned Medical Examiner activities each week and was affecting mortuary capacity.

An update on pay parity and whether this would enable further Medical Examiner cover was expected after the meeting. A planned audit of statutory requirements is also being undertaken following an external review of another service.

Work also continues to finalise a standard operating procedure describing the escalation route when resident doctors require consultant support with MCCD completion or referral to the Coroner.

4. LeDeR report summary: MSG received an update in August from the Learning Disability and Autism Team.

Formal LeDeR reviews commissioned through NHS Dorset remain paused due to the ongoing ICB reconfiguration, and there remains no confirmed date for recommencement. Despite this, UHD continues to notify deaths and undertake local review of cases to identify immediate learning and provide assurance.
A review of deaths during Q1 2026/27 identified several recurring themes:

- **Mental Capacity Act documentation and Best Interest decision-making** was inconsistent in some cases. Whilst DNACPR decisions were appropriately documented, supporting capacity assessments and Best Interest documentation were not always evident where capacity was questioned.
- **Reasonable Adjustments** were not consistently documented, with some patients lacking completed reasonable adjustment records or EPR flags

- **Communication and person-centred care planning** remain key areas for improvement. The review noted limited evidence of personalised end-of-life wishes being documented and opportunities to improve communication with care home staff as well as family members.
- **Early referral to Learning Disability and Autism practitioners** was highlighted as important, with one patient dying before specialist support could be provided following a late referral.

The group was also advised that the Learning Disability and Autism Team has developed alternative arrangements for learning whilst national LeDeR reviews remain paused, including attendance at multi-agency mortality review meetings led by Dorset HealthCare. The team continues to work with care groups to promote Mental Capacity Act compliance, documentation of personalised wishes, use of hospital passports and communication with carers and support providers.
A structured education and simulation programme led through the Safeguarding Team to improve staff confidence and competence in Mental Capacity Assessment and Best Interest Decision Making has been developed, starting in September. This initiative directly responds to recurrent themes identified through mortality review, LeDeR learning and wider governance processes and provides assurance that learning is being translated into practical improvement activity.

5. Clinical Coding Report:

Clinical Coding did not provide a separate verbal update in September. However, coding remained central to discussion of the mortality indicators.

The criteria for applying the palliative care code Z51.5 are now being used more tightly, so the code will be applied only where the full criteria are met. This is expected to increase HSMR and will need to be considered when interpreting the next few months of data.

- SHMI currently includes deaths at Forest Holme and the Macmillan Unit because their official ODS names do not contain the word “hospice”. A request has been made to amend the ODS names so that these deaths can be excluded as intended.
- Weekly Clinical Coding attendance at neonatal and special care baby unit grand rounds has started and is supporting clarification of clinical information and more granular coding. A suitably experienced coder is expected to continue this work.
- The rolling and in-month mortality positions will continue to be monitored alongside the coding changes, with any sustained movement brought back to MSG.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	People and Culture Committee – Chair's Report
Presented by:	Sharath Ranjan, Chair of the People and Culture Committee
Agenda items discussed:	At its meeting on **2 November 2026**, The Committee received the following: • Staff story: The ARTS at University Hospitals Dorset with Laura Joy, Arts Manager • 2026/27 Board Assurance Framework Q2 • Risk Register: review of significant risks; new risks rated 12 and above (People and Culture) • Chief People Officer's report • People Strategy progress • Integrated Performance Report – Our People • Workforce Operational Efficiency and Reduction Plan (WORP) Q2 • Workforce Plan Delivery Review • Education, Workforce Development Annual Report • 10 point plan to improve resident doctors' working lives-annual update • National letter regarding unauthorised, inappropriate and unjustifiable access to confidential patient information • Transforming People Services OBC • Freedom to Speak Up Q2 • Guardian of Safe Working Hours Q2 • Modern Slavery Statement

ALERT	The Committee wishes to alert members of the Board that: **Appraisals** The number of appraisals recorded remains below the agreed target of 90%. Values based appraisal (AfC) compliance was 61.83% in September. Medical and Dental appraisal compliance was 80.26% in September. The committee received a workforce report which identifies hotspots across the organisation which requires attention across several metrics. A recovery plan is underway with HR Business Partners working with care groups and directorates to improve completion rates. **Sickness Absence** Sickness absence rate of 5.0% is above the trajectory of 4.4% (requirement to achieve 4.1% by March 2027). A range of targeted actions continue to support improvement, including enhanced support to areas with the highest absence levels, strengthening management oversight and line manager training, together with earlier actions through HR, Psychological/ Occupational health and musculoskeletal support/ interventions. Flu vaccination rate is currently at 50.10%. **Statutory and Mandatory Training** The trust is currently achieving 86.75% compliance against a 90% target. There is particular concern around compliance related to Safeguarding and Resuscitation. A recovery plan is in place and a new learning management system (Totara) should support improvements. This will continue to be monitored through this committee.
ASSURE	The Committee wishes to assure members of the Board that: **Resident Doctor - 10-point plan** UHD has successfully embedded many aspects of the 10-Point Plan within existing governance, workforce and educational arrangements, with oversight now managed through established business-as-usual processes. UHD continues to utilise the NHS England Board Assurance Framework and remains 90% compliant, with 18 of 20 assessed areas rated as compliant. An annual Provider Self-Assessment (PSA), incorporating a range of education and training indicators including Resident Doctor working lives and delivery of the 10-Point Plan, is currently being completed and is due for submission to NHS England by 18 November 2026. There is still work to be done in relation to annual leave policy alignment with the nationally stipulated minimum standards and payroll reporting improvements. **Workforce Plan and Reporting** The committee received its first assurance report around people related data with summaries on national submissions and triangulation with finance and workforce. The heatmap

	dashboard is a useful tool to aid oversight and scrutiny beyond aggregated data. **Workforce Operational Efficiency and Reduction Plan** Overall workforce performance remains positive, with substantive staffing below plan, vacancy WTE reducing for a third consecutive month, stable turnover, and continued favourable agency performance. Targeted recruitment activity continues to strengthen workforce supply in key pressure areas. Challenges remain in bank usage, which is above plan despite month-on-month improvement. Off-framework agency spend reduced significantly in September (M06). Key achievements include achieving the Consultant Job Planning target (95%), sustained reductions in vacancies, and continued growth in the substantive workforce. The total workforce for September has performed favourably, achieving a positive variance of 10.06 WTE against the in-month plan.
ADVISE	The Committee wishes to advise the Board that: **People Strategy Progress** The People Strategy delivery is being delivered through 51 projects and agreed milestones. The committee was presented with a draft dashboard and in future would receive AAA highlight reports. The committee was assured about the methodology and approach. The committee was partially assured about the capacity to deliver over 400 milestones by the end of Q4. Future reports will provide a fuller understanding of progress.
Review of Risks	The committee reviewed the BAF and the strategic priority related to Our People – Great place to work. The risks in Q2 remained at the targeted risk score of 12 with a target to reduce to 9 in Q3 and Q4. The committee discussed whether this was achievable considering winter pressures and moves in April 2027 and were satisfied with the controls and mitigations currently in place. The risks are aligned to the projects and programmes delivering the refreshed People Strategy. In addition to the Care group and Directorate workforce risks, 7 new people service risks have been recorded on the risk register and work is underway to mitigate them.
Celebrating Outstanding	The committee heard from Laura Joy, Arts Manager at UHD. Several initiatives continue to make UHD an inspiring space for staff and patients across all our sites.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **6.6.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Modern Slavery and Human Trafficking Statement
Prepared by:	Deepa Pappu, EDI lead
Presented by:	Sue Smith, Interim Chief People Officer
Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☒ Patient Experience ☐ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	Trust strategic priority: Our People - *Be a great place to work*
Purpose of paper:	Decision/Approval
Executive summary:	The attached statement is a statutory requirement and is required to be published on the Trust's website. The Trust must comply with section 54 of the Modern Slavery Act 2015 as the following applies: • UHD is committed to preventing modern slavery and human trafficking. • Ensures suppliers comply with legal and NHS standards. • Carries out robust pre-employment checks and fair employment practices. • Provides safeguarding training to help staff identify risks. • Promotes Speaking Up through confidential reporting channels.
ALERT:	N/A
ASSURE:	The statement assures that UHD is meeting its legal, ethical and corporate social responsibilities to prevent modern slavery. The statement will be published on the UHD website with a link in a prominent place on the EDI page. The Trust is committed to implementing robust procurement, employment, safeguarding, training, and reporting measures to help prevent and address modern slavery and human trafficking. Any incident of modern slavery will be dealt with appropriately and relevant remedies made available to potential victims.

ADVISE:	N/A
Celebrating Outstanding:	N/A
RECOMMENDATION:	The Board is asked to approve the Moder Slavery Statement.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☒ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
People and Culture Committee	02/11/2026	The Committee endorsed the statement with recommendation to Board to approve it.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☒ Patient confidentiality ☒ Staff confidentiality ☒ Other exceptional reason ☐	

Modern Slavery and Human Trafficking Statement

This statement, made in accordance with section 54(1) of the Modern Slavery Act 2015, sets out the approach taken by University Hospitals Dorset NHS Foundation Trust (UHD) to understand all potential modern slavery risks related to its business, and the actions undertaken to mitigate any such risks during the financial year, ending 31 March 2027.

What is Modern Slavery?

Slavery is a violation of a person's human rights. Modern slavery encompasses many forms of slavery including the form of human trafficking, forced labour, bonded labour, forced or servile marriage, descent-based slavery and domestic slavery. A person is in modern slavery if they are:

- Forced to work through mental or physical threat or coercion.
- Owned or controlled by an "employer", usually through mental or physical abuse.
- Dehumanised, treated as a commodity, or sold or bought as "property."
- Physically constrained or has restrictions placed on their freedom of movement.

Trust's Compliance Requirements with the Modern Slavery Statement

We are committed to delivering high standards of corporate governance and a key element of this is managing the Trust in a socially responsible way. We are absolutely committed to preventing slavery and human trafficking in our corporate activities and supply chains. We also expect the same high standards which we set for ourselves from those parties with whom we engage, such as our suppliers and customers.

The steps we have taken to combat modern slavery and human trafficking

In relation to our supply chains, which include the sourcing of all products and services necessary for the provision of high-quality health care to our patients:

- We expect and require all our suppliers to comply with all local, national and (where applicable) international laws and regulations.
- All our orders are placed in accordance with standard NHS terms and conditions (T's & Cs). Within these terms are statements requiring suppliers to ensure they conduct business in a manner that is consistent with any anti-slavery Policy of the Authority and shall provide to the Authority any reports or other information that the Authority may request as evidence of the Supplier's compliance and/or as may be requested or otherwise required by the Authority in accordance with its anti-slavery Policy.
- Our suppliers must comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and notify the Authority immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains.
- We expect all those in our supply chain and contractors to comply with our values.

- We will not support or deal with any business knowingly involved in modern slavery and human trafficking. All suspicions of modern slavery and human trafficking will be reported to the relevant authority.
- We will consider modern slavery issues when making procurement decisions.

In relation to due diligence and risk management (other than our supply chains):

- We undertake appropriate pre-employment checks and require our agencies on approved frameworks to do the same.
- We protect staff from poor treatment and/or exploitation and comply with all respective laws and regulations including fair pay rates and terms of conditions of employment.
- We consult and negotiate with Trade Unions on proposed changes to employment, work organisation, and contractual relations.

Trust's policies and procedures on Modern Slavery and Human Rights which set the tone for how we as an organisation operate:

- We have a clear Freedom to speak Up policy that applies to all individuals working for our Trust and is published on our intranet site. If there are any genuine concerns about any wrongdoing or breaches of the law, including modern slavery laws, these concerns can be raised in confidence and without fear of disciplinary action.
- We have appointed a Freedom to Speak Up Guardian and Ambassadors to promote, listen, support and provide an impartial view to staff when speaking up and to contribute to a culture of speaking up where staff feel safe and confident to raise concerns.

Training of our staff:

- Our Level 1 Safeguarding training for staff includes how to recognise and respond to indicators of human rights abuses. It includes examples of red flags specific to our industry, explain our reporting procedures for suspicions and promote an organisation wide sense of responsibility.

- UHD Safeguarding Team support staff through learning and supervision to ensure safeguarding is everyone's business. All referrals made by staff are overseen by the safeguarding team. Staff can access advice and support from the safeguarding team.

This statement will be reviewed annually.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Transforming Care Together Steering Group – Chair's Report
Presented by:	Judy Gillow, ch of the Transforming Care Together Steering Group
Agenda items discussed:	At its meeting held on **5 October 2026**, the Group received, and reviewed in detail the following: • Programme Risks • Build Ready Update, including focus where off plan • Reconfiguration Ready Update ○ Phase 3 Move Planning, including focus where off plan • People Ready Update, including focus where off plan • Communications and Engagement Update • TCT Digital Update • Deep Dive - Phase 3 Delivery Plan
ALERT	People Ready risk – This has increased to 16, as 12 teams have not completed their workforce plans. It was agreed that urgent action was required to ensure time for the consultation and implementation phase. Interim CPO agreed to take this forward. This will remain under close review.
ADVISE	Program risks currently being refreshed to reflect that the move plans are delivered by April 2027 and the potential impact of any further delay. Concern raised re delivery of NCtR. Additional funding for P1 capacity has been agreed with ICB and BCP. It was advised that system escalation routes were being used to hold partners to account. It was agreed that the phase 3 narrative needs to be reviewed with a targeted engagement to build confidence in the phase 3 plans and a targeted focus on opportunities and service improvements, rather than just on the build program. Via communications, staff, the public and partners to be kept informed of the Coast program developments keeping the focus on the clinical benefits, quality and safety linked to the rationale for the April 2027 moves
ASSURE	The financial impact and risks of the phase 3 model to be considered in detail by FPC at the December meeting. Phase 3 delivery plan mainly on track with detailed planning taking place on future bed allocations. It was agreed that the term 'Occupied beds' would be used as the principal measure for tracking delivery.

Review of Risks	Workforce risk increased and programme risks being refreshed
Celebrating Outstanding	Endoscopy Hub now gone live

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **6.8**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Integrated Performance Report (Safety, quality, experience, workforce and operational performance)
Prepared by:	Executive Directors, Leanna Rathbone, Mark Major, Judith May, David Mills, Irene Mardon, Jo Sims, Vivian Alividza and Adrian Tron.
Presented by:	UHD Chief Officers
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	All BAF Risks Operational Plan exception report - Appendix A
Purpose of paper:	Assurance
Executive summary:	**Forward Look: Building on Improvement, Accelerating Recovery** September shows positive progress in planned care, workforce and productivity, with all three key RTT trajectories achieved, vacancies reducing and staff engagement improving. There are encouraging signs of recovery in diagnostics and cancer, although further improvement is required to meet planned trajectories. Urgent and emergency care and wider system flow remain the most significant operational challenges. Increasing demand, delayed discharges and limited onward care capacity continue to affect patient experience and access to timely care. Quality and safety, cancer recovery and the delivery of sustainable financial savings also require continued focus. The priority is to build on progress through **clear accountability, pace and sustained delivery**. This means translating improvement plans into measurable outcomes for patients, strengthening partnership working across Dorset, and ensuring the Trust delivers its operational, quality and financial commitments.

Performance Alerts

Population & Systems (2) *"See our patients sooner"*

Alert 1: No Criteria to Reside: No Criteria to Reside (NCTR) stood at 259 on 6th October, including Pathways 0 to 3, and remains a significant concern, having shown little improvement since June. By comparison, NCTR was 177 on the same date in 2025, highlighting a continued deterioration in system flow performance.

Alert 2: Cancer standards: The Trust demonstrated a 5.4% improvement against the 62 Day Standard in August 26 from the July 26 position, although this did not achieve the Trust's operational plan of 75.8%. The 31D standard also delivered an improved position of 95.8% (+2.2% from July 26), but falling 0.2% below the 96% trajectory.

In August 2026, the 28 Day Faster Diagnosis Standard deteriorated by 1.5%, delivering a position of 73.8% (trajectory 78.9%). The targeted actions in August of reducing the fast-track backlog has delivered a 17% improvement to date in patients being seen within 14 days in September, which will support performance in Q3.

Quality Outcomes and Safety (1): *Save lives, improve patient safety*"

Alert 1: Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemia.
Two cases of MRSA bacteraemia identified in September 2026. After Action Reviews (AARs) underway for both cases.

Patient Experience (1) *"Improve patient experience listen and act"*

Alert 1: 90% of Complaints closed within 35 days remains not achieved.
Following multiple small but significant actions, improvements are now being seen.

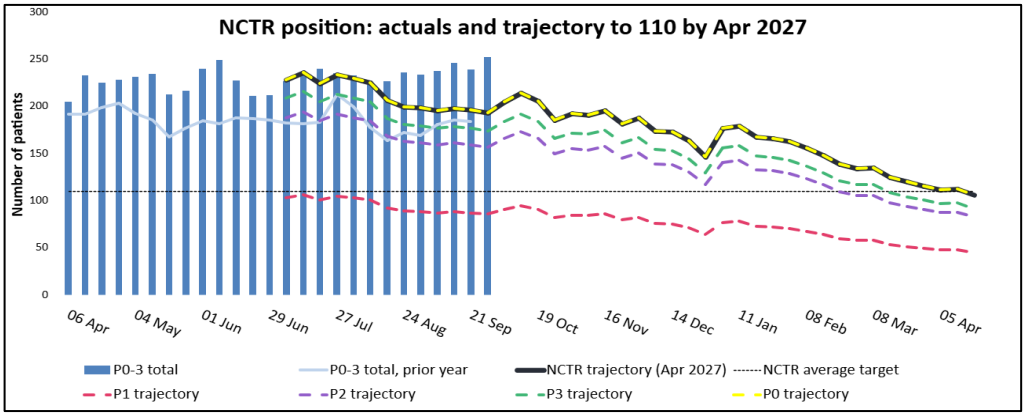
Our People (5) *"Be a great place to work"*

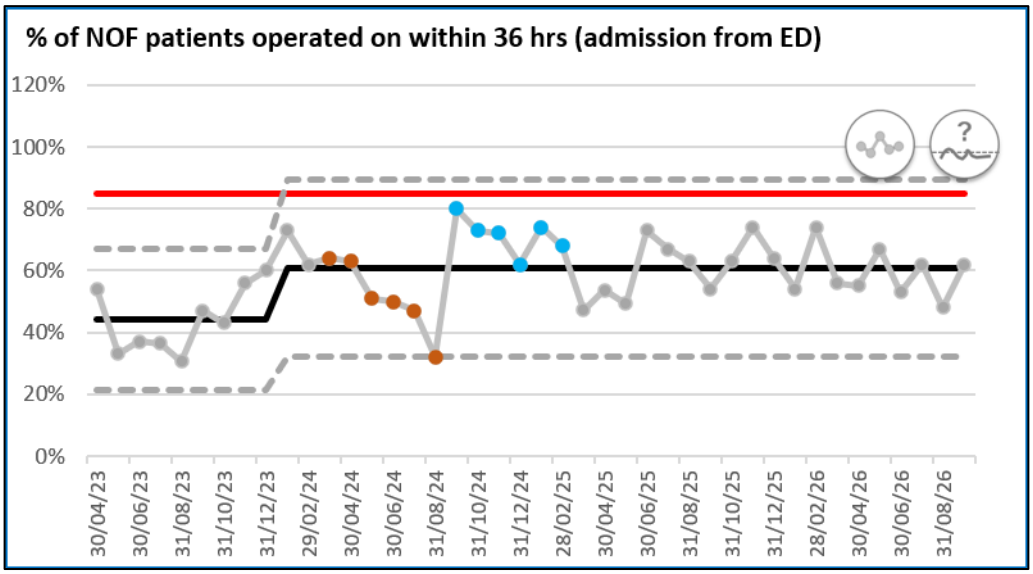
Alert 1: Bank Usage: During September, the Trusts bank usage was 41.08 WTE above plan, despite reflecting a decrease of 7.92 WTE from August. Substantive recruitment continues, with specific support to areas with high bank usage, including the Emergency Department, Stroke Unit, AMU Nursing staff and Older Peoples Assessment Unit.

Alert 2: Off-Framework Agency Usage. In Month 6, off framework spend decreased by £11,564, representing a 31% decrease compared to August (month 5). 18 shifts were required for general registered nurses, with a further 11 shifts required for registered mental health nurses. A cessation date for off-framework use is still outstanding for agreement to ensure the NHS England target is met.

Alert 3: **Recruitment.** Time to Hire remains above the NHS England ambition of 30 working days and has increased during the latest reporting period. Agenda for Change Time to Hire is **35.3 working days**, while Medical & Dental remains significantly higher at **71 working days**. The increase reinforces the need for continued focus on recruitment-stage performance, with separate reporting

	maintained to provide visibility of the longer Medical & Dental recruitment pathway. **Alert 4: Appraisals.** The number of appraisals recorded remains below the agreed target of 90%: • Values based appraisal (AfC) compliance was 61.83% in September. • Medical and Dental appraisal compliance was 80.26% in September. Variation remains present across Care Groups and corporate services. Additional training and support are in place. **Alert 5: Sickness Absence.** Sickness absence rate of 5.0% is above the trajectory of 4.4% (requirement to achieve 4.1% by March 2027). A range of targeted actions continue to support improvement, including enhanced support to areas with the highest absence levels, strengthening management oversight and line manager training, together with earlier actions through HR, Psychological/ Occupational health and musculoskeletal support/ interventions. **Sustainable Services – Finance (2) *"Use every NHS pound wisely"*** **Alert 1: Revenue Outturn** At the end September, the Trust has delivered within the agreed budget, reporting a deficit of £13.9m being £38,000 favourable to plan. The detailed forecast indicates a considerable risk; however, a breakeven forecast remains achievable if all identified mitigations are delivered. **Alert 2: Efficiency Improvement Programme** At the end of September, the Trust has delivered efficiency savings of £21.0 million being £26,000 behind the phased plan. The trust has identified savings opportunities of £52.0 million; however, this is reduced to £42.7 million when adjusted to reflect the risk of delivery in year. This position continues to improve month on month but remains significantly short of the full year savings target. The recurrent delivery within this represents a significant medium term sustainability risk for the Trust. The MTFP assumed 60% recurrent efficiencies, but at 32% delivery currently, this is a £19.4 million medium term risk if this performance does not improve. **Sustainable Services – Digital (1) *"Use every NHS pound wisely"*** **Alert 1: ICE for Ordering vs paper** With the progress of the electronic requesting there is an improvement in the data quality of the requests within the ICE system. There has also been agreement to a level of auto filing of results. However, the care groups need to continue to focus on the filing as current month filing stands at 56% of results being electronically filed.
Population & Systems **Urgent & Emergency Care**	**Breakthrough Objective: To achieve shorter waiting times and improved outcomes for patients as measured by achievement of access trajectories within the operational plan (UEC)** **Alert 1: No Criteria to Reside:** No Criteria to Reside (NCTR) stood at 259 on 6th October, including Pathways 0 to 3, and remains a significant concern, having shown little improvement since June. *By comparison, NCTR was 177 on the same date in 2025*, highlighting a continued deterioration in system flow

	performance. NCtR performance remains constrained by limited P1 capacity, delays in complex discharge pathways and social work assessment capacity.  **Key actions:** 1. fortnightly executive escalation with BCP colleagues , As of today, 1,553 of the 3,640 commissioned P1 hours are not being used for active reablement, representing 42.66% NCRT. A time-bound recovery plan developed by BCP to release blocked bed hours. 2. Fortnightly executive escalation for escalated complex discharge patients and access to STICC funding 3. Escalation meeting with local authority housing colleagues to work through trust 4. The Better Care, Better Flow programme continues to mature, with 14 active PDSAs progressing across pathways, alongside GIRFT corridor-care standards embedding and ongoing 5. UHD agreement to progress the development of an alternative plan if numbers don't start to reduce as part of Phase 3 hospital change 6. Discussion at the regional review meeting on the wider system responsibility for reducing delays.
Urgent & Emergency Care **ADVISE: 2**	**Advise (1): Ambulance Performance**: Ambulance handover performance in September remained relatively static at 31 minutes as compared to August being 32mins. New process in place for corridor care use/escalation and embedding GIRFT standards to eradicate corridor care and 24hrs waits, which will drive ambulance handover performance. Monthly reporting shows corridor usage remains below the mean. **Advise (2): Trauma: September performance for time to theatre for fractured neck of femur (NoF) patients saw 62.3% of patients operated on within 36 hours of admission.** Performance in September (62.3%) returned to be in line with the process mean. There is a pattern of normal variation and further actions are required to deliver improvement, though the targets remain within the process control limits. A number of contributing factors include: • Capacity within the medical and anaesthetic staff rota to manage the volume of trauma case • 18% of NOF patients (15 patients) were not fit for surgery on admission, however, 80% of patients achieved surgery within 36 hours of being fit for surgery. • ACP staffing for Trauma Hand Hub



Key actions:

- Collaborative focus from Ortho Geri/Anaesthetic Pre-Op/ACP for NOF patients unfit, to carry out all actions to seek clinical optimisation to become fit for Anaesthetic/Surgery
- Daily review of trauma position and appropriate early interventions to provide additional Theatre & Fracture Clinic capacity in response to higher level 2 and when in level 3 escalation specifically during seasonal demand variations
- New Junior Clinical Fellows starting October 2026.
- Ratification of new Standard Operating Procedure for pre-op anaesthetics in October 2026.

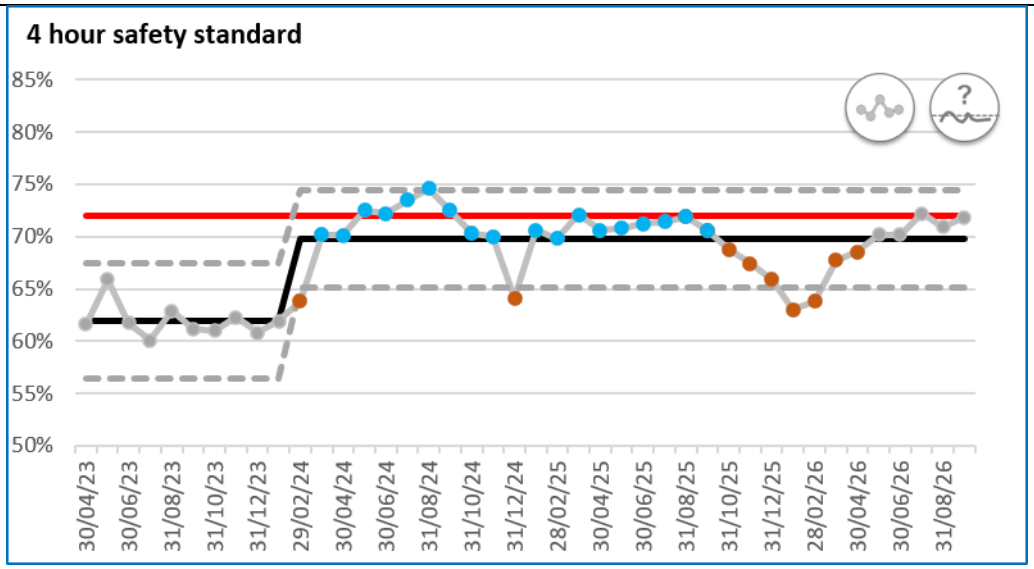
Urgent & Emergency Care

ASSURE (3)

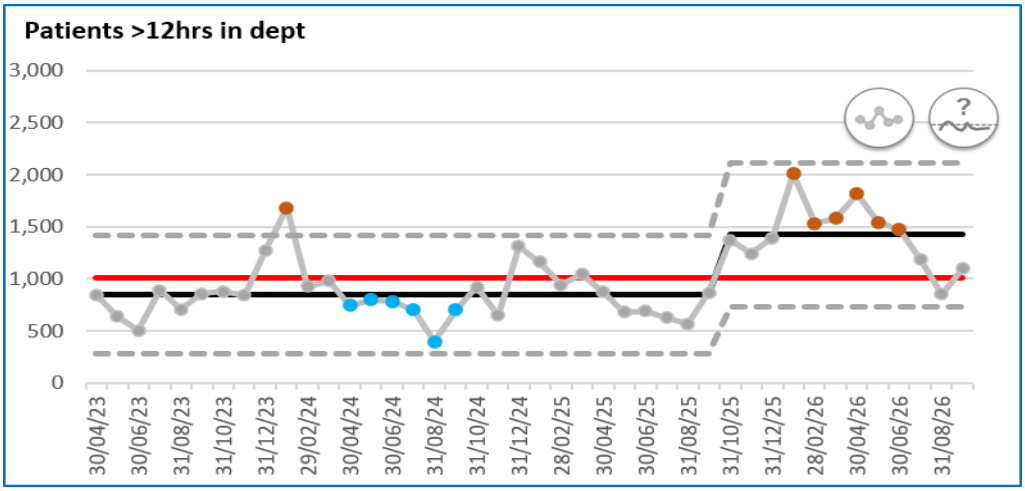
Assure (1) Performance against the admitted 4 - hour Organisational standard.

The Trust delivered against 71.85% in September against a trajectory of 72%. Admitted performance saw a small decline within the realms of normal variation to 30.6% down from 31.6% in August.
This was also mirrored in Non-admitted performance which increased slightly within normal variation to 82.3% from 81.1%. Daily attendances did see a steep increase to 683 attendances a day, up from 601 patients.

