University Hospitals Dorset
NHS Foundation Trust

# UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

## BOARD OF DIRECTORS - PART 1 MEETING

**Wednesday 14 January 2026**

**09:30 – 12:30**

**Boardrooms, 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**

**BOARD OF DIRECTORS – PART 1 HELD IN PUBLIC**

The next meeting of the University Hospitals Dorset NHS Foundation Trust Board of Directors Part 1 will be held at 9:30 on Wednesday 14 January 2026 in the Boardroom Poole Hospital and via Microsoft Teams.

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

**Judy Gillow**
**Interim Trust Chair**

**AGENDA – PART 1 PUBLIC MEETING**

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**9:30 on Wednesday 14 January 2026**

| Time | Item | | Method | Purpose | Lead |
|---|---|---|---|---|---|
| **9:30** | **1** | Welcome, Introductions, Apologies & Quorum | **Verbal** | | **Chair** |
| **9:32** | **2** | Declarations of Interest | **Paper** | **Review** | **Chair** |
| **9:35** | **3** | Patient Story | **Verbal** | **Receive** | **CNO** |
| **10:00** | **4** | Notification of Any Urgent Business | **Verbal** | **Review** | **Chair** |
| **10:02** | **5** | Minutes of the meeting held on 5 November 2025 | **Paper** | **Agree** | **Chair** |
| **10:03** | **6** | Matters Arising - Action List *(none-outstanding)*<br>• Verbal update from the Council of Governors | **Verbal**<br>**Verbal** | **Review**<br>**Note** | **Chair**<br>**Lead Governor** |
| | **7** | **TRUST CHAIR AND CHIEF EXECUTIVE UPDATES** | | | |
| **10:05** | **7.1** | Trust Chair's Update | **Verbal** | **Note** | **Chair** |
| **10:10** | **7.2** | Chief Executive Officer's Report | **Paper** | **Note** | **CEO** |
| | **8** | **PATIENT FIRST STRATEGY** *Population and Systems, Our People, Patient Experience, Quality Outcomes and Safety, and Sustainable Services* | | | |
| **10:30** | **8.1** | UHD Charity Annual Report and Accounts | **Paper** | **Approve** | **CFO** |
| **10:50** | **8.2** | Digital Strategy | **Paper** | **Approve** | **CDO** |
| **11:10** | **8.3** | Maternity Incentive Scheme | **Paper** | **Approve** | **DOM** |
| **11:15** | | **15 MINUTE BREAK 11:15 to 11:30** | | | |

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| | **9** | **RISK AND PERFORMANCE** | | | |
| **11:30** | **9.1** | Corporate Risk Register | **Paper** | **Note** | **CNO/ Execs** |
| **11:40** | **9.2** | Integrated Quality, Performance, Workforce, Finance and Informatics Escalation Report<br>• Committee Chairs' Escalations | **Paper** | **Note** | **Execs** |
| | **10** | **ASSURANCE REPORTS TO NOTE** | | | |
| **12:10** | **10.1** | • 2025/26 Annual In-Patient Establishment Review<br>• Quality Impact Assessment Overview<br>• Patient Safety Event Report<br>• Guardian of Safe Working Hours Report<br>• Committee Chairs Assurance Reports:<br>➢ Quality Committee (25 Nov, 16 Dec, 6 Jan)<br>➢ Finance and Performance Committee (24 Nov, 15 Dec, 5 Jan)<br>➢ People and Culture Committee (5 Jan)<br>➢ Charitable Funds Committee (10 Nov)<br>➢ Transforming Care Together Group (15 Dec) | **Paper** | **Note** | **Chair** |
| **12:20** | **11** | Reflections on the Board Meeting | **Verbal** | **Discuss** | **Chair** |
| **12.25** | **12** | Questions from the Council of Governors and Public arising from the agenda.<br><br>Governors and Members of the public are requested to submit questions relating to the agenda by no later than noon on Friday 9 January 2026 to:<br>uhd.company.secretary-team@nhs.net | | | |
| | **13** | **Date and Time of Next Board of Directors Part 1 Meeting:**<br>Board of Directors Part 1 Meeting on Wednesday 11 March 2026 at 9:30. | | | |
| | **14** | **Resolution Regarding Press, Public and Others:**<br>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. | | | |
| **12:30** | **15** | **Close**<br>(30-minute break - Part 2 to start at 13:00) | **Verbal** | | **Chair** |

* Late paper
[R] Associated item in Reading Room

**This meeting is being recorded for minutes of the meeting to be produced.**
**The recording will be deleted after the minutes of the meeting have been approved.**

**Items for Next Board Part 1 Agenda**
Standing Reports

- Staff Story
- Trust Chair's Update
- Chief Executive Officer's Update
- Committee Chairs' Assurance Reports
- Integrated Performance Report
- Maternity Safety Champions Report
- Patient Safety Report

Quarterly/Bi-annual/Annual Reports

- Mortality Report
- Maternity and Neonatal Quality and Safety Report
- Guardian of Safe Working Hours Report
- Nursing Establishment Review
- Maternity Staffing Report
- Gender Pay Report
- Operational Plan (subject to national timeline)
- Estates Strategy

## AGENDA – PART 2 PRIVATE MEETING

**13:00 on Wednesday 14 January 2026**

| Time | Item | | Method | Purpose | Lead |
|---|---|---|---|---|---|
| **13:00** | **16** | Welcome, Introductions, Apologies & Quorum | **Verbal** | | **Chair** |
| | **17** | Declarations of Interest | **Verbal** | **Note** | **Chair** |
| | **18** | Notification of Urgent Business/Confidential Escalations | **Verbal** | **Review** | **Chair** |
| | **19** | **MINUTES AND ACTIONS** | | | |
| **13:05** | **19.1** | Minutes of the Board Part 2 Meeting held on 3 December 2025 | **Paper** | **Agree** | **Chair** |
| | **19.2** | Matters Arising – Action List (none) | **Verbal** | **Review** | **Chair** |
| | **20** | **CHIEF EXECUTIVE OFFICER'S UPDATE** | | | |
| **13:10** | **20.1** | Chief Executive Officer's Update:<br>• Finance Update | **Verbal**<br>**Paper** | **Note** | **CEO**<br>**CFO** |
| | **21** | **PATIENT FIRST STRATEGY** *Population and Systems, Our People, Patient Experience, Quality Outcomes and Safety, and Sustainable Services* | | | |
| **13:30** | **21.1** | Operating Plan - 2026/2027 | **Paper** | **Approve** | **CFO** |
| | **22** | **ITEMS FOR APPROVAL** | | | |
| **13:50** | **22.1** | Pathology South Six Business Case | **Paper** | **Approve** | **COO** |
| | **22.2** | Use of seal: LST Contracts Ltd – Ward 5 Poole Hospital | **Paper** [R] | **Approve** | **CSTO** |
| | **22.3** | Use of seal: SWAST Lease for Parking and Accommodation | **Paper** | **Approve** | **CSTO** |
| | **22.4** | Private Patients Joint Venture Partnership | **Paper** [R] | **Approve** | **CSTO** |
| | **22.5** | Contrast Media | **Paper** | **Approve** | **CSTO** |
| | **22.6** | Public Procurement Thresholds update | **Paper** | **Approve** | **CFO** |
| | **22.7** | The Supply of Urology Equipment | **Paper** | **Approve** | **CFO** |

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| | **22.8** | The Supply of Theatres Equipment (Head and Neck) | **Paper** | **Approve** | **CFO** |
| | **22.9** | The Supply of CT Scanner | **Paper** | **Approve** | **CFO** |
| | **22.10** | Interventional Cardiology Consumables | **Paper** | **Approve** | **CFO** |
| | **22.11** | The supply of Equipment for Endoscopy (Olympus) | **Paper** | **Approve** | **CFO** |
| | **23** | **CORPORATE GOVERNANCE** | | | |
| **14:00** | **23.1** | UHD Charity – ISO260 and Letter of Representation | **Paper** | **Receive** | **CFO** |
| **14:05** | **24** | Reflections on the Board Meeting | **Verbal** | **Discuss** | **Chair** |
| | **25** | **Date and Time of Next Standing Board of Directors Part 2 Meeting:** Board of Directors Part 2 Meeting on Wednesday 11 March 2026 at 12:30. | | | |
| **14:10** | **26** | **Close** 20 min break – Seminar Session at 14:30 | **Verbal** | | **Chair** |

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**Reading Room**

- Finance Report *(for agenda item 20.1)*
- EIP report *(for agenda item 20.1)*
- Dorset ICS Finance Summary *(for agenda item 20.1)*
- UHD PPU proposal *(for agenda item 22.4)*

**Items for Next Standing Board Part 2 Agenda**

Standing Reports

- Chief Executive's Update
- Recommendation Reports for approval

Annual Report

- Operational Plan/Budget (subject to national timeline)

**List of abbreviations:**

Officer titles

CPO – Chief People Officer
CFO – Chief Finance Officer
CSTO – Chief Strategy and Transformation Officer
CEO – Chief Executive Officer
CNO – Chief Nursing Officer
CoSec – Director of Corporate Governance

**UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST**

**REGISTER OF BOARD OF DIRECTORS' INTERESTS**

The following interests, as at 1 January 2026, were declared by the Board of Directors of University Hospitals Dorset NHS Foundation Trust:

| NAME AND ROLE | INTERESTS DECLARED |
|---|---|
| **Judith Gillow MBE**<br>Interim Trust Chair | • Volunteer – Milford-on-Sea Community Café<br>• Company Secretary – A.W.R Electronics |
| **Siobhan Harrington**<br>Chief Executive | • Brother – Chief Executive of ELEMIS Limited |
| **Beverley Bryant**<br>Chief Digital Officer | • Director – Wildtrack Telemetry Systems |
| **Sarah Herbert**<br>Chief Nursing Officer | • None |
| **Tracie Langley**<br>Non-Executive Director | • Treasurer of Wool and Winfrith Football Club (charity) – voluntary role<br>• Owner and director – Fincom Strategic Advisory Services Limited<br>• Director and Shareholder – Agora Software Limited<br>• Consultancy contract – Harlow District Council<br>• Peer advisor - Shropshire Council Council |
| **Femi Macaulay**<br>Non-Executive Director | • Chair, Board of Trustees - Linacre College, University of Oxford<br>• Trustee, Stuckton Adventure Centre |
| **Michael Marsh**<br>Non-Executive Director | • Non-Executive Director Moorfields Eye Hospital NHS Foundation Trust |
| **Alastair Matthews**<br>Non-Executive Director | • None |
| **Dr Helena McKeown**<br>Non-Executive Director | • Trustee – Salisbury City Almshouse and Welfare Charities<br>• Medical Director: Professional Development and Quality – Royal College of General Practitioners<br>• Dorset LMC Member – Wessex Local Medical Committees Limited<br>• Medical Womens Federation – South-West Regional Representative<br>• General Practitioner – Gillingham Medical Centre<br>• Appraiser – NHS England South East<br>• Senior Appraiser – NHS England South West |

| NAME AND ROLE | INTERESTS DECLARED |
|---|---|
| | • Lead Appraiser – Clinical Partners (private provider of mental health services)<br>• Appraiser – Wessex Appraisal Services Limited |
| **Mark Mould**<br>Chief Operating Officer | • Director of Concept Works Ltd (property rental company) 50% share.<br>• Wife owns iSkincare Ltd (Aesthetic Company)<br>• Daughter – Masters in Nursing<br>• Daughter – Bank Contract with UHD (Admin & Clerical)<br>• Member of Roche Diagnostics Executive Advisory Council |
| **Pete Papworth**<br>Chief Finance Officer | • Trustee/Non-Executive Director - Initio Learning Trust (voluntary role)<br>• Wife – HR Business Partner at Dorset Healthcare University NHS Foundation Trust |
| **Sharath Ranjan**<br>Non-Executive Director | • Independent Governor – Solent University |
| **Richard Renaut**<br>Chief Strategy and Transformation Officer | • Wife employed by local Primary Care Network |
| **Claire Whitaker CBE**<br>Non-Executive Director | • Chief Executive – Southampton Forward<br>• Board Member – Southampton Renaissance Board<br>• Director – Cricket Dorset Limited<br>• Director – Triangle Consultants Ltd<br>• Director – Aster Homes Ltd<br>• Director – Aster Property Ltd<br>• Director – Seriously Inclusive Ltd<br>• Director – In All Seriousness Music Ltd<br>• Trustee – Enham Trust<br>• NED – BIMM University |
| **Melanie Whitfield**<br>Chief People Officer | • None |
| **Dr Peter Wilson**<br>Chief Medical Officer | • None |

**Standing Attendees**

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| **Andrew Doe**<br>Associate Non-Executive Director | • Shareholder and director - Gizme Limited, a management consultancy business which works with other NHS organisations and providers to the NHS<br>• CEO and Shareholder - CognitionHub.com Limited, a provider of AI consultancy and services which also seeks to do business with the NHS<br>• Trustee - Wildscreen (charity number 299450)<br>• Non-Executive Director - Viridi Co2 Limited (company number 13063405)<br>• Director – Make IT Plain Limited, Sports Port Limited |
| **Alison Honour**<br>Associate Non-Executive Director | • Vice Chancellor – Bournemouth University |

In compliance with section B, 2.14 of the code of governance for NHS provider trusts, no full-time executive director holds more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.