- Mean time in the department remained static despite an increase in presentations. Though decision to admit time did decrease again back down to 268 minutes.
- Ambulance handovers remained relatively static with average ambulance handover time of 31 mins against a target of 25 mins.



Assure (2) Patients >12hrs in the Emergency dept.
For 12 hour performance the Trust continues to see an overall positive improvement though the trajectory in September was missed, actual delivery was 1096 against a trajectory of 1015.



Key progress

- A site flow PDSA has begun focusing on quality and outcomes to create capacity through greater ownership to optimise discharge potential to create flow through the organisation. This is being followed up with some patient process mapping.
- Improvement cycles completed across Specialist and Networked medicine cross site with Older People's ward now planned. This will create a blue-print forward processes including Board / Ward rounds and discharge planning and will standardise the approach across the Trust.

Trust Recovery Plan for 12 hours in Emergency Department

Action to recover agreed plan	Description	Responsible officer / Forum	Actions completed	Ongoing actions *incl. due date and milestones to year end*
1. Immediate actions to improve pace of delivery and oversight and safety of the 12 hour Operational Indicator, with learning applied across other operational metrics	To provide the Board and executive team with improved visibility and to drive the day to day actions required to recover delivery against the agreed operational trajectories, with particular focus on the 12 hour position. *Note: given the shared drivers of front door flow, this action is also the primary lever for recovery of the 4 hour standard and for reducing 30 minute ambulance handover delays.*	UHD Chief Operating Officer (COO) Trust Management Group	• Implemented changes to the Trust Integrated Performance Report (IPR) for the July report • Improved operational daily visibility of the 12 hour position • Escalation SOP implemented across both sites • Weekly multidisciplinary review meeting established to examine all patients identified on the 12 hour ED report • Counter Measure Summaries completed outside business rules • Daily 12 hour, 4 hour and ambulance handover data triangulated into a single daily report • Weekly triangulated performance meeting for operational standards, chaired by the COO	Extend the daily escalation SOP to include ambulance handover triggers (by 15th Sept) • Review embedding of the Accountability Framework, (Oct 2026) • Develop a revised 12 hour trajectory to year end, with monthly milestones to monitor against 26/27 (by 7th Sept 26) • Risk entry for 'Non-delivery of planning assumptions underpinning the 2026/27 operational trajectories' including mitigations and controls to be delivered reported through to Trust Risk Oversight Committee, (29th Sept 26)
Action to recover agreed plan	**Description**	**Responsible officer / Forum**	**Actions completed**	**Ongoing actions incl. due date and milestones to year end**
2. Holding UHD improvements already in place, transferred to the Better Flow, Better Care programme	The ways of working established through our Dorset system Future Care programme, including the transfer of care hub referral discipline and Same Day Emergency Care streaming and utilisation, are now embedded within the Better Flow, Better Care programme. *Note: These embedded gains directly reduce the pool of patients waiting over 12 hours and lower ambulance conveyance where SDEC streaming diverts appropriate patients away from the ED front door.*	UHD COO Trust Management Group via Better Flow Better Care Steering Group	• Internal element of the Future Care work programme transferred to Better Flow, Better Care • Daily SDEC utilisation and conversion data monitored, showing improved performance against pre Future Care levels (ongoing) • Flow Improvement dashboard developed to support oversight of patient flow across the Trust • SDEC access gap analysis completed against the NHS England SDEC service specification • Gap analysis completed against the Model Emergency Department standards for high performing urgent and emergency care pathways • Review completed against the Model Acute Pathway standards for care of acutely unwell patients in their first 72 hours	• Future Care closure report to be shared with Trust Board, with agreement on next steps (9th Sept 26)
3. Delivering the Trust Better Flow, Better Care Programme, a structured, multi workstream change programme	An executive-sponsored programme '***Better Flow Better Care' (BFBC)*** delivers improvement through four clinical workstreams: Emergency Department, Same Day Emergency Care, Sick Specialty and Sick Frail, each with an executive sponsor, clinical lead and SRO.	UHD Deputy Chief Executive Officer Trust Management Group via Better Flow Better Care Steering Group	• Appointment of an external Clinical Advisor for Urgent & Emergency Care (BCBF) • Mobilisation of the BCBF programme and Workstreams • Initial set of PDSA's have been agreed • Communications plan has been developed • The strategy document developed by 30 clinical leaders has now been socialised. • Inaugural steering group held, 29 June 2026	• Steering group to continue meeting monthly for programme oversight, with individual workstream meetings fortnightly (Ongoing) • Each workstream, Emergency Department, Same Day Emergency Care, Sick Specialty and Sick Frail, to report agreed PDSA outcomes and their impact against the 12 hour, 4 hour and handover metrics to the steering group (by 30 Sept 26) • Programme level milestone and benefits review to be presented to Trust Management Group, (1st Oct 26)

4. Hospital emergency flow redesign and optimisation	Sustained focus on delivering the emergency and planned care split ahead of the Phase 3 timeline, through optimised Same Day Emergency Care, Call Before Convey, expansion of Hospital at Home and a Command Centre view of patient flow.	UHD COO Trust Management Group via Reconfiguration Ready Steering Group	1. High Impact Changes agreed through an organisational innovation event 2. SROs for each high impact change agreed and progress tracked through the Emergency Hospital Oversight Group, with key deliverables aligned to wider Better Flow, Better Care metrics 3. Agreement on plans to enhance Our Operating Model 'Opportunities for Our Patients' agreed through the UHD Trust Management Group	• Scope of high impact changes confirmed and prioritised (by 30 Sep 26) • System wide meeting to be mobilised to inform the design plan for Urgent Care Command Centres (by 10th Oct 26) • Command Centre view extended to include an ambulance handover indicator alongside the 12 hour and 4-hour dashboards, (by end Sept 26) • Hospital at Home business case expansion trajectory, with bed equivalent capacity by month, agreed (by Oct 26)
Action to recover agreed plan	**Description**	**Responsible officer / Forum**	**Actions completed**	**Ongoing actions incl. due date and milestones to year end**
5. NCRT reduction, system redesign and re-commissioning	Around 50 acute beds are occupied by patients whose needs exceed Local Authority commissioning thresholds. Four conditions to reach the 110 no criteria to reside target; progress being tracked jointly with the ICB, BCP Council and system partners and shared with the Trust Board monthly. Current position: no criteria to reside numbers are averaging around 230, against the 110 target. **Four Conditions** 1.Close commissioning gaps (ring-fenced placement budget, delirium in-reach 2.Discharge-to-Assess operationalisation 3. Right-size community P1 and P2 commissioning 4. Optimise BCP Adult Social Care response times	System Partners through Dorset Recovery and Delivery Board UHD Trust Management Group via Reconfiguration Ready Steering Group	• A new Dorset wide Recovery and Delivery Board has been established which will oversee delivery of these plans. This is Chaired by the ICB Chief Executive. • £1.8m additional intermediate care investment through the Discharge to Assess Partnership supported by the ICB and Investment Panel, July 2026 (Condition 1) • Partnership agreement signed off (Condition 2) • Patients worked up to support discharge, August 2026 • Patients have started to leave UHD on the agreed pathway • ICB to oversee delivery through the Discharge to Assess Partnership, with impact on no criteria to reside levels, discharge performance and system capacity monitored monthly (ongoing). • ICB, via Dorset HealthCare, to progress the Dorset Transfer of Care Operating Model to strengthen Home First decision-making and Pathway 1/2 flow, overseen through the pan-Dorset senior leadership group and Weekly Improvement Group (ongoing). • ICB to align system partners, investment and oversight behind the factors with the greatest impact on emergency admissions and patient flow, in support of sustained 12-hour ED performance improvement (ongoing).	• ICB/Local Authority/ UHD to set a Monthly no criteria to reside trajectory, current ask 110 with milestones to March 2027, published by Oct 26 • ICB to finalise Tier 1 cohort plans and improvement trajectory through the Neighbourhood and Wellbeing Programme Board, supported by Macmillan Social Investment funding, with targeted interventions mobilised ahead of winter (by end Sept 26) • ICB to mobilise a targeted demand management programme for the Tier 1 cohort — 1.2% of the population but 16.5% of ED attendances and 21.3% of emergency admissions — aimed at reducing avoidable attendances and admissions through earlier intervention and coordinated care. Trajectory and impact measures to be agreed through the Neighbourhood and Wellbeing Programme Board, supported by Macmillan Social Investment funding, by end September 2026, with interventions mobilised ahead of winter.

Assure (3): Alternatives to Admission:

Avoided admissions through SDECs has continued to outperform the forecast and trajectory. Ongoing improvement work to further exploit opportunities and to extend the service, will be driven through the Better Flow, Better Care Programme with a focus on optimising available SDEC pathways using nationally recommended clinical pathways.

- **SDEC** now supports 20% more patients attending hospital, without needing to admit them. Despite hospital attendances increasing by 6% compared to last year, admissions have decreased by 1%. This has been supported by improvements in SDEC 2 x PDSA.

- **Transfers of Care Hub** continues to develop and mature in line with the ward rollout program to wrap around the broader systems and processes.
- **Enhanced Urgent Care Single point of access** went live across the Dorset system. Senior Clinical Decision Maker (SCDM) accessible to ambulance teams and all health professionals Admission avoidance – keeping patients safely at home

Planning requirement	Aug 26	September 2026	
4 Hour safety standard	70.93%	71.85%	Trajectory 72%
Patients >12hrs in dept	854	1,101	Plan trajectory 1,015
Overnight total general and acute bed occupancy %	92%	94%	Plan Trajectory 95.91%%
Average handover time (Total Handover time (ED and non-ED)/No. of handovers (ED and non-ED)	00:32:23	00:32:50	Plan Trajectory 00:25:00
NCtR (daily average per month)	230	230	Local Ambition by April 27 – 110

Population & Systems: Planned Care including Cancer standards

Breakthrough Objective: To achieve shorter waiting times and improved outcomes for patients as measured by achievement of access trajectories within the operational plan. (Planned, Diagnostics and Cancer)

ALERT: 1

Alert (1) Cancer Waiting Times

Following a challenging start to the Q1 position, recovery actions have been implemented to support improvements which have started to be realised however, the Cancer Waiting Times are not yet meeting the national standards for 26/27.

The Trust demonstrated a 5.4% improvement against the 62 Day Standard in August 26 from the July 26 position, although this did not achieve the Trust's operational plan of 75.8%. The 31D standard also delivered an improved position of 95.8% (+2.2% from July 26), but falling 0.2% below the 96% trajectory.

In August 2026, the 28 Day Faster Diagnosis Standard deteriorated by 1.5%, delivering a position of 73.8% (trajectory 78.9%). The targeted actions in August of reducing the fast track backlog has delivered a 17% improvement to date in patients being seen within 14 days in September, which will support performance in Q3. The early view of September shows a similar position for the Faster Diagnosis Standard in September with an improved position in October following key improvement actions.

There are a **set of agreed recovery actions in progress for Q3 of 26/27**:

- Focus recovery actions for all standards with weekly Executive level support, now reporting into the weekly Cancer Improvement Group and the bi-monthly Trust Strategic Cancer Group.
- Implementation of the 'Wid-Easy' swab on the endometrial pathway, reducing the requirement for hysteroscopies and enabling 90% of patients to receive a diagnosis within 3 days.

- Delivering further activity across Urology, Colorectal, Gynaecology and Breast following additional recovery funding from the Wessex Cancer Alliance.
- Utilising additional Prostate MRI capacity to support all of the cancer standards following the demand and capacity modelling in Q2.
- Removing the 'second read' of Skin patients going through the Skin Analytics AI platform following NICE approval and clinical safety approval to improve the speed of diagnosis.

Please note there is further validation to be completed and treatments to be reported before the September position is finalised on 30th October 2026.

Planning requirement	July 26	August 2026		Current Sept 2026 (as of 14/10/26)
Cancer 28 day standard	75.3%	73.8%	Trajectory 78.9%	73.3%
Cancer 31 day standard	93.6%	95.8%	Trajectory 96%	92.6%
Cancer 62 day standard	64.7%	70.1%	Trajectory 75.8%	66.3%*
62 Day Backlog	176	169	179	

ADVISE: 2

Advise (1) The operational plan trajectory for Community Services waiting times (neurodevelopmental services) <18 weeks has been met however does not meet the national ambition and the % of patients waiting >52 weeks remains high (75.3%).

The Trust's Community Health Services (non RTT) waiting list is solely made up of patients waiting for a neurodevelopmental assessment, where there is limited capacity (reflected nationally) and patients are waiting longer than we would like. 7.5% of patients were seen within 18 weeks, which meets the operational plan trajectory for September (3.8%) but is below the national ambition for 2026/27.

Both metrics have scored highly within the NHS Oversight Framework domain for Access to Services in Quarter 1.

The Trust continues to support families to access Right to Choose providers in Dorset and to work with ICB partners on launching the Neurodevelopmental Exploration and Strengths tool (NEST) pilot to support demand management.

Key actions:
1. Deploy additional NHSE awarded funding to support neurodevelopmental assessments and maximise access to Right to Choose providers for longest waiting patients
2. Implement plan for children 'ageing out' of waiting list. 100 slots commissioned with Right to Choose Provider in August and additional outsourcing contract to be mobilised. Transition Pathway workshop with partners to be scheduled in December 2026.
3. Engage with DHC to access the Neurodevelopmental Exploration and Strengths tool (NEST) for UHD patients.

4. Undertake workforce planning for Nurse Medical Prescriber roles to increase long term capacity.

Advise (2) The DM01 (Diagnostic) standard performance improved to 9.1% in September, but not sufficiently to deliver the operational plan trajectory (7.5%).

September 2026	Total Waiting List	<6 weeks	>6 weeks	Performance
UHD	12,114	11,009	1,105	**9.1%**

Performance improved against the target, reducing the variance to plan to 2.1%. Two key contributing factors are:

- **Echocardiology:** Performance demonstrated partial recovery in September to 18.3% (was 40.6% August) as forecasted with additional insourcing reducing the backlog of referrals experienced since March/April 2026. The service is on plan with its recovery trajectory.
- **Endoscopy:** Year to date capacity along with a depleted bookings team and higher complexity colonoscopy procedures has restricted improvement in endoscopy. A recovery plan however is in place to deliver <5% by January 2027. This includes the opening of a new purpose-built CDC Endoscopy Unit at Poole Hospital which was successfully delivered in September 2026.

ASSURE: 2

Assure (1) All 3 key RTT planned care operational targets were met in September: RTT Performance, total RTT waiting list size and 52 week waits

The Trust's operational plan RTT performance trajectory (66.6%) was exceeded in September 2026 at 67.3%. This was supported by a high proportion of patients receiving a first contact (OPA or diagnostic) within 18 weeks of referral (74.7% of patients seen under 18 weeks).

A reduction in the total RTT waiting list was delivered and the number of patients breaching 52 weeks decreased by 75 to 582 in September, which represents <0.9% of the total waiting list. Both metrics therefore met or exceeded their operational plan trajectories. Delivery plans are in place to ensure the Trust can maintain compliance against trajectory.

Planning requirement	Aug 26	September 2026	
Referral to treatment 18-week performance	66.0%	67.3%	National standard 92% Trajectory 66.6% September 2026
Reduce >52+ weeks	657 (0.98%)	582 (0.87%)	Plan Trajectory, 587 by September 2026 (0.88%)
Reduce Waiting List size	67,260	66,984	Plan Trajectory 67,015 September 2026
Waits for first activity <18 weeks	73.5%	74.7%	Plan trajectory 73.7% September 2026

Celebrating Outstanding:	The Trust is showing sustained delivery of the RTT performance trajectory. Physiological measurement continues to achieve the national constitutional diagnostic standard (1%)
Population & Systems **Operational Productivity** **ADVISE 1**	**Advise (1) Capped theatre utilisation in September was 81%, which is 2% variant to the improvement trajectory** Theatre utilisation was impacted by a combination of patient-related cancelations, increased procedural complexity leading to overruns, changes in planned treatment pathways, and emergency activity taking precedence over elective cases. Short-notice anaesthetic and theatre staffing pressures also impacted performance, reducing flexibility to fully optimise theatre capacity and delivery. Key recovery actions in October: • Successful recruitment into the department against the new workforce plan to improve staffing resilience. • New Theatre Planning meetings are being implemented from October onwards, starting with Gynae and a refresh of the theatre scheduling tool. This will improve adherence to GIRFT guidance and national best practice around Theatre Planning. • Implementation of the new Da Vinci 5 surgical robot is planned for 13th October 2026 in Theatre 16 at Poole. Having a dedicated robotic theatre will improve robotic utilisation and improve our capacity to deliver more HVLC (High Volume Low Complexity) activity.
ASSURE 2	**Assure (1) The British Association of Day Surgery (BADS) day surgery rate target (85%) has been exceeded in the latest reported data (May 2026) at 85.8%.** This performance continues the improvement seen at the end of 2025. Both theatre and day case improvement programmes are overseen by the Planned Care Improvement Group. **Assure (2) Elective activity has exceeded the volumes of activity planned year to date at Month 6.** At M6 YTD (post freeze date) the Trust is exceeding the operational plan for both outpatient first and follow up appointments. A greater shift to day case than planned has resulted in under delivery of elective inpatients but over delivery of day cases. The operational plan however assumed Phase 3 reconfiguration would take place in June/July with an associated fall in activity. Reprofiling activity to be based on a working day rate identifies the Trust is below plan for Outpatient Firsts and elective inpatients. Both the theatre improvement programme
Quality Outcomes and Safety	**Breakthrough Objective: To improve mortality and morbidity across the trust as measured by a 5% reduction in hospitalised standardised mortality rate through an improvement in key morbidity metrics.**
Maternity **ADVISE: 1**	**Maternity** **Key Areas of Focus**

	• **Postpartum Haemorrhage** > 1500mls – 33.1 aggregated 3 months (national target of 30) • **Neonatal nursing sickness** Mitigations and HR support in place to support the team to reduce sickness. • **Amos and Ockenden** 100-day sprint for 10 immediate actions underway Triage benchmarking tool now completed • **Thirlwell Report** and recommendations received by the trust. Initial 5 recommendations in process of implementation within required timeframes.
Celebrating Outstanding:	**Areas to note improvement:** • **Bookings** completed before 10 weeks 79.7% (July 74.6%) against a target of 65% • **ATAIN** Avoidable term admission to Neonatal unit 3.16% better than regional target of 5% • **PROMPT Training compliance** for Anaesthetic teams has improved in the last month and is now meeting requirements for MIS
Quality Outcomes and Safety	**Infection Prevention and Control:** **Strategic goals: To achieve top 20% of Trusts in the country for mortality (HSMR)** **To reduce moderate/severe harm patient safety events by 30% through the development of an outstanding learning culture**
ALERT: 1	**Alert (1) Methicillin Resistant *Staphylococcus aureus (*MRSA) bacteraemia:** Two cases of MRSA bacteraemia identified in September 2026. 1 x COHA skin and soft tissue source in Surgical Care Group. 1 x HOHA other source identified in WCCSS Care Group. AARs underway for both cases.
ASSURE: 1	**Assure (1) *E.coli* bacteraemia:** Nine cases of *E.coli* bacteraemia were identified in September 2026, a reduction from 13 cases seen in August. Five HOHA cases were identified and 4 COHA cases. All have been reviewed through the PSIRF process, with no recurrent source themes identified. Three cases triaged as amber and five cases requiring team reflection regarding documentation.
ADVISE: 4	**Advise (1) *Klebsiella* bacteraemia**: One HOHA and three COHA cases reported in September 2026, an increase of one compared to August 2026 **Advise (2) *Pseudomonas* bacteraemia:** Two HOHA cases reported in September 2026 **Advise (3) Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia:** Four HOHA cases identified in September 2026, a decrease compared to August 2026, however two cases were identified as line related. Ongoing work to launch revised cannulation policy, which has been approved at IPCG and awaiting PPG to ensure consistency of practice cross site. Supporting education package to be rolled out with launch. **Advise (4) *Clostridioides difficile* cases**: Five cases of hospital associated *C.difficile* cases were reported and investigated in August 2026, three HOHA and two COHA. Whilst numbers remain level compared to August, two cases identified requirement for case

	review relating to antimicrobial prescribing and two cases requiring team reflection. | Organism	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
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MRSA	0	0	1	0	2	0	0	1	1	0	1	0	2
MSSA	5	5	3	3	4	5	1	6	7	3	3	9	4
C Diff	8	12	10	8	6	9	5	14	11	14	13	9	5
E Coli	7	12	11	11	8	5	19	10	9	9	15	13	9
Kleb	3	2	2	3	4	3	3	4	2	4	3	4	6
Pseudo	2	4	6	1	0	2	2	0	3	1	0	3	2
Outbreaks	0	0	1	8	12	7	0	8	1	1	0	0	3
Clinical Practice Team **ALERT: 0**	**Falls prevention & management**:
ADVISE: 1	**Advise (1)**: Reported falls have remained below last year's position for three consecutive months; falls resulting in moderate or greater harm have increased, indicating a higher proportion of falls are causing injury. September 2026 rate: 6.7 per 1,000 bed days. Ten inpatient falls resulted in moderate or greater physical harm, equating to 0.3 per 1,000 bed days.
ASSURE: 2	**Assure (1)**: eObs functionality for standardised recording of lying and standing blood pressure is now live **Assure (2)**: The NAIF Annual Report 2026 is now available and will be used to guide the review of existing improvement work and inform future priorities and objectives.
Nurse Staffing: **ALERT: 0**	**Care Hours per Patient Day (CHPPD):** No areas to alert
ADVISE: 2	**Advise (1)** **CHPPD** CHPPD for Registered Nurses/Midwives (RN&M) at UHD for September 2026 is 5.5, a 0.6 increase from August 2026. • RBH site, 5.9 (includes maternity, NICU, UHD Critical Care, CCU) • Poole site, 4.7 The UHD total CHPPD for registered and non- registered care staff combined is 8.8, a 0.9 increase from August 2026. • Total CHPPD for RBH site:9.2 • Total CHPPD for Poole site: 8.2 **Roster Fill rate** • The Registered Nurse/Midwives fill rate for the trust is 92% • The non-registered fill rate for the trust is 89.6% • A total percentage rota fill rate against planned staffing (day and night all nursing/care staff) for August 2026 was 91.3%. This is a decrease of 0.9% from August 2026.

	Ward moves took place at the Poole site during the month, but figures remain consistent with previous months. As the moves occurred late in the month, October data will be monitored for any impact. **Advise (2)** **Red Flag Reporting:** There has been a reduction in the occurrence of Red Flags in September 2026 by 20. 21 Red Flags occurred on adult inpatient wards overall in the Trust: • 85 % (18) Patient at Risk as unable to provide Enhanced Care • 15% (3) Omission in fundamental care
ASSURE: 1	**Workforce Controls:** **Assure (1)** Red flags are reviewed by Matrons and data is triangulated with other quality and safety information in preparation for unannounced assurance visits to in-patient wards. Red flag review meetings are now in place with directorates who require additional support and challenge to ensure timely and appropriate review of red flags. Monthly review of Open Red flags by Senior Nursing staff within the Workforce Assurance group
Patient Experience	**Breakthrough Objective: To understand the experience of our patients by actively listening to feedback and using it to inform change in the way we deliver care in a timely way.**
ALERT: 1	**Alert (1) 90% of Complaints closed within 35 days:** Remains not achieved. Following multiple small but significant actions, improvements are now being seen. Average Complaint response time September = 61 days (decrease from August 70 days) number of complaints closed per month has doubled (116 closed in September). Increased numbers of complaints are being logged each month (82 in September, 53 in August) which, if sustained, may slow the predicted trajectory of recovery by end of Q3.
ADVISE: 2	**Advise (1) Maintaining prompt complaint logging:** Allocated staff in the corporate team to ensure that complaints are logged and uploaded to care groups within 3 days of receipt for Q3. **Advise (2) Strengthen early care group engagement through weekly complaints meetings:** Improved attendance from senior matrons and service managers at care groups at weekly meetings, meaning that early resolution can be allocated to appropriate staff with appropriate care group oversight. Complaint investigation responses from clinical teams are directly impacted by activity, seeing delays from high activity areas. Mitigated by improved attendance at weekly care group complaints meetings. **Advise (3) Deliver Trust-wide complaint-response training for contributors:** To improve response quality and reduce the need for clarification, further information requests and follow-up queries.

	Advise (4) Triage all new complaints on receipt by complexity (low, moderate, high) Timescales proportionate to complexity. Agree extended timescales with complainants at the outset for complex, multi-directorate cases.
ASSURE: 2	**Assure (1) – Quality of complaint responses:** During period of high activity, close monitoring of reopened rate and referrals to PSO both remain low. Process in place for senior oversight of all responses. **Assure (2) - Learning from complaints:** Contributors are capturing learning from complaints and is documented in the final response.
Our People	**Breakthrough Objective: To improve permanent staff availability across all professions as measured by the reduction in temporary staffing usage.**
ALERT: 5	**Alert (1): Workforce Performance - Bank Usage:** During September (M06), the Trusts bank usage was 41.08 WTE above plan, despite reflecting a decrease of 7.92 WTE from August (M05). Substantive recruitment continues, with specific support to areas with high bank usage, including the Emergency Department, Stroke Unit, AMU Nursing staff and Older Peoples Assessment Unit. **Alert (2): Workforce Performance - Off-Framework Agency Usage:** In Month 6, off-framework spend decreased by £11,564, representing a 31% decrease compared to August (M05). 18 shifts were required for general registered nurses, with a further 11 shifts required for registered mental health nurses. A cessation date for off-framework use is still outstanding for agreement to ensure the NHS England target is met. **Alert (3): Recruitment:** Time to Hire remains above the NHS England ambition of 30 working days and has increased during the latest reporting period. Agenda for Change Time to Hire is **35.3 working days**, while Medical & Dental remains significantly higher at **71 working days**. The increase reinforces the need for continued focus on recruitment-stage performance, with separate reporting maintained to provide visibility of the longer Medical & Dental recruitment pathway. **Alert (4): Appraisals:** The number of appraisals recorded remains below the agreed target of 90%: • Values based appraisal (AfC) compliance was 61.83% in September. • Medical and Dental appraisal compliance was 80.26% in September. Variation remains present across Care Groups and corporate services. Additional training and support is in place. **Alert (5): Sickness Absence:** sickness absence rate of 5.0% is above the trajectory of 4.4% (requirement to achieve 4.1% by March 2027). A range of targeted actions continue to support improvement, including enhanced support to areas with the highest absence levels, strengthening management oversight and line manager training, together with earlier actions through HR, Psychological/ Occupational health and musculoskeletal support/ interventions.
ADVISE: 5	**Advise (1): Workforce Performance - Agency:** Registered Learning Disability Nurses (RNLD) onboarding is underway, this role is aimed at strengthening the Trust's enhanced care capacity and reduce off-framework escalation.

	Advise (2): Workforce Performance - Substantive WTE: The finance team are producing figures that compare actual WTE, whilst considering transformation delays and unidentified savings. The Workforce program team in collaboration with finance are running an analysis of this data for reporting. This will enable greater scrutiny of the Trust's position against planned WTE figures. **Advise (3): People Pulse:** The July 2026 NHS People Pulse Survey demonstrated a significant improvement in colleague engagement and participation across the Trust, with 1,334 staff responding, the highest response rate since 2024 and more than double that achieved in January 2026. The Trust's overall staff engagement score increased to 6.32, its highest level in the last 12 months and now closely aligned with the national average of 6.34. Encouragingly, advocacy measures improved, with more staff reporting that patient care is the organisation's top priority and that they would be happy for friends and relatives to receive care at the Trust. Strong team support continues to be a key strength. However, the survey also highlighted the need for continued focus on communication, staff involvement in organisational change, workload and wellbeing, with fewer staff reporting that they feel well informed about important organisational developments. Directorate level data continues to be shared and discussed to support local improvement plans. **Advise (4): Recruitment:** The finalised August vacancy rate is 8.1% (803.63 WTE), with vacancy WTE reducing for the third consecutive month, down 37.79 WTE from July. This has been achieved while both funded establishment and the substantive workforce increased by 24 WTE, with turnover remaining stable at 9.6%. Vacancy pressure is not evenly distributed: Additional Clinical Services remains the most significant hotspot at 14.3% (255.65 WTE), against the Trust target of 7.5%. Targeted HCSW and Theatre recruitment activity is therefore being used alongside earlier vacancy intervention to focus activity where workforce pressures are greatest. **Advise (5): Transition of Locally Employed Doctors to Permanent Contracts:** National guidance published in September 2026 sets an expectation that Locally Employed Doctors are ordinarily appointed to permanent contracts, with fixed-term arrangements used only where there is a clear and evidenced business justification. Whilst implementation arrangements continue to be developed nationally, the guidance may have implications for recruitment processes, workforce planning and the use of time-limited medical staffing posts. The Trust has established arrangements in place to oversee implementation of relevant national medical workforce initiatives and is monitoring the potential operational and workforce implications of this guidance. Work is ongoing to understand the local impact. Further updates will be provided as national expectations and implementation guidance evolve.
ASSURE: 5	**Assure (1): Workforce Performance – Substantive:** Substantive staffing continued to report a favourable position, being 10.06 WTE below the in-month plan for M06.

	Assure (2): Workforce Performance – Governance: Enhanced controls remain in place through the 'Break Glass' process, supporting greater oversight and visibility at Care Group levels. This process is under review currently, with consideration being given to a 'Break Glass' process for registered mental health nurses. **Assure (3): Off framework:** Active engagement is ongoing with framework providers to broaden recruitment searches across specialist staffing groups, including Radiology, Nuclear Medicine, Clinical Coders, Theatre Scrub and Recovery Nurses, and Biomedical Scientists. **Assure (4): Recruitment:** Despite the increase in Time to Hire, the underlying vacancy position continues to improve, with vacancy WTE reducing for three consecutive months alongside substantive workforce growth and stable turnover. Agenda for Change employment checks remain within KPI at 16.8 working days against the 22-day standard. Digitalised ID Checks and New Starter Forms (Amiqus) have secured part approval, and the business case is progressing for final consideration. Subject to approval, implementation will support further reductions in manual employment-check activity and onboarding timelines. **Assure (5): Specialty Associate Specialist (SAS) Doctor Eligibility and Permanency Framework**: The Trust has taken proactive steps to implement the NHS SAS Eligibility and Permanency Framework, which provides a structured route for eligible Locally Employed Doctors (LEDs) who have undertaken work comparable to SAS roles for a continuous period of two years or more to transfer onto permanent nationally agreed SAS contracts. The framework supports career progression, enhances job security and promotes equitable access to nationally agreed terms and conditions. Expression of Interest (EOI) notifications have been issued to all eligible doctors, with the EOI window opening on 7 September and remaining open for six months. The process is being overseen by a dedicated Task and Finish Group to ensure a consistent, transparent and supportive approach. Implementation is progressing as planned.
Celebrating Outstanding (3):	**Overall Workforce:** The total workforce for September continued to perform favourably, achieving a positive variance of 10.06 WTE against the in-month plan. **Agency:** Agency WTE and spend are favourable against planned levels and demonstrate a continuation of this trend seen over 11 of the past 12 months. **Recruitment:** Vacancy WTE has reduced for the third consecutive month despite growth in funded establishment, with substantive workforce increasing and turnover remaining stable. Targeted recruitment activity is increasingly focused on the areas of greatest vacancy pressure.
Sustainable Services	**Breakthrough Objective: To operate within the approved budget, including delivering the budgeted Efficiency Improvement Programme target, with at least 60% achieved recurrently.**
	Trust Finance Position

ALERT: 2	**Alert 1: Revenue Outturn** At the end September, the Trust has delivered within the agreed budget, reporting a deficit of £13.9m being £38,000 favourable to plan. The detailed forecast indicates a considerable risk, however a breakeven forecast remains achievable if all identified mitigations are delivered. **Alert 2: Efficiency Improvement Programme** At the end of September, the Trust has delivered efficiency savings of £21.0 million being £26,000 behind the phased plan. The trust has identified savings opportunities of £52.0 million; however, this is reduced to £42.7 million when adjusted to reflect the risk of delivery in year. This position continues to improve month on month but remains significantly short of the full year savings target. The recurrent delivery within this represents a significant medium term sustainability risk for the Trust. The MTFP assumed 60% recurrent efficiencies, but at 32% delivery currently, this is a £19.4 million medium term risk if this performance does not improve.
ADVISE: 1	**Advise 1: Capital Outturn** The Trust has reported total capital expenditure of £34.0 million, being £333,000 above the phased plan. The Trust is forecasting to spend £350,000 less than the available capital before the financial year-end, due to the MHLDA PDC funded item which is not expected to be spent this year – with ongoing discussion with NHS England to resolve. The medium-term capital plan is currently being refreshed, for consideration through the Capital Management Group.
ASSURE: 2	**Assure 1: Cash** At the end of September, the Trust is holding a consolidated cash balance of £71.1 million. After adjusting for the £22.0 million of capital payables, this represents 19 days of operating expenditure and an underlying cash balance of £49.0 million. **Assure 2: Public Sector Payment Policy** In relation to the timely payment of invoices, the Trust has exceeded the national standard of 95% with a cumulative performance of 96.7%.
Sustainable Services	**Digital**
ALERT: 1	**Alert (1) ICE for Ordering vs paper** With the progress of the electronic requesting there is an improvement in the data quality of the requests within the ICE system. There has also been agreement to a level of auto filing of results. However, the care groups need to continue to focus on the filing as current month filing stands at 56% of results being electronically filed.
ADVISE: 1	**Advise (1) The rate of Advice and guidance requests per 100 first attendances demonstrate significant improvement however the target sits outside the current process control limits** All specialties are now live with Consultant Connect for Advice & Guidance.

ASSURE: 2	**Assure (1) Did not attend or missed appointment rates are demonstrating an improving trajectory at 5.8% (5% target)** DNA rate (5.8% Sept 2026) is within the process control limits, along with the target (5%) and mean performance, indicating that it is achievable. Performance demonstrates common cause variation. A targeted relaunch of the DNA predictor in Dr Doctor is taking place from October 2026. **Assure (2) ICE for Ordering vs paper** The Task and Finish Group approved the Go on the move to paperless requesting and the support of rejection of paper requests for all tests that can be safely done electronically. The current position in this is 99.5% of all electronic requests that can be done are being done which is a huge achievement.
RECOMMENDA-TION:	Members are asked to note the content of the report.
Implications associated with this item:	Council of Governors ☒ Environmental Sustainability ☒ Equality, Equity, Diversity & Inclusion ☒ Financial ☐ Health Inequalities ☒ Operational Performance ☒ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Trust Management Group	22/10/2026	The Group noted the report.
Finance and Performance Committee	02/11/2026	The Committee noted the report.
People and Culture Committee	02/11/2026	The Committee noted the report.
Quality Committee	03/11/2026	The Committee noted the report.





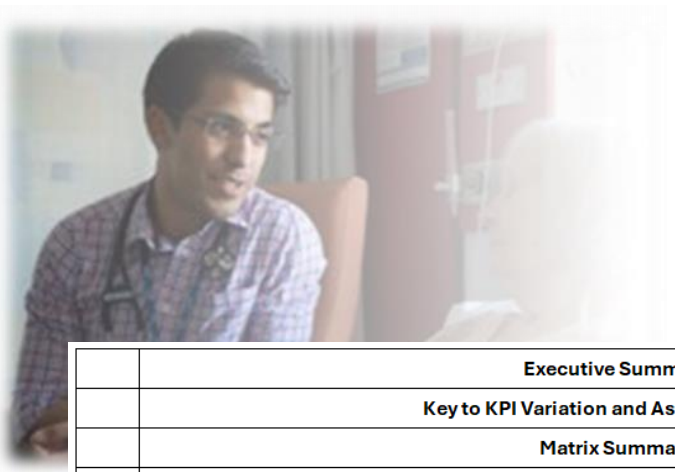


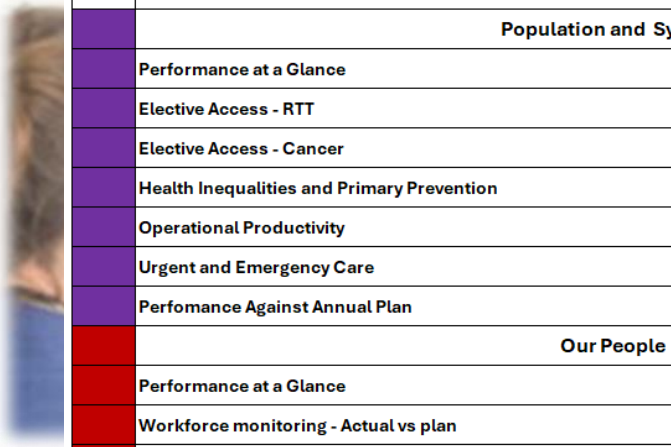
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NHS Foundation Trust

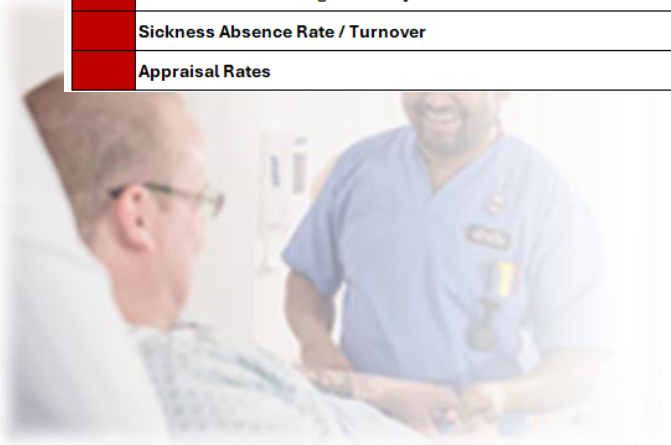
Integrated Performance Report

Reporting month: September 2026

Meeting Months : October/November 2026







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Executive Summary

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Forward Look: Building on Improvement, Accelerating Recovery

September shows positive progress in planned care, workforce and productivity, with all three key RTT trajectories achieved, vacancies reducing and staff engagement improving. There are encouraging signs of recovery in diagnostics and cancer, although further improvement is required to meet planned trajectories.

Urgent and emergency care and wider system flow remain the most significant operational challenges. Increasing demand, delayed discharges and limited onward care capacity continue to affect patient experience and access to timely care. Quality and safety, cancer recovery and the delivery of sustainable financial savings also require continued focus.

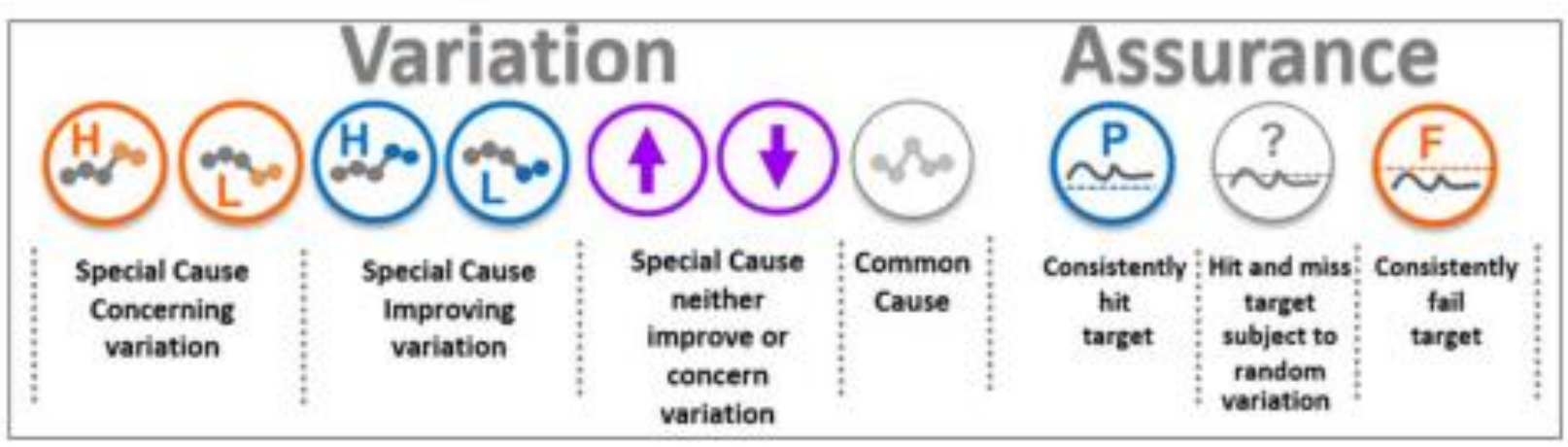
The priority is to build on progress through **clear accountability, pace and sustained delivery**. This means translating improvement plans into measurable outcomes for patients, strengthening partnership working across Dorset, and ensuring the Trust delivers its operational, quality and financial commitments.

To provide excellent healthcare for our patients and wider community and be a great place to work, now and for future generations



Key to KPI Variation and Assurance Icons

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Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is upwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

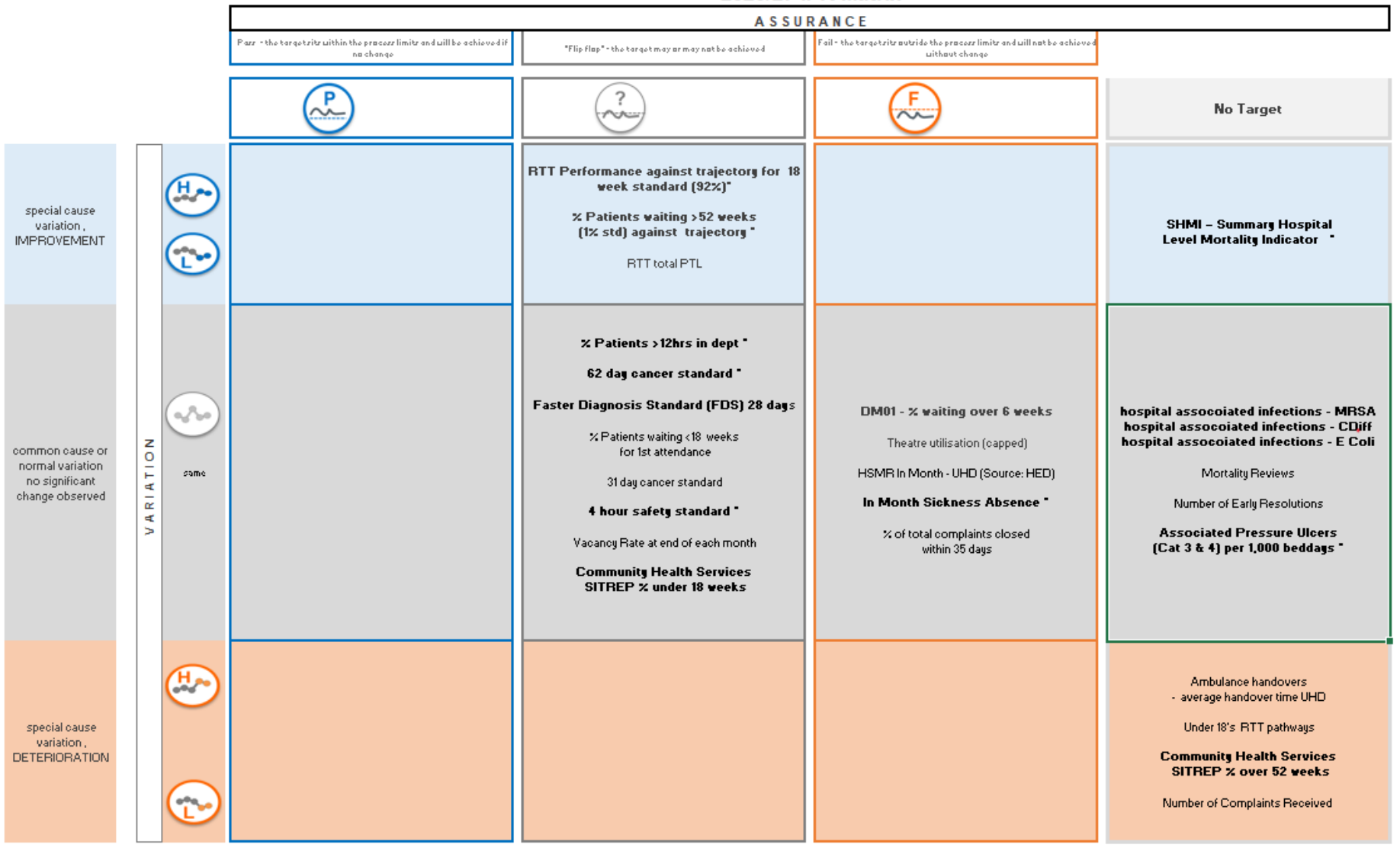
Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in a favourable direction. Low (L) special cause concern indicates that variation is upward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (H) is where the variance is downwards for a metric that requires performance to be below a target or threshold e.g. Pressure Ulcers or Falls.

Further Reading / other resources The NHS Improvement website has a range of resources to support Boards using the Making Data Count methodology. This includes are number of videos explaining the approach and a series of case studies – these can be accessed via the following link - https://improvement.nhs.uk/resources/making-data-count

Matrix Summary

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2026/27 IPR Matrix



*scored in NOF

National Oversight Framework

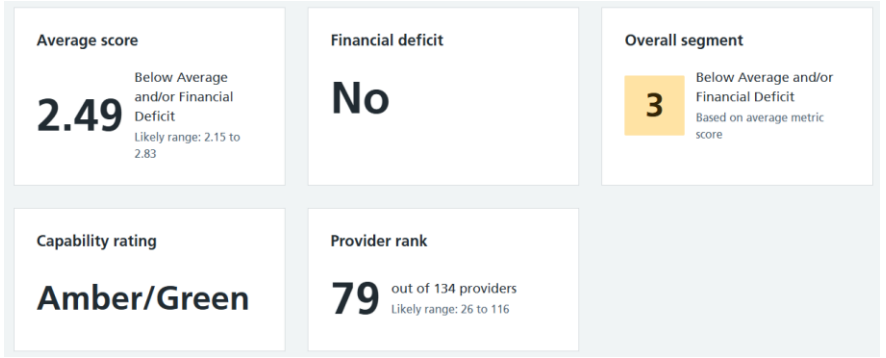
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UHD has been placed into **segment 3** of the NHS Oversight Framework (NOF) in **Quarter 1, 2026/27** (published September 2026), with a rank of #79/134 acute and specialist providers and an average metric score of 2.49 (previous quarter 2.34).

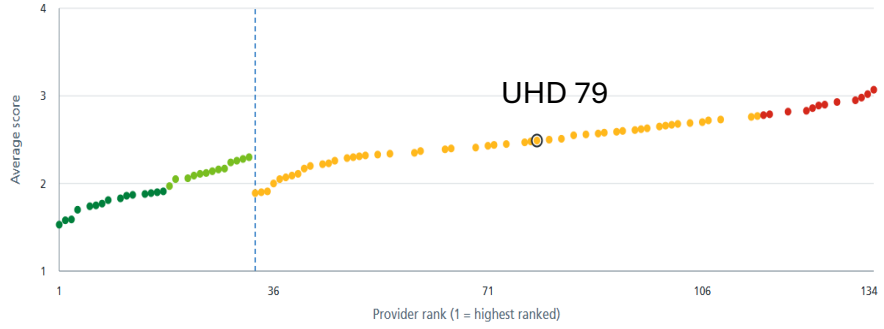
Scores and ranks are refreshed quarterly (Segment 1 is best , representing the highest scoring 25%)

Domain	Domain Score June 2026	Segment (1 is best - higehst scoring 25%)	Direction of Travel since last segmentation	Previous score March 2026
Access to services	3.09	4	↓	Domain score 2.57 / Segment 3
Patient safety	1.87	2	↓	Domain score 1.78 / Segment 1
Finance, productivity and innovation	2.12	2	↔	Domain score 1.95 / Segment 2 *(previously Finance and Productivity)*
People	2.06	2	↔	Domain score 2.17 / Segment 2 *(previously People and Workforce)*
Experience of Care	2.13	2	↑	Domain score 2.49 / Segment 3 *(previously Effectiveness and Experience of Care)*
Effectiveness of care and population health	2.79	4	↓	

Trust Overview



Average score by provider rank placement



Population & System



Mark Mould
Chief Operating Officer

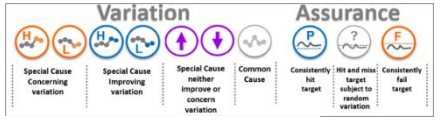
Operational Leads:
Judith May – Director of Operational Performance and Oversight
Sean Kedzia – Deputy Chief Operating Officer
Abigail Daughters – Group Director of Operations – Surgery
Lisa Clarke – Group Director of Operations – Women's, Children, Cancer and Support Services
Leanna Rathbone- Group Director of Operations – Medicine

Committees:
Finance and Performance Committee

Performance at a Glance

Population & System

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UHD Elective Care

KPI	Latest month	Measure	Target	Variation	Assurance
RTT Total Waiting List Size	Sep 26	66984	67015		
RTT Performance against trajectory for 18 week standard (92%)	**Sep 26**	**67.3%**	**66.6%**		
Patients waiting >52 weeks	Sep 26	582	587		
% Patients waiting >52 weeks (1% std) against trajectory	**Sep 26**	**0.87%**	**0.88%**		
Patients waiting >65 weeks	Sep 26	0	0		
% Patients waiting <18 weeks for 1st attendance	Sep 26	74.7%	73.7%		
Under 18's RTT pathways	Sep 26	5056	-		
DM01 - % waiting over 6 weeks (1% std)	**Sep 26**	**9.1%**	**7.0%**		
DM01 - % waiting over 13 weeks	Sep 26	1.1%	0.0%		
Community Health Services SITREP %<18weeks	**Sep 26**	**7.5%**	**3.9%**		
Community Health Services SITREP % over 52 weeks	**Sep 26**	**75.3%**	-		
Faster Diagnosis Standard (FDS) 28 days (75% std)	**Aug 26**	**73.8%**	**79.25%**		
31 day standard (96% std)	Aug 26	95.8%	96.0%		
62 day standard (85% std)	**Aug 26**	**70.1%**	**73.6%**		
Trauma Admissions	Sep 26	411	-		
% of NOF patients operated on within 36 hrs (admission from ED)	Sep 26	62.0%	85.0%		
% Outpatient appointments with procedures	Sep 26	24.1%			
UHD - Total Outpatient - Virtual (%)	Sep 26	17.3%	25.0%		
UHD Outpatient DNA rate	Sep 26	5.8%	5.0%		
Theatre utilisation (capped)	Sep 26	80.7%	85.0%		
UHD Theatre case opportunity	Sep 26	16.4%	15.0%		

UHD Urgent and Emergency Care

KPI	Latest month	Measure	Target	Variation	Assurance
Arrival time to initial assessment	Sep 26	14	15		
Clinician seen <60 mins %	Sep 26	31%	-		
Patients >12hrs from DTA to admission	Sep 26	342	0		
Patients >12hrs in dept	Sep 26	1101	1015		
% Patients >12hrs in dept	**Sep 26**	**5.9%**	**7.2%**		
4 hour safety standard	**Sep 26**	**71.85%**	**72.00%**		
Ambulance handovers - average handover time UHD	Sep 26	30.9	-		
Ambulance handovers - average handover time RBH	Sep 26	33.5	-		
Ambulance handovers - average handover time Poole	Sep 26	28.0			
Ambulance handover >60mins breaches	Sep 26	228	0		
Ambulance handovers	Sep 26	4180	-		
Bed Occupancy (capacity incl escalation)	Sep 26	94%	85%		
Stranded patients: Length of stay 7 days	Sep 26	506	-		
Stranded patients: Length of stay 14 days	Sep 26	320	-		
Stranded patients: Length of stay 21 days	Sep 26	224			
Non-elective admissions	Sep 26	6758	-		
> 1 day non-elective admissions	Sep 26	3798	-		
Same Day Emergency Care (SDEC)	Sep 26	2958	-		
Conversion rate (admitted from ED)	Sep 26	25.3%	30.0%		
30 day emergency re-admission rate	Jun 26	10.2%	-		
Corridor Care in ED (average daily - over 45mins)	Sep 26	15.17	-		

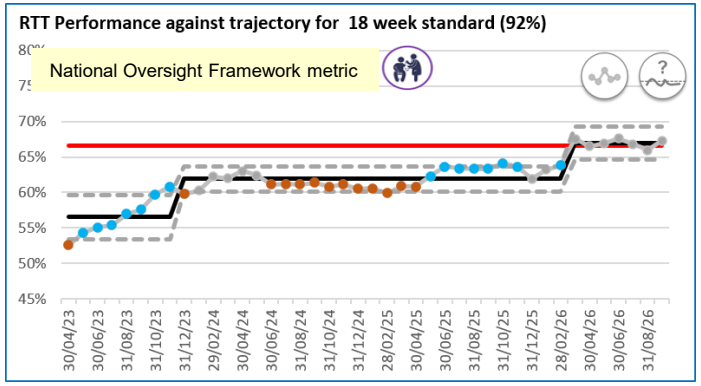
National Oversight Framework metrics

Patient First "Seeing our patients sooner" – Breakthrough metric

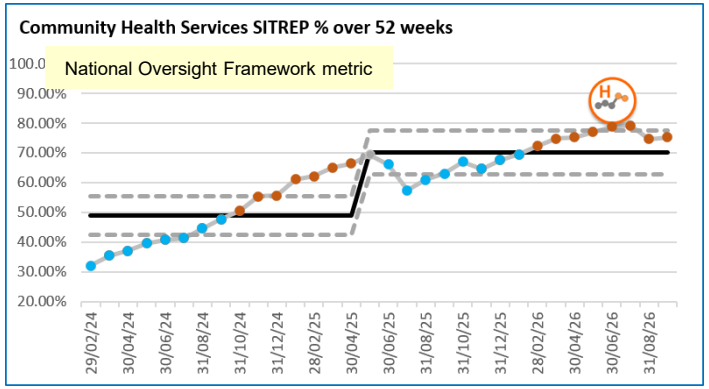
Elective Access - RTT

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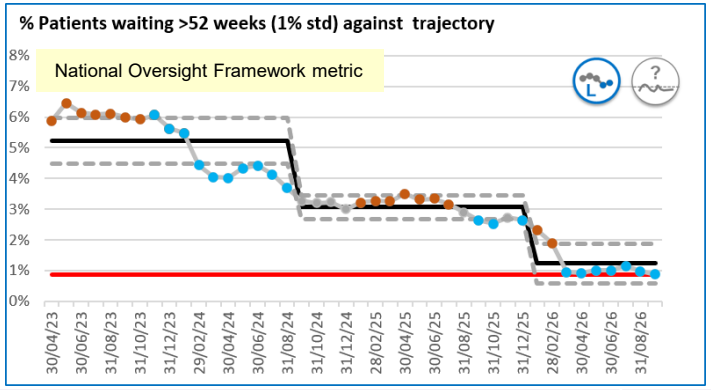
September 26
67.3%
Variance/Assurance
Plan Trajectory
66.6%
Business Rule
Achieving Plan



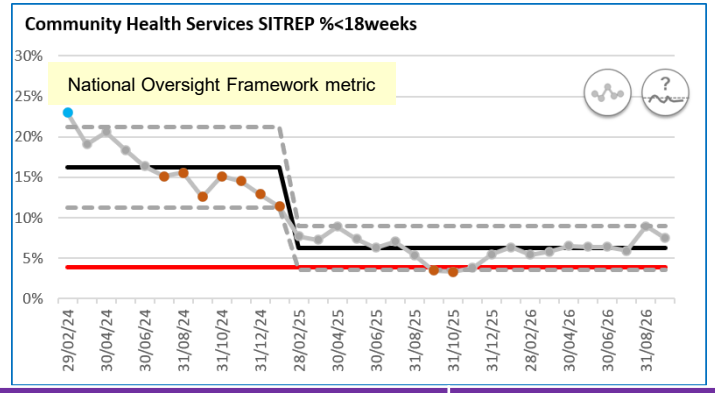
September 26
75.3%
Variance/Assurance
Targeting (Internal)
Reduction
Business Rule
Note performance



September 26
0.87%
Variance/Assurance
Plan Trajectory
0.88%
Business Rule
Achieving Plan



September 26
7.5%
Variance/Assurance
Plan Trajectory
3.8%
Business Rule
Achieving Plan



Summary

All 3 RTT performance trajectories were met in September

- Both RTT 18 week performance and total waiting list continue to perform better than trajectory.
- RTT waits over 52 weeks were 5 below plan, hence the % >52 week waits also met trajectory. Activity plans for Quarter 3 are being enacted to give confidence to remaining on plan.

Community Health Services waiting times

- 7.5% of patients on the Community Health Services waiting list have waited less than 18 weeks achieving the plan trajectory but is significantly below the national ambition.
- The proportion waiting >52 weeks for Community Health services (CYP neuro developmental) remains an area above the process mean, with the rate of children breaching 52 weeks exceeding the number of children seen or transferred to Right to Choose providers.

Actions

- **RTT:** Continue to maximise delivery of elective activity in Q3, including implementing activity plans with trusted in/outsourcing providers and improving internal productivity.
- Continue targeted validation of the waiting list (16+ weeks) to ensure patients who no longer need to be seen are discharged.
- Flex theatre allocations to target specialities with higher waiting lists.
- **Community Health:** 1. Maximise access to Right to Choose providers for longest waiting patients 2.Implement plan for children 'ageing out' of waiting list. 100 slots commissioned with Right to Choose Provider in August and additional outsourcing contract to be mobilised. Transition Pathway workshop with partners to be scheduled in December 2026. 3. DHC to commence Neurodevelopmental Exploration and Strengths tool (NEST) pilot to support demand management. This will support 5 patients per month initially from UHD including assessment. 4. Workforce planning for Nurse Medical Prescriber roles to increase long term capacity.