**1 January 2026**

**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 5 November 2025 at 9:30 in Boardroom 1, Poole Hospital and via Microsoft Teams.

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| **Present:** | Judy Gillow | Trust Chair *(Chair)* |
| | Siobhan Harrington | Chief Executive Officer |
| | Beverley Bryant | Chief Digital Officer |
| | Sarah Herbert | Chief Nursing Officer |
| | Tracie Langley | Non-Executive Director |
| | Femi Macaulay | Non-Executive Director |
| | Michael Marsh | Non-Executive Director |
| | Alastair Matthews | Non-Executive Director |
| | Helena McKeown | Non-Executive Director |
| | Mark Mould | Chief Operating Officer |
| | Pete Papworth | Chief Finance Officer |
| | Sharath Ranjan | Non-Executive Director |
| | Richard Renaut | Chief Strategy and Transformation Officer |
| | Claire Whitaker | Non-Executive Director |
| | Melanie Whitfield | Chief People Officer |
| **In attendance:** | Funke Adewoye | Staff Observer |
| | Colin Blebta | Public Governor |
| | Dr Deniz Cetinkaya | Public Governor |
| | Sharon Collett | Public Governor |
| | Steve Dickens | Public Governor |
| | Andrew Doe | Associate Non-Executive Director |
| | Rob Flux | Staff Governor |
| | Dr Megan Howarth | UHD Consultant |
| | Eiri Jones | Non-Executive Director, Dorset County Hospital |
| | Joe Kinsella | UHD Medical Staff |
| | Helen Martin | Freedom To Speak Up Guardian |
| | Deepa Pappu | Equality Diversity Inclusion Lead |
| | Truda Scriven | Interim Company Secretary |
| | Diane Smelt | Public Governor |
| | Carrie Stone | Public Governor |
| | Lorraine Tonge | Director of Midwifery |
| | Kani Trehorn | Staff Governor |
| | Tara Vachell | Freedom To Speak Up Guardian |
| | Michele Whitehurst | Public Governor |
| | Klaudia Zwolinska | Corporate Governance Manager |
| | (Three members of the public in attendance) | |

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| **BoD287/25** | **Welcome, Introductions, Apologies & Quorum**<br>The Chair welcomed attendees and formally introduced Alastair Matthews, newly appointed Non-Executive Director, who would chair the Finance and Performance Committee. Truda Scriven was welcomed as Interim Company Secretary.<br>Apologies had been received from Peter Wilson, Chief Medical Officer, who was on annual leave. |

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| | The meeting was declared quorate. |
| **BoD288/25** | **Declarations of Interest**<br>No existing interests were declared in conflict with the agenda.<br>Existing interests were noted as recorded in the register.<br>No new declarations were made. |
| **BoD289/25** | **Staff Story**<br>Helen Martin and Tara Vachell, Freedom to Speak Up Guardians, introduced Dr Megan Howarth, Consultant, who shared a deeply reflective account of her experiences in community care and her involvement in the development of the Trust's Behaviour Charter.<br><br>The Charter, launched in August 2025 following engagement with over 1,000 stakeholders, aims to foster kindness and address unkind behaviours through supportive, non-punitive approaches.<br><br>Meghan shared a reflective account of her experiences from the previous year, focusing on her role in admission avoidance and the challenges faced in delivering compassionate care.<br><br>Megan described encounters with two patients who had declined potentially life-prolonging treatments due to previous experiences of unkind treatment within the hospital. Meghan expressed that this was unusual in her experience, as patients typically declined treatment due to clinical limitations rather than emotional distress.<br><br>Meghan conveyed her concern not only for the patients but also for the staff involved, noting that the behaviours described were not indicative of inherently unkind individuals, but rather symptoms of burnout and systemic pressures. She reflected that these were not bad people, but people exhibiting unkind behaviours shaped by the system.<br><br>Members acknowledged the concept of moral injury and distress and the need to create psychologically safe environments for staff and patients. The Chair reaffirmed the Board's commitment to cultural improvement and compassionate leadership.<br><br>Siobhan would meet with Megan and other safety champions to explore feedback further. The People and Culture Committee would maintain oversight of the Behaviour Charter's implementation.<br><br>The Board expressed appreciation for Megan's honesty and insight and thanked her for coming to the Board to tell her story.<br><br>The Staff Story was NOTED. |
| **BoD290/25** | **Minutes of the Board of Directors Meeting held on 8 September 2025**<br>The minutes of the Part 1 meeting of the Board of Directors held on 8 September 2025 were AGREED as an accurate record. |
| **BoD291/25** | **Matters Arising – Action List**<br>***BoD232/25 – Washing Facilities:*** *To review the provision of religious washing facilities in male toilets* Richard Renaut confirmed that religious washing facilities |

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| | were available in male toilets and that the issue related to awareness. The Chaplaincy team would support wider communication.<br>Action CLOSED. No other outstanding actions were due. |
| **BoD292/25** | **Trust Chair's Update**<br>Judy Gillow reported a busy month of activity across the Trust, including site visits to Christchurch, Bournemouth, and Poole. Despite operational pressures, staff continued to demonstrate exceptional commitment, particularly during Black History Month events, which were described as inspirational and inclusive. She thanked Femi Macaulay and Sharath Ranjan for their contributions to these sessions and highlighted the importance of ongoing cultural engagement.<br>Judy Gillow highlighted engagement with the Organisational Development team and a maternity listening event, reinforcing the importance of connecting with both clinical and non-clinical teams. A joint Board-to-Board meeting with Dorset County Hospital and Dorset Healthcare had taken place, with plans for a follow-up in the new year.<br>She concluded by encouraging continued Board visibility and staff engagement across all areas of the Trust.<br>The Chair's update was NOTED. |
| **BoD293/25** | **Chief Executive Officer's Report (including ICB minutes)**<br>Siobhan Harrington presented her Chief Executive's update and reflected on the Trust's preparations for winter, thanking staff for their resilience, teamwork and commitment to patient care. She noted the ongoing national changes, including the future launch of NHS Online in 2027, and explained that UHD had stopped its shared services company proposal following new NHS England guidance requiring stronger union engagement and protection of NHS terms and conditions. Engagement with trade unions, supported by ACAS, was now underway to rebuild confidence and consider next steps. The Trust was no longer in dispute with UNISON.<br>Siobhan briefed the Board on wider national developments, including the new Medium Term Planning Framework, the introduction of NHS performance league tables, where UHD was placed mid-table, and the continued national emphasis on elective recovery, urgent and emergency care improvement, and financial sustainability. She welcomed the national expansion of Martha's Rule, noting UHD's early involvement and the positive impact on patient safety. Further national actions on maternity and neonatal care, anti-racism and antisemitism, and promoting research-positive cultures across clinical professions were also highlighted, with relevant UHD teams reviewing the implications.<br>Turning to the Dorset system, Siobhan reported leadership changes across the new cluster ICB and described ongoing work to develop a refreshed clinical strategy for the county. The Provider Collaborative continued to strengthen joint working across organisations. Within UHD, Siobhan acknowledged the continued pressure in urgent and emergency care, driven largely by delayed discharges, while recognising that ambulance handover performance had remained strong. Elective care had continued to recover well, waiting lists had stabilised, and two national cancer standards had been achieved. Diagnostics performance remained among the strongest in the region.<br>She explained that UHD remained on plan financially at the mid-year point but faced a challenging second half of the year. A detailed plan was in place to reduce spend and accelerate efficiency schemes, while discussions continued with system partners on addressing a remaining financial risk. She updated the Board on major digital progress, including the identification of a recommended supplier for the HealthSet electronic health record and the work now beginning to prepare for |

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| | implementation and the planned switch-over in 2028. Transformation projects also continued at pace, including the development of the new planned and emergency hospital facilities and significant progress on the CDC Endoscopy Hub at Poole.<br>Siobhan then reflected on the people-focused elements of the report. Staff Survey engagement remained ahead of national averages, and efforts continued to improve flu vaccination uptake ahead of winter. She shared highlights from recent staff network and inclusion events and explained the work underway to apply updated national job evaluation profiles for nursing and midwifery staff. Partnership working with trade unions would continue to be central to the delivery of future collaborative initiatives. She also briefed the Board on forthcoming immigration changes that could affect staffing and the support being offered to teams most impacted. Finally, she welcomed the arrival of the new Medical Director for Integrated Care and shared the success of the first Pan-Dorset simulation event.<br>Siobhan concluded by reaffirming her appreciation for staff during a period of sustained challenge and by emphasising the importance of listening, collaboration and maintaining a focus on quality and safety.<br>The need for inclusive leadership and anti-racism messaging across the Trust was emphasised by Siobhan. Black History Month events were commended. A proposal for a joint anti-racism statement with system partners was being explored by Siobhan. Sharath Ranjan encouraged Board members to act as allies to expand participation in inclusivity events beyond those already engaged. The Board noted that a campaign to address racism within UHD was being prepared. Best practice from other anchor institutions and public sector leaders would be explored by Siobhan to inform UHD's approach.<br>The CEO's report and ICB minutes were NOTED. |
| **BoD294/25** | **Quality Committee – Chair's Report – September and October 2025**<br>Michael Marsh emphasised several key areas requiring continued focus, including medical device replacement. He noted that assurance around safety, effectiveness, and financial planning remained a priority.<br>Michael provided an update on the risk register, highlighting improvements in development and oversight, particularly through the establishment of the Oversite Risk Group. He referenced progress on public legislation compliance.<br>The Committee had also considered national standards of healthcare food and drink but had not yet reached full assurance at this stage.<br>The Care Quality Commission (CQC) had arrived that morning to for a planned inspection of the Radiology Department under the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). The Chair and Chief Executive had welcomed them on site.<br>Siobhan provided additional assurance by celebrating the results of the recent CQC inpatient survey, noting significant improvements across most domains and consistency between the Poole and Bournemouth sites. The Board acknowledged that the Trust had moved up to second overall in the region and agreed that this achievement should be celebrated across the Trust.<br><br><u>Maternity and Neonatal Quality and Safety Report – Q2</u><br><br>Lorraine Tonge presented the report which had been discussed at the Quality Committee and at the Safety Champions meeting.<br><br>The report provided assurance on:<br>• Neonatal workforce compliance with BAPM standards<br>• Midwifery workforce fully funded to Birthrate Plus |

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| | • Training compliance monitored monthly<br>• Appointment of Michael Marsh as Safety Champion<br><br>Board members noted the Maternity incentive scheme (MIS) compliance in the following matters:<br><br>Workforce<br><br>Lorraine Tonge was pleased to be able to inform the Board that the Neonatal medical workforce now met the BAPM recommendations as the seventh Neonatal Consultant was appointed in October 2025,<br><br>The neonatal nursing workforce had an agreed action plan with the Operational Delivery Network (ODR) to ensure that neonatal nurses were supported with qualifications in speciality (QIS) training. The standard to be achieved was 70%. Currently the Trust stood at 65% and was expected to meet the 70% standard in November 2025. The action plan would continue over the next two years to deliver training.<br><br>The midwifery workforce was fully funded to Birthrate Plus. The Board and executives were thanked for their support to over recruit by appointing our newly qualified midwives to backfill maternity leave and for responding and listening to staff feedback. These midwives had now started in post.<br><br>Training<br><br>The Board noted training compliance and the agreed action plan. The rotational doctors and anaesthetist, who had commenced employment in the Trust after 1 July 2025, would meet the training standard within a six-month period. This would be monitored monthly through safety champions reporting.<br><br>Safety champions<br><br>Michael Marsh, NED, was formally welcomed as a new Safety Champion.<br><br>Safety champions met with the perinatal leadership team at the monthly safety champions meeting. Discussions and support took place regarding improving the Maternity Neonatal culture plan. This month's focus had been on the behaviour charter with our clinical leaders ensuring that they had the tools to make changes in behaviour.<br><br>Maternity Services – Assurance and Discussion<br><br>The Board received a detailed report on maternity services.<br><br>Michael Marsh provided context on the Trust's stillbirth rate, which was slightly above the national average. He noted statutory reporting complexities and confirmed that each case was individually reviewed. Investigations were conducted in collaboration with the Dorset County Hospital, with consideration given to health inequalities. |