Assurance & Timescale for Improvement

Planned Care Improvement Group providing oversight and weekly performance huddle in place. Timescales:

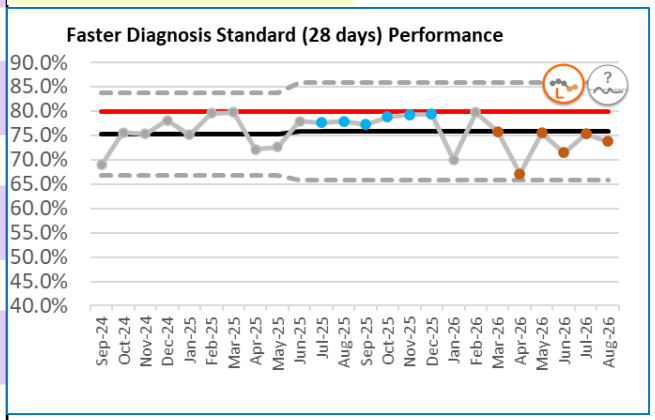
- Maintain RTT performance, 52 week wait performance and total waiting list on plan – Q3/4.
- Reduction in longest waits for patients waiting neuro-developmental assessment not seen at end of Q3. Additional funding secured to increase capacity in Q3.
- Oversight via WCCSS Care Group Performance Huddle & Child Health SDR, including Patient First implementation in Community Paediatrics Team.

Elective Access - Cancer

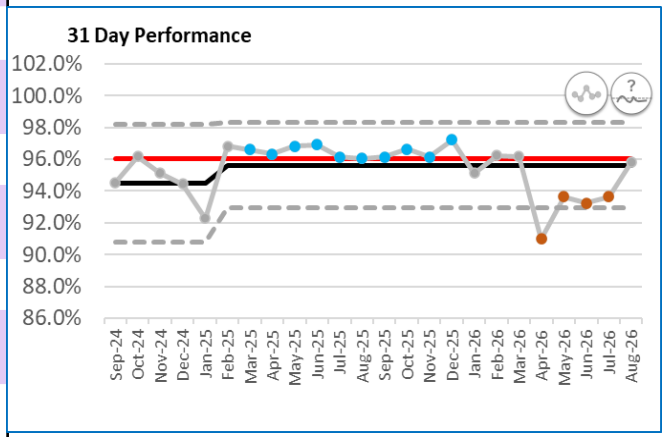
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August 26
73.8%
Variance/ Assurance
Plan Trajectory
78.9%
Business Rule
Off Plan

National Oversight Framework metric

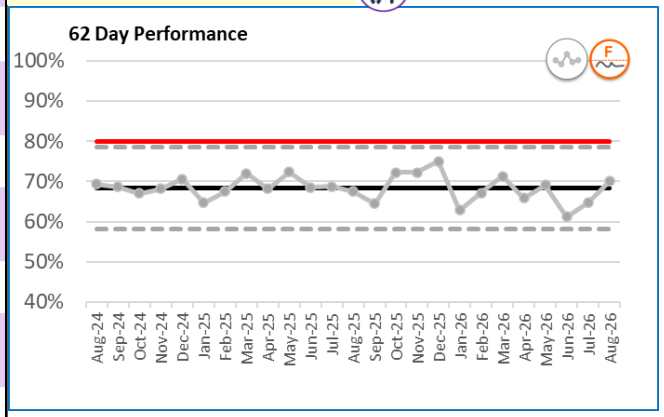


August 26
95.8%
Variance/ Assurance
Plan Trajectory
96.0%
Business Rule
Off plan



August 26
70.1%
Variance/ Assurance
Plan Trajectory
75.8%
Business Rule
Off plan

National Oversight Framework metric



Summary

The Trust did not achieve all three of the operational plan trajectories for the National Cancer standards in Aug 2026:
FDS 28D: August-26 performance of 73.8% did not achieve the Trust's operational plan target. Performances in recent months has shown special cause variation of a concerning nature. Site-specific recovery actions are in progress with a focus on reducing variation in performance and recovery by Oct 26.
31 Day: August-26 performance of 95.8% fell just short of achieving the 96% national standard and therefore returned to common cause variation. The deterioration in performance compared to 2025/26 is due to theatre capacity and Interventional Radiology capacity. Recovery actions are in place.
62 Day: August-26 performance of 70.1% demonstrated improvement but did not achieve the Trust's operational plan target. Performance remains within common cause variation, and recovery actions are focused on bringing about process changes which will ensure the longer-term recovery target is achievable for UHD.
The **over 62 Day PTL** is at 169 patients for the August-26 month-end position. September-26 month-end position increased slightly, reporting 179 patients >62 Days.

Actions

Key specialty actions are:

- **Colorectal** – Standing up Cancer Action & Oversight group following enhanced support from the Wessex Cancer Alliance; Securing a third day time theatre list for additional treatment capacity, following the elimination of the fast-track backlog.
- **Urology** – Confirming additional Prostate MRI capacity to support all standards, and actions are being taken to protect additional capacity throughout 26/27 to positively impact performance against the 62D standard.
- **Gynaecology** – Additional activity scheduled to eliminate the fast-track backlog and recover the FDS position by October 26.
- **Skin** – Redistribution of routine activity and insourcing to support fast track pathways remain priorities over Q3.
- **UGI & IDA –** Collaborative improvement task & finish group to be stood up in October with endoscopy and IDA service to improve overall UGI pathway management.
- **All sites** – Focus on increased pace of recovery actions for all standards with weekly Executive level support, now reporting into the weekly Cancer Improvement Group and the bi-monthly Trust Strategic Cancer Group.

Assurance & Timescale for Improvement

- Following targeted actions to eliminate the fast track backlogs, the number of patients now being seen within 14 days has improved by 17% from August which will support all of standards in Q3.
- Funding bids have been submitted to the Wessex Cancer Alliance for £125k to support Q3 & Q4 recovery actions. Priority schemes submitted from Urology, Breast, Gynae, Colorectal and Histopathology.
- Bi-weekly tumour site level communications on key actions are being circulated to services, as well as daily escalation of individual cases.
- Impact of Colorectal improvement plan for 62D standard is on track for Q4 26/27 following approval in principle of business case in June 26.
- Gynaecology recovery actions are being monitored through the care group enhanced support weekly meeting.
- The FIT100 pathway in Colorectal is scheduled for clinical governance approval in October 26 with a go-live date for Jan 27.

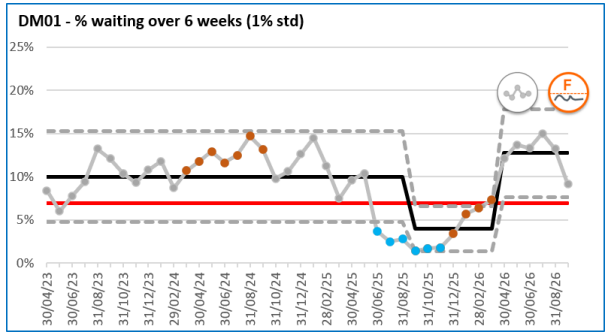
Health Inequalities and Primary Prevention

Diagnostic Access , 30 day Readmissions and Smoking Referrals

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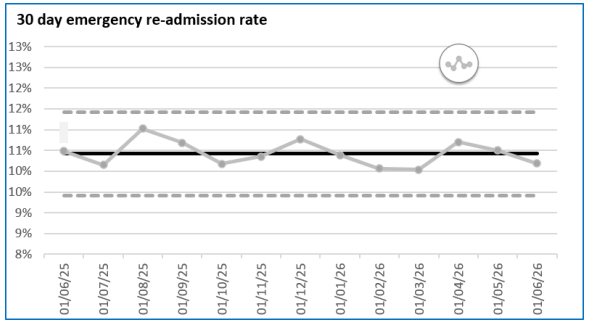
Sep 26
9.1%
Variance/ Assurance
Trajectory
7.0%
Business Rule
Off Plan

National Oversight Framework metric



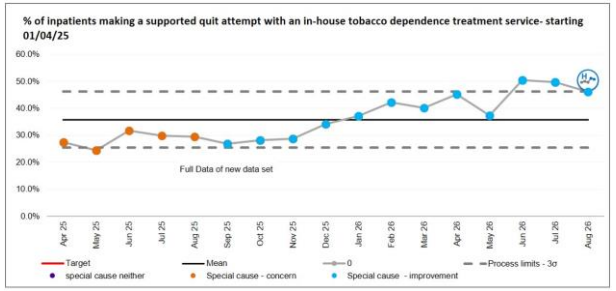
June 26
10.19%
Variance/ Assurance
Targeting (Internal)
Business Rule
Note Performance

National Oversight Framework metric



August 26
46.23%
Variance/ Assurance
Targeting (Internal)
(NOF scored)
Business Rule
Note Performance

National Oversight Framework metric



Note : 1 month delay in reporting

Summary

DM01 Diagnostics performance improved against the target but is 2.1% above plan.
Contributing reasons:

1. Echocardiology: Performance recovered in September to 18.3% (was 40.6% August) as a result of additional insourcing to manage a backlog of referrals following a spike in March/April 2026.
2. Endoscopy: Year to date capacity along with a depleted bookings admission team and higher complexity colonoscopy procedures has restricted improvement in endoscopy. A recovery plan however is in place to deliver <5% by January 2027.
3. Imaging (2.6%) and physiological measurement (0%) are both exceeding the internal target.

30 day Emergency Readmission Rate : This metric has been added to the national oversight framework for 26/27 and the Trust has been score in the 4th Quartile. Segmentation is based on benchmarking against the national position, rather than performance against a target. Latest performance (June 26) shows a pattern of normal variation.

UHD Tobacco Service: The latest published data is September 2026

1. Referral Activity: 319 referrals recording in Sep 2026, with 84% (268 patients) seen following referral
2. 28-day quit outcomes: Latest complete quit data (Aug 2026) shows a 31.5% quit rate, with reporting subject to the 28-day follow-up period.

Actions

Diagnostics:

- Continuation of insourcing in both high-pressured modalities and use of Wimborne Hospital (Endoscopy) to maximise capacity.
- New Endoscopy Unit opened early October; continue to build capacity and resilience.
- Following successful recruitment, training of additional staff to undertake endoscopy booking processes is in progress and expected to improve utilisation in October.
- In Echocardiology, new staff have been recruited alongside additional insourcing planned for Quarter 3.
- Both services have a phased recovery plan in place focused on restoring utilisation, strengthening the booking function (endoscopy), stabilising clinical capacity, and deploying targeted additional activity.

Readmission rates: A review of readmissions by speciality is underway

Tobacco Service: Continued focus on improving quit-rate follow-up and reporting completeness through reallocated staff capacity, monthly weekend follow-up clinics and improved alignment with BI reporting timescales.

Assurance & Timescale for Improvement

DM01: Recovery plans are in place for cardiology and endoscopy with oversight managed through the Planned Care Improvement Group. Recovery against operation plan is expected by January 2027.

Operational Productivity

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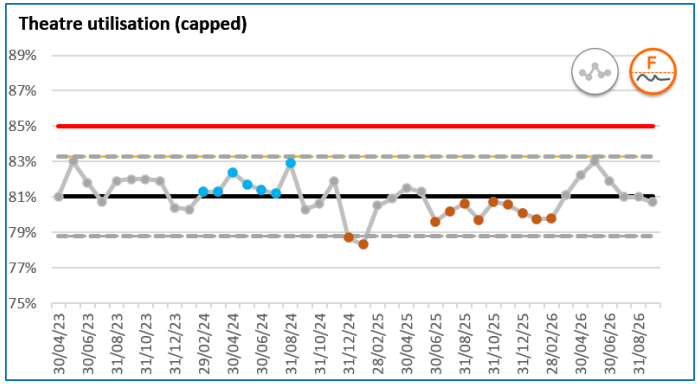
Month 6 YTD freeze activity vs annual plan.

Activity POD	M6 YTD Plan	M6 YTD Actual	% Variance
1st outpatients	118,397	118,669	100%
Follow-up outpatients	143,037	144,405	101%
Elective day cases	42,290	46,815	111%
Elective inpatients	6,689	5,597	84%

1st and follow up outpatients **achieving plan**
Day case **achieving plan**
Elective inpatients **off plan**

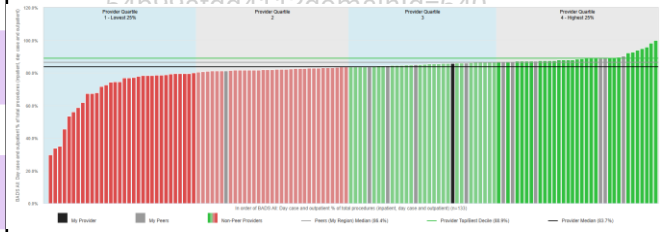
Sep 26
80.71%
Variance/ Assurance

Targeting (Internal)
85%
Business Rule
On plan



May 26
85.8%
Variance/ Assurance
n/a
Targeting (Internal)
85%
Business Rule
On plan

BADS All: Day case and outpatient % of total procedures (inpatient, day case and outpatient)



Summary

- **Capped Theatre utilisation –** Remained close to the process mean at 80.71% in September, but below the improvement trajectory of 83%. Theatre utilisation was impacted by a combination of patient- related cancelations, increased procedural complexity leading to overruns, changes in planned treatment pathways, and emergency activity taking precedence over elective cases. Performance was further affected by short- notice anaesthetic and theatre staffing pressures, reducing flexibility to fully optimise theatre capacity and delivery.
- **BADS Daycase rate** (May 2026) is 85.79%, maintaining performance above the national target (85%). Within this Day cases were above National average (60.12% vs 46.24%) and outpatient procedures below (25.67% vs 36.4%).
- **Implied productivity growth:** UHD is currently reporting a productivity decline of 2.2%in implied productivity. At M03 YTD (April-June 2026/27 compared with the same period in 2025/26): Output (activity) growth: +1.4%; Input (real terms resource) growth: +3.7%; and Productivity growth: -2.2%. This means expenditure has increased significantly faster than activity delivered. The productivity challenge is therefore primarily an input growth issue rather than an activity collapse.
- **Elective activity** at M6 YTD (post freeze date) the Trust is exceeding the operational plan for both outpatient first and follow up appointments. A greater shift to day case than planned has resulted in under delivery of elective inpatients but over delivery of day cases. The operational plan however assumed Phase 3 reconfiguration would take place in June/July with an associated fall in activity. Reprofiling activity to be based on a working day rate identifies the Trust is below plan for Outpatient Firsts and elective inpatients.

Actions

Actions progressed in September:

- Successful recruitment into the department against the new workforce plan. Once the new staff are fully trained and competent, this will improve our staffing resilience.
- New Theatre Planning meetings are being implemented from October onwards, starting with Gynae and a refresh of the theatre scheduling tool. This will improve adherence to GIRFT guidance and national best practice around Theatre Planning e.g. the 6-4-2 process and weekly reflections of utilisation.
- Task & Finish group is ongoing to support the opening of RBH Theatres 14 and 15.
- Implementation of the new Da Vinci 5 surgical robot is planned for 13th October 2026 in Theatre 16 at Poole. Having a dedicated robotic theatre will improve robotic utilisation and improve our capacity to deliver more HVLC (High Volume Low Complexity) activity.
- The practice of stacking instrument sets, has ceased in order to help reduce cancellations. Metal caskets are also being trialled by SSD for heavier sets.

Day Case Improvement Programme: Key areas of focus

- Expansion of T&O day case activity to increase productivity, includes increased use of procedure rooms. 100 feet and 50 hand injections have been migrated away from theatres. Planning around St Mary's CDC to support hip injections is next step.
- Working through coding of activity to ensure it is fully captured.
- Increasing use of procedure rooms and Day Theatres being driven through GIRFT programme.
- Review of gynaecology pathways to increase day case opportunities and improve flow.
- Analysis of BADS benchmark data, including emergency procedures, to identify opportunities for further improvement in day surgery performance alongside a refreshed monthly specialty meeting from Nov 26.

Assurance & Timescale for Improvement

The Planned Care Improvement programme provides oversight to elective activity, and Theatre Improvement and Daycase programmes.

The Theatre Improvement programme is delivering oversight of the improvement plans for specialties.
2026/27 trajectories have been reset. Aim to deliver >85% standard consistently from December 2026.

There are 5 workstreams in the programme:

1. Peri- Operative Medicine
2. List Planning and Scheduling
3. Workforce Optimisation
4. Data and Governance
5. Estates and Equipment

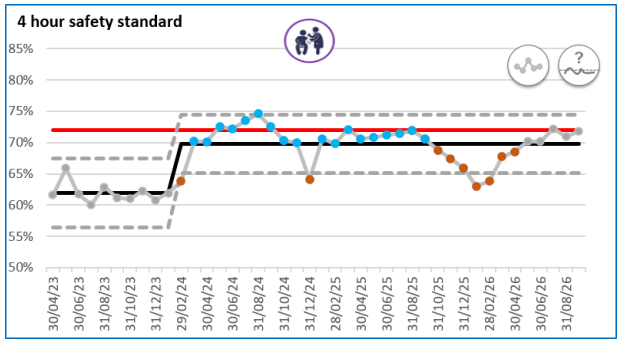
Maintain BADS day case rate – current performance delivered above >85% target.

Urgent and Emergency Care

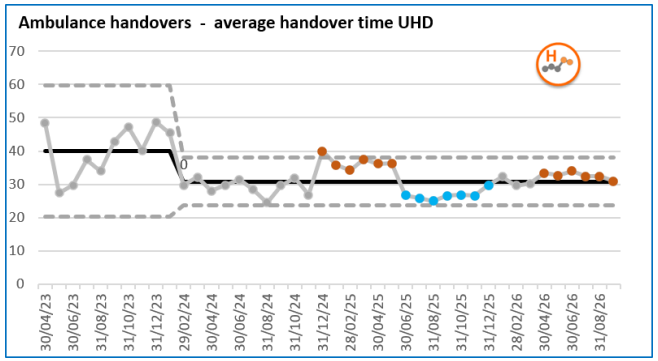
University Hospitals Dorset
NHS Foundation Trust

Sep 26
71.85%
Variance/ Assurance
Trajectory
72.0%
Business Rule
Off Plan

National Oversight Framework metric

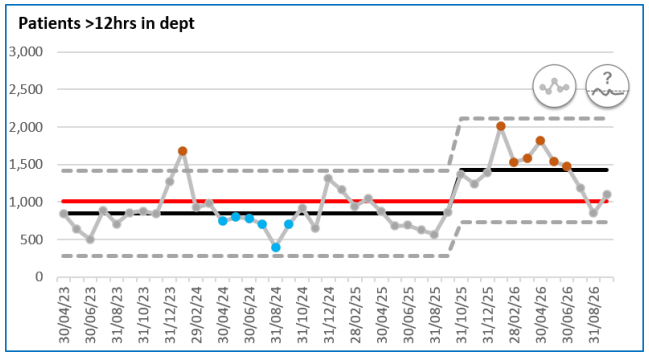


Sep 26
30.9 minutes
Variance/ Assurance
Targeting (Internal)
28 minutes
Business Rule
Note performance



Sep 26
5.9%
Variance/ Assurance
Targeting (Internal)
7.2%
Business Rule
On Plan

National Oversight Framework metric



Summary

- The Trust delivered against 71.85% in September against a trajectory of 72%.
- Admitted performance saw a small decline within the realms of normal variation to 30.6% down from 31.6% in August.
- This was also mirrored in Non-admitted performance which increased slightly within normal variation to 82.3% from 81.1%.
- Daily attendances did see a steep increase to 683 attendances a day, up from 601 patients.
- There also continues to be a small decrease in Type 3 activity though within the realms of normal variation of circa 200 patients. This was driven by both UTC activity and MIUs.
- Mean time in the department remained static despite an increase in presentations. Though decision to admit time did decrease again back down to 268 minutes.
- For 12 hour performance the Trust continues to see an overall positive improvement though we did just miss the trajectory in September, actual delivery was 1096 against a trajectory of 1015.
- Ambulance handovers remained relatively static with average ambulance handover time of 31 mins against a target of 25 mins.
- The NCTR average remains unchanged at 230 in September. P1 capacity continues to be a driving factor and flow through available capacity exceeds the limit required to match referrals coming in. Complex discharges are only matching new admissions, the backlog remains uncleared, prompting executive escalations to BCP and Dorset Councils over P1 availability and assessment delays. The partnership agreement was signed and to date 2 patients have left in this space totaling a LOS 283 days.

Actions

- Pilot call before appointment with 111 Service has been running since May to enable the clinical triage of activity to either a virtual contact or to stream away from ED to better utilise capacity.
- Review now underway of nursing and medical workforce to expedite reconfiguration proposal to meet increased demand and senior decision making at RBH site and enable pilot continuity.
- Business case being presented to the system UEC delivery group for decision around i) short term funding to support complex discharges and ii) assessment out of hospital (D2A). This will establish a funding route out of hospital for patients with complex needs who remain within an acute bed. In addition, the case advocates for an increase in P1 capacity to mitigate in part the withdrawal of hours and the apparent impact on NCtR number.
- Ongoing focus on NCtR recovery actions including review of trajectory, with four priority areas requiring coordinated effort and agreement from system partners.
- Board paper drafted with actions attributed to reducing NCTR, risk register updated to align.
- A site flow PDSA has begun focusing on quality and outcomes to create capacity through greater ownership to optimise discharge potential to create flow through the organisation. This is being followed up with some patient process mapping.
- Improvement cycles completed across Specialist and Networked medicine cross site with Older People's ward now planned. This will create a blue-print forward processes including Board / Ward rounds and discharge planning and will standardise the approach across the Trust. Focus for the next reporting period will be to continue to roll out to the wider Trust.
- GIRFT standards and processes being embedded in relation to Corridor care and greater than 24 hrs wait, with a structured judgement review underway. Governance for reporting themes has been set underway, working through how this aligns and informs.
- BCP has been asked to provide a time-bound recovery plan with clear system ownership to address delays contributing to extended lengths of stay. The plan should identify the actions required to release approximately 1,500 blocked bed hours, improve discharge flow and increase bed turnover to support current and anticipated system demand.

Assurance & Timescale for Improvement

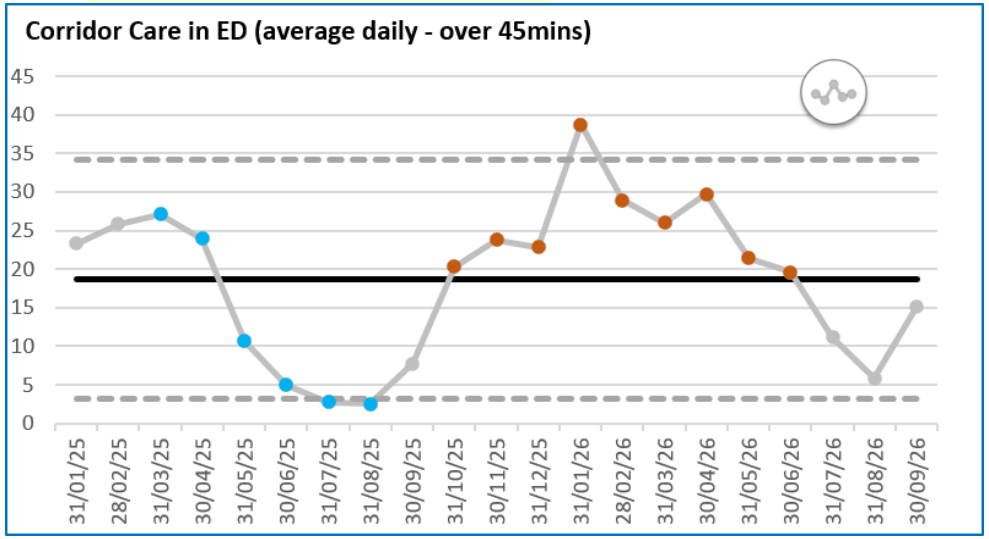
- Front Door: Same-Day Emergency Care (SDEC) now supports 20% more patients attending hospital, without needing to admit them. Despite hospital attendances increasing by 6% compared to last year, admissions have decreased by 1%. This has been supported by improvements in SDEC 2 x PDSA.
- Transfers of Care Hub continues to develop and mature in line with the ward rollout program to wrap around the broader systems and processes.
- Case for interim care budget to support complex pathways supported, Trust discussion regarding allocation 21/07/26 to maximise opportunity.
- Executive escalation process in place enhancing the visibility of the commissioning gaps and approach to discharge across Dorset- weekly alerts ongoing.
- The Better Flow , Better Care programme commenced in May 26. The PDSA's running across the program has increased to 25 in total with 9 closed.

Corridor Care (ED)

University Hospitals Dorset
NHS Foundation Trust

National Oversight Framework metric - Contextual

Sep 26
16 per day 455 total
Variance/ Assurance
Targeting (Internal)
Business Rule
Note performance



Summary	Actions	Assurance & Timescale for Improvement
Corridor care, (previously temporary escalation space care) was published nationally for the first time by NHSE (July position). Statistics » Corridor Care – Urgent and Emergency Care Daily Situation Reports The national ambition is to end corridor care, and this metric is contextual in the National Oversight Framework for 26/27. • NHSE recognise that this metric is immature and have therefore classified the data in this report as “contextual” • The data is collected as part of the UEC Daily SitRep, guidance for the collection was refined after it was first issued in March. Nationally, data quality and completeness work is ongoing. Within the Southwest Region, UHD ranked 4 out of 12 trusts in September 2026. Daily rates in the SW Region ranged from 2 –30 per day. The SPC chart show that the volume of corridor care periods has dropped below the mean and moved from special cause variation (concern) to common cause variation indicating some improvement on previous months.	Within Urgent and Emergency Care slide	Within Urgent and Emergency Care slide

Population and System Performance against Annual Plan 26/27 trajectory

University Hospitals Dorset
NHS Foundation Trust

		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 % within 18 weeks	plan trajectory	66.26%	66.82%	66.22%	65.22%	65.22%	66.63%	68.23%	69.82%	70.05%	70.55%	71.46%	73.10%
	actual	66.50%	66.90%	67.62%	66.80%	65.97%	67.32%						
	var	0.24%	0.08%	1.40%	1.58%	0.75%	0.69%						
Number of 52+ week RTT waits	plan trajectory	631	602	642	664	661	587	423	315	267	202	154	0
	actual	619	672	672	773	657	582						
	var	-12	70	30	109	-4	-5						
RTT waiting list – total	plan trajectory	66,552	66,447	66,647	67,367	67,305	67,015	66,840	66,618	66,713	66,671	66,523	66,485
	actual	67800	67497	67378	67365	67260	66984						
	var	1248	1050	731	-2	-45	-31						
Childrens community WL % within 18 wks	plan trajectory	3.6%	3.7%	3.7%	3.8%	3.8%	3.9%	3.9%	3.9%	4.0%	4.1%	4.1%	4.2%
	actual	6.5%	6.4%	6.4%	5.9%	8.9%	7.5%						
	var	2.9%	2.7%	2.7%	2.2%	5.1%	3.6%						
DM01 - % waiting over 6 weeks	plan trajectory	7.5%	7.4%	7.4%	7.7%	7.5%	7.0%	6.4%	5.5%	5.2%	5.2%	4.9%	4.4%
	actual	12.1%	13.7%	13.3%	15.0%	13.2%	9.1%						
	var	4.6%	6.3%	5.9%	7.3%	5.7%	2.1%						
cancer 28 day FDS standard *	plan trajectory	78.4%	79.3%	79.3%	78.3%	78.9%	80.0%	82.1%	82.2%	80.5%	79.4%	80.5%	81.8%
	actual	67.2%	75.5%	71.5%	75.3%	73.8%	*73.3%*						
	var	-11.2%	-3.8%	-7.8%	-3.0%	-5.1%	*-6.7%*						
cancer 31 day standard *	plan trajectory	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%
	actual	91.0%	93.6%	93.2%	93.6%	95.8%	*91.2%*						
	var	-5.0%	-2.4%	-2.8%	-2.4%	-0.2%	*-4.8%*						
cancer 62 day standard *	plan trajectory	75.0%	75.2%	75.4%	75.6%	75.8%	76.0%	76.5%	77.0%	77.5%	78.0%	79.0%	80.0%
	actual	65.8%	69.1%	61.2%	64.7%	70.1%	*64.5%*						
	var	-9.2%	-6.1%	-14.2%	-10.9%	-5.7%	*-11.5%*						
4 hour safety standard	plan trajectory	70.0%	70.0%	70.0%	68.0%	70.0%	72.0%	74.0%	76.0%	76.0%	77.0%	79.0%	82.0%
	actual	68.5%	70.2%	70.2%	72.2%	70.9%	71.8%						
	var	-1.5%	0.2%	0.2%	4.2%	0.9%	-0.2%						
Patients >12hrs in dept	plan trajectory	1,015	1,049	1,015	1,049	1,049	1,015	1,049	1,015	1,072	1,072	948	1,049
	actual	1815	1542	1472	1189	881	1110						
	var	800	493	457	140	-168	95						
Overnight total general and acute bed occupancy %	plan trajectory	96.37%	95.89%	95.89%	100.40%	101.11%	95.91%	96.41%	96.16%	97.24%	97.24%	96.29%	94.24%
	actual	94.40%	93.30%	93.20%	93.10%	91.90%	93.80%						
	var	-1.97%	-2.59%	-2.69%	-7.30%	-9.21%	-2.11%						
Average handover time (Total Handover time (ED and non ED) / No of handovers (ED and non-ED)	plan trajectory	00:28:00	00:28:00	00:29:00	00:28:00	00:25:00	00:25:00	00:26:00	00:26:00	00:28:00	00:28:00	00:27:00	00:26:00
	actual	00:33:20	00:32:40	00:33:55	00:32:24	00:32:23	00:30:50						
	var	00:05:20	00:04:40	00:04:55	00:04:24	00:07:23	00:05:50						

** performance in italics is provisional as at 06/10/26*

University Hospitals Dorset
NHS Foundation Trust

Our People



Sue Smith
Chief People Officer

Operational Leads:
Irene Mardon - Deputy Chief People Officer

Committees:
People and Culture Committee

Performance at a Glance
Our People

University Hospitals Dorset
NHS Foundation Trust

UHD Workforce

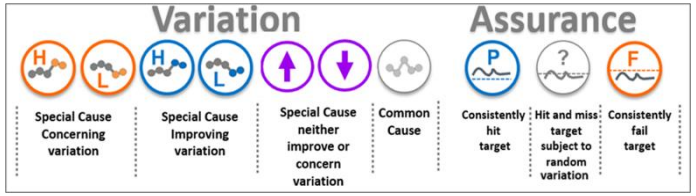
KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Vacancy Rate at end of each month	Aug 26	8.2%	7.5%			7.4%	5.3%	9.6%
In Month Sickness Absence	**Sep 26**	**5.0%**	**4.0%**			**4.7%**	**4.1%**	**5.3%**
Mandatory Training Compliance at end of each month	Sep 26	86.8%	90.0%			88.8%	87.7%	89.9%

Vacancy rate is reported 1 month in arrears

National Oversight Framework Metric

NHS Staff Survey Results and the National Education and Training Survey also form part of the NOF and will be reported annually
Healthcare Worker Flu Vaccination Rate is a seasonal metric and will be reported later in the year.
(Healthcare Worker Flu Vaccination Rate for 25/6 was 50% achieving the ICB target)

"Be a great place to work" – Patient First breakthrough metric



Workforce monitoring - Actual vs plan

University Hospitals Dorset
NHS Foundation Trust

Operational Plan Monitoring

Staff Type	Plan/Actual	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Substantive	Actual	9146.0	9170.3	9148.8	9146.6	9205.0	9243.9						
	Plan	9229.8	9252.2	9317.1	9322.8	9305.2	9288.6	9280.5	9272.4	9264.3	9251.2	9239.2	9226.1
Bank	Actual	664.8	590.7	604.0	578.1	588.5	587.7						
	Plan	579.8	557.2	540.4	537.3	540.4	546.6	552.9	559.2	565.5	568.5	559.2	534.1
Agency	Actual	55.2	60.0	56.3	73.1	64.7	61.7						
	Plan	83.8	78.1	72.2	70.2	69.6	68.2	67.7	70.0	75.0	73.9	68.0	63.5

Staff Type	Plan/Actual	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 Staff	Actual	9866.0	9821.0	9809.1	9797.9	9858.2	9893.3						
	Plan	9893.4	9887.5	9929.6	9930.2	9915.2	9903.4	9901.0	9901.6	9904.8	9893.7	9866.3	9823.6

"Be a great place to work" – breakthrough metric

- Variance to Total Funded Establishment (WTE)
- Variance to Temporary Staffing (Bank) Spend Cap

Summary

- In September, the total workforce was 9893.3 whole time equivalent (WTE), being a favourable variance of 10.06 WTE against the in-month plan. Within this:
  - Substantive workforce had a favourable variance of 44.67WTE
  - Bank usage was above plan by 41.08 WTE
  - Agency usage was below plan by 6.48 WTE.

Actions

Close monitoring of bank and agency WTE and spend continues, focused specifically on directorates reporting above their expenditure limits.

Detailed WTE and finance trackers support the identification and challenge to outliers, with an additional report now reviewed weekly at the executive meeting enabling prompt action to mitigate any emerging concerns.

Additionally, the finance team are producing figures that compare actual WTE, whilst considering transformation delays and unidentified savings. This will enable greater scrutiny of the Trust's position against planned WTE figures.

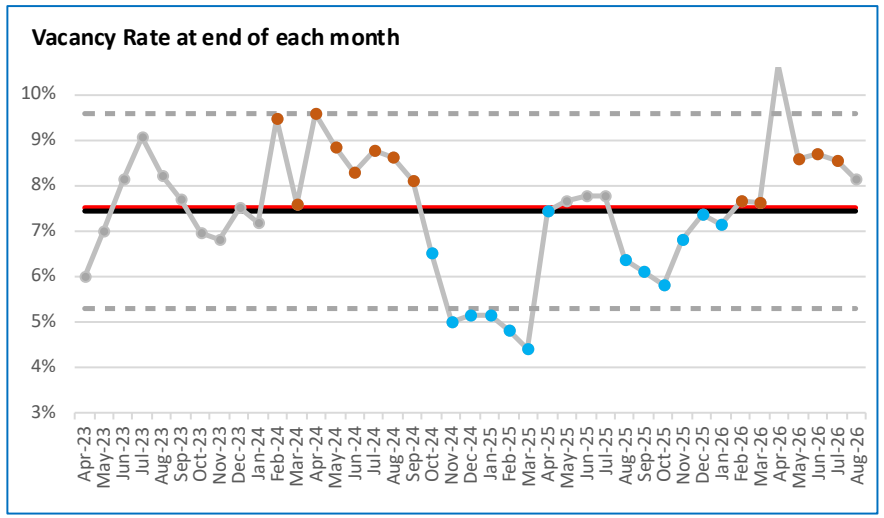
Assurance & Timescale for Improvement

- Active engagement with framework providers to widen searches across specialist staffing groups - Radiology, Nuclear Medicine, Clinical coders, Theatre Scrub and Recovery Nurses, and Biomedical Scientists.
- Substantive recruitment continues to progress for high bank usage areas including the Emergency Department, Stroke Unit, and Older Peoples Assessment Unit. The impact against reduction of Bank usage will be seen across Quarter 3 in line with supernumerary periods.
- Oversight and assurance will continue to be provided through the People and Culture Group and Sustainable Services Group. Detailed highlight reporting will be scrutinised at the monthly People and Workforce delivery group, commencing on 10th November.

Workforce monitoring - Vacancy Rate

August 26
8.2%
Variance/ Assurance

Targeting (Internal)
7.5%
Business Rule
Verbal CMS



University Hospitals Dorset
NHS Foundation Trust

Summary

The finalised August vacancy rate is 8.2% (804.95 WTE), with vacancy WTE reducing for the third consecutive month, down 37.79 WTE from July. The provisional vacancy rate position for September is currently 7.56%

Funded establishment and the substantive workforce both increased by 24 WTE during August, with sustained recruitment activity supporting the continued reduction in vacancies.

Turnover remains stable at 9.6% (excluding internal moves), while vacancy WTE has reduced for three consecutive months, indicating that workforce growth is being driven by recruitment rather than reduced staff movement.

Additional Clinical Services remains a key vacancy hotspot at 14.3% (255.65 WTE), compared with the Trust target of 7.5%, with targeted HCSW recruitment activity underway.

Actions

Progress Digitalised ID Checks and New Starter Forms (Amiqus) following SSG approval, with the business case progressing to TMG for final consideration to support further sustained reductions in employment-check timelines.

Deliver targeted HCSW and Theatre recruitment campaigns, focused on identified vacancy hotspots and converting candidates into substantive appointments.

Develop earlier manager engagement at the point of resignation to improve recruitment readiness and reduce vacancy lead times.

Use separate Medical & Dental TTH reporting and vacancy hotspot intelligence to target improvement activity where the greatest workforce pressures remain.

Assurance & Timescale for Improvement

Agenda for Change Time to Hire is 35.3 working days, with performance continuing to be tracked against the NHS England ambition of 30 working days by March 2027.

Medical & Dental Time to Hire is 71 working days, with separate reporting maintaining visibility of this longer recruitment pathway.

Agenda for Change employment checks are 16.8 days against the 22-day KPI, providing assurance on the speed of candidate onboarding.

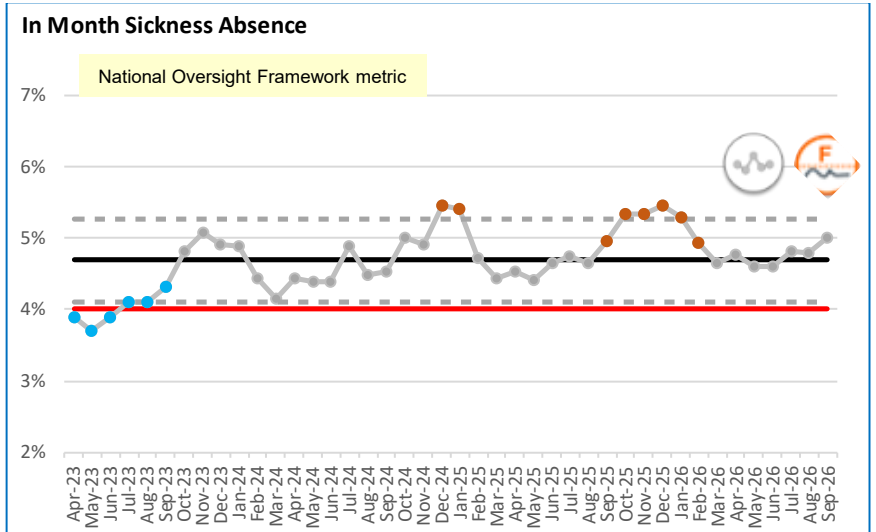
Digitalised ID Checks and New Starter Forms (Amiqus) have secured SSG approval and progress to TMG for consideration. Subject to approval, implementation will support further reductions in employment-check and onboarding timelines.

Sickness Absence Rate / Turnover

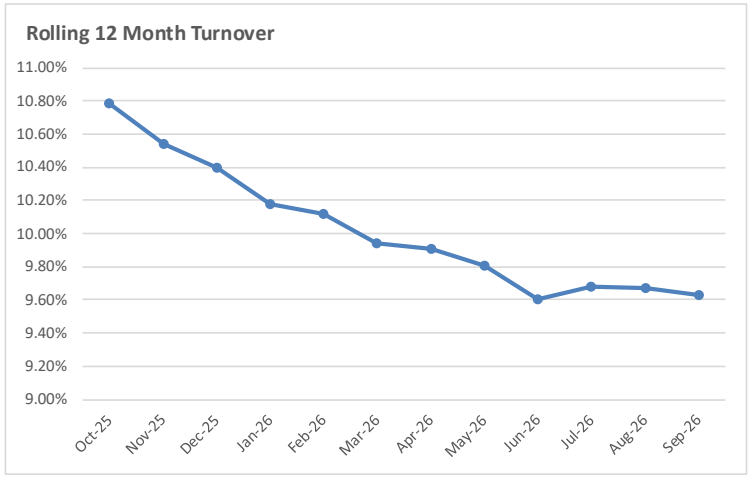
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September 26
5.0%
Variance/ Assurance

Targeting (Internal)
4.0%
Business Rule
Verbal CMS



September 26
9.6%
Variance/ Assurance
N/A
Targeting (Internal)
10%
Business Rule
Verbal CMS



Summary

- In month sickness absence for September is 5.0%, this has increased from August by 0.2%. The rolling sickness absence remains stable at 4.9%. This comprises 3.13% short term sickness absence and 1.83% long term sickness absence.
- Medical and Operations saw a slight decrease in sickness whilst Corporate, Surgical, WCCSS Groups saw a slight increase.
- The top three reasons for sickness absence were
  - Anxiety/ stress/ depression/other psychiatric illnesses (1.2%)
  - Cold/cough/flu (0.6%)
  - Other known cause (0.5%)
- Turnover has remained at 9.6% for September (same as August).

Actions

Focus remains on sickness absence management, across all services through the enabling of managers by the Employee Relations, Business Partnering and OH&WB Teams to actively manage sickness absence, and interventions to support colleagues to be well at work. This has included running bespoke sickness training sessions to support specific hotspot areas such as Outpatients and Estates. Additional activity includes management development and capability building at management away days and Masterclasses.
Whilst turnover remains reasonably stable, there remains a focus on areas with the highest rates.

Assurance & Timescale for Improvement

All Trusts must demonstrate progress to reduce sickness absence rates to 4.1% by March 2027.

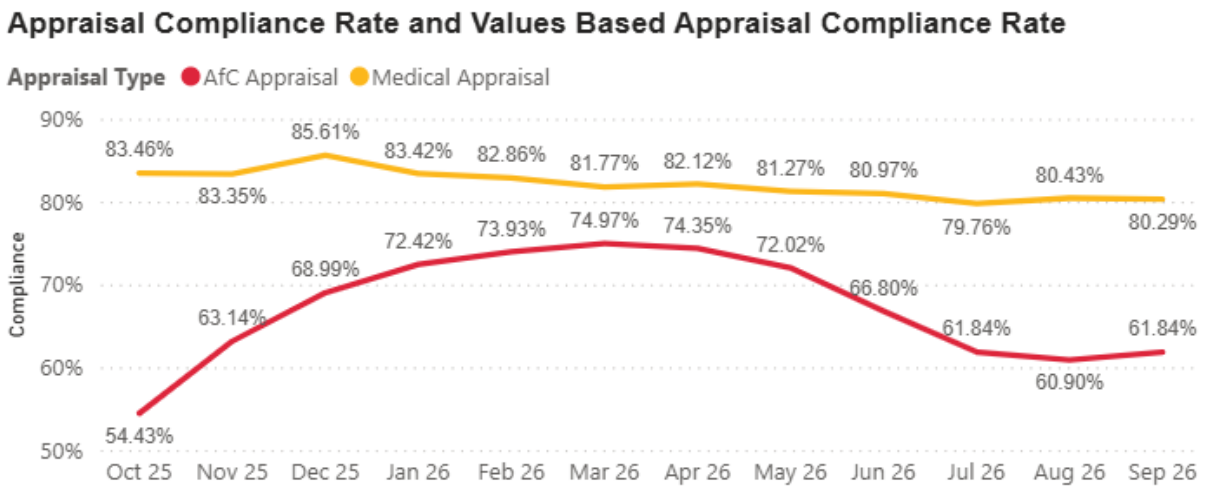
Progress against the Trusts trajectory continues to be monitored, with specific focus on areas where sickness has increased, working holistically with colleagues to review team and environmental factors.

A review into current sickness levels, active sickness management and hotspots, is underway to review and identify areas where greater management intervention is required with oversight through the People and Culture Group.

Appraisal Rates

University Hospitals Dorset
NHS Foundation Trust

AFC Appraisal September 26
61.84 %
Variance/ Assurance
N/A
Targeting (Internal)
90%
Business Rule
Full CMS



Medical Appraisal September 26
80.29%
Variance/ Assurance
N/A
Targeting (Internal)
90%
Business Rule
Full CMS

Summary

The AfC appraisal compliance for September shows a slight improvement from 60.90% in August to 61.84% in September.

Medical appraisal has decreased from 80.43% in August to 80.29% in September. The number of Medical Appraisers has decreased over a period of time owing to a combination of retirement, recruitment challenges and changes to job plans.

The staff group with the lowest appraisal rate is Nursing and Midwifery with 59.29%. This highest scoring staff group is Healthcare Scientists with 73.42%.

66 staff have completed the Appraisal training this year.

Actions

The new Learning Management System continues at pace with a planned launch date of 16th November 2026. Robust communications will be shared as part of the launch.

The People Directorate is planning an Appraisal workshop to explore the challenges around achieving appraisal compliance. This will include identifying solutions and strategies to support staff with appraisals.

Highlight the insufficient levels of appraisers to Group Medical Directors, Deputy Group Medical Directors, with a request to support colleagues to appropriately utilise SPA time to facilitate the provision of appraisers. Additionally monitor through the Responsible Officer's Advisory Group (ROAG).

Assurance & Timescale for Improvement

Managers continue to receive oversight and identification of low compliance areas regarding appraisal performance through the Human Resources Business Partners who continue to monitor appraisal rates across each Care Group and Directorate, with management accountability held at SDR meetings and oversight from the People and Culture Group.

The Communications team is supporting an awareness campaign to encourage line managers to complete appraisals and upload them on ESR. The Workforce System team are assisting with uploading ESR queries.

University Hospitals Dorset
NHS Foundation Trust

Quality Outcomes & Safety





Sarah Herbert
Chief Nursing Officer

Dr Peter Wilson
Chief Medical Officer

Operational Leads:
Vivian Alividza – Deputy Chief Nursing Officer

Jo Sims – Associate Director Quality, Governance and Risk
Amy Stubbs – Director of Midwifery
James Balmforth – Clinical Director
Darren Jose – Interim Care Group Director of Operations, Women's, Children, Cancer and Support Services

Committees:
Quality Committee

Performance at a Glance
Quality Outcomes & Safety

University Hospitals Dorset
NHS Foundation Trust

Quality IPR

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Patient Safety Incidents (All) per 1,000 beddays	Sep 26	43.10	-			38.65	32.28	45.03
Patient Safety Incidents (Moderate +) per 1,000 beddays - Closed only	Sep 26	0.60	-			0.47	0.10	0.85
Medication Incidents (All) per 1,000 beddays	Sep 26	4.40	-			5.04	3.23	6.86
Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays	**Sep 26**	**0.40**	-			**0.41**	**0.15**	**0.67**
Inpatient Falls (Moderate +) per 1,000 beddays	Sep 26	0.30	-			0.18	-0.04	0.40
Hospital Associated Infections - MRSA	**Sep 26**	**2**	-			**1**	**-2**	**3**
Hospital Associated Infections - MSSA	Sep 26	4	-			5	-1	10
Hospital Associated Infections - C Diff	**Sep 26**	**5**	-			**9**	**-1**	**19**
Hospital Associated Infections - E Coli	**Sep 26**	**9**	-			**11**	**1**	**21**
Hospital Associated Infections - Kleb	Sep 26	6	-			5	-2	11
Hospital Associated Infections - Pseudo	Sep 26	2	-			2	-2	6
Friends & Family Test	Sep 26	91.2%	-			93.5%	91.8%	95.2%
Complaints Received	Sep 26	82	-			84	-5	174
Complaint Response Rate (Grade Based Target)	Sep 26	21%	100%			44%	14%	73%
Mixed Sex Accommodation Breaches	Sep 26	0	-			6	-5	18
HSMR In Month - UHD (Source: HED)	Jun 26	107.30	0.95			96.90	82.79	111.01
SHMI - Summary Hospital Level Mortality Indicator	**Apr 26**	**0.86**	**0.85**			**0.87**	**0.86**	**0.88**

National Oversight Framework metrics

NHS Staff Survey results and CQC inpatient survey results will be reported annually
Rate of pregnant women with a planned induction that are delayed - Quarterly
SHMI – Summary Hospital Level Mortality Indicator is included on slide 25
30 day readmission rate band – Quarterly (slide 11)
Breadth and depth of clinical audit outliers - Quarterly

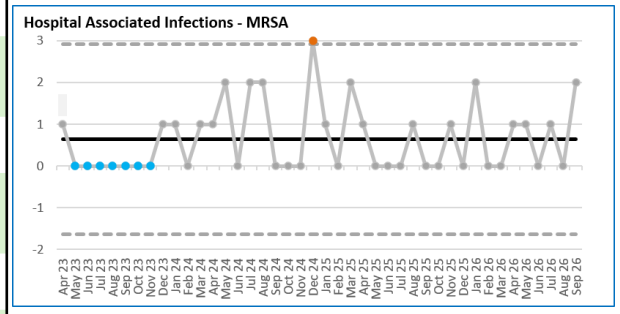
"Save lives, improve patient safety" – Patient First breakthrough metric

Hospital Associated Infections

University Hospitals Dorset
NHS Foundation Trust

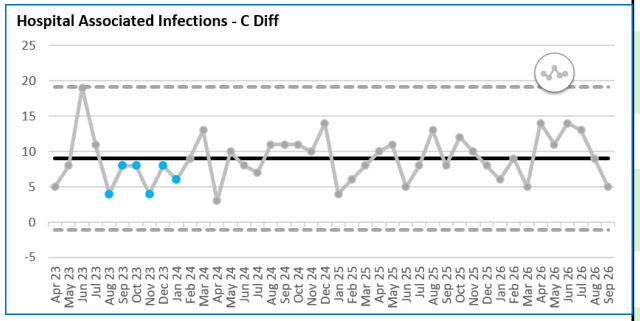
Sept 26
2
Variance/ Assurance
Targeting (Internal)
-
Business Rule
N/A

National Oversight Framework metric



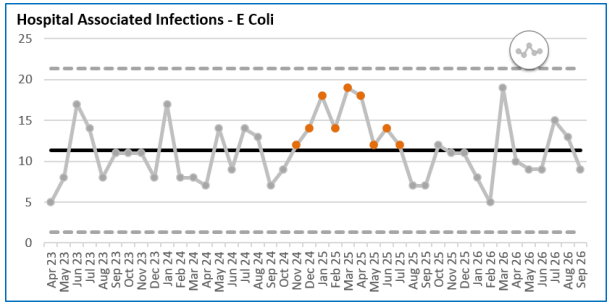
Sept 26
5
Variance /Assurance
Targeting (Internal)
-
Business Rule
N/A

National Oversight Framework metric



Sept 26
9
Variance /Assurance
Targeting (Internal)
0
Business Rule
Full CMS

National Oversight Framework metric



Summary

September 2026:
Hospital associated MRSA bacteraemia – 2 (1 x COHA, 1x HOHA)
Hospital associated MSSA bacteraemia – 4 (4 x HOHA)
Clostridiodes difficile hospital associated cases – 5 (2 x COHA, 3 x HOHA)
Escherichia coli bacteraemia cases – 9 (6 x COHA, 3 x HOHA)
Klebsiella cases – 5 (1 x COHA, 3 x HOHA)
Pseudomonas cases – 2 (2 x HOHA)

Outbreaks – 3 x COVID-19 on Poole site

Actions

Hand Hygiene (HH) - wards have installed end of bed alcohol hand rub across Poole and Bournemouth sites with approximately 70% of wards now compliant. IPC reviewing and supporting areas where this has not been completed

Peer review HH audits continue quarterly with action plans for non-compliance

Strengthened governance and reporting into and upward from IPC Monthly Care Group meetings in place

Assurance & Timescale for Improvement

Trust wide Hand Hygiene campaign ongoing with actions for launch during International IPC week from 19th October 26.

IPC hand hygiene assurance audits starting to show an upward improvement trend, remaining below reduction of transmission levels however improving towards this.

Reduction in *E.coli* numbers compared to August 26

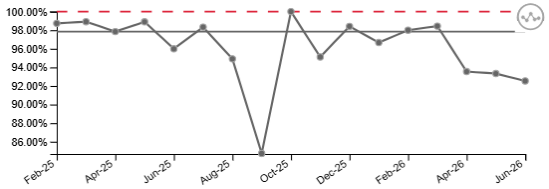
We are caring one team listening to understand open and honest always improving inclusive

eMortality Consultant Review Compliance
HSMR < 100

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NHS Foundation Trust

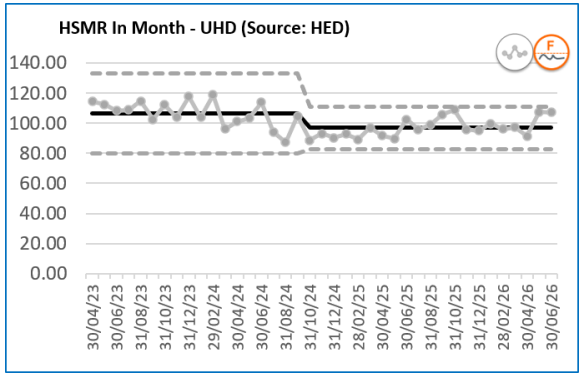
Jun 26
92.5%
Variance/ Assurance
Targeting (Internal)
100%
Business Rule
Verbal CMS

Consultant Mortality Reviews



Jun 26
107.6
Variance /Assurance
Targeting (Internal)
96.0
Business Rule
Verbal CMS

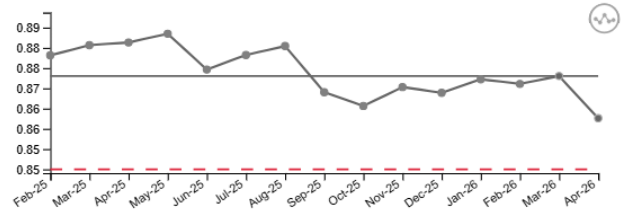
HSMR in month



April 26
0.86
Variance /Assurance
Targeting (Internal)
0.85
Business Rule
Verbal CMS

National Oversight Framework metric

SHMI – Summary Hospital Level Mortality Indicator



Summary

E-Mortality review compliance remains below target at 92.5%. This is reported 3 months in arrears.

HSMR in month has stayed similar to May, at 107.6 for June. This remains within the control limits so expected variation. Rolling 12 months (July 2025 – June 2026) remains just below the national average of 100, at 99.9.

SHMI remains below national average at 0.86, however slightly higher than internal target of 0.85.

Actions

Continued education and engagement of consultants
Working to ensure that the reviews are completed by the most appropriate team for learning e.g. ITU
Ongoing issues around identifying the correct consultant delay reviews.
Audit in progress to ensure pathways are correctly followed to identify patients for eLFD review to ensure 30% of all cases are consistently reviewed as per policy.

External audit of mortality coding in progress to review codes and accuracy. Risk (2302) agreed around coding accuracy and potential impact on HSMR
Flow chart to use to address HED alerts presented March MSG for review.

Assurance & Timescale for Improvement

Significant improvement noted, particularly in medicine. Plan for pathway for specific group of ITU patients to be reviewed directly by ITU and further links from ITU M&M to support teams with eLFD forms planned. The aim is for these pathways to be finalised and introduced by April.
Updates to HoW will support clinicians to change owning consultant in real time to improve accuracy of ECamis.

UHD is in the top 14 trusts of the 119 trusts included in the SHMI reporting.

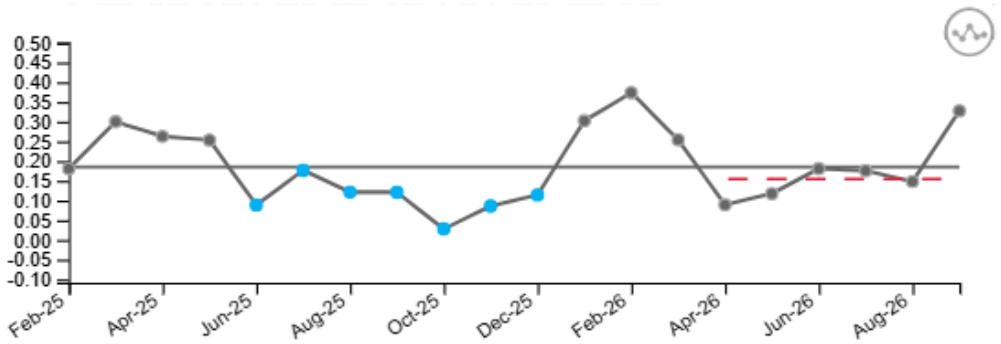
New flowchart will ensure that all alerts are assessed for accuracy and to identify concerns within that patient cohort.

Patient Safety – Falls

University Hospitals Dorset
NHS Foundation Trust

September 2026
0.3
Variance/ Assurance
Targeting (Interna)
-
Business Rule
N/A

Falls per 1,000 bed days (moderate and above)



Summary

- Falls remain within the expected range on the SPC Chart. However, September saw an increase in falls resulting in moderate harm or above.
- Overall inpatient fall rate in September 2026: 6.7 per 1000 bed days.
- Eight inpatient falls resulted in moderate or greater physical harm (fractures, head injuries), equating to 0.3 per 1,000 bed days. No fatalities reported.
- 91% of falls were recorded as low or no harm.

Actions

PSIRF Learning: 14 incidents triggered a SWARM learning response. Four were subsequently downgraded to low harm, as the impact of the injury on the patient and their care pathway was minimal.

- **Key themes** 80% occurred after 17:00. Patients had significant comorbidities affecting bone health, cognition, muscle strength and balance.
- **Learning highlights include** the importance of effective communication during high-pressure shifts to support coordinated care, early and repeated 4AT delirium screening, staff presence within the bay.
- Falls prevention targeted improvements implemented as part of Fundamentals of Care supported with PDSA cycles.

Falls Steering Group: Monthly meetings continue chaired by the WCCSS GDON.