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| | A short-term rise in stillbirths, was reported consistent with previous years. A deep dive had been completed with no healthcare issues identified. The Quality Committee would continue to monitor trends and review findings.<br><br>Staff morale in maternity was discussed as a key challenge. The Board acknowledged its responsibility to support staff in a highly scrutinised environment and welcomed improvements to patient experience following recent infrastructure developments.<br><br>Concerns were raised regarding sickness absence. It was confirmed that care groups were undertaking deep dives with HR to implement targeted support. Absence rates had decreased in September. Lorraine Tonge highlighted pressures in triage due to sickness absence. The importance of leadership visibility and phased return-to-work arrangements was emphasised. The People and Culture Committee would continue to review wellbeing interventions.<br><br>Further workforce flexibility was being developed through multiskilling and cross-site resource sharing. Sarath Ranjan stressed the need for constructive Board support without operational interference.<br><br>It was confirmed that the baby tagging system had performed effectively during a recent drill and would be reviewed following relocation to the BEACH building.<br><br>A recent CQC visit to maternity had taken place, with results pending.<br><br>In summary, Michael Marsh confirmed:<br>• Assurance had been received on individual review of stillbirth cases.<br>• A deep dive had informed improvement actions.<br>• Staff wellbeing remained under close review.<br>• Patient safety systems, including baby tagging, were functioning effectively.<br>• Visible leadership and staff support were ongoing priorities.<br>• Recruitment, retention, and wellbeing remained central to service development.<br><br>Lorraine Tonge and her team were thanked for their work and for a thorough report.<br><br>The Q2 Maternity and Neonatal Quality and Safety Report was NOTED.<br><br><u>Annual End of Life Care Report</u><br><br>Sarah Herbert presented the report, celebrating positive outcomes and performance above national benchmarking in several areas. A small number of indicators had fallen short, but overall, the team demonstrated compassion and kindness in caring for dying patients. This continued to be a powerful and valued area of work.<br><br>The Board was assured that end-of-life care remained a strength of the Trust, underpinned by a committed and compassionate team.<br><br><u>Mortality Report</u><br><br>Sarah Herbert presented the latest mortality data, which showed a continued downward trend with a small temporary increase identified. Alastair Matthews enquired about the implementation of the new Learning from Deaths process. Sarah Herbert confirmed that Structured Judgement Reviews (SJRs) were being |

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| | undertaken monthly within care groups, with themes and learning shared. The Board noted the positive feedback from the Coroner.<br><br>The Board NOTED the Annual End of Life Care Report and Mortality Report. |
| **BoD295/25** | **Finance and Performance Committee – Chair's Report – September 2025 and October 2025**<br>Claire Whitaker presented the assurance report for October 2025 and Sharath Ranjan for September 2025.<br>Key items discussed had included the Green Strategy and Estates work and the New Hospitals Programme. The Committee also reviewed the HealthSet work and Electronic Patient Record (EPR) stability programme.<br>The Committee had reviewed *No Criteria to Reside* (which was addressed in the Integrated Performance Report) and general performance, including updates on the New Hospitals Programme.<br>Additional discussion had concerned the Private Patients Strategy. Richard Renaut confirmed that the strategy had been scrutinised and returned to the Board with clear assurances regarding gateway controls ensuring that (i) activity was additional to NHS-commissioned services, (ii) reinvestment of any surplus funds was into NHS care and (iii) there was a robust audit process for recording staff time and allocation.<br>The Board NOTED the assurance reports.<br><br><u>The Green Plan</u><br>The Finance and Performance Committee had recommended The Green Plan for approval.<br>The Board commended the high quality of the Green Plan and the leadership of Stuart Lane, Sustainability and Energy Manager. The Board reflected on the importance of embedding sustainability into everyday practice, noting:<br>• £375,000+ savings from solar panel installations<br>• Staff engagement through the Eco Earn app<br>• Positive feedback from younger nurses on waste reduction<br>A review of the communications plan for the Green Plan would take place by the Executive team.<br><br>The Board APPROVED the Green Plan 2025 - Revised Edition, as the Trust's updated Sustainable Development Strategy.<br><br><u>Estates Master Plan 2025-28</u><br>The Board received an update on the Estates Master Plan, which reflected the significant progress made.<br>The Masterplan outlined strategic infrastructure priorities across all three sites. The Board endorsed:<br>• Completion of the Major Emergency Hospital at Royal Bournemouth and Major Planned Hospital at Poole<br>• Christchurch continuing as a community hub<br>• Embedding decarbonisation, sustainable travel, and climate resilience<br>• Reducing backlog maintenance and strengthening infrastructure<br><br>The Plan signposted future opportunities, including the potential for space reallocation and development. The Board was informed that the Trust was |

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| | proactively preparing bids and engaging in early discussions with external partners, including charities such as Maggie's, to support future initiatives.<br><br>The Board APPROVED the Estates Masterplan 2025-2028. |
| **BoD296/25** | **People and Culture Committee – Chair's Report – October 2025**<br>Sharath Ranjan presented the report and highlighted that, considerable workforce assurance had been received from care groups and further work was ongoing.<br>Appraisal rates were improving, but greater focus was required. The Committee would continue to maintain oversight and provide updates through future assurance reports.<br>Sharath Ranjan explained that analysing data solely by one characteristic, such as race, without considering other factors such as gender, disability, or age, limited the depth of understanding. An intersectional approach to workforce data would provide a more comprehensive view of workforce experiences and inequalities, particularly in areas such as promotion opportunities and exposure to formal disciplinary processes.<br>The Board acknowledged the importance of prioritising initiatives, especially during a period of significant organisational change. It was noted that limited resources should be directed toward areas with the greatest potential impact. Two priority areas were identified (i) reducing disproportionate entry into formal disciplinary processes and (ii) improving equitable access to promotion and appointment opportunities.<br>The Board NOTED the assurance report.<br>The Modern Slavery Statement was APPROVED. |
| **BoD297/25** | **Transforming Care Together – Chair's Report – October 2025**<br>Judy Gillow presented the assurance report.<br>Workforce plans were behind target in some areas, although progress was being made in collaboration with care groups.<br>The Committee reviewed the communications and engagement strategy for upcoming changes, particularly the July 2026 site split. An external review of the plan had been requested to ensure its effectiveness. The importance of strong engagement with staff, communities, and system partners was emphasised.<br>Risks around Emergency Department demand and capacity were discussed, with a focus on improving internal efficiency and diversion strategies. Staff were commended for their exceptional efforts during the transition, and plans were in place to recognise formally their contributions.<br>Additional service changes, including oncology relocation and the opening of a new endoscopy unit, were noted. The Committee would maintain close oversight of all transformation activities and associated risks.<br>The Board NOTED the assurance report. |
| **BoD298/25** | **Audit Committee – Chair's Report – October 2025**<br>Claire Whitaker provided a summary of key areas discussed at the meeting.<br>A recent deep dive into housing had provided valuable insights. Current housing provisions were compliant. Future planning for key worker housing was discussed. The Trust's standards were strong compared to wider health service benchmarks.<br>Research activity had been discussed. Research-related questions had been incorporated into the consultant interview processes, with positive feedback from recent panels. Further integration of research into recruitment and workforce development was encouraged. |

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| | Cybersecurity was another area of focus. The increasing sophistication of global threats was recognised. The Committee was reassured by the mitigations in place and the work led by the CDO.<br>The Board NOTED the assurance report.<br>The Board APPROVED the updated Standing Financial Instructions. |
| **BoD299/25** | **Board Assurance Framework**<br>The Board received an update on the development of the Board Assurance Framework (BAF). The current iteration represented a significant improvement, with greater clarity around controls and sources of assurance.<br>Further refinement was being considered, including applying risk weightings. It was commented that risk scoring allowed the Board to assess the impact of mitigating actions. The Executive team agreed to develop draft proposals, with a view to returning to the Board in January 2026.<br>The Audit Committee had reviewed the BAF in detail and expressed support for its current structure. The Risk Oversight Committee also maintained oversight of its development.<br>Given the anticipated CQC Well-Led inspection, expected within the current financial year, the Board agreed that there was a need to progress this work with pace. The importance of ensuring that the BAF reflected the Trust's risk appetite and risk tolerance was emphasised.<br>The Board thanked those staff involved in producing the report. The BAF would be maintained as a standing item for ongoing Board-level scrutiny.<br>The Board NOTED the Board Assurance Framework for Q2 (July-Sept 2025). |
| **BoD300/25** | **Integrated Quality, Performance, Workforce, Finance and Informatics Report (IPR)**<br>The Board received the September 2025 IPR, which provided updates on key operational metrics including Emergency Department (ED) performance, Criteria to Reside, cancer standards, complaints, workforce indicators, and the impact of ongoing industrial action.<br>Mark Mould introduced the September 2025 position reminding members that there was a person behind each number. He highlighted the new format of the document, and the focus on breakthrough objectives.<br><br><u>Criteria to Reside and Discharge Planning</u><br>The Board discussed the ongoing challenge of the high number of patients in hospital who no longer met the Criteria to Reside. There was concern about the persistently high numbers, identifying this as a key area for improvement. The importance of addressing discharge delays was emphasised, particularly in preparation for the anticipated CQC Well-Led inspection, where system coordination and patient flow would be closely scrutinised.<br>The Board reviewed system-wide efforts to reduce these numbers, including collaboration with local authorities, tracking of discharge delays, and identifying key bottlenecks such as care allocation and social work assignment. Following discussion, the Board supported enhanced data sharing and system-wide visibility of discharge processes, using tools such as Future Care to provide a unified view of delays and support engagement with system partners.<br>Board members emphasised the need to maintain focus on discharge challenges, holding executives accountable for progress, and strengthening collaboration with local authorities to address shared responsibilities. |

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| | Emergency and Elective Care Performance<br>The Board reviewed performance against the four-hour emergency department (ED) target. While the position remained stable, improvement was required. The ED continued to receive enhanced support, with executive oversight and the application of the Patient First methodology to drive improvements in rapid assessment and timely decision-making.<br>The Board welcomed the significant progress in expanding Same Day Emergency Care (SDEC), with new services scheduled to operate seven days a week from December 2025. This expansion included extended hours and additional investment in staff and resources.<br>The elective recovery programme remained on track, demonstrating organisational resilience. Capacity was being strategically balanced to protect elective activity while responding to urgent care pressures. Targeted flow initiatives were being implemented to minimise the risk of increased waiting times and to safeguard elective procedures from cancellation.<br><br>Cancer Performance and Clinical Engagement<br>Further clarity on the Trust's position regarding cancer metrics was requested, particularly the 62-day standard. Mark Mould confirmed that performance remained challenged, with delays in diagnostic pathways and treatment starts contributing to breaches. Recovery plans were in place, and additional capacity was being explored through mutual aid and pathway redesign.<br>The Board queried the level of clinical engagement in the cancer recovery work and the prioritisation of patient communication. It was confirmed that clinical teams were actively involved and that communication with patients experiencing delays was being managed carefully.<br><br>Organ and Corneal Donation<br>Dr Helena McKeown raised a query regarding potential barriers to increasing corneal donation rates. it was reported that although clinical engagement was improving, further work was required to normalise donation conversations within routine practice, particularly outside of critical care settings.<br>Siobhan emphasised the need to align donation activity with the Trust's values and patient-centred approach. Dr Helena McKeown highlighted the significant impact of corneal donation on recipients and encouraged wider promotion across the Trust. The Board was informed that benchmarking data was available through NHSBT and that the Trust was reviewing its performance against regional comparators.<br>The Board agreed that organ and corneal donation should remain a priority area, recognising its clinical importance and contribution to compassionate care.<br>A further update on donation activity would be given in the coming months. Specific reference would be given to corneal donation awareness and referral rates.<br><br>Financial Performance and Planning<br>The Board discussed the current financial position, including the impact of the discontinued subsidiary initiative, efficiency programmes, productivity metrics, and planning for the next financial year. The financial forecast for the year was reviewed, with financial discipline being maintained through the management of capacity escalation costs.<br>There was currently an unmitigated financial risk of £14.7 million due primarily to the cessation of the subsidiary initiative. The CFO was working closely with system partners and NHS England to agree how this financial gap could be covered. |

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| | The importance of delivering the elective and cancer recovery programmes efficiently was emphasised. This would help mitigate the financial and patient waiting time risks associated with activity shortfalls. Weekly tracking of efficiency programmes was ongoing, with recent improvements noted.<br>Initial operating plans for the 2026/27 financial year were due to NHS England in December 2025. Final plans would be submitted in January and approved in March 2026. The planning process included detailed workforce, finance, and performance trajectories, with technical guidance expected imminently.<br><br><u>Workforce and Staff Experience</u><br>Siobhan raised the issue of industrial action, noting that the next round of resident doctor strikes was scheduled from 14 to 19 November 2025. She reported that Trust management and medical directors were actively planning for the strike period. While no immediate risks had been identified, the cumulative impact on morale, teamwork, financial performance, and service delivery was acknowledged as significant.<br>Melanie Whitfield reported that several workforce indicators were trending negatively. She noted that staff engagement remained a key driver of performance outcomes. Femi Macaulay spoke about the concept of discretionary effort. He noted that when morale was low, staff may reduce their informal contributions, which could affect productivity and service quality. Claire Whitaker supported this view. It was requested that any quick-win opportunities be identified for staff wellbeing that could be implemented alongside longer-term strategies. The importance of visible progress to support morale and performance was recognised.<br><br><u>Complaints</u><br>The Board noted a rise in formal complaints, particularly in areas linked to access and communication. The Patient Experience team was reviewing themes and working with operational leads to address any underlying issues.<br>A deeper dive into complaint trends would be held at a future meeting.<br><br><u>Other Matters</u><br>The Board was pleased to note that the Newtons team had been engaged to identify best practice from other trusts. A recent deep dive on CIP by NHS England had resulted in positive feedback. The Trust's approach was commended and may be shared nationally.<br><br>Judy Gillow thanked the Executive team for their updates and acknowledged the complexity of the current operating environment. She reiterated the importance of maintaining momentum on performance improvements and ensuring readiness for external scrutiny.<br><br>The Board NOTED the Integrated Quality, Performance, Workforce, Finance and Informatics Report. |
| **BoD301/25** | **Trust Strategy**<br>The Board received the updated Trust Strategy overarching document. Members welcomed the clarity and structure of the strategy and discussed its excellent presentation, alignment with national priorities, and future implementation.<br>Michael Marsh raised a question regarding the inclusion of individual accountability within the document. This would be reviewed by the Executive team. |