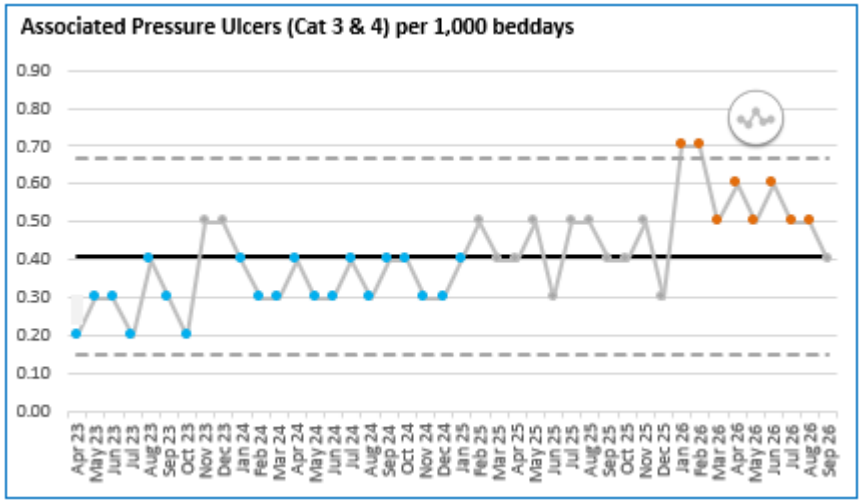
Assurance & Timescale for Improvement

- **PSIRF Learning:** the Falls Steering Group will provide trust-wide oversight of falls incidents and assurance of completion of identified learning, actions and Duty of Candour requirements.
- **Digital Integration:** The eObs Functionality for standardized single point of recording for lying and standing blood pressure results is now live.
- **UHD Annual Bed Rail Audit** has been registered on AMaT with implementation scheduled for November 2026
- **The NAIF Annual Report 2026** is now available and will be used to guide the review of existing improvement work and inform future priorities and objectives.

Patient Safety – Pressures Ulcers

University Hospitals Dorset
NHS Foundation Trust

September 2026
0.4
Variance/ Assurance
Targeting (Internal)
-
Business Rule
N/A



Summary

A total of 12 patients have acquired full thickness pressure damage during August 2026.

- **Category 4 n=2**
- Category 3 n=10

Category 4 damage- AAR: One AAR completed, One AAR yet to be convened
Category 3 damage- learning. Of the 10 patients who acquired category 3 damage, 8 incidents had learning themes identified: namely gaps in timing and efficacy of repositioning to most common themes.
In two instances all care was delivered as planned.

NB: Pressure ulcer data reported 4-8 weeks in arrears

Actions

- Severe incidents escalated and AAR's scheduled to ensure local ward improvement plans.
- Audits now added to AMaT system- aSSKINg bundle and Purpose T
- Resource Folder developed, added to Intranet and being distributed to all wards in hard copy
- Practice Educators (together with TVN) delivering practical training across Medical Care Group wards
- Bespoke scheduled training delivered on request

Assurance & Timescale for Improvement

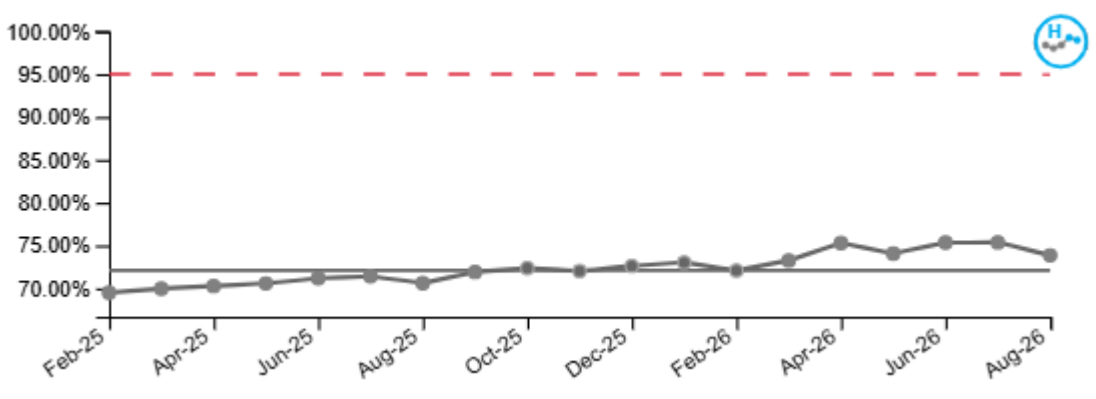
- Pressure ulcer steering group,-monthly meeting for oversight and governance
- aSSKINg bundle roll out nearing completion Trust wide
- Fundamentals of Care (FoC)- local wards supported with PDSA cycles for service improvement
- Several wards using twice daily skin huddles to improve awareness and assurance
- Repositioning/ Turns white boards/ wipe boards being trialed to improve visibility re timing of care

Patient Safety – VTE Prophylaxis

University Hospitals Dorset
NHS Foundation Trust

August 2026
73.9%
Variance/ Assurance
Targeting (Internal)
95%
Business Rule
Full CMS

VTE Prophylaxis Prescribing Compliance



VTE is reported 1 month in arrears

Summary

- VTE risk assessment is mandated in EPMA and Trust achieves national mandated target of 95% however there is no electronic mandate to prescribe using current EPMA
- EPMA does not allow visualisation of what is not prescribed
- Not all patients are on EPMA.
- Trust and NICE Guidelines require VTE prescription within 14 hours which is not always possible due to clinical conditions for example awaiting surgery/procedures or awaiting investigation results i.e CT Head.
- New Trust target set to achieve 95% prescribing compliance
- This metric is now reported 1 month in arrears to take into account coding timescales

Actions

- Issues raised with EPMA
- Creation of Dummy Drugs to allow identification of clinical decision that patient does not require VTE prophylaxis
- Twice daily EPMA reports highlighting patients without prophylaxis issued to all wards and clinical depts
- Improved engagement in Thrombosis Group
- New COSMOS report including VTE risk assessment and prophylaxis prescribing timings
- Updated Patient Information and developed Information Videos
- Training Videos for staff circulated
- Raised on RISK register
- VTE on SDR reporting
- VTE Thematic review completed
- TG continues to support Specialty Governance groups
- Care Group Working Groups developing Actions
- VTE audits completed in Cardiology and AMU Trust wide VTE audit on AMat being developed for Trust wide Cascade
- HAT audit now on AMat
- Cohort Review

Assurance & Timescale for Improvement

- RCA reporting of all hospital acquired thrombosis
- Thrombosis Group confirmed overarching review into MOG and VTE action log
- MOG requires VTE assurance actions and updates from each Care Group
- SDR reporting with timescales for improvement

Maternity and Neonatal Care

	Overall	Safe	Effective	Caring	Responsive	Well-led
CQC Maternity Ratings UHD Assessment Sept 2025	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement

University Hospitals Dorset
NHS Foundation Trust

National position & overview

- **The Perinatal Quality Surveillance Dashboard describes a standard data set for Trust Board overview**
- **The dashboard implementation using the Perinatal Quality Surveillance Tool forms part of our Mat Neo assurance to Trust Board**
- **There are several items which require narrative rather than graphic benchmarking and these are described below**

Findings of review of all perinatal deaths using the national monitoring tool

MBRRACE reportable cases:

There was 1 reportable cases to MBRRACE in September 2026 – Antenatal Stillbirth 33+3 attending service with reduced fetal movements since previous day. MDT review undertaken with learning points identified regarding escalation at time of attendance. Case to be reviewed for learning through the PMRT process.

MNSI new cases:
There were no case referrals to MNSI in September

MNSI ongoing cases:
MAT 003-xxx Neonatal death following significant antepartum hemorrhage at home- Cat 1 LSCS delivered in poor condition and passed soon after delivery

MAT 004-xx 40+1 abnormal CTG – Cat 1 LSCS baby delivered in poor condition –ventilated and went to UHS for cooling.

Matters for Board information and awareness

Patient Safety Incident Response Framework (PSIRF) has been implemented in maternity.

Ongoing PSIRF incidences:
There is currently 1 PSII and 1 After Action review open to maternity and neonatal Services in September 2026. 6 Cases were escalated for learning responses at the Rapid Review meeting.

Completed PSIRF incident:
- No final reports received in September 2026.

Top incidences LFPSE
- Post partum hemorrhage >1500mls = 8
- Term admission to neonatal unit = 9
- Readmission of mother -10

Safety champions reviews and assurance in September
- Consultant attendance on as per RCOG guidance
- Maternal Care Bundle Implementation Plan
- Cultural Improvement Plan
- Quarterly PMRT report
- Quarterly ATAIN report
- Quarterly Claims and Litigation report

Progress in achievement of maternity improvement plan

QC action plan -
Recent inspection in September 2025 – final report in March 2026 – rated as requires improvement. Initial recommendations and action plan in place . Director of Midwifery (DOM) meeting with corporate assurance team to review and update on current actions. Repeat abduction simulation planned for October 2026.

Maternity incentive scheme year 8 -
Ongoing implementation of standards and monthly assurance meetings in place to monitor and achieve compliance for November 2026 deadline- ontrack.

CQC Maternity Survey 2026
Initial report received, currently embargoed. 3rd best response rate nationally. Improvement plan based upon results has been developed in conjunction with the Maternity and Neonatal Voices Partnership.

Service users –
MNVP currently carrying 2 vacant posts within the team. DOM to meet with lead in next month to agree recruitment and prioritise workload to ensure that service user voice continues to be heard in key areas of concern.

Staff survey: Initial results show staff feel confident that the Trust prioritises patient care. Areas to focus – improving staff health and well-being, reducing exhaustion and increase opportunities for teams to meet and discuss effectiveness. Local heat maps disseminated and the team have commenced work in all areas

Culture improvement plan
Cultural Improvement Plan to be submitted to Safety Champions meeting in September 2026.

Amos and Ockenden –
10 immediate actions within 100-day sprint . Initial Benchmarking and evidence has been submitted to Trust board and South West regional team in September 2026
Initial baseline assessment completed with project leads identified for each action, fortnightly progress meetings in place. Implementation progress report planned for Trust board December 2026.

We are caring one team listening to understand open and honest always improving inclusive

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Perinatal Quality Surveillance

Maternity and Neonatal Dashboard

			Provider	UHD			
Group	Metric Id	MetricName	Latest Date	Value	Target	Variation	Assurance
Birth	1	No. of women delivered (all births)	Sep 26	341			
	2	No. women delivered (unregistrable baby/babies only)	Sep 26	6			
	3	Number of women delivered (multiple births where at least one unregistrable and one registrable)	Sep 26	1			
	6	Number of babies born	Sep 26	348			
	7	No. of registrable babies born	Sep 26	341			
Booking	15	Total number of bookings	Sep 26	315			
	16	% bookings completed <10 weeks gestation	Sep 26	79.7%	65%		
Continuity of Carer	17	% of women on continuity of carer pathway by 29 weeks' gestation	Sep 26	6.53%			
	18	% of Black and Asian women on continuity of carer pathway by 28 weeks' gestation	Sep 26	86.4%			
	19	% of women (IMD-1) placed on a continuity of carer pathway	Sep 26	0%			
Infant Feeding	35	% of babies receiving breast milk at first feed	Sep 26	79.4%	72%		
	36	% babies receiving breast milk at discharge from midwifery care to HV/GP (10 - 28 days PN)	Sep 26	73.3%			
Maternal Morbidity & Mortality	13	Rate per 1,000 Women with >= PPH 1500ml(previous 3 months aggregated)	Sep 26	33.1	30		
	14	Rate per 1,000 women with 3rd/4th degree tears (current three months aggregated)	Sep 26	19.3	28		

Data and Target

The national PQS Diis Scorecard is rated based on SPC methods and comparison to national targets.

Performance

Areas to note improvement :

- **Bookings** completed before 10 weeks 79.7% (July 74.6%) against a target of 65%
- **ATAIN** Avoidable term admission to Neonatal unit 3.16% better than regional target of 5%

Both of these metrics continue to be on a downward trajectory

- PROMPT Training compliance for Anaesthetic teams has improved in the last month and is now meeting requirements for MIS

Key Areas of Focus

- **Postpartum Haemorrhage > 1500mls** – 33.1 aggregated 3 months (national target of 30)
- **Neonatal nursing sickness** Mitigations and HR support in place to support the team to reduce sickness.
- **Amos and Ockenden** 100-day sprint for 10 immediate actions underway Triage benchmarking tool now completed
- **Thirlwell Report and recommendations** received by the trust. Initial 5 recommendations in process of implementation within required timeframes.

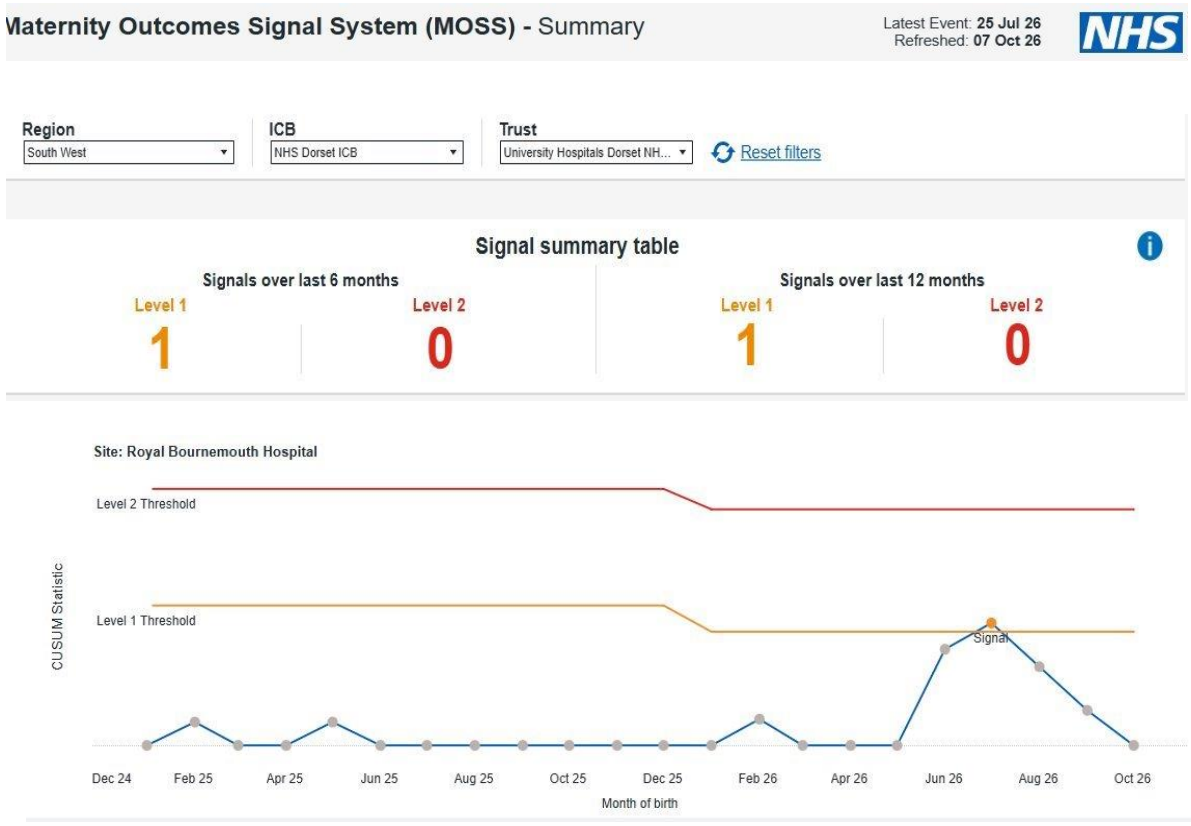
Perinatal Quality Surveillance

Maternity and Neonatal Dashboard

Group	Metric Id	MetricName	Provider Latest Date	UHD Value	UHD Target	UHD Variation	UHD Assurance
Maternal Morbidity & Mortality	26	Maternal death - number of deaths of women during or up to 1 year following the end of pregnancy (irrespective of place/circumstances of death)	Sep 26	0			
	27	Number of women admitted to ITU associated with birth up to 28 days post-natal (any birth, not including any other trust birth)	Sep 26	0			
Perinatal Morbidity	8	% of term babies admitted to NNU	Sep 26	3.16%	5%		
	22	% of babies <3rd birthweight centile, born >37+6 weeks	Sep 26	0%			
	62	Rate per 1,000 babies born at term with an Apgar score <7 at 5 minutes (CQIMApgar)	Sep 26	12.3	13		
Perinatal Mortality	11	No. of still births per month	Sep 26	1			
	12	No. of neonatal deaths < 28 Days	Sep 26	0			
	20	Annual rate of stillbirths per 1,000 births - rolling 12mths	Sep 26	2.60	2.5		
	41	Rate per 1,000 of live birth babies who died within 28 days of birth - rolling 12mths	Sep 26	1.83			
Preterm Birth Data	23	No. of singleton babies born <27 weeks' or multiples born <28 weeks' gestation or birthweight <800g	Sep 26	0			
	33	Rate per 1,000 births which are preterm (< 37 week's gestation)	Sep 26	73.3	60		
Treating Tobacco Dependency	9	% of women smoking at booking	Sep 26	9.21%			
	10	% of women smoking at delivery (previous month)	Sep 26	6.12%	6%		
	37	% of women with a CO measurement at time of booking	Sep 26	93.3%	95%		
	38	% of women with a CO measurement at time of 36 weeks' gestation	Sep 26	83.8%	95%		

University Hospitals Dorset
NHS Foundation Trust

MOSS - Maternity Outcomes Signal System



Actions taken

1. The last MOSS signal received by the trust was in July 2026 and the following actions were taken following this
2. Critical safety check completed within 8- day timeframe by maternity senior leadership team
3. Data cross checked and queries sent to MOSS team
4. Completed assessment signed off by Chief Medical Officer, Director of Midwifery and Clinical Director
5. Submitted to region and ICB

Findings

1. That it has been identified that in a 3-month period that Cat 2 LSCS have been delayed greater than the 75-minute target with 58% compliant. There is no set target however from this review improvements can be made in the following areas
    - Identification of a second obstetric theatre team
    - Streamlining the elective caesarean section processes to avoid impact on the ability to undertake a Category 2 ceasarean

2. The Trust Board has awareness of the Medical Obstetric staffing risk at 15and there is a plan in place with mitigations and expected solution in October. Plan is on track to find resolution.

Next Steps

- Working party set up to analyse cases where Cat 2 LSCS within 75 minutes to understand risks and safety concerns
- New Director of Maternity and Clinical Director in post September 2026- to pick up leadership of this work

University Hospitals Dorset
NHS Foundation Trust

Patient Experience



Sarah Herbert
Chief Nursing Officer

Operational Leads:
Vivian Alividza – Deputy Chief Nursing Officer

Jo Sims – Associate Director Quality, Governance and Risk
Lorraine Tonge – Director of Midwifery
James Balmforth – Clinical Director
Darren Jose – Interim Care Group Director of Operations, Women's, Children, Cancer and Support Services

Committees:
Quality Committee

Performance at a Glance
Patient Experience

University Hospitals Dorset
NHS Foundation Trust

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Friends & Family Test	Sep 26	91.2%	-			93.5%	91.8%	95.2%
Complaints Received	Sep 26	82	-			84	-5	174
Complaint Response Rate (Grade Based Target)	Sep 26	21%	100%			44%	14%	73%
Mixed Sex Accommodation Breaches	Sep 26	0	-			6	-5	18

"Improve patient experience, listen and act " – Patient First breakthrough metric

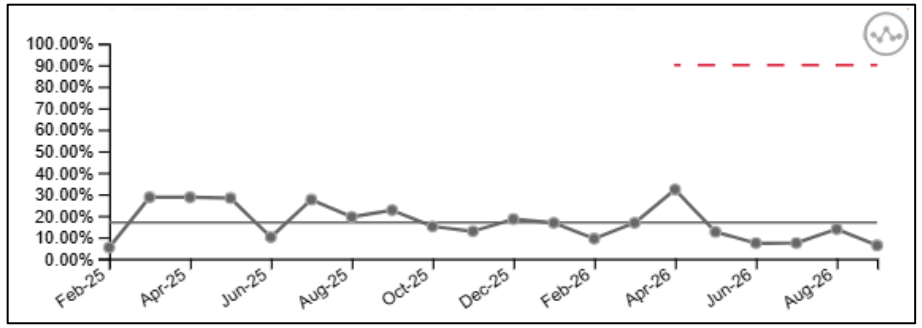
Survey Results will be reported annually

Patient Experience

University Hospitals Dorset
NHS Foundation Trust

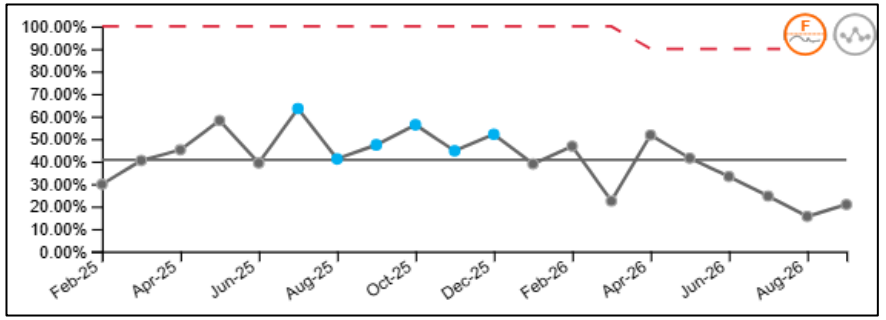
September 26
6.3%
Variance/ Assurance
Targeting (Internal)
90%
Business Rule
Verbal CMS

% of Early Resolutions closed within 10 days



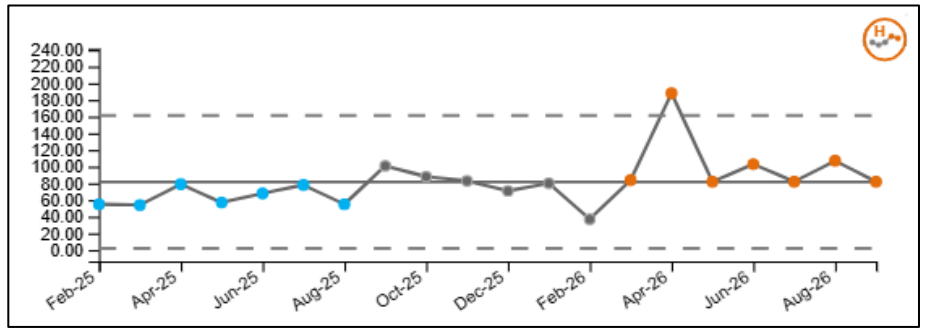
September 26
20.9%
Variance/ Assurance
Targeting (Internal)
90%
Business Rule
Full CMS

% of total complaints closed within 35 days

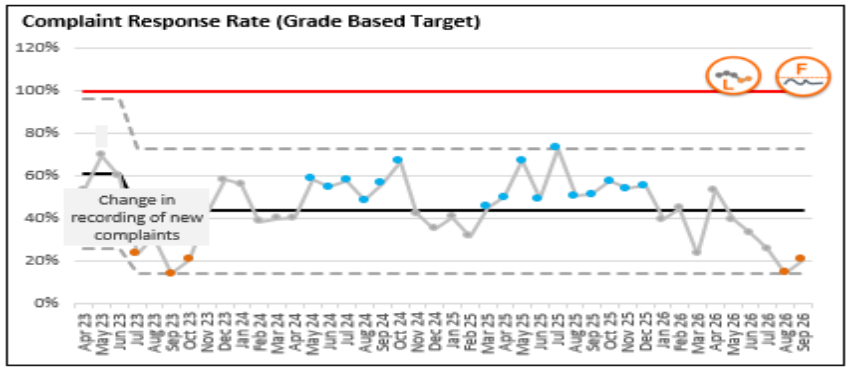


September 26
82
Variance/ Assurance
Targeting (Internal)
-
Business Rule
Verbal CMS

Number of complaints received



September 26
20.7%
Variance/ Assurance
Targeting (Internal)
-
Business Rule
Verbal CMS



Summary

Formal complaints logged - 82 September (August = 53)
Complaints closed in Sept 116 (August = 91)

Early Resolution Complaints - Early staff involvement and local resolution discussed in weekly care group meetings with clinical staff. Delays in formal summary letters as required for ERC's continue.

Average Complaint response time – 61 Days in Sept (decrease from 70 days from August)

Actions

- Maintain prompt complaint logging and strengthen early care group engagement through weekly complaints meetings, ensuring escalations are raised and addressed effectively and promptly.
- Deliver Trust-wide complaint-response training for contributors to improve response time.
- Triage all new complaints on receipt by complexity (low, moderate, high), with timescales proportionate to complexity.

Assurance & Timescale for Improvement

Complaints performance monitored through the Patient Experience Group.
Closely monitoring of the rate of reopened complaints and PSO referrals during this period of high activity.
Backlog of complaints is addressed- Historically, day one started when sent out for investigation not on receipt. (Addressing of backlog seen in April data for complaints received)
Slow but steady improvement is being made in reducing response times as seen by the uptick in the data.
Trajectory for improvement predicted by end of Q3.

University Hospitals Dorset
NHS Foundation Trust

Sustainable Services

Finance



Pete Papworth
Chief Finance Officer

Operational Lead:
Adrian Tron, Deputy Chief Finance Officer

Committees:
Finance and Performance Committee

Performance at a Glance

University Hospitals Dorset
NHS Foundation Trust

Sustainable Services

Finance

All values £'000 Driver Metric	Latest Month	In Month Plan	In Month Actual	In Month Variance	Year To Date Plan	Year To Date Actual	Year To Date Variance
Revenue Control Total	Sep-26	(2,129)	(2,156)	(27)	(13,915)	(13,877)	38
Capital Control Total	Sep-26	6,188	7,213	(1,025)	33,621	33,954	(333)
Efficiency Programme	Sep-26	3,498	3,513	15	20,984	20,958	(26)
Cash Balance	Sep-26	55,371	71,113	15,742	55,371	71,113	15,742
Better Payment Practice Code	Sep-26	95.0%	97.3%	2.3%	95.0%	96.7%	1.7%

National Oversight Metrics

1. Planned surplus or deficit: The overall level of planned surplus/deficit of the organisation for the financial year once deficit support funding has been removed
2. Variance to plan year to date: The variance between the year-to-date planned surplus/deficit and the year-to-date actual surplus/deficit

Productivity: Relative cost difference – annual
% of clinical trials set up within 90 days – Quarterly
Data Quality Maturity Index - Quarterly

"Use every pound wisely" – Patient First breakthrough metric

Financial Management – YTD Variance to budget

University Hospitals Dorset
NHS Foundation Trust

September 26
£0
Variance/ Assurance
P
Targeting (Internal)
£0
Business Rule
Verbal Update

Summary I&E	Year to date			Forecast		
	Budget	Actual	Variance	Budget	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Patient Care Income	432,974	432,522	(452)	868,021	869,932	1,911
Other Operating Income	33,463	36,389	2,926	60,619	67,565	6,946
Charitable Income	1,935	1,765	(170)	3,193	3,539	346
Total Income	**468,372**	**470,677**	**2,304**	**931,833**	**941,036**	**9,202**
Employee expenses	(319,060)	(317,912)	1,148	(629,633)	(625,148)	4,484
Clinical supplies expenses	(38,671)	(39,378)	(707)	(77,199)	(80,679)	(3,480)
Drugs expenses	(45,032)	(45,320)	(288)	(90,514)	(90,197)	316
Purchase of healthcare and social care	(8,679)	(11,229)	(2,550)	(15,889)	(19,720)	(3,831)
Depreciation and amortisation expense	(20,952)	(20,367)	584	(41,434)	(41,434)	0
Clinical negligence expense	(10,155)	(9,981)	174	(20,310)	(19,276)	1,034
Premises & fixed plant	(16,989)	(17,211)	(222)	(33,837)	(33,119)	718
Other operating expenses	(25,199)	(18,127)	7,072	(54,924)	(28,776)	26,147
Operating Expenses	**(484,736)**	**(479,525)**	**5,211**	**(963,739)**	**(938,350)**	**25,390**
Net finance costs	(7,043)	(5,161)	1,881	(14,085)	(11,232)	2,853
Other adj to control total basis	9,492	133	(9,359)	45,991	8,546	(37,445)
Control Total Surplus/ (Deficit)	**(13,915)**	**(13,877)**	**38**	**0**	**0**	**0**

September 26
£93,186
Variance/ Assurance
F
Targeting (Internal)
£93,536
Business Rule
Full CMS

Capital	Year to date			Forecast		
	Budget	Actual	Variance	Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Estate Schemes	3,950	3,345	605	18,107	18,397	(290)
IT Schemes	7,004	7,243	(239)	13,466	13,466	0
Medical Equipment	1,376	1,130	246	3,994	3,615	379
Other Central Projects	0	0	0	(1,417)	(1,328)	(89)
Total Operational CDEL	**12,330**	**11,718**	**612**	**34,150**	**34,150**	**0**
Total Donated Assets	**482**	**1,104**	**(622)**	**2,979**	**2,979**	**0**
CDC - Endoscopy Hub Build	0	0	0	0	0	0
CDC - Outpatient Assessment Centre	1,250	0	1,250	13,700	13,700	0
ESF - Estates Safety Fund (was CIR)	1,500	1,198	302	3,200	3,200	0
NHP - New Hospitals Programme - FBCA & Enab	5,400	6,894	(1,494)	8,001	8,001	0
NHP - New Hospitals Programme - FBCB	12,309	13,040	(731)	29,156	29,156	0
STPW1 - Beach Building & PH Theatres (ESL & C	0	0	0	0	0	0
UEC - Urgent Emergency Care	0	0	0	2,000	2,000	0
MHLDA - Mental Health, Learning Disability and	350	0	350	350	0	350
Total Central PDC	**20,809**	**21,132**	**(323)**	**56,407**	**56,057**	**350**
UHD Capital Total	**33,621**	**33,954**	**(333)**	**93,536**	**93,186**	**350**

Summary

I&E : At the end September, the Trust has delivered within the agreed budget, reporting a deficit of £13.9 million being £38,000 favourable to plan. The detailed forecast indicates a considerable risk, however a breakeven forecast remains achievable if all identified mitigations are delivered.