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| | Implementation of the Long-Term Plan would shape the next phase of strategic development. Current initiatives, such as Criteria to Reside and community integration, were already aligned with national priorities. It was noted that the clinical strategy, under development and coordinated with wider system planning, would return to the Board in March 2026 to provide a more detailed framework for alignment.<br>Judy Gillow noted that the current strategy served as a strong baseline document for communication and engagement, and that future iterations would incorporate national developments and system feedback.<br>The Trust Strategy overarching document was APPROVED. |
| **BoD302/25** | **Board capability self-assessment**<br>The NHS Provider Capability Self-Assessment had been submitted to NHS England, under the delegated authority of the Chair and CEO. The document was presented as part of the Trust's ongoing commitment to transparency, improvement, and alignment with national expectations. Feedback from NHS England would be received on the submission.<br>The Board's annual development programme would include the capability assessment, and the output from this would be included as part of the Annual Report.<br>The Board RATIFIED the NHS Provider Capability Self-Assessment. |
| **BoD303/25** | **Workforce Plan**<br>The Workforce Plan was presented for review and discussion. The paper had not yet been considered by the People and Culture Committee.<br>Melanie Whitfield offered assurance on the Trust's approach to managing workforce capacity. She highlighted the analysis of whole-time equivalent (WTE) staffing against both funded and actual establishment, noting that the establishment was broadly stable. Weekly reporting on Workforce metrics was in place.<br>The Board agreed that workforce remained a key area of focus, particularly in light of the anticipated CQC Well-Led inspection, where leadership, culture, and workforce planning would be key areas of scrutiny.<br>A communication gap had been identified in the staff understanding of the recruitment pause for A&C staff. Sarah Herbert stated that in some areas the headcount reduction was causing understaffing and overwork. Maternity was well-staffed but the perception of staff differed.<br>The Board raised workforce morale concerns and whether staff resting areas could be increased. Richard Renaut would work with staff champions to identify any quick wins for staff rest space improvements.<br>The Workforce Plan was referred to the People and Culture Committee for further review.<br>The Board NOTED the Workforce Plan. |
| **BoD304/25** | **Freedom to Speak Up Guardian Report for Q1 2025/6**<br>Helen Martin and Tara Vachell, Freedom to Speak Up Guardians, presented the Q1 Freedom to Speak Up Guardian Report.<br>The Board reviewed the speaking up culture for Q1, 2025/6 and noted why our staff were raising concerns and what had been learnt. Helen shared thematic findings from recent data, noting that 54% of respondents identified their manager either as part of the issue or as not resolving concerns. It was agreed that this figure should be disaggregated for specific information. The Board examined the thematic findings and the proposed improvement strategy, which aimed to foster psychological safety and open dialogue across all levels of the Trust. |

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| | During the presentation, Helen provided clarification on specific points, including a recommendation from the Lucy Letby inquiry regarding ratings and unresolved cases.<br>The Board highlighted the importance of the Behaviour Charter, and that kindness and compassion formed its foundation. Nevertheless, there was a need to balance these values with zero tolerance for inappropriate behaviour with clear accountability and consequences.<br>Judy Gillow thanked Helen and her FTSU team for their important contributions.<br>The statement of commitment of the Sir Robert Francis principles of Freedom to Speak up and the annual declaration of behaviours were APPROVED. The FTSU improvement strategy for the next 3 years until 2029 was APPROVED. |
| **BoD305/25** | **See ME First**<br>Deepa Pappu, Equality Diversity Inclusion Lead, gave a presentation on the See ME First campaign, which aimed to promote inclusion, respect, and visibility for staff from diverse backgrounds across the Trust. The Board found the campaign interesting and impactful, noting its potential to influence positively workplace culture and staff experience.<br>Board members were invited to make a personal pledge in support of the campaign demonstrating their commitment to fostering an inclusive culture.<br>Deepa Pappu was thanked for her valued support of the wellbeing of staff.<br>The Board NOTED the See ME First presentation. |
| **BoD306/25** | **Risk Register**<br>The report was presented to the Board in accordance with the UHD Risk Management Strategy. It was agreed that dates should be added to the actions and that the register should continue to be developed as a dynamic document.<br>The Board NOTED the Risk Register. |
| **BoD307/25** | **Composition of Board of Directors: Amendment to Trust's Constitution**<br>The Board APPROVED the amended UHD Constitution and authorised the executive to submit it to the appropriate NHS body and to make it publicly available.<br>The amendment, reinstating the casting vote of the Chair, had previously been approved by the Council of Governors. |
| **BoD308/25** | **Board Meeting Schedule**<br>Subject to some changes, the Board APPROVED the Meeting Schedule for 2026. |
| **BoD309/25** | **Risk Oversight Committee Terms of Reference**<br>The Board APPROVED the Risk Oversight Committee Terms of Reference. |
| **BoD310/25** | **Any Other Business**<br>There was no other business. |
| **BoD311/25** | **Reflections on the Board Meeting**<br>It was felt that the length and structure of the agenda should be reviewed.<br>Assurance reports had been well received. |

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| **BoD312/25** | **Questions from the Council of Governors and Public arising from the agenda**<br>A question was received from Governor Keith Mitchell regarding assurance on strategic planning for sufficient capacity following the forthcoming transfer of Poole's Emergency Department to Royal Bournemouth Hospital.<br>In response, Judy Gillow acknowledged the importance of the issue and confirmed that full assurance could not yet be provided as the programme remained in development. Assurance would strengthen as key milestones were achieved and the programme progressed towards safe and effective separation. |
| **BoD313/25** | **Resolution Regarding Press, Public and Others**<br>The Board APPROVED, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board, 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 nature of the business to be transacted.<br><br>There being no further business, the meeting was closed. |
| | **The date and time of the next Standing Board of Directors Part 1 Meeting was Wednesday 14 January 2026 at 9:30** |

**JANUARY 2026 TRUST BOARD**
**CHIEF EXECUTIVE UPDATE**

## 1 INTRODUCTION

As we move further into winter, I want to thank you all for your continued efforts. This is always a demanding time of year, and we are already feeling the seasonal pressures across our wards and emergency pathways. A specific thank you for how we coped through the industrial action just before Christmas.

For those who were able to take time off over the festive period, I hope that you found the chance to rest properly and spend meaningful time with the people who matter most to you. Taking time to recharge is not just helpful, it is essential.

We now look ahead to a year of significant transition and opportunity. The work underway across services, programmes and partnerships reflects both the challenges that we face and the ambition that we share for improving outcomes for our patients and communities. I am confident that, with the expertise and dedication of our teams, we are well placed to navigate the months ahead.

Thank you for everything that you do. Your commitment and resilience underpin the quality of the care that we provide, and I am truly grateful for your ongoing hard work.

## 2 NATIONAL UPDATES

### 2.1 Strategic Commissioning Framework

NHS England's Strategic Commissioning Framework (Nov 2025) sets out how Integrated Care Boards (ICBs) will evolve into strategic commissioners, moving from short-term contracting to long-term, outcomes-based planning. The framework introduces a four-stage cycle: understanding population needs, developing a five-year strategy, delivering through intelligent contracting, and evaluating impact.

Commissioning will operate across neighbourhood, place, and national levels, supported by seven key enablers including leadership, data, and partnerships. ICBs must complete baseline assessments by early 2026, with full implementation expected in 2026/27. A national development programme will support capability building. The framework presents a coherent national strategy but highlights risk around capacity, alignment, and governance.

Link to full framework: https://www.england.nhs.uk/publication/nhs-strategic-commissioning-framework/

### 2.2 Annual Budget Statement

The Chancellor of the Exchequer, Rt Hon Rachel Reeves MP, delivered the annual Budget in a speech to Parliament on 26 November 2026.

The key announcements for health and care include:

- £300m of funding for NHS technology to support staff in their work and boost productivity.
- The rollout of 250 new neighbourhood health centres which will co-locate GPs, nurses, dentists and pharmacists together in one community-based clinic. This will include new facilities which will be funded as public-private partnerships.
- Soft drinks industry levy extended to cover more products including milk-based drinks, from 1 January 2028.

- NHS prescription charges frozen at £9.90 for 2026/27, saving patients around £12 million.

The Trust will be reviewing the opportunities for the coming year.

### 2.3 Urgent and Emergency Care payment model

NHS England has confirmed that a new blended payment model for urgent and emergency care will be introduced from April 2026. This approach combines a fixed payment based on planned activity with a variable adjustment for volumes above or below plan, aiming to incentivise efficiency while maintaining service resilience. This change will require us to review our financial and operational modelling to ensure readiness.

### 2.4 Resident Doctors' Industrial Action

We have successfully navigated two periods of industrial action since my last report, and our teams have shown exceptional resilience and collaboration throughout. The British Medical Association has now opened a further ballot to extend the resident doctors' industrial action mandate until August 2026, following 13 previous rounds of action.

I want to offer my sincere thanks to all colleagues who worked tirelessly to maintain services and safeguard patients during these challenging periods. I am equally grateful to everyone who supported resident doctors' right to take industrial action in a respectful and professional way.

I remain hopeful that a constructive agreement can be reached soon.

## 3 DORSET UPDATES

### 3.1 Dorset Healthcare – Advanced Foundation Trust (AFT)

NHS England has announced that Dorset HealthCare University NHS Foundation Trust has been selected as one of the first eight trusts nationally to enter the new Advanced Foundation Trust Programme. This national initiative aims to recognise high-performing providers through enhanced autonomy and greater local decision-making freedoms. According to NHS England, inclusion in the first wave reflects strong performance against the NHS Oversight Framework and high-quality care evidenced through CQC assessments. Trusts in the programme will be evaluated against priority areas of leadership, quality, and financial sustainability, with the prospect of additional flexibilities for those who meet the required standards.

### 3.2 Our Dorset Provider Collaborative (ODPC)

The ODPC Board met in November to review progress against the six key programmes of work. Of note is the progress being made within the programme to establish a shared procurement service across Dorset which will now be hosted by UHD. The Board also heard progress with the Dorset Digital strategy and next steps for implementation. Finally, a framework for transformation of a small number of clinical services towards Dorset-wide models of service was approved.

## 4 UNIVERSITY HOSPITALS DORSET

### 4.1 Performance Headlines

#### Urgent & Emergency Care and Elective Care

We have seen an anticipated increase of demand typically associated with winter, against a challenged wider system position with regards to No Criteria to Reside position (NCtR). Despite the pressure we have maintained an improved length of stay; increased our use of SDECs to pull from Emergency Departments and avoid admission and continued to increase

referrals to hospital at home. In addition, and following collaborative work with our Ambulance Partner SWAST, we have also improved our ambulance handover times.

The Trust's performance against the organisational four-hour safety standard in November was nevertheless finalised at 67.4%, failing to meet the improvement trajectory of 70.07%. A set of improvement actions have been agreed with partners to support a reduction in NCtR, focusing on reducing delays and increasing discharges. The Dorset system has agreed an improvement trajectory to reduce NCtR to 110 by the end of April 2026 with clear targets by responsible organisation.

In terms of elective activity, we have continued to deliver an increase in planned operations, procedures and appointments for patients compared to the 2019/20 baseline period. The Trust has delivered 115.3% elective activity in 2025/26 year to date, exceeding the Trust's operational plan trajectory of 108.2%. We also continue to see a reduction in the number of patients on our RTT waiting list and all but one patient waiting greater than 65 weeks was seen and treated at the end of November. The single breach was due to waits for corneal graft material. Over three quarters of patients are now receiving a first OPA or diagnostic test within 18 weeks of referral, meaning that we are achieving earlier identification of whether they can be discharged or require treatment.

We have not reduced waits over 52 weeks at the pace we expected; however, we continue to optimise our capacity and ensure that our longest waits have access to the care they need.

We are achieving the target performance for two out of the three national cancer standards (Faster Diagnostic Standard and 31 Day performance) and in October (latest reporting period) we also saw a significant 7.8% improvement in delivery of the 62-day time to treatment standard.

Finally, the National Oversight Framework Q2 segmentation was published in November. UHD has been placed into segment 3 by NHSE, with a rank of #71/134 acute and specialist providers and an average metric score of 2.37 (previous quarter 2.36).

**Finance**

At the end of November, the Trust reported a deficit of £6.4 million, being £28,000 better than plan. The Trust has a detailed plan to recover the year-to-date deficit and deliver within the full year budget. This plan requires the acceleration of identified efficiency schemes currently expected to deliver in 2026/27, a further tightening of workforce controls including a considerable reduction in bank expenditure, together with a range of smaller mitigations. In addition, it is reliant upon non-recurrent funding from NHS England to mitigate the financial impact of ceasing the planned Wholly Owned Subsidiary.

However, the Trust is currently experiencing significant operational pressures, including caring for over 220 patients who no longer require acute care (90 more than the ICS agreed trajectory) which is putting significant pressure on the forecast outturn. Additionally, the confirmed Industrial Action during Decembre will put further pressure on the Trusts finances. As such, there remains considerable risk in the delivery of the full year plan.