Capital : The Trust has reported total capital expenditure of £34.0 million, being £333,000 above the phased plan. The Trust is forecasting to spend £350,000 less than the available capital before the financial year-end. The underspend relates to MHLDA PDC funding which will not be spent in the current year.

Actions

I&E : The primary action is for directorates to deliver all identified efficiency schemes, to improve confidence in the savings forecast. Similarly, the Trust continues to focus on identifying further schemes and financial mitigations to off-set the current shortfall in identified savings and wider cost pressures.

Capital : The medium-term capital plan is currently being refreshed, for consideration through the Capital Management Group. Ongoing discussion with NHS England to resolve the MHLDA PDC funded item which is not expected to be spent in this year driving the current forecast underspend.

Assurance & Timescale for Improvement

I&E : Assurance over the financial performance of the Trust will continue through the Trust Management Group, supported by the Sustainable Service Group and Care Group SDR meetings.

Capital : Assurance over the delivery of the capital programme will continue through the Trust Management Group, supported by the Sustainable Service Group and Capital Management Group.

Efficiency Improvement Programme

University Hospitals Dorset
NHS Foundation Trust

September 26
62%
Variance/ Assurance

Targeting (Internal)
100%
Business Rule
Full CMS

	Actual cash Releasing (£000's)			Forecast Cash Releasing (£000's)						Forecast Recurrent Cash releasing (£000's)			
	Year to date			Risk Adjusted			Risk adjusted	Non risk adjusted	Non-Risk adjusted	Risk Adjusted			Risk adjusted
Care Groups	Target	Actual	Variance	Target	Forecast	Variance	% of target	Forecast	% of target	Forecast	FY Impact	Variance	% of target
Surgical	(5,676)	5,255	(421)	(11,534)	9,107	(2,427)	79%	9,997	87%	4,219	2,351	(4,965)	57%
Medical	(6,971)	3,326	(3,645)	(13,942)	5,258	(8,684)	38%	7,497	54%	2,270	293	(11,379)	18%
WCCSS	(5,811)	3,441	(2,370)	(11,644)	7,060	(4,584)	61%	7,343	63%	5,321	211	(6,112)	48%
Operations	(1,175)	969	(206)	(2,382)	1,605	(777)	67%	2,044	86%	539	313	(1,531)	36%
Corporate	(1,351)	2,642	1,290	(2,702)	4,395	1,693	163%	4,415	163%	2,022	0	(681)	75%
Trust Wide	0	5,325	5,325	(26,295)	15,318	(10,977)	58%	16,917	64%	3,991	201	(22,103)	16%
UHD	**(20,984)**	**20,958**	**(26)**	**(68,500)**	**42,742**	**(25,757)**	**62%**	**48,213**	**70%**	**18,360**	**3,369**	**(46,770)**	**32%**
Opportunities								3,791	6%				
UHD	**(20,984)**	**20,958**	**(26)**	**(68,500)**	**42,742**	**(25,757)**	**62%**	**52,005**	**76%**	**18,360**	**3,369**	**(46,770)**	**32%**

Summary

At the end of September, the Trust has delivered efficiency savings of £21.0 million being £26,000 behind the phased plan. The trust has identified savings opportunities of £52.0 million; however, this is reduced to £42.7 million when adjusted to reflect the risk of delivery in year. This position continues to improve month on month but remains significantly short of the full year savings target.
The recurrent delivery within this represents a significant medium term sustainability risk for the Trust. The MTFP assumed 60% recurrent efficiencies, but at 32% delivery currently, this is a £19.4 million medium term risk if this performance does not improve.

Actions

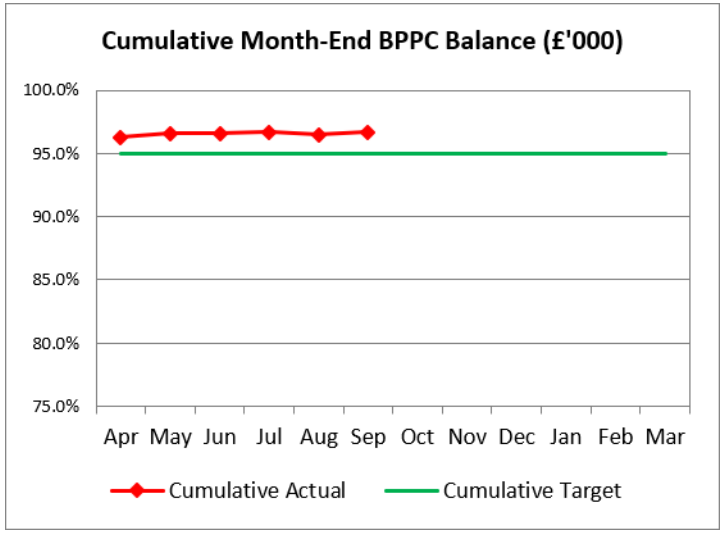
The Trust has strong governance in place in relation to its Efficiency Improvement Programme and has received external assurance over this. The current focus is to identify additional schemes to deliver the 2026/27 savings requirement in full, whilst simultaneously progressing the identified schemes through the gateway process to reduce the risk adjustment. Additional weekly EIP checkpoints have been instigated with Care groups to ensure timely support and escalation is in place.

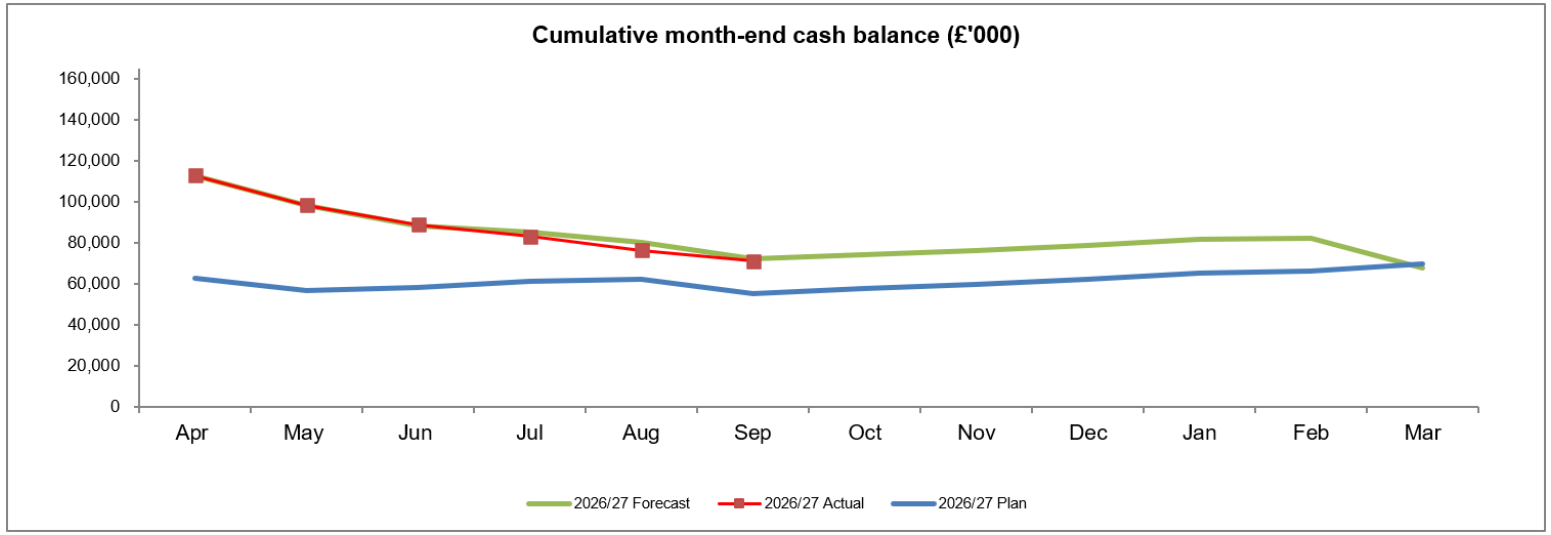
Assurance & Timescale for Improvement

Monitoring of improvements in the identification and delivery of efficiency schemes will continue weekly through the executive team meeting and monthly through Care Group SDR meetings, the Sustainable Services Group and Trust Management Group.

Working Capital

University Hospitals Dorset
NHS Foundation Trust





Summary	Actions	Assurance & Timescale for Improvement
Public Sector Payment Policy : In relation to the timely payment of supplier invoices, the Trust is delivering performance of 96.7%, above the national standard of 95%.	**Public Sector Payment Policy :** This remains a key focus for the Trust, with training and support being offered to budget holders where appropriate.	**Public Sector Payment Policy :** Performance will continue to be monitored and assured through the Sustainable Services Group.
Cash : At the end of September, the Trust is holding a consolidated cash balance of £71.1 million. After adjusting for the £22.0 million of capital payables, this represents 19 days of operating expenditure and an underlying cash balance of £49.0 million. This remains above the planned level due to additional funding, increased capital creditors and continued rigour in the Trusts payment processes.	**Cash :** The cash forecast is currently being refreshed to reflect the additional income and the expected timing of payments.	**Cash** : The cash forecast will continue to be reviewed and updated on a monthly basis.

We are caring one team listening to understand open and honest always improving inclusive

Data Quality Maturity Index

National Oversight Framework metric - Scored

University Hospitals Dorset
NHS Foundation Trust

Data Quality Maturity Index (DQMI) - Provider DQMI Values

NHS England

Select an Organisation Type, Provider or Reporting Period below.

Org Type: All

Provider Name and code: UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST (R0D)

Reporting Period: July 2026

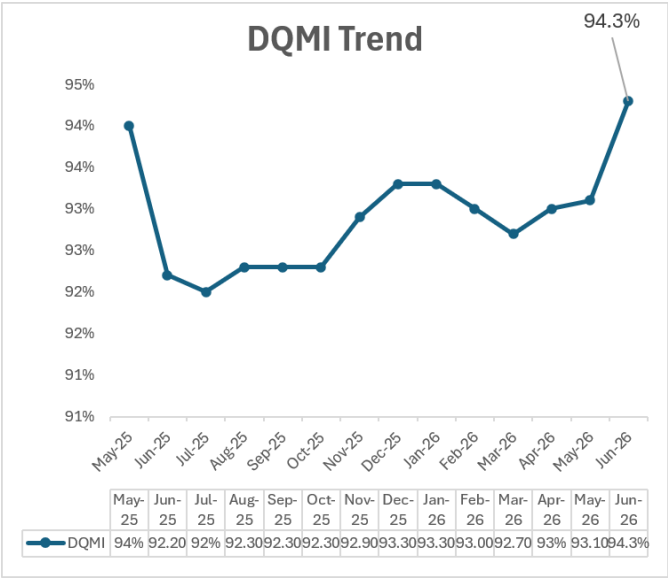
Each tile below shows the dataset DQMI scores and the overall 'DQMI Score (%)' for the provider selected. The standard DQMI is the official score. The experimental DQMI incorporates additional fields for potential future inclusion in the standard DQMI score, to model the impact their inclusion would have on a providers official DQMI score.

	APC (%)	CSDS (%)	DID (%)	ECDS (%)	IAPT (%)	MHSDS (%)	MSDS (%)	OP (%)	WLMDS (%)	DQMI Score (%)
Standard	99.7			88.5			100.0	97.3	-	94.3
Experimental		CSDS (%)			IAPT (%)	MHSDS (%)			WLMDS (%) 97.1	DQMI Score (%) 95.1

Provider Data Set Score >= National Data Set Score

Provider Data Set Score < National Data Set Score

Provider Data Set Score < 50



Summary	Actions	Assurance & Timescale for Improvement
This metric is a new addition to the National oversight framework for 2026/27 within the Innovation section. The dataset submissions that make up the overall score are : • Admitted Care (inpatient and daycase) (99.7%) • Emergency care (ED) (88.5%) • Maternity (100%) • Outpatients (97.3%) Noting all remain above the national average benchmark, but the ED dataset is currently the lowest scoring.	This metric and its drivers are presented and discussed at the monthly Data Quality meeting to ensure any areas falling short of the national score are identified and addressed.	

% of clinical trials set up within 90 days

University Hospitals Dorset
NHS Foundation Trust

September 26
75%
Variance/ Assurance
Target (national)
80%
Business Rule
Target not achieved

National Oversight Framework metric - Scored

90 day metric (site selected to first patient first visit (FPFV)

Trust name	Trust code	Studies that reported FPFV at the	Studies with FPFV within 90 days	Studies with FPFV after 90 days	Median days - to first partipant first visit (in days)
University Hospitals Dorset NHS Foundation Trust	RØD	12	8	4	65.5
Totals		12	8	4	65.5

Summary	Actions	Assurance & Timescale for Improvement
This metric is a new addition to the National oversight framework for 2026/27 within the Innovation section. Current performance is 75% ytd (70% last month)against the national target is 80%. UHD perfomance is ranked 2nd in SW region (most recent data) In terms of NOF segmentation , only organisations with a result greater than or equal to 95% receive a score of 1.00, all organisations with a result lesser than 80% receive a score of 4.00. Within the SW region all but 2 trusts scored 4. This metric can be broken down into 2 parts 1. 60 days to confirmation of capacity (agreement to take on study from date of site selection) • Performance is currently 100% against a national target 80% 2. 30 days (from opening to first patient first visit) main driver to improve the 90 day metric • Performance is currently 58.3% against a national target 80%		

University Hospitals Dorset
NHS Foundation Trust

Sustainable Services

Digital



Beverley Bryant
Chief Digital Officer

University Hospitals Dorset
NHS Foundation Trust

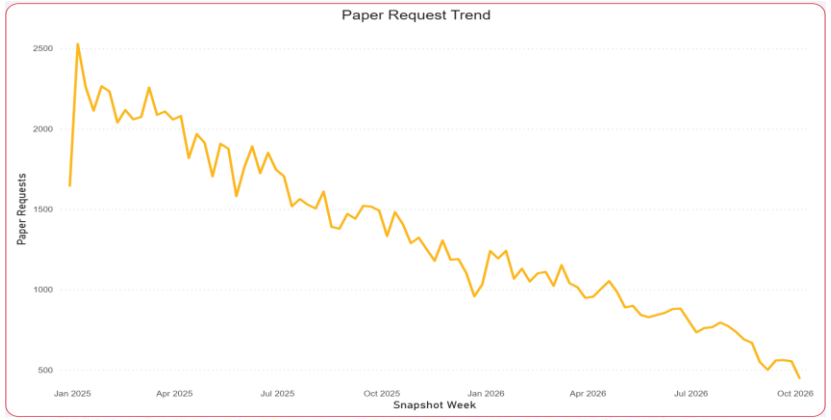
Digital : Outpatient Transformation & Care Coordination

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
DNA rate against SMS sent	Target needs to be defined - need to review all work related to DNA rate and impact of Dr Doctor							
Digital letters vs paper	Target for all patient letters to go via Synertec so 100% for that but then this is patient choice for Digtial vs Paper							
Uptake of 'Advice & Guidance'		100%			This is to monitor move of A&G to Consultant Connect			
ICE for Ordering vs paper	99.5%	95%	Oct 26		This is the current number of electronic requests.			
ICE results acknowledgement	56.1%	90%	Oct 26		This is the ICE filing position			
No. of attendances streamed away via NHS S&R tool	Target for this to be calculated as many different measures in this space							

ICE Filing

Target	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26
						95.0%	95.0%	95.0%	95.0%	95.0%

Break Level 1	Break Level 2	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26
Total		58.8%	60.6%	61.5%	61.2%	60.8%	60.9%	61.1%	60.8%	60.5%	56.1%
0	Total	58.8%	60.6%	61.5%	61.2%	60.8%	60.9%	61.1%	60.8%	60.5%	56.1%
	0	58.8%	60.6%	61.5%	61.2%	60.8%	60.9%	61.1%	60.8%	60.5%	56.1%



Digital

Summary	Actions	Assurance & Timescale for Improvement
DNA rate (5.8% Sept 2026) is within the process control limits, along with the target (5%) and mean indicating that it is achievable. Performance demonstrates common cause variation.	Ongoing roll out of Dr Doctor functionalities to support scheduling is taking place. Integration between the Cardiology booking system (Tomcat) and Dr Doctor was achieved in May to further extend the reach of digital appointment reminders. Appointment reminders for admissions has also launched in Gynaecology in July 2026. A targeted relaunch of the DNA predictor in Dr Doctor is taking place from October 2026.	DNA and A&G rates are part of a suite of metrics monitored at the Programme Board of the Outpatient Improvement (Corporate) Programme.
Digital Letters Vs Paper – initial scoping has identified opportunities to increase the availability of patient letters digitally. Admin workflow mapping is underway alongside an analysis of postage and printing spend.	Ongoing review of the use of Synertec / Dr Doctor for the progress of electronic letters. Some elements will need letters to be redesigned / updated as part of the programme.	This is a project under Transforming and Valuing Administration.
Advice & Guidance is the adoption of Consultant Connect as the new process for A&G and referral management through ERS. All appropriate specialties are now live with consultant connect for A&G and 2 are live with advice and refer ahead of the transition to 10 services having single points of access (SPOA) in place by October 2026.	Deliver the Single Point of Access programme by October 2026; System wide programme governance is now established.	All specialties are now live and therefore this Project will be closed as complete and moved to Business as Usual. Outpatient transformation to now look at SPOA and impact of that.
ICE Ordering and Results Acknowledgement – Task & Finish group is now agreeing the Trust wide roll out of electronic requesting on ICE to further support increased adoption of results sign off with accuracy of requesting.	The Patient First dashboard is now live as is the report to monitor paper requesting so this can be monitored and tracked by Care Group. Paperless requesting has now been supported by the Trust with the exception of Blood Transfusion and Histopathology and is now part of the SDR monitoring.	Paperless requesting is now live for pathology requesting and 99.5% of all requests are done electronically. However, ICE filing still remains low for the month at only 56.1%. It has been agreed for an auto file to take place but this will not impact the monthly figure. This needs ongoing monitoring in the care groups.
No of Attendances Streamed away via NHS S&R Tool – need to clarify the metrics we intend to monitor for this change.	No further actions other than the tracking on metrics when this data is available.	Fully live and in business as usual.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **7.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Trust Constitution
Prepared by:	Leonora May, Director of Corporate Governance
Presented by:	Leonora May, Director of Corporate Governance
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Decision/Approval
Executive summary:	The Trust is currently facing a number of changes to the composition of the Council of Governors, including existing vacancies and the expiry of a significant number of governor terms on 31 December 2026. At the same time, there remains uncertainty regarding the future role of NHS Foundation Trust governors. In response, the Council of Governors has considered a range of options to maintain the effectiveness, continuity and stability of the Council whilst taking a pragmatic approach to governance arrangements and avoiding elections where suitable alternatives are available. At its October 2026 meeting, the Council of Governors approved a package of measures to address current and anticipated vacancies and to support continuity of governor engagement. The Council also approved a proposed amendment to the Trust Constitution to enable the appointment of co-opted governors in exceptional circumstances, subject to approval by the Board of Directors. The purpose of this report is to seek Board approval for the proposed constitutional amendment.
ALERT:	The Trust currently has one vacant public governor position and one vacant staff governor position with remaining term which can be filled. In addition, the term of office of one appointed governor, two staff governors and six public governors will expire on 31 December 2026.

	Collectively, these changes have the potential to significantly reduce the experience, organisational knowledge and capacity of the Council of Governors. The Council of Governors considered this position in the context of broader national developments. Whilst no legislative changes have yet been enacted, the Government's stated intention to abolish Councils of Governors creates uncertainty regarding the future operating environment. The Council therefore considered that a proportionate and pragmatic response was required to maintain the effectiveness of the Council whilst minimising the resource and cost associated with holding multiple elections over a potentially short timeframe. A constitutional amendment is required if the Trust wishes to introduce the ability to appoint co-opted governors following the expiry of a governor's term of office.
ASSURE:	At its October 2026 meeting, the Council of Governors Part 1 Meeting approved a broader package of actions designed to maintain the resilience and effectiveness of the Council. These included: • Inviting the next highest polling candidate from the most recent non-clinical staff governor election to fill the current staff governor vacancy. • Inviting the next highest polling candidate from the most recent Bournemouth public governor election to fill the current public governor vacancy. • Seeking confirmation regarding appointment or reappointment to the appointed governor position from BCP Council. • Offering governors whose terms expire on 31 December 2026 the opportunity to continue contributing to the work of the Council on a co-opted basis, subject to approval of a constitutional amendment. The Council considered that these actions represent a pragmatic and proportionate approach which supports continuity, preserves valuable experience and organisational memory, and enables the Council to continue to discharge its statutory duties effectively whilst broader national policy developments become clearer. The Council of Governors approved the proposed constitutional amendment at its October 2026 meeting and recommended that the amendment be presented to the Board of Directors for consideration and approval. The intention of the co-opted governor arrangement is to provide a way of retaining valuable knowledge, experience and continuity at a time when a significant number of governor terms are due to end. This would help support the induction of new governors and enable the Council to continue to operate effectively during a period of considerable change and uncertainty. Whilst co-opted governors would be able to attend Council meetings, contribute to discussions and continue to support the work of the Council, they would not be elected or appointed governors and would not have any voting rights. They would therefore provide advice, experience and continuity, rather than

	forming part of the Council's formal decision-making membership. The Council considered that this strikes an appropriate balance between maintaining continuity and preserving the integrity of the governor election and appointment arrangements set out in the Constitution.
ADVISE:	The Board is asked to approve an amendment to Section 13 of the Trust Constitution through the addition of the following new provision: **13.10 In exceptional circumstances, where the Council of Governors and Board of Directors consider it to be in the best interests of the Trust, and to support the effective functioning of the Council of Governors, a Governor whose term of office has ended may be appointed as a Co-opted Governor for a maximum period of 12 months or until the statutory abolition of the Council of Governors via the Health Bill, whichever is sooner.** The proposed amendment would provide the Trust with additional flexibility to maintain an effective Council of Governors during a period of significant turnover and uncertainty. Any use of the provision would be time limited, would require consideration by both the Council of Governors and the Board of Directors, and would not alter the Trust's existing arrangements for governor elections and appointments.
Celebrating Outstanding:	N/A
RECOMMENDATION:	The Board is asked to **approve** an amendment to Section 13 of the Trust Constitution through the addition of the following new provision: *13.10 In exceptional circumstances, where the Council of Governors and Board of Directors consider it to be in the best interests of the Trust, and to support the effective functioning of the Council of Governors, a Governor whose term of office has ended may be appointed as a Co-opted Governor for a maximum period of 12 months or until the statutory abolition of the Council of Governors via the Health Bill, whichever is sooner.* The Board is asked to **approve** the appointment of elected governors whose terms end on 31 December 2026 as co-opted governors.
Implications associated with this item:	Council of Governors ☒ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☐

CQC Assessment Framework:		
	Safe	☐
	Effective	☐
	Caring	☐
	Responsive	☐
	Well-Led	☒
	Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Council of Governors	30/10/2026	Approved change to the Trust's Constitution
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: Corporate Governance Team to insert agenda item number

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Establishment of Strategy and Transformation Committee
Prepared by:	Leonora May, Director of Corporate Governance
Presented by:	Leonora May, Director of Corporate Governance
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	BAF- **Transforming Care Together** Corporate Risk Register- **2339 Risk of delays to the April 2027 planned reconfiguration date and creation of the Planned and Emergency Hospitals**
Purpose of paper:	Decision/Approval
Executive summary:	This paper seeks Board approval to establish a **Strategy and Transformation Committee** as a formal sub-committee of the Board of Directors. The proposal reflects the increasing breadth and complexity of the Trust's strategic transformation agenda and is intended to strengthen Board oversight of strategic delivery, major transformation programmes and key enabling strategies. The proposed Committee will provide dedicated scrutiny and assurance in relation to delivery of the Trust's strategy, transformation portfolio, strategic partnerships, digital transformation, estates strategy, sustainability and other enabling programmes. It will bring together strategic and transformational oversight within a single Board committee, providing a more integrated approach to monitoring delivery of the Trust's long-term objectives. The proposal represents the evolution of existing governance arrangements rather than the creation of a new layer of governance. As the Trust's strategic transformation agenda has matured, it is appropriate that oversight transitions from a programme steering group to a formal Board committee, providing enhanced accountability, Board assurance, clarity of delegated responsibilities and alignment with the Trust's wider committee structure. It is proposed that the Committee assumes responsibility for matters currently overseen by the Transforming Care Together

	Steering Group and that the Steering Group is subsequently disbanded. In addition, oversight of digital, estates and other strategic enabling programmes would transfer from the Finance and Performance Committee to the new Committee. This would enable the Finance and Performance Committee to maintain greater focus on delivery of the Trust's financial plans, operational performance and financial sustainability. The proposal is consistent with the Trust's Standing Orders, which permit the Board to establish committees, determine their membership and terms of reference, and amend committee arrangements as necessary to support the discharge of its responsibilities. To support continuity during the final stages of the Transforming Care Together programme and delivery of the Phase 3 moves, it is proposed that the Committee's membership broadly reflects the existing Transforming Care Together Steering Group arrangements and that the Committee is initially chaired by the Trust Chair. Recognising that governance arrangements should evolve in line with organisational priorities, it is proposed that the Committee's membership, remit and chairing arrangements are reviewed in May 2027 following completion of the Phase 3 moves and the embedding of the new governance structure. The review will consider whether the Committee's membership, chairing arrangements and delegated responsibilities remain appropriate for the next phase of the Trust's strategic development. **Supporting Appendices** • **Appendix 1** – Strategy and Transformation Committee Terms of Reference • **Appendix 2** – Revised Finance and Performance Committee Terms of Reference The Finance and Performance Committee has reviewed and supported the proposed amendments to its Terms of Reference and Governance Cycle. The governance cycle for the proposed Strategy and Transformation Committee has been developed to align with its delegated responsibilities and will be submitted to the Committee for approval at its inaugural meeting.
ALERT:	The Board is asked to note that the Trust's strategic transformation agenda continues to expand, encompassing delivery of the Trust Strategy, major transformation programmes, digital transformation, estates development, strategic partnerships and system working. Whilst oversight of these areas currently exists through a combination of governance forums, there is no dedicated Board committee with specific responsibility for providing integrated oversight of the Trust's strategic and transformation programmes. The breadth of matters currently considered by the Finance and Performance Committee can also reduce the time available for focused consideration of financial and operational performance. As the Trust enters a critical period of strategic delivery, including completion of the Transforming Care Together programme, there is an opportunity to align governance arrangements more closely with the Board's strategic priorities.

ASSURE:	The Trust's Standing Orders provide the Board with authority to establish committees, determine their membership and approve their terms of reference. Standing Orders further provide for the establishment of additional committees where required to support the discharge of the Board's responsibilities and allow the Board to revise its committee structure without amendment to the Standing Orders. The proposed Strategy and Transformation Committee has been designed to provide clear lines of accountability and assurance to the Board. The Committee will be accountable to the Board of Directors, provide regular reporting on its activities and maintain oversight of strategic risks within its remit, supporting the Board's consideration of the delivery of strategic objectives and the associated Board Assurance Framework risks. The proposed Terms of Reference establish a clear scope of responsibility for oversight of strategy, transformation, digital, estates and strategic partnership activity, whilst maintaining appropriate interfaces with the Board's other assurance committees. A draft governance cycle has also been developed for the Committee, aligned to its Terms of Reference and areas of delegated responsibility. This will provide a structured programme of business to ensure that all aspects of the Committee's remit are considered throughout the year and will be presented to the Committee for approval at its inaugural meeting. Consequential amendments have been made to the Terms of Reference and governance cycle of the Finance and Performance Committee to reflect the transfer of digital, estates and transformation oversight to the proposed Strategy and Transformation Committee. These changes have been reviewed and supported by the Finance and Performance Committee, which recommends their approval by the Board. The proposed arrangements preserve continuity of oversight during delivery of the Transforming Care Together Phase 3 programme by retaining membership that reflects current transformation governance arrangements and by initially appointing the Trust Chair as Committee Chair. The Terms of Reference also include provision for periodic review of the Committee's effectiveness and remit.
ADVISE:	The first meeting of the new committee is scheduled to be held at the end of November 2026.
Celebrating Outstanding:	NA
RECOMMENDATION:	The Board is asked to **approve** the establishment of the Strategy and Transformation Committee as a formal sub-committee of the Trust Board, and: - **Approve** the membership and terms of reference for the Strategy and Transformation Committee - **Approve** the transfer of responsibilities for strategic transformation, digital, estates and associated enabling programmes to the Strategy and Transformation Committee, as set out within the proposed Terms of Reference

	- **Approve** the revised terms of reference of the Finance and Performance Committee - **Approve** the disbanding of the Transforming Care Together Steering Group - **Support** a review of the Strategy and Transformation Committee membership and arrangements during May 2026, to ensure that the committee remains aligned to priorities
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☒ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☐ Regulatory ☐ Strategy/Transformation ☒ System ☐
CQC Assessment Framework:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well-Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Board Part 2	14/10/2026	The Board supported the establishment of the committee.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

University Hospitals Dorset
NHS Foundation Trust

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Strategy and Transformation Committee

DOCUMENT DETAILS

Author:	Leonora May Klaudia Zwolinska
Job Title:	Director of Corporate Governance Deputy Company Secretary
Signed:	
Date:	11/11/2026
Version No: (Author Allocated)	1
Next Review Date:	17/11/2027

Approving Body/Committee:	Board of Directors
Chair:	Judy Gillow
Signed:	
Date Approved:	11 November 2026
Target Audience:	Board of Directors

Document History					
Date of Issue	**Version No:**	**Next Review Date:**	**Date Approved:**	**Person responsible for Change**	**Nature of Change**
November 2026	1	November 2027	11 November 2026	Director of Corporate Governance	Terms of Reference for newly established Committee

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TERMS OF REFERENCE

COMMITTEE NAME:	**Strategy and Transformation Committee**
PURPOSE *(1.2)*:	The Strategy and Transformation Committee exists to support the Trust in achieving its strategic objectives and long-term ambitions. The Committee provides focused assurance, scrutiny and advice to the Board on the development, alignment, delivery and evaluation of the Trust Strategy, the Trust transformation portfolio and the key enabling strategies that support delivery. It ensures appropriate alignment with national, regional and system priorities, including the NHS 10 Year Health Plan and Integrated Care Board strategy, and undertakes strategic horizon scanning. Its remit includes the UHD five year strategy and its enabling strategies, strategic partnerships, digital and estates. The Committee also oversees Trust's contribution to working with system partners to deliver for the population, major transformation programmes including the New Hospital Programme, and provides assurance on digital transformation, artificial intelligence, cyber security and digital resilience, estates compliance and assurance, and strategic sustainability initiatives. The Committee makes recommendations and escalates issues to the Board in line with its delegated authority.