**Medium Term Planning:**

The Trust submitted its draft Operational Plan on 17 December, covering a 2-year period. The final plan, covering a 3-year period, is due for submission on 12 February. The draft plan reflects an incredibly challenging position, with a material deficit forecast in both 2026/27 and 2027/28 despite significant efficiency assumptions. The impact of the current years' efficiency delivery (with both an under achievement of the target together with a significant element delivered through non-recurrent savings), together with a new efficiency requirement of 2%, and a further adjustment of 2.5% linked to the 2026/27 finance and contracting guidance, has not allowed the Trust to confirm a balanced plan. In turn, this reflects in the performance

trajectories, which do not currently meet the national expectations or the service we would wish for our local population. Further work will now take place with commissioners to agree appropriate demand/ growth assumptions and finalise a detailed activity plan for the year ahead. This is expected to improve the performance trajectories and reduce the planned deficits.

### 4.2 Digital

The HealthSet Electronic Health Record (EHR) Programme for Dorset and Somerset reached a major milestone in November with the completion of the formal supplier evaluation. A preferred supplier recommendation was approved by all Trust Boards and the Cabinet Office, enabling us to confirm Epic as the chosen partner for our unified EHR solution on 9 December. This achievement marks a significant step toward delivering a single, integrated health record across our services, improving patient care and reducing the need for individuals to repeat their story as they move through the system. The procurement process involved extensive collaboration across four Trusts, with over 168 evaluators contributing to the outcome. The next steps include finalising the contract with Epic by March 2026, following anticipated approval of the Full Business Case in February 2026.

Alongside this, the Our Dorset Digital Strategy has been completed, with full Board approval expected in January 2026. The strategy has been developed through a highly collaborative, iterative co-creation process, co-designed and co-owned by digital, clinical, and operational leaders across Dorset's health and care system. Every stage, from mobilisation to completion, has been shaped through engagement, evidence, and shared ownership, ensuring the strategy is both ambitious and grounded in real-world delivery. Progress has been guided by system-wide engagement and alignment with the Dorset vision, resulting in a collectively owned, evidence-based strategy endorsed by digital leadership and system partners. Once approved, the next phase will focus on developing the roadmap for implementation, beginning with a planning workshop on 22 January 2026.

### 4.3 Strategy & Transformation

Work continues at pace across the Trust to prepare for the next stage of our transformation programme, and several key developments are now beginning to take shape across our sites.

The most significant focus for the year ahead is the preparation for the clinical moves scheduled for July 2026, which will see the full separation of planned and emergency services, an important milestone first agreed in the plans approved in 2019. Engagement with patients, partners and colleagues will increase further over the coming months to ensure the transition is clear, coordinated and clinically led.

At the Royal Bournemouth Hospital, our new cancer ward and surgical admissions ward will shortly open following a £20m investment to convert former office and laboratory areas into modern, purpose-built clinical spaces. These new facilities provide improved environments for patients and staff, including an increased number of single rooms.

We have also finalised the purchase of the Wessex Fields site adjacent to RBH. This acquisition will support additional temporary staff parking, helping free up capacity closer to the hospital for patients and visitors. During 2026 we will begin developing the longer-term masterplan for the site, incorporating sustainable energy solutions, key worker accommodation, and dedicated education and research space.

At Poole, construction work is commencing to install an additional CT and MRI scanner near Churchfield House, alongside a programme of ward refurbishments across both Poole and RBH. These upgrades will improve diagnostic resilience and refresh ageing estates to support better patient experience and operational flow.

### Psychological Wellbeing

To further enhance staff support, expansion works for the Psychological Wellbeing Service will continue through January and February. This will create additional consulting rooms and increase capacity for colleagues to access timely, confidential support when needed.

### Clinical Strategy

Finally, development of our Trust-wide clinical strategy is progressing. Specialty teams are now drafting their contributions, which will be brought together between January and March ahead of a broader engagement phase. This work aligns closely with the wider Dorset health and care strategy and builds on recent public engagement linked to the NHS Long Term Plan. Our ambition remains clear: to make Dorset the healthiest place to live in the UK.

## 4.4 Trust Management Group Update

TMG approved the final Phase 3 relocation plan for July 2026, confirming a clinically led, three-stage sequence of ward and service moves aligned with the opening of the Coast building and the shift to a single emergency site at RBH. The plan is supported by detailed pathway simulations and coordinated staffing, equipment, transport and clinical planning.

The Group also reviewed key enabling work, including prioritisation of high-value equipment for Phases 2b and 3, and endorsed an interim therapies solution to support the new Continuing Care wards at Poole from January until the full model goes live in July 2026.

Updated Terms of Reference were proposed, strengthening governance and decision-making. TMG received updates from Clinical Governance, Digital Governance, Operational Delivery, People & Culture and the Patient First programme, noting progress on the Alert–Assure–Advise model, the Dorset digital strategy, and continued rollout of improvement practices.

## 4.5 OUR PEOPLE

### Staff Survey

The 2025 National Staff Survey closed with a 54.78% response rate for UHD (down from 57.8% in 2024), and the bank staff survey closed at 20.8% (27% in 2024). 13 teams achieved 100% participation, with prizes awarded accordingly. The next steps will include a full results review, comparison with national benchmarks, and sharing heatmaps to support team action plans throughout 2026.

### Staff Network Events

In December, the ProAbility Network hosted a keynote speaker, Jamie McAnsh, Head of Inclusion at Champions UK, for Positively Purple Day. We also had some awareness stands across the sites. Our Diverse Ethnicity Network hosted a listening event for their members which was also attended by several of our senior leaders prompting further discussion about the focus of our support in the year ahead.

In January we are looking forward to reinvigorating the Staff Network Leads community of practice and regular huddles and to agree a calendar of events for 2026.

### Nursing and Midwifery - Job Evaluation

Following the 2023 Agenda for Change pay agreement, which reaffirmed the requirement for fair and consistent application of the NHS Job Evaluation Scheme, the Trust has reviewed its local arrangements in response to updated national nursing and midwifery job matching profiles (band 4+) issued in the summer of 2025. Working in partnership with trade unions and senior nursing leaders, an action plan is in development to ensure job descriptions are accurate, current and aligned to national profiles. In accordance with national guidance, priority will be given to the review of Band 5 roles and those at higher risk of being out of date. A

supporting communications approach will ensure transparency with colleagues. The programme is expected to complete within 12–18 months and will provide assurance of robust local application of the Job Evaluation Scheme

**Partnership Working**

Last month I referred to our renewed commitment of partnership working as colleagues across the Dorset services community progress with collaborations to improve our Procurement and Pathology services as just two examples. This work has continued at pace, and several colleagues are actively involved in the future designs enabling a strong sense of improvement and increasing sustainability and resilience to meet service demands.

**Education and Training**

Trust compliance for Statutory and Mandatory training has dipped slightly to 87.62% due to the recent allocation of Oliver McGowan and Safeguarding Level 3 training.

The Mandatory Learning Oversight Group (MLOG) has commenced at UHD with the objective to review all essential to role training and reduce the learner burden. The Core Skills Training Framework is being reviewed by NHSE and is expected to launch in March 2026.

Finally, our BEAT/VLE 'Green Brain' licence is due to expire in March 2026 and we are currently out to procurement with a view to a new eLearning platform incorporating all IT training across Dorset with a new provider, Totara.

**Seasons Celebrations:**

Amongst many lovely season’s celebrations, we held our first Christmas Carol Services since Covid, which was very well attended and celebrated Hanukkah in our Multi Faith rooms at Bournemouth. We were also graced with two choirs and soloists who sang in the Atrium at Royal Bournemouth Hospital.

**Monthly Staff Excellence Awards**

- Claire Best, Infection Prevention & Control, RBH
- Jo Bradley, Labour Ward Shift Leader, RBH
- Olivia Dibden, ODP, Theatres, Poole
- Alice Jesse, Finance, Poole
- Dr. Thomas Taylor, Ophthalmology – Eye ward, RBH
- Kat Dixon, Head of Nuclear Medicine, Poole Hospital
- Vascular Therapy Team, RBH
- Millie Fisher, Ward 5 Discharge Coordinator, RBH

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 14 January 2026**

**Agenda item: 8.1**

| | |
|---|---|
| **Subject:** | Charity Annual Report and Accounts |
| **Prepared by:** | Debbie Anderson – Head of Charity<br>Andrew Monahan - Head of Financial Services |
| **Presented by:** | Pete Papworth – Chief Finance Officer |

| | |
|---|---|
| **Strategic themes that this item supports/impacts:** | Population & System ☐<br>Our People ☐<br>Patient Experience ☐<br>Quality Outcomes & Safety ☒<br>Sustainable Services ☒ |
| **BAF/Corporate Risk Register: (if applicable)** | Charity risk register<br>• CFC2 Investments<br>• CFC6 Fundraising Framework<br>• CFC7 High fund balances |
| **Purpose of paper:** | Decision/Approval |
| **Executive Summary**: | To approve the 2024/25 draft Annual Report and Accounts |
| **Background:** | The attached 2024/25 Annual Report and Accounts have been substantially audited with an unqualified opinion proposed.<br><br>External Audit Report ISA 260 and Management Representation letter attached.<br><br>No findings and no unadjusted/adjusted audit differences have been reported with only a few matters of audit work to be completed (see page 5 of the ISA260).<br><br>The final audited Accounts and Trustee's Report has to be submitted to the Charity Commission by 31 January 2026. |
| **Key Recommendations**: | The Board is asked to approve the 2024/25 Annual Report and Accounts for the UHD Charity.<br><br>Approval is sought on the condition the Chief Finance Officer will report any significant findings or amendments (should they arise from the remaining |

| | |
|---|---|
| | external audit work), prior to submission to the Charity Commission. |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality, Equity, Diversity & Inclusion ☐<br>Financial ☒<br>Health Inequalities ☐<br>Operational Performance ☐<br>People (inc Staff, Patients) ☐<br>Public Consultation ☐<br>Quality ☐<br>Regulatory ☒<br>Strategy/Transformation ☐<br>System ☐ |
| **CQC Reference:** | Safe ☐<br>Effective ☐<br>Caring ☐<br>Responsive ☐<br>Well Led ☒<br>Use of Resources ☒ |

| Report History: Committees/Meetings at which the item has been considered: | Date | Outcome |
|---|---|---|
| Charitable Funds Committee | 10/11/2025 | The committee endorsed the Annual Report and Accounts and the signing of the Letter of Representation with a recommendation to the Board to approve. |

| | |
|---|---|
| **Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)** | Commercial confidentiality ☐<br>Patient confidentiality ☐<br>Staff confidentiality ☐<br>Other exceptional reason ☐ |

# ANNUAL REPORT 2024/25

University Hospitals Dorset NHS Charity

Registered Charity No.1057366

# CONTENTS





# CHAIR'S WELCOME

As I look back on the past year, I'm filled with deep admiration for the extraordinary spirit that drives our charity forward; **a spirit of kindness, community, and commitment.**

2024/25 has been a year of *connection, compassion, and momentum.* From children's elf dashes along the prom to courageous climbs up Kilimanjaro, each act of generosity has shaped our progress and brought comfort and care to those who need it most. Behind every pound raised is a story - a story of remembrance, resilience, or simple human kindness. Together, they form a powerful narrative of hope and healing.

A standout highlight has been the launch of the **BEACH Appeal**, the Charity's most ambitious fundraising campaign to date. Designed to enhance care in the new six-storey BEACH Building at Royal Bournemouth Hospital, the appeal has already raised over **£641,000** towards a £1.5 million goal. Whether through support for an additional CT scanner in the new Emergency Department to significantly reduce waiting times, interactive sensory rooms to aid young patients' mental wellbeing when coming into hospital unexpectedly, or a peaceful Critical Care Garden for ICU patients, their families and our hardworking ICU staff - every donation is helping to transform the future of care for Dorset.

The year has also been rich with **personal stories of generosity:** from Joshie's handmade rainbow headbands to fund epilepsy pillows for children, to the wonderful Knit and Natter group's tireless support of Gully's Place; from community walks around our beautiful county to daring skydives to memory evenings on the prom lit with lanterns - all demonstrating just how deeply our cause resonates.

**"To our dedicated hospital staff, tireless volunteers, generous donors, and brilliant charity team: thank you. Your energy, passion, and belief in what we do ensure that we can continue going above and beyond NHS funding to create a better experience for patients, families, and staff at our Hospitals."**

And we mustn't forget our **corporate champions**, who have gone above and beyond to stand beside us. With partners like Morebus, HOT Radio, and Haskins Garden Centres, we are not only raising funds - we are building lasting relationships that continue to grow our reach and amplify our message.

Looking ahead, we remain focused on completing the BEACH Appeal, expanding support for our hospital teams, and ensuring that everyone who steps through our doors feels the warmth, dignity, and excellence they deserve. Thank you for standing with us. Let's keep building something extraordinary together.

With warmest regards,

C L Whitaker

**Claire Whitaker MBE,**
**Chair of Charitable Funds Committee**

# AIMS AND OBJECTIVES

University Hospitals Dorset NHS Charity raises funds to enhance the care and treatment of patients accessing NHS services at Poole, Royal Bournemouth and Christchurch Hospitals by fundraising to provide enhanced facilities and support NHS staff health, wellbeing and development.

University Hospitals Dorset NHS Charity supports every area of the Trust and enables supporters to donate directly to a clinical area or hospital of their choice across all three hospitals.