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RESPONSIBILITIES *(2.1)*:	The Committee is responsible for the following:
	
	Strategy and strategic objectives
	• Review and scrutinise the development and periodic refresh of the Trust Strategy before recommendation to the Board.
	• Monitor progress against the Trust Strategy and Board-approved strategic objectives.
	• Review the proposed key strategic objectives for the financial year ahead and make recommendations to the Board.
	• Assess whether the Trust's enabling strategies remain aligned with the Trust Strategy and with each other.
	• Ensure the Trust Strategy and transformation priorities remain aligned with relevant national, regional and system priorities, including the NHS 10 Year Health Plan and ICB strategy.
	• Undertake strategic horizon scanning and advise the Board on material opportunities, risks and implications.
	
	Transformation
	• Oversee the Trust's strategic transformation portfolio, including the New Hospital Programme and associated organisational transformation.
	• Receive assurance on programme scope, milestones, dependencies, benefits, risks and delivery.
	• Monitor whether transformation programmes are aligned with the Trust Strategy and are supported by appropriate clinical, workforce, quality, digital, estates, financial, communications and engagement plans.
	• Escalate significant barriers, interdependencies and strategic risks to the Board.
	
	Oversight of key enabling strategies:
	• Oversight of the development and delivery of the:
	  ○ Digital Strategy
	  ○ Sustainability Strategy (Green Plan)
	  ○ Estates Strategy and Masterplan
	  ○ Bournemouth University Partnership Strategy.
	
	Digital, technology and innovation
	• Monitor delivery of the HealthSet Programme and its contribution to strategic transformation.
	• Receive assurance on the governance, implementation and strategic use of artificial intelligence.
	• Receive assurance on cyber security and digital resilience, including risks that may affect strategic delivery.
	• Consider whether digital programmes and technology investments are aligned with the Trust Strategy and transformation priorities.
	
	Estates
	• Oversee the strategic direction and delivery of the Estates Strategy and Masterplan.
	• Receive assurance through estates compliance reporting and the Premises Assurance Model.

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	• Consider estates implications and dependencies of major transformation programmes. • Review strategic estates risks and escalate significant concerns to the Board or relevant committee. **Partnerships** • Oversee the strategic development of the Trust's partnership with Bournemouth University. • Consider other strategic partnerships where these support the Trust Strategy and transformation priorities. **Risk management and assurance** • Review the Board Assurance Framework and risk register for risks within the Committee's remit. • Monitor strategic and programme risks, mitigations and interdependencies. • Seek assurance that material risks are appropriately owned, controlled and escalated. • Refer financial, operational, quality, workforce or audit matters to the relevant Board committee where these fall outside the Committee's principal remit. **Governance and effectiveness** • Approve and monitor the Committee governance cycle. • Review the Committee's effectiveness annually and agree improvement actions. • Prepare an annual report to the Board describing how the Committee has discharged its responsibilities. • Review these Terms of Reference annually and recommend any amendments to the Board.

MEMBERS *(3.1):*	Membership of the Committee comprises:
	• Chair (who must be a Non-Executive Director)
	• Chairs of:
	  ○ Finance and Performance Committee,
	  ○ Quality Committee, People and Culture Committee, and
	  ○ Audit Committee
	• Chief Executive Officer
	• Chief Strategy and Transformation Officer
	• Chief Operating Officer
	• Chief Finance Officer
	• Chief Nursing Officer
	• Chief People Officer
	• Chief Digital Officer
	• Chief Medical Officer
		STANDING ATTENDEES *(3.2):*	Standing attendees:
			• Medical Director for Transformation
			• Director of Integration
			• Director for Transformation

CHAIR (*3.3*):	The Committee will be chaired by the Chair of the Board.	**DEPUTY CHAIR *(3.3)*:**	A Non-Executive Deputy Chair should be nominated. In the absence of the Committee Chair and/or any appointed Deputy, the remaining members will elect one of the Non-Executive Directors present to chair the meeting.	**SECRETARY *(5.5)*:**	The **Director of Corporate Governance or** their nominee will be responsible for preparing minutes and updating action log
MEETING TIMING (FREQUENCY AND DURATION) *(5.1)*:	Meetings will normally be held **bi-monthly**, six times per year, with additional meetings scheduled as required.		**QUORUM *(5.2)***	Meetings will be quorate if at least **three members** are present, which will include: • two Non-Executive Directors • one Executive Director or their deputies.	
ACCOUNTABLE TO: (the Accountable Group) *(6)*	The Committee is accountable to the Board of Directors		**REPORTING GROUPS *(6.5)*:**	The Committee will refer to the Audit Committee, Charitable Funds Committee, Finance and Performance Committee, Quality Committee, People and Culture Committee any matters requiring review or decision in such forum(s). For the avoidance of doubt: • People and Culture Committee will have oversight of the development by the Trust of an effective staff structure and workforce operating model across the organisation; • Quality Committee will have oversight of quality and	

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			safety issues including private patient care as part of the quality governance process • The Finance and Performance Committee will have oversight of the financial (capital and revenue) plans, and the operational performance; The Committee will receive reports from sub-groups of the Trust Management Group (including the Build Ready, Service Ready, People Ready and Digital Demand highlight reports). The Group shall also receive, from time to time, such reports from such sub-groups as it may require to provide it with assurance relating to matters within the scope of the Group's responsibilities.

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UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

TERMS OF REFERENCE

1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 The purpose of the Committee and how it will achieve its purpose is as set out above.

1.3 The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. RESPONSIBILITIES

2.1 The responsibilities of the Committee are set out above.

3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Committee is set out above.

3.2 Standing attendees are set out above. In addition, other individuals may be invited to attend with agreement of the Chair (or in their absence the Deputy Chair).

3.3 The Committee will be chaired by the role holder above. A Deputy Chair may be nominated. In the absence of the Chair and/or an appointed Deputy Chair, the remaining members shall elect another member to present to chair the meeting (which, in the case of a Board Committee shall be a Non-Executive Director).

3.4 Subject to paragraph 3.2 above, only members of the Committee have the right to attend meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting. (In the case of a Board Committee, a deputy will not have voting rights at the meeting). The Chair or other person chairing the meeting may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

3.5 Committee members should aim to attend all scheduled meetings but in any event are expected to attend a minimum of three quarters of all meetings. For the purposes of calculating attendance, a deputy attending on behalf of a member shall not count towards the members' attendance. A record of members' attendance shall be maintained.

4. AUTHORITY

4.1 The Committee is authorised to approve its governance cycle.

4.2 This paragraph 4.2 applies to Board Committees/Groups. The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference.

4.3 This paragraph 4.3 applies to Board Committees/Groups. The Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

4.4 This paragraph 4.4 applies to Board Committees/Groups The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

5. CONDUCT OF BUSINESS

5.1 The Committee will normally meet at the frequency set out above and at such other times as the Chair shall require.

5.2 Meetings of the Committee will be quorate if there are at least the members present set out above for a quorum.

5.3 If a meeting of the Committee is inquorate, then the meeting can progress if those present determine. However, no business shall be transacted.

5.4 Meetings of the Committee will be called by the Secretary at the request of the Chair. The Secretary of the Committee will be as stated above.

5.5 The Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Committee Chair. The Secretary (or their nominee) shall collate and circulate papers to Committee members. Unless otherwise agreed by the Committee Chair, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

5.6 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee at the next meeting.

5.7 Committee business may be transacted through virtual media (including, but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair shall be responsible for determining that the meeting is quorate.

5.8 Proceedings and decisions made will be recorded in the form of minutes or notes (as specified above), which will be submitted to the next meeting of the Committee for approval.

5.9 Members will be expected to conduct business in line with the Trust's values and objectives.

6. RELATIONSHIPS AND REPORTING

6.1 The Committee will be accountable to the group set out above (the Accountable Group), to whom it shall make recommendations in relation to issues that require decision or resolution.

6.2 The Committee will present a report summarising the proceedings of each of its meetings at the next meeting of the Accountable Group. For the avoidance of doubt, where practicable, this shall be a written report, with a verbal update being provided as necessary.

6.4 The Committee may refer to the other groups specified above any matters requiring review or decision in such forum(s).

6.5 The Committee will receive reports from the Reporting Groups set out above..

7. MONITORING

7.1 Attendance will be monitored at each Committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 This paragraph 7.2 applies to Board Committees. The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Accountable Group detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate.

8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee will be reviewed at least every three years.

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APPENDIX A

ATTENDANCE AT COMMITTEE MEETINGS

NAME OF [Amend as appropriate: **COMMITTEE/**	[Insert name of Committee]											
Present (*include names of members present at the meeting)*	**Meeting Dates**											
In Attendance												
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)												

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TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Finance and Performance Committee

DOCUMENT DETAILS

Author:	Klaudia Zwolinska
Job Title:	Deputy Company Secretary
Signed:	
Date:	11/11/2026
Version No: (Author Allocated)	2.0
Next Review Date:	10/11/2027

Approving Body/Committee:	Board of Directors
Chair:	Judy Gillow, Interim Chair
Signed:	
Date Approved:	November 2026
Target Audience:	Board of Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Person responsible for Change	Nature of Change
March 2026	1	March 2027	11 March 2026	Director of Corporate Governance	New Terms of Reference template
November 2026	2	November 2027	11 November 2026	Director of Corporate Governance	The revisions ensure that the Finance and Performance Committee retains oversight of financial sustainability, operational performance and productivity, while strategic development, transformation and major change, digital and estates

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					will fall within the remit of the Strategy and Transformation Committee

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TERMS OF REFERENCE

COMMITTEE NAME:	Finance and Performance Committee
PURPOSE *(1.2)*:	The Finance and Performance Committee exists to support the Trust in achieving its strategic objectives: *See our patients sooner* and *use every NHS pound wisely.* The Committee provides focused assurance, scrutiny and advice to the Board on financial planning and sustainability, operational performance, productivity and efficiency, capital programme delivery, procurement performance and the financial and operational delivery of approved plans. The Committee scrutinises the affordability and financial consequences of strategies, transformation programmes and major investments. Strategic direction and the development and alignment of the Trust Strategy, transformation portfolio and key enabling strategies are overseen by the Strategy and Transformation Committee. The Committee makes recommendations and escalates issues to the Board, in line with its delegated authority.
RESPONSIBILITIES *(2.1)*:	The Committee is responsible for the following: **Strategic Objectives and Annual Planning** • Receive annual confirmation of the strategic objectives and breakthrough initiatives delegated by the Board and monitor the financial and operational contribution to their delivery. • Review and recommend the Annual Operating Plan and associated financial, operational, workforce and activity assumptions to the Board. • Monitor delivery of the Annual Operating Plan, identifying material variances, barriers and recovery actions. **Statutory Requirements** • Review the draft Annual Report and Accounts with the Audit Committee and recommend the final version to the Board following external audit. **Financial Planning and Reporting** • Review and recommend annual, medium-term and long-term financial plans, including capital investment, borrowing and financial risks. • Scrutinise revenue and capital budgets, tenders and business cases above delegated limits. • Monitor financial performance, variances, financial controls, cash flow, efficiency targets and capital programme delivery. • Obtain assurance on the Trust's financial sustainability and compliance with applicable financial requirements • Review the quality and timeliness of financial, operational and analytical information. **Operational Performance** • Monitor performance against constitutional standards, NHS England requirements and Board-approved operational plans.

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	• Review Care Group-level delivery, productivity, performance trajectories and recovery plans. • Monitor patient flow, access and other operational performance measures within the Committee's governance cycle. • Review the quality and timeliness of operational performance information. **Productivity, efficiency and benefits realisation** • Review and recommend the Productivity and Efficiency Plan. • Monitor delivery of productivity, efficiency and cost improvement requirements. • Receive assurance on the financial and operational realisation of benefits arising from transformation, integration and service change. **Commercial, Procurement and Private Patients** • Oversee the Trust's commercial, procurement and private patient activities, ensuring alignment with approved financial and operational plans. • Review and monitor the delivery of the One Dorset Procurement Strategy, including associated performance, financial benefits, value for money and risks. • Monitor commercial and procurement performance, including financial contribution, contract delivery and associated risks. • Receive assurance on the performance, development and governance of private patient services, including income delivery and compliance with applicable requirements. **Risk Management** • Review Board Assurance Framework risks allocated to the Committee. • Monitor high-level (rated 12-25) financial, operational, productivity, capital and procurement risks and associated action plans. • Seek assurance that risks are appropriately owned, controlled and escalated. **Governance and effectiveness** • Approve and monitor the Committee governance cycle. • Review the Committee's effectiveness annually and agree improvement actions. • Prepare an annual report to the Board describing how the Committee has discharged its responsibilities. • Review these Terms of Reference annually and recommend amendments to the Board.

MEMBERS ***(3.1):***	Membership of the Committee comprises: • **Four Non-Executive Directors** (including at least one with recent financial experience)	**STANDING ATTENDEES** ***(3.2):***	Standing attendees: • **Chief People Officer** • **Deputy Chief Finance Officer**

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	• **Chief Finance Officer** • **Chief Operating Officer** • **Chief Strategy and Transformation Officer**				
CHAIR *(3.3)*:	**Non-Executive Director** (not the Trust Chair or Audit Committee Chair)	**DEPUTY CHAIR *(3.3)*:**	**Non-Executive Director Deputy Chair-Executive Director Deputy Chair** (not the Trust Chair or Audit Committee Chair)	**SECRETARY *(5.5)*:**	The **Director of Corporate Governance or** their nominee. An **Executive Assistant/ Business Manager** will be responsible for preparing minutes and updating action log.
MEETING TIMING (FREQUENCY AND DURATION) *(5.1)*:	Meetings are usually held **monthly** (not fewer than 10 times per year) with additional meetings scheduled as required.		**QUORUM *(5.2)***	Meetings will be quorate if at least **three members** are present: • two Non-Executive Directors-Executive Director • one Executive Director If the Chief Finance Officer is absent, the Deputy CFO must attend.	
ACCOUNTABLE TO: (the Accountable Group) *(6)*	The Committee is accountable to the Board of Directors.		**REPORTING GROUPS *(6.5)*:**	The Committee receives reports from sub-groups of the Trust Management Group and may refer issues to the Audit Committee, Quality Committee and People and Culture Committee.	

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UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

TERMS OF REFERENCE

1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 The purpose of the Committee and how it will achieve its purpose is as set out above.

1.3 The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. RESPONSIBILITIES

2.1 The responsibilities of the Committee are set out above.

3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Committee is set out above.

3.2 Standing attendees are set out above. In addition, other individuals may be invited to attend with agreement of the Chair (or in their absence the Deputy Chair).

3.3 The Committee will be chaired by the role holder above. A Deputy Chair may be nominated. In the absence of the Chair and/or an appointed Deputy Chair, the remaining members will elect another member present to chair the meeting (which, in the case of a Board committee will be a Non-Executive Director).

3.4 Subject to paragraph 3.2 above, only members of the Committee have the right to attend meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting (in the case of a Board Committee, a deputy will not have voting rights at the meeting). The Chair or other person chairing the meeting may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

3.5 Committee members should aim to attend all scheduled meetings but in any event are expected to attend a minimum of three quarters of all meetings. For the purposes of calculating attendance, a deputy attending on behalf of a member will not count towards the members' attendance. A record of members' attendance will be maintained.

4. AUTHORITY

4.1 The Committee is authorised to approve its governance cycle.

4.2 The Committee is authorised by the Board to investigate/review any activity within the Terms of Reference.

4.3 The Committee is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

4.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

5. CONDUCT OF BUSINESS

5.1 The Committee will normally meet at the frequency set out above and at such other times as the Chair will require.

5.2 Meetings of the Committee will be quorate if there are at least the members present set out above for a quorum.

5.3 If a meeting of the Committee is inquorate, then the meeting can progress if those present determine. However, no business will be transacted.

5.4 Meetings of the Committee will be called by the secretary at the request of the Chair. The secretary of the Committee will be as stated above.

5.5 The secretary (or their nominee) is responsible for preparing the agenda for agreement by the Committee Chair. The secretary (or their nominee) will collate and circulate papers to Committee members. Unless otherwise agreed by the Committee Chair, papers should be provided no less than seven working days before the meeting and the agenda and papers should be circulated no less than five working days before the meeting.

5.6 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee in advance and carried out either by: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee at the next meeting.

5.7 Committee business may be transacted through virtual media (including, but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair will be responsible for determining that the meeting is quorate.

5.8 Proceedings and decisions made will be recorded in the form of minutes, which will be submitted to the next meeting of the Committee for approval.

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5.9 Members will be expected to conduct business in line with the Trust's values and objectives.

6. RELATIONSHIPS AND REPORTING

6.1 The Committee will be accountable to the group set out above (the Accountable Group), to whom it will make recommendations in relation to issues that require decision or resolution.

6.2 The Committee will present a report summarising the proceedings of each of its meetings at the next meeting of the Accountable Group. For the avoidance of doubt, where practicable, this will be a written report, with a verbal update being provided as necessary.

6.4 The Committee may refer to the other groups specified above any matters requiring review or decision in such forum(s).

6.5 The Committee will receive reports from the Reporting Groups set out above.

7. MONITORING

7.1 Attendance will be monitored at each Committee meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee will provide a self-assessment report to the Accountable Group detailing how the Committee has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate.

8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee will be reviewed at least every three years.

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APPENDIX A

ATTENDANCE AT COMMITTEE MEETINGS

NAME OF [Amend as appropriate: **COMMITTEE/**	[Insert name of Committee]											
Present (*include names of members present at the meeting)*	**Meeting Dates**											
In Attendance												
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)												

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University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 11 November 2026

Agenda item: **7.3**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Board governance cycle 2027/28
Prepared by:	Klaudia Zwolinska, Deputy Company Secretary
Presented by:	Leonora May, Director of Corporate Governance
Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Decision/Approval
Executive summary:	The Board Governance Cycle has been reviewed and updated as part of the annual review. Key changes include revised reporting frequencies, incorporation of the new Strategy and Transformation Committee, and improved alignment of reporting with Committee meeting schedules.
ALERT:	N/A
ASSURE:	The Board can be assured that the Governance Cycle has been reviewed to ensure that key statutory, regulatory, strategic and assurance reports are scheduled for consideration by the Board or the appropriate Board Committee. Reporting arrangements have also been updated to reflect the establishment of the Strategy and Transformation Committee and to support appropriate Committee scrutiny before matters are reported or escalated to the Board.
ADVISE:	The Board is advised that the frequency and timing of some reports have been revised to improve alignment with Committee meeting schedules and reporting requirements. The cycle now includes the reporting responsibilities of the Strategy and Transformation Committee and provides greater clarity on when key strategies, annual reports and governance reviews will be considered.
Celebrating Outstanding:	N/A
RECOMMENDATION:	The Board is asked to • approve the revised Board Governance Cycle for 2027 onwards; and

	• note that the cycle will continue to be kept under review and updated when national requirements, reporting arrangements or Committee schedules change
Implications associated with this item:	Council of Governors ☒ Environmental Sustainability ☒ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
N/A	N/A	N/A
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

BOARD OF DIRECTORS PART 1	MAY	JULY	SEPT	NOV	JAN	MAR	LEAD	MONTH AT COMMITTEE
Standing reports								
Declarations of Conflicts of Interest	X	X	X	X	X	X	**Chair**	~
Minutes of the previous meeting	X	X	X	X	X	X	**Chair**	~
Action List and Matters Arising	X	X	X	X	X	X	**Chair**	~
Update from the Council of Governors		X			X		**Lead Governor**	~
Patient Story	X		X		X		**CNO**	~
Staff Story		X		X		X	**CPO**	~
Chair's Report	X	X	X	X	X	X	**Chair**	
Chief Executive Officer's Report (to include ICB minutes)	X	X	X	X	X	X	**CEO**	~
Committee Chair's Assurance Reports	X	X	X	X	X	X	**Committee Chair**	
Integrated Quality, Performance, Workforce, Finance and Informatics - Operational Plan Exception Report - NHS Oversight Framework	X	X	X	X	X	X	**Exec Leads**	~
Corporate Risk Register	X	X	X	X	X	X	**Exec Leads**	~
Board Assurance Framework	X	X		X	X		**Exec Leads**	~

Audit Committee								
Governance								
Audit Committee Annual Report	X						**Chair/CoSec**	April
Annual Review of Meeting Effectiveness		X					**Chair/CoSec**	June
Audit Committee Terms of Reference						X	**Chair/CoSec**	Jan
Annual Reports								
Provider Licence Compliance Report and CoS7 Certificate	X						**CEO/Co Sec**	April
Code of Governance Compliance Report	X						**CEO/Co Sec**	April
FPPT compliance		X						July
EPRR annual report				X				October
Draft Board Assurance Framework - Coming Year	X						**CNO**	April
DSPT including SIRO report		X					**CDO**	July
Scheme of Delegation Review					X		**Co Sec**	Jan
Standing Financial Instructions Review					X		**CFO**	Jan
Declarations of Interest Policy Compliance Report		X					**CoSec**	July
Policy on the use of External Auditors for Non-Audit Work (triennially -*next due in 2027*)				X			**CFO**	October

Charitable Funds								
Governance								
Charitable Funds Committee Annual Report	X						**Chair/CoSec**	May
Annual Review of Meeting Effectiveness	X						**Chair/CoSec**	May
Charitable Funds Committee Terms of Reference						X	**Chair/CoSec**	Feb
Case for becoming independent Charity					X		**CFO**	Nov
Annual Reports								
UHD Charity - Annual Report and Accounts					X		**CFO**	Nov

| Finance and Performance Committee | | |

Quality Committee								
Governance								
Quality Committee Annual Report	X						**Chair/CoSec**	April
Annual Review of Meeting Effectiveness	X						**Chair/CoSec**	May
Quality Committee Terms of Reference						X	**Chair/CoSec**	March
Quarterly Reports								
Perinatal Quality Oversight Report	X		X		X	X	**Director of Midwifery**	Monthly reporting to QC
Patient safety report	X		X		X	X	**CNO**	Monthly
Bi-annual Reports								
7 Day Board Assurance Framework	X			X			**CMO**	Apr Oct
	X			X				
Annual Reports								
Annual Safeguarding Report and Statement & Annual Looked After Children Report		X					**CNO**	July
Annual Infection Prevention & Control Report and Statement		X					**CNO**	July
Annual Mortality Report (incl. Learning from deaths)			X				**CMO**	September
Annual Complaints Report		X					**CNO**	July
Annual Mortuary report			X				**CMO/ CNO**	September
Mixed Sex Accommodation Declaration			X				**CNO**	September
Maternity Incentive Scheme Submission (final)					X		**CNO/Director of Midwifery**	January

Strategy and Transformation Committee								
Governance								
Strategy and Transformation Committee Annual Report	X						**Chair/CoSec**	April
Annual Review of Meeting Effectiveness	X						**Chair/CoSec**	April
Committee Terms of Reference						X	**Chair/CoSec**	February
Our Dorset Provider Collaborative	X	X	X	X	X	X	**Programme Director**	Bi-annual
Trust Strategy progress report		X			X		**CSTO**	June, December
National and regional aligment (NHS 10 Year plan, ICB strategy)		X			X		**CSTO**	June, December
Annual Reports								
Overview enabling strategy delivery				X			**CSTO**	October
Estates strategy and masterplan					X		**CSTO**	December
Sustainability strategy (Green Plan)		X					**CSTO**	June
Digital Strategy			X				**CDO**	August
Premises assurance model			X				**CSTO**	August
Key strategic objectives for the financial year ahead						X	**CSTO**	February

Corporate Governance Team								
Board Meeting Schedule					X		**CoSec**	~
Board Effectiveness Review						X	**Chair/CoSec**	~
Board Governance Cycle					X		**CoSec**	~
Board Committee Terms of Reference						X	**CoSec**	~
Seal of Documents Register	X						**CoSec**	~
Register of Directors' Interests	X	X	X	X	X	X	**CoSec**	~
Trust Constitution	X						**CoSec**	~

Ad hoc			
National Inpatient and Outpatient Survey Results		CNO	~
CQC Reports		CNO	~
Annual report on learning from Patient Stories to Board	X	CNO	~
Supporting strategies		CSTO	~
Constitution (3 yearly) - Council of Governors to approve		Chair/Co Sec	~
Private practice joint venture		CTSO	
Strategic Plan (5 year)		CSTO	~

BOARD OF DIRECTORS PART 2	APRIL	MAY	JUN	JULY	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	LEAD	MONTH AT COMMITTEE
Standing reports													
Apologies	X	X	X	X	X	X	X	X	X	X	X	**Chair**	
Declarations of Conflicts of Interest	X	X	X	X	X	X	X	X	X	X	X	**Chair**	
Notification of any Urgent Business or Confidential Escalations	X	X	X	X	X	X	X	X	X	X	X	**Chair**	
Minutes of the previous meeting	X	X	X	X	X	X	X	X	X	X	X	**Chair**	
Action List and Matters Arising	X	X	X	X	X	X	X	X	X	X	X	**Chair**	
Trust Chair's Update	X	X	X	X	X	X	X	X	X	X	X	**Chair**	
Chief Executive Officer's Update	X	X	X	X	X	X	X	X	X	X	X	**CEO**	
Partnership Board udpate (HealthSet)	X	X	X	X	X	X	X	X	X	X	X	**CDO**	
Escalations from Committee Chairs (not already covered in Part 1)	X	X	X	X	X	X	X	X	X	X	X	**Committee Chairs**	
Audit Committee													
Draft Annual Governance Statement		X										**CEO/DoCG**	Apr
External Auditors Report on the Financial Statements			X	X								**CFO**	JA&FPC
Annual Report & Accounts		X	X									**CSTO/CFO**	Jun, JA&FPC
Letter of Representation		X										**CFO**	JA&FPC
Charitable Funds													
Business Cases/Charitable Funds Applications (Over 250k)	X	X	X	X	X	X	X	X	X	X	X	**CFO**	Ad hoc
Finance and Performance Committee													
Recommendation reports (as required)	X	X	X	X	X	X	X	X	X	X	X	**CFO**	Every month
Annual Operational Plan	X	X										**COO, CFO**	Feb, March, April
Draft Annual Accounts (Joint with Audit Committee)		X										**CFO**	JA&FPC
Annual Report and Accounts (joint with Audit Committee)		X										**CFO**	JA&FPC
Strategy and Transformation Committee													
Cyber Security and Digital Resilience					X						X	**CDO**	June, Feb
Quality Committee													
Quality Account (final draft)			X									**CNO**	Jun

Appendix - Attendance at Part 1 Board Meetings

Part 1		13 May 2026	15 July 2026	09 September 2026
Members Present	Beverley Bryant			
	Judy Gillow			A
	Siobhan Harrington			
	Sarah Herbert			
	Tracie Langley			
	Femi Macaulay			
	Alastair Matthews			
	Michael Marsh			A
	Helena McKeown			
	Mark Mould			
	Pete Papworth			
	Sharath Ranjan			
	Richard Renaut			
	Claire Whitaker			
	Melanie Whitfield			
	Peter Wilson			
In attendance	Andrew Doe			
	Alison Honour			
	Leonora May			
	Klaudia Zwolinska			
Was the meeting quorate?		Y	Y	Y

Key

	Present
	Not in Attendance
A	Apologies
D	Delegate Sent