**"Thanks to our supporters the charity continues to be there for everyone who needs us at a time they need the NHS most."**

We help hospital staff provide the very best care and treatments to our local community. Whether it is funding state-of-the-art equipment and modern patient environments or the small but meaningful things like activity boxes for dementia patients, our charity and lifeline of supporters make invaluable differences to help improve the lives of our patients and staff.

# CHARITABLE PURPOSE

University Hospitals Dorset NHS Charity legal purpose is to raise funds for any purposes relating to the NHS wholly or mainly for the services provided by the University Hospitals Dorset NHS Foundation Trust.

The charity supports both capital and ongoing projects that are in line with the Hospitals vision and strategy, and that which will enhance the provision of care and treatment to our patients.

**"We aim to make a difference to every patient and every condition that is treated at our hospitals above and beyond that which can be provided through NHS funding."**

## The charity raises funds to:

- Enhance patient care and comfort
- Provide state-of-the-art and extra equipment and facilities
- Invest in our experienced staff to support improved patient health and wellbeing

**Working with the community and our supporters we aim to speed up patient treatment, reduce anxiety, aid quicker recovery, provide less intrusive treatment and improve the health and wellbeing of both patients and staff within the Poole, Royal Bournemouth and Christchurch hospitals.**



# MISSION, VALUES AND GOALS

## University Hospitals Dorset NHS Charity mission is:

**To enhance the care and treatment of patients accessing NHS services at Poole, Royal Bournemouth and Christchurch Hospitals by fundraising to provide enhanced facilities, state-of-the-art equipment and to support NHS staff health, wellbeing and development to enable the hospitals to deliver safe and high-quality care.**

## Our strategic goals are;

1. **To work alongside the Trust to enhance the experience of patients and staff above and beyond what can be delivered through core funding.**
2. **To deliver an excellent supporter experience to our donors and volunteers.**
3. **To develop great relationships with our partners to deliver benefits to patients across our hospitals.**
4. **To be financially secure, responsive and have good governance.**

## The following values underpin our work:

- INTEGRITY
- COMPASSION
- INNOVATION

These are reflected in the Trust values: we are caring, we are one team, we listen to understand, we are always improving, we are open, honest and inclusive.

## Fundraising Practices

At University Hospitals Dorset NHS Charity, we are committed to ensuring our supporters and donors are treated fairly and with respect. We comply with charity sector best practice across all our fundraising activities and look for ways to improve, innovate and be more economical alongside adopting new regulations. We are a member of the Fundraising Regulator and have complied with all fundraising standards as far as the charity is aware in 2024/25.

## Our fundraising promise:

**We commit to high standards across all our fundraising:**

**We will be...**

- **clear, honest and open**
- **respectful**
- **fair and reasonable**
- **accountable and responsible**

# FACTS AND FIGURES

## Why is the charity needed?

The charity's income supports services, patient welfare items and new equipment across our three hospitals. In 2024/25 the hospitals supported:

**670,493**
OUTPATIENT APPOINTMENTS

**111,810**
INPATIENT APPOINTMENTS

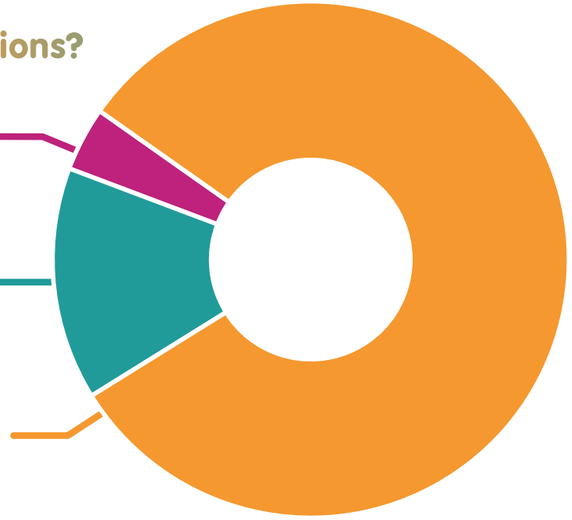
**87,397**
EMERGENCY DEPARTMENT ADMISSIONS

## How did we spend your donations?

4% STAFF EDUCATION

15% STAFF WELFARE & AMENITIES

81% PATIENT WELFARE INC. MEDICAL EQUIPMENT



**How much did we raise in total?**

**£6,031,279**



## How many people raised funds for the charity?


## How many organisations supported the charity?

**56** LEGACIES

**15** CHARITABLE TRUSTS AND FOUNDATIONS

**96** CLUBS & ORGANISATIONS

**6** AFFILIATE CHARITIES

**83** BUSINESSES

## It costs the charity 14p to raise £1

# LOOKING BACK AT 2024 - 2025

APRIL

## London Marathon 2024

In a spectacular show of stamina and spirit, eight passionate runners took on the iconic London Marathon, **each stride dedicated to improving lives at UHD.**

Together, they raised an incredible £17,913, helping to fund specialist equipment including a space-and-tilt wheelchair; an essential asset for patients undergoing therapy after severe brain and spinal injuries.







RAISED £17,913

MAY


## Reegan & Ridha's Head Shave

In a bold and beautiful act of remembrance for their friend Trey, these incredible siblings shaved their heads and **raised £369 for Gully's Place.** Their courage and compassion captured the hearts of many.

RAISED £369



RAISED £20,837

## Twilight Walk

As the sky turned dusky pink over Bournemouth Pier, 305 supporters walked in unison, lighting up the coastline to **honour loved ones and support breast cancer services.** With heartfelt tributes and glowing lanterns, they raised a remarkable £20,837.





JUNE

RAISED £673

## Marcus' 100 Mile Bike Challenge

Pushing pedals across scenic countryside, Marcus rode 100 miles in support of SPRING, raising **£673 to support bereaved families.** His solo ride turned into a journey of community spirit and healing.

JULY

## Joshie's Awesome HeadBands Biz for Epilepsy

At just 11 years old, Joshie launched a rainbow-coloured campaign, creating and selling BANZ headbands to raise money for **epilepsy care**. His efforts brought in £3,000, proving you're never too young to make a difference.

RAISED £3,000





AUGUST

## Hev Fest, Embracing Summer Vibes for Radiotherapy

Turning a difficult chapter into a celebration of care, Clive and Heather held a mini festival in their garden to **thank the brilliant radiotherapy team who stood by them during Clive's throat cancer journey.**

In the summer of 2024, their friends and family turned up to HevFest to celebrate Clive's recovery and raised £2,674 for the Radiotherapy Department.

RAISED £2,674

## Daniel's Spectacular Skydiving for Cancer

RAISED £1,585

Jumping from 15,000 feet takes nerves of steel - and **Daniel did it all to raise £1,585 for cancer care.** His leap of faith was a tribute to those fighting daily battles.

SEPTEMBER

## Walk for Wards

More than 300 participants donned their walking boots and UHD T-shirts to take part in our flagship Walk for Wards at Upton Park. They wandered along forest paths to enjoy festive activities, from face painting to live music. **Raising an astonishing £21,355 to support every corner of the hospital.**



RAISED £21,355

## Broadstone Cricket Social

Broadstone Cricket Club planned to hold a charity match to raise funds for Cancer Services at UHD as a team member is undergoing treatment. **Due to a pretty serious storm it was turned into a social event and the members turned out in force raising £2,068.**

RAISED £2,068

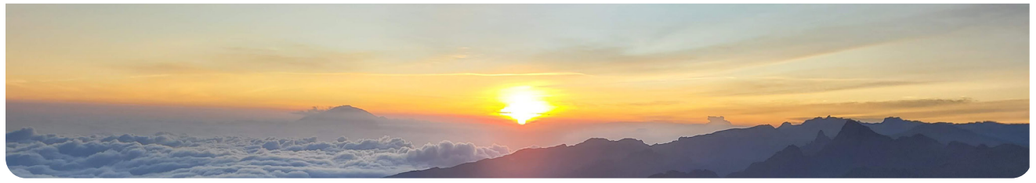


OCTOBER

## Five Epic Adventurers Climb Kilimanjaro

Five of our incredible UHD staff members ascended Africa's highest peak, **facing altitude and adversity to raise £6,779**. Their journey, both physical and emotional, supported a range of hospital departments.

RAISED £6,779



NOVEMBER

## Light up the Prom Shines Again

Almost 400 people came together to honour loved ones, casting a sea of glowing tribute lanterns along the shore wth the soaring voices of Bournemouth Male Voice Choir and a breathtaking ocean-lit fireworks display, **the evening was a moving celebration of life and remembrance.** Thanks to the kindness and spirit of all who took part, the event raised an incredible £8,887 - **a shining reminder of the enduring power of memory and togetherness.**

RAISED £8,779

DECEMBER

## Elves Dash for Charity Along Boscombe Prom

At the Elf Dash, **171 cheerful elves jingled their way along Boscombe Promenade, raising a fantastic £6,105 for the BEACH Appeal.** With stripy tights, tinsel, and plenty of festive fun, it was a brilliant day of community spirit and fundraising magic.

RAISED £6,105

## Poole Centenary Club Shares the Spirit of Giving

The wonderful Poole Centenary Club chose to support Gully's Place for a second year running - raising **£4,535 through year-round collections and a dazzling Christmas mega raffle.** From bottles of wine to luxury dining and unforgettable experiences, the prizes added sparkle to the season and brought people together for a cause close to their hearts.

RAISED £4,535


Gully's Place



JANUARY

## Our ACTS Team smashed their Dry January 10k race!

Our incredible Addiction Care & Treatment Services Team pounded the pavement on race day to raise awareness about the benefits of going sober in January. **They raised a tremendous £2,000 in support of the ACT Services at University Hospitals Dorset.**

RAISED £2,000

FEBRUARY

## A Night of Sparkle for ACTS

With sequins, song and a whole lot of soul, **Gina and GJ Cabaret brought back their heartfelt show, Loved Ones Lost, raising £1,415 for Addiction Care and Treatment Services (ACTS).** Held in memory of Gina's dad, it was a night that mixed fun with meaning - honouring lives lost while supporting recovery journeys still being written.

RAISED £1,415

MARCH

## Stepping Up for Men's Health

Supporters laced up their shoes for a powerful walk in support of **prostate cancer awareness**. Whether walking in memory, celebration or solidarity, the event brought people together to break the silence around men's health - one step, one story, one show of strength at a time.


RAISED £26,685



# CORPORATE CHAMPIONS - PARTNERS IN CARE

Our corporate partners are more than sponsors, they're compassionate allies, helping us deliver extraordinary care and create lasting impact for patients and families across our community.

## Morebus

Morebus didn't just get on board, they drove our mission forward in every sense. Naming us their Charity of the Year, they wrapped their buses with our branding, rallied their 700-strong driver team, and kept our cause on the move across Dorset. **Their phenomenal £50,000 donation, our biggest ever from a corporate partner**, has helped to pay for new items in the Maternity Unit like recliner chairs and also towards funding an additional CT scanner.

## Haskins Garden Centres

Bursting with warmth, joy, and generosity, Haskins Garden Centres **raised a phenomenal £17,343 for SPRING**, our service supporting families facing the heartbreak of baby loss. Through magical Santa's Grottos, festive jumper days, and more, their heartfelt efforts offered comfort, hope, and connection to those navigating unimaginable grief.

## HOT Radio

HOT Radio kept our mission loud and clear all year long dialling up the heart and turning up the volume for the BEACH Appeal. With regular on-air shoutouts, interviews, and updates, they helped our message hit the airwaves and reach new ears across the community. Their fundraising team, **the HOT Walkers, returned to Walk for Wards and smashed the dial, raising an amazing £7,377** - beating last year's total by over £1,000 and proving they've got staying power both on and off the air.

## Philip Trim Contractors

Every summer, local legend Philip Trim throws open the gates of Throop Hollow Farm for a charity fundraiser that's full of heart and powered by love. Held in memory of his much-missed wife, Jane, the event brings the community together for laughter, generosity, and purpose. **This year's efforts raised a fantastic £7,500 for our Radiotherapy Department,** helping others face cancer with strength and support. It's a tribute that grows deeper roots each year - turning personal loss into lasting impact.

# Gully's Place - A lifeline for families when they need it most

Gully's Place

At the heart of Gully's Place is a simple but powerful promise: to stand beside families during some of the most challenging and heart-wrenching times of their lives. From the neonatal unit to end-of-life care for children and young people, Gully's Place provides comfort, compassion, and practical support that extends far beyond the hospital walls.

Thanks to your continued generosity, Gully's Place has been able to offer vital care and create moments of peace, dignity, and togetherness when they matter most.

## John McDermott's 100km Ultra Challenge

Taking on a mammoth 100km from London to Brighton, John McDermott laced up his trainers and hit the road to **raise an incredible £2,300 for the Gully's Place facility.** Every mile he ran was a tribute to the strength of families Gully's Place supports - and his efforts will help ensure no family walks this journey alone.


## Santa Sleigh Run Lights Up Lychett Matravers

The team at Lychett Matravers Twinning Association brought festive cheer to our community with their Santa's Sleigh Run, lighting up faces and raising £876 to support our youngest patients and their families.

## Crafting For A Cause

The wonderful Knit and Natter group continued their amazing support in 2024, raising an outstanding £8,000 for Gully's Place. Meeting twice a week at Rockley Park, this dedicated team of crafters sell handmade treasures with love, purpose, and an unwavering commitment to making a difference. Their warmth and creativity are stitched into every penny raised.





# SPRING - Standing with Families Through Baby Loss

SPRING

SPRING provides compassionate care for families affected by the loss of a baby - whether during pregnancy, at birth, or shortly after. Every donation helps provide counselling, memory-making opportunities, and a safe space to grieve.

## Running in Memory of Lily


In February 2023 Matt Burgum and his wife Beth received the devastating news that their daughter Lily had passed away at 28 weeks. **SPRING offered them a quiet private space to be with Lily, holding her, sharing stories and creating precious memories.** Over a year later Matt ran his first half marathon at Run Bournemouth in Lily's memory, raising over £3,100 for SPRING.

## Erasure-ish, A Tribute with Heart

The fantastic tribute band Erasure-ish lit up the stage for SPRING with a charity concert that combined celebration and remembrance. **Raising a brilliant £2,640, the event was a joyful night that made a huge difference for bereaved families.**


## Phantasia - Music in Memory

Violinist Emma-Marie Kabanova, who received support from SPRING after the loss of her babies, turned grief into grace by organising three moving concerts of the Mystery Sonatas with her ensemble Phantasia. **She raised £1,002, honouring her children and giving back to the service that supported her.**

# SPEND - What we achieved together in 2024-25

## A Breath of Fresh Air - The Critical Care Garden

For patients in our Intensive Care Unit, the simplest things like feeling the sun on their face or hearing birdsong can feel impossibly out of reach. Connected to life-saving machines and often too unwell to be moved, the chance to step outside has long been a logistical challenge.

But that's changing. Thanks to an incredible £15,000 donation from Talbot Village Trust, we've begun creating a Critical Care Garden. A peaceful, private outdoor space within the new BEACH Building, designed to be safely accessible for both patients and the dedicated staff who care for them.

This garden will offer something extraordinary: a sense of normality, nature, and calm in the midst of intensive treatment.

It will be a place where families can share precious moments, where staff can pause to recharge, and where healing can begin not just with medicine, but with light, air, and hope.

Work is already underway, and every paving stone, plant, and bench tells a story of care, community, and compassion.



## Say My Name – Theatre Hats for Our Hidden Heroes

Behind every successful surgery is a team of quiet professionals working seamlessly together - our theatre staff, the hidden heroes who often go unseen but never unnoticed.

Through your support, we were able to fund personalised theatre hats for our surgical teams. Embroidered with each team member's name and proudly adorned with our charity's logo, these hats are more than just part of a uniform - they're a powerful tool for connection, communication, and pride.

In the high-pressure, fast-paced environment of the operating theatre, clear communication is critical. Having names visible helps break down barriers, strengthens teamwork, and creates a safer, more human space for both staff and patients. Each hat costs just a small amount - but the value is immeasurable.

For our staff, it's a boost of identity and recognition. For our patients, it's reassuring to see the names of those caring for them in such vulnerable moments. And for our charity, it's a chance to stand beside our hospital family, stitch by stitch.

Thank you for helping us bring a little warmth, pride, and personal touch to those who give their all behind the scenes.


**We feel so proud to have our logo on the hats of our amazing theatre team!**

# Fast-Tracking Care – A New CT Scanner for the BEACH Building


Every second counts in our Emergency Department. For patients arriving in pain, distress, or with life-threatening conditions, fast and accurate diagnosis can mean the difference between life and death.

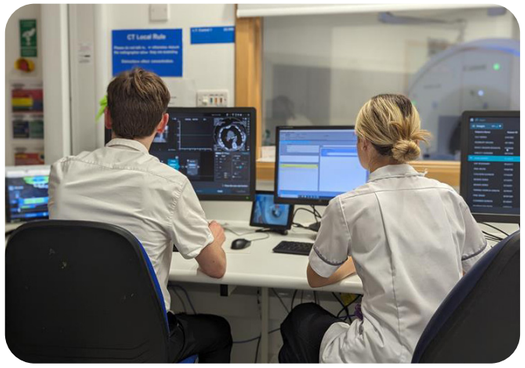
That's why, through the generosity of our community and the power of the BEACH Appeal, we've been able to fundraise for a much-needed additional CT scanner in the new BEACH Building.

This vital piece of equipment will allow our clinical teams to scan an extra 13,000 to 15,000 patients every year - significantly reducing waiting times in ED and across the hospital. With quicker access to detailed imaging, our clinicians can diagnose and begin treatment faster, easing anxiety for patients and improving outcomes from the very start.

The new scanner will also help relieve pressure on existing imaging services, ensuring that more patients get the answers and care they need, when they need it most.

Behind every scan is a story - a worried parent, a sudden collapse, a moment of uncertainty turned into clarity. And behind every story is someone who gave, someone who walked, baked, donated, or shared our message.

Thanks to you, we're not just building a hospital - we're transforming the future of care.

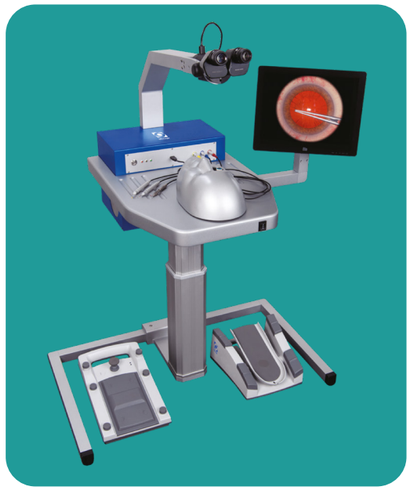




# Precision Training for Vision Care – Eye Sim Comes to the BEACH

Funding the new and innovative Eye Sim, costing £201,000, is a clear investment for the future of eye surgery for everybody across Dorset and Wessex.

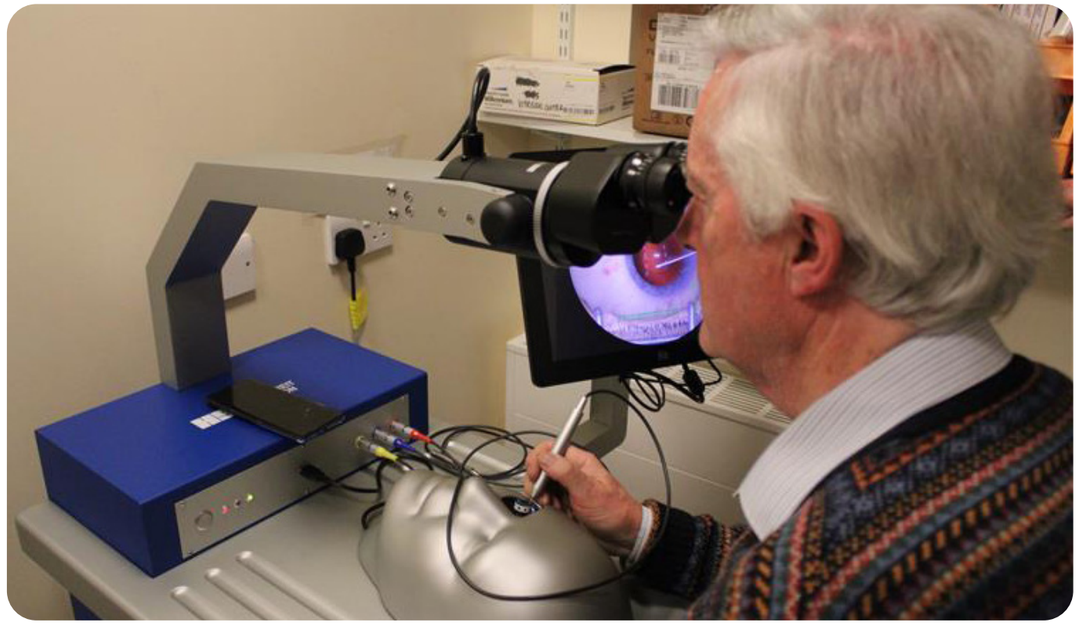
Generous supporters across the region and beyond have helped University Hospitals Dorset NHS Charity reach the full fundraising target to purchase a new eye simulator. This includes £49,986 donation from the Friends of the Bournemouth Eye Unit, £20,000 from the Roger Raymond Charitable Trust and £10,000 from the Valentine Charitable Trust all ensuring the next generation of surgeons receive the best training at our hospitals.



Surgery for common eye conditions, like cataracts and glaucoma, can be very complicated. They require comprehensive ophthalmic specialist training, which takes seven years.

Before concluding their specialist training, surgeons are expected to carry out 300 complete cataract procedures. Experienced surgeons can complete the highly technical procedure in 20 minutes.

Using the simulator is beneficial because trainee surgeons will learn to operate in a small cube of 5x5x5mm and account for the natural movement of the eye. Learning these skills on a simulator before operating on patients is crucial to ensure patient safety. It also frees up theatre time for those awaiting sight-saving surgeries rather than for training purposes.



# SUPPORT ACROSS OUR HOSPITALS

## Support for staff

The charity is passionate about investing in the health and wellbeing of our hospital staff. This may include the provision of refreshments for those working long hours due to operational pressures. The charity also funded an interactive health kiosk at each hospital site to encourage staff to access a confidential health MOT that includes blood pressure, weight, heart rate, BMI, body fat and wellbeing age.

Several wellbeing and team building days have been supported by the charity to give staff a break from clinical settings and time to recharge and destress.

## Equipment

The charity has worked with supporters to fund many additional equipment items to make patients more comfortable. This includes an over-bed trainer to assist in the ongoing rehabilitation of ICU patients; this is used to improve strength in the patient's limbs and improve cardiovascular performance. For a range of patients who are unable to actively participate this piece of equipment will be able to passively exercise their joints, muscles and other tissues.

Other items include a point of care ultrasound, a specialist tilt and space wheelchair and a hand grip strength monitor.

## Training

The charity is proud to support additional staff training to enhance patient care such as funding the attendance at a lower limbs ulcer management course, a two-day musculoskeletal ultrasound course, understanding blood result courses and a spinal cord injury study day.

## Patient Welfare

A wide range of items are provided each year to ease the hospital experience for patients. For example, funding presents for patients who need to spend Christmas in hospital, providing yoga classes to patients living with cancer, an activities trolley with games and activities for inpatients to be supported by volunteers, music therapy sessions for both children with neurodevelopmental disorders and our acquired brain injury patients.

We were also pleased to provide bags with comfort items for patients starting their chemotherapy journey, additional bedside TV access for patients for the Olympics opening ceremony, meal vouchers for carers and care packages for homeless patients on discharge. This all helps us care for our teams that care for you.

# FUTURE PLANS & OBJECTIVES

A detailed strategy for 2025/26 has been agreed and recognises the continued volatile financial landscape given the current fundraising environment and the cost-of-living crisis.

The main focus for the charity continues to be raising funds within our local community to complete the £1.5 million fundraising appeal for additional items to enhance the care we provide in our new six-storey BEACH building at the Royal Bournemouth Hospital, beyond what the NHS can fund. The BEACH Appeal was launched in April 2024 and some of the fundraising items include an additional CT scanner, indoor and outdoor play areas for the children's department and a wellbeing garden for critical care staff, patients and their visitors.

In summary, The BEACH Appeal aims to enhance the experience of everybody who walks through those doors and contribute to the BEACH building standing as a beacon of exceptional care and support for the local community.

Underpinning this is the continued objective to support all areas of the hospitals, specific capital/equipment fundraising appeals and the health and wellbeing of staff plus the aim to excel in our stewardship of our donors and maximise long term donor value.

Future plans provide a framework within which charitable fundraising linked to the University Hospitals Dorset NHS Foundation Trust should be conducted; and how charity money raised is spent to benefit staff and patients within the Trust.

The strategy has the following objectives:

**To work alongside the Trust to enhance the experience of patients and staff above and beyond what can be delivered through core funding**

**To deliver an excellent supporter experience to our donors and volunteers**

**To develop great relationships with our partners to deliver benefits to patients across our hospitals**

**To be financially secure, responsive and have good governance**

# FUNDRAISING POLICY

The Trust employs a fundraising team to carry out activities for generating funds; this includes fundraising events, challenges, campaigns and stewarding donors. In addition, proactive marketing is undertaken to maximise all opportunities to raise funds across our local communities for specific projects.

The team also provides guidelines for groups and individuals and monitors fundraising activities on our behalf in the community to ensure that fundraising activities are compliant with relevant legislation.

The Charity is a member of the Fundraising Regulator, which includes the Fundraising Code of Practice and is signed up to the Fundraising Preference scheme. During 2024/25 there has been no failure to comply with these schemes and no material complaints about the Charity's activity.

The Charity has several policies which provide additional reassurance regarding our activities and donor care, including an acceptance and refusal of donations policy which highlights how we will treat donors particularly relating to receiving donations from individuals who may be vulnerable.

Excellent donor care and stewardship underpins the fundraising team's activities and approach to proactive fundraising.

# RESERVES POLICY

Most of the expenditure incurred by the Charity is in respect of contributions to patients, staff and the purchase of medical equipment. The policy of holding reserves is a balance between keeping a relatively small sum of money in individual funds for which specific donations have been made and planning for additional capital investment.

The Trustees considered the reserves policy during 2024/25 and agreed that a minimum reserve of £2 million should be retained in unrestricted funds. Expenditure plans will be adjusted in line with actual income performance specifically recognising potential volatility in investment markets in year. This position is monitored on a regular basis by the Committee.

# REFERENCE & ADMINISTRATIVE DETAILS

The accounts on which this report is based have been prepared in accordance with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed.

The registered Charity Commission number for the University Hospitals Dorset NHS Charity is 1057366.

The registered address is: Royal Bournemouth Hospital, Castle Lane East, Bournemouth, Dorset, BH7 7DW

The Governing Document (dated 17 May 1996, amended by supplemental deed 1 June 2007, 1 October 2020 and 2 March 2021) of the charity is in the form of Trust Deeds and has been registered with The Charity Commission. This document encompasses the main objectives of the charity for "For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the service provided by the University Hospitals Dorset NHS Foundation Trust "with the Board of Directors acting as a Trustee. The Trustee is given the authority to efficiently and effectively manage the Charitable Funds.



# TRUSTEE

The Trustee of University Hospitals Dorset NHS Charity is the board of Directors for University Hospitals Dorset Foundation trust.

The Directors of University Hospitals Dorset NHS Foundation Trust are not individual trustees under Charity Law but act as agents on behalf of the Corporate Trustee. The Board members who served during the financial year and to the date of signing the financial statements were as follows:

**Siobhan Harrington,** Chief Executive Officer

**Peter Wilson,** Chief Medical Officer

**Pete Papworth,** Chief Finance Officer

**Mark Mould,** Chief Operating Officer

**Paula Shobbrook,** Chief Nursing Officer (until 09 April 2024)

**Fiona Hoskins,** Interim Chief Nursing Officer (from 08 April 2024 to 12 May 2024)

**Sarah Herbert,** Chief Nursing Officer (from 13 May 2024)

**Richard Renaut,** Chief Strategy and Transformation Officer

**Irene Mardon**, Interim Chief People Officer (from 01 December 2023 to 29 February 2024)

**Tina Ricketts,** Chief People Officer (from 26 February 2024)

**Rob Whiteman CBE,** Trust Chair

**John Lelliott OBE,** Non-Executive Director

**Pankaj Davé,** Non-Executive Director

**Clifford Shearman OBE,** Non-Executive Director

**Stephen Mount,** Non-Executive Director (until 30 September 2023)

**Claire Whitaker CBE**, Non-Executive Director (from 1 October 2023)

**Philip Green**, Non-Executive Director (until 30 September 2023)

**Caroline Tapster CBE,** Non-Executive Director (until 31 December 2023)

**Judy Gillow MBE,** Non-Executive Director

**Sharath Ranjan,** Non-Executive Director

**Helena McKeown**, Non-Executive Director (from 1 October 2023)

University Hospitals Dorset NHS Foundation Trust is the Corporate Trustee of the Charitable Fund governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Acts 2011. The NHS Foundation Trust Board also comprises the Charitable Funds Committee and meets not less than quarterly.

The Charitable Fund is registered with the Charity Commission (no. 1057366) in accordance with the Charities Act 2011.

# STRUCTURE, GOVERNANCE & MANAGEMENT

The charity raises funds that can be accessed and not unreasonably restricted for the benefit of all members of the public. Due regard has been paid to the public benefit guidance published by the Charity Commission.

The Trustee of the Charitable Fund is the Board of Directors of University Hospitals Dorset NHS Foundation Trust. The Board of Directors has appointed a Charitable Funds Committee to oversee the arrangements of the charity. This committee monitors the requirements imposed on the Trust by statutory legislation and by the Charity Commission. The committee is also responsible for monitoring the performance of the investments of the charity through its external advisors and approves significant expenditure proposals.

The following were members of the Charitable Funds Committee at the financial year end:

**Claire Whitaker**

Non-Executive Director (Chair)

**Pankaj Davé**

Non-Executive Director

**Helena McKeown**

Non-Executive Director

**Pete Papworth**

Chief Finance Officer

**Tina Ricketts**

Chief People Officer

In addition to the voting members, the following attend committee meetings in an advisory capacity:

**Debbie Anderson**

Charity Director

The Trustee has delegated authorisation of requests for funds based on the following limits:

- Up to £5,000: Authorised Fund Manager
- Over £5,000: Fund Manager and Sustainable Services Group or Care Group Board
- Any requests for funds above £25,000 require the additional approval from the Charitable Funds Committee
- Any requests for funds above £250,000 require the additional approval of the Trust Board
- Any requests for medical equipment, regardless of value, must receive approval from the Medical Equipment Committee in addition to the financial approvals above

The Trustee has agreed that University Hospitals Dorset NHS Foundation Trust will provide administrative support to the charitable funds. This takes the form of managerial and accounting services, financial monitoring and advice. An annual fixed sum is recharged, together with actual fundraising costs incurred throughout the year.



# RISK MANAGEMENT

The major risks to which the Charity is exposed have been identified and considered by the Trustee.

Key risks have historically included increased local competition; the current economic climate; adverse publicity; and a potential fall in the value of investments. In addition, the cost-of-living crisis has been noted as a risk with an ongoing impact on fundraising across all income streams both short and long term.

A continued cautious strategy for the new University Hospitals Dorset NHS Charity has been adopted for 2025/26 and where appropriate, systems, policies and procedures have been established to mitigate specific risks. The Trustee is confident that reliance can be placed upon the management arrangements in place, which include internal and external audit services, to minimise any risk to the funds.

The most significant risk identified is the possibility of losses from a fall in the value of investments and the level of reserves available to mitigate the impact of such losses. Investments are held by qualified and experienced Investment Fund Managers who act in accordance with the agreed Investment Policy. These investments are subject to regular review, with unrealised gains and losses allocated to funds at agreed intervals.

Procedures are in place to ensure that financial commitments remain affordable within the fund balance. Income and expenditure are covered by the Trusts standing financial instructions and there is an agreed criteria for recognition in place for the receipt of donations.

There are clear approval procedures in place which give the Corporate Trustee confidence that expenditure will remain in line with the limits of the charities resources, ensuring continued compliance with the agreed reserves policy.



# UNIVERSITY HOSPITALS DORSET NHS CHARITY ANNUAL ACCOUNTS AS AT 31 MARCH 2025

## CONTENTS



## Introduction

University Hospitals Dorset NHS Charity (formerly Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust Charitable Fund), was entered on the Central Register of Charities on 6 August 1996.

The charity is registered with the Charity Commission (Charity Number 1057366) in accordance with the Charities Act of 2011.

The board of University Hospitals Dorset NHS Foundation Trust is the Corporate Trustee of the charity governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011.

Members of the Board of Directors are not individual trustees under charity law but act as agents on behalf of the Corporate Trustee.

## Main Purpose of the Funds Held on Trust

The main purpose of the charitable funds held on trust is to apply income for any charitable purpose relating to the National Health Service, wholly or mainly for the services provided by University Hospitals Dorset NHS Foundation Trust.

# EXECUTIVE SUMMARY

The year ended 31 March 2025 was a successful year for University Hospitals Dorset NHS Charity in the current market conditions.

On 1 April 2021, the Bournemouth Hospital Charity was renamed as University Hospitals Dorset NHS Charity and the assets and liabilities of Poole Hospital Charity were transferred into the newly named charity.

During 2024/25 the charity had total incoming resources amounting to £6,031k (2023/24: £4,970k). This includes legacies bequeathed totalling £3,757k (2023/24: £3,196k), donations of £720k (2023/24 £613k) and investment income of £486k (2023/24: £437k). The charity also received £930k (2023/24: £461k) from other trading activities and £138k (2023/24: £263k) from other income. These fundraising events help raise the profile of the hospitals in the local community.

Resources expended in 2024/25 totalled £3,332k (2023/24: £3,222k), of which £1,964k (2023/24: £1,594k) related to patient welfare, £355k (2023/24: £612k) to staff welfare and amenities. A decrease in commitments of £63k (2023/24: increase of £106k) is included, and further details on the expenditure for the year can be found in the Annual Report 2024/25.

For 2024/25, the investments portfolio increased by £116k (2023/24: £831k increase in market value). The charitable funds increased overall by £2,720k (2023/24: increased by £2,541k), leaving a closing balance of £17,965k (2023/24: £15,245k). The Financial Report is set out in two parts: the Annual Report followed by the Financial Statements, which include the Notes to the Accounts.

Charitable expenditure is of paramount importance in the continuation of the high quality service offered to our patients, and also assists staff in their working lives.

The Trustee wishes to thank all patients, relatives, staff, volunteers and supporters whose energy and dedication has enabled us to achieve our charitable objectives.

**Date: 10/11/2025**

**Pete Papworth**

**Chief Finance Officer**



# STATEMENT OF TRUSTEE'S RESPONSIBILITIES IN RESPECT OF THE TRUSTEE'S ANNUAL REPORT AND THE FINANCIAL STATEMENTS

Under the trust deed and charity law, the trustee is responsible for preparing the Trustees' Annual Report and the financial statements in accordance with applicable law and regulations. The trustee has elected to prepare the financial statements inaccordance with UK Accounting Standards, including FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland.

The financial statements are required by law to give a true and fair view of the state of affairs of the charity and of the excess of expenditure over income for that period.

In preparing these financial statements, generally accepted accounting practice entails that the trustee:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards and the Statement of Recommended Practice have been followed, subject to any material departures disclosed and explained in the financial statements;
- state whether the financial statements comply with the trust deed, subject to any material departures disclosed and explainedin the financial statements;
- assess the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

The trustee is required to act in accordance with the trust deed of the charity, within the framework of trust law. They areresponsible for keeping proper accounting records, sufficient to disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the trustee to ensure that, where any statements of accounts are prepared by them under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulationsunder that provision. They are responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and have general responsibilityfor taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The financial statements set out on pages 38 to 39 attached have been compiled from and are in accordance with the financial records maintained by the Trustee. By Order of the Trustee.

**Chair of the Charitable Funds Committee**

**Date: 10/11/2025**

**Member of the Charitable Funds Committee**

**Date: 10/11/2025**

**Femi Macauley - Non-Executive Director**

**Pete Papworth - Chief Finance Officer**

# INDEPENDENT AUDITORS REPORT

## Independent auditor's report to the Trustees of University Hospitals Dorset NHS Charity

### Opinion

We have audited the financial statements of University Hospitals Dorset NHS Charity ("the Charity") for the year ended 31 March 2025 which comprise the Statement of Financial Activities, Statement of Financial Position and related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Charity's affairs as at 31 March 2025 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with UK accounting standards, including FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

### Basis for opinion

We have been appointed as auditor under section 149 of the Charities Act 2011 (or its predecessors) and report in accordance with regulations made under section 154 of that Act.

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

### Going concern

The Trustees have prepared the financial statements on the going concern basis as they do not intend to liquidate the Charity or to cease its operations, and as they have concluded that the Charity's financial position means that this is realistic. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Trustees' conclusions, we considered the inherent risks to the Charity's business model and analysed how those risks might affect the Charity's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Trustees' use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and



- we have not identified, and concur with the Trustees' assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Charity's ability to continue as a going concern for the going concern period.
- However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Charity will continue in operation.

### Fraud and breaches of laws and regulations – ability to detect

*Identifying and responding to risks of material misstatement due to fraud*

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

- Enquiring of management and inspection of policy documentation as to the Charity's high-level policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Charitable Fund Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

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

As required by auditing standards, we perform procedures to address the risk of management override of controls, in particular the risk that management may be in a position to make inappropriate accounting entries. On this audit we do not believe there is a fraud risk related to revenue recognition because of the limited opportunity for fraud due to the simplistic nature of revenue.

We did not identify any additional fraud risks. We also performed procedures including:

Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included those posted to unusual accounts.

- Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general commercial and sector experience and discussed with the trustees and other management the policies and procedures regarding compliance with laws and regulations.

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

The potential effect of these laws and regulations on the financial statements varies considerably. The charity is subject to laws and regulations that directly affect the financial statements including financial reporting legislation (including charities legislation) distributable profits legislation, and taxation legislation and we assessed the extent of compliance with these laws and regulations as a part of our procedures on the related financial statement items.

Whilst the charity is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

*Context of the ability of the audit to detect fraud or breaches of law or regulation*

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

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

## Other information

The Trustees are responsible for the other information, which comprises the Trustees' Annual Report. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. We are required to report to you if:

- based solely on that work, we have identified material misstatements in the other information; or
- in our opinion, the information given in the Trustees' Annual Report is inconsistent in any material respect with the financial statements.

We have nothing to report in these respects.

## Matters on which we are required to report by exception

Under the Charities Act 2011 we are required to report to you if, in our opinion:

- the Charity has not kept sufficient accounting records; or
- the financial statements are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

We have nothing to report in these respects.



## Trustees' responsibilities

As explained more fully in their statement set out on page 2, the Trustees are responsible for: the preparation of financial statements which give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they either intend to liquidate the Charity or to cease operations, or have no realistic alternative but to do so.

## Auditor's responsibilities

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

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

## The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Charity's Trustees as a body, in accordance with section 149 of the Charities Act 2011 (or its predecessors) and regulations made under section 154 of that Act. Our audit work has been undertaken so that we might state to the Charity's Trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Charity and its Trustees, as a body, for our audit work, for this report, or for the opinions we have formed.

**Jonathan Brown**

**for and on behalf of KPMG LLP, Statutory Auditor**

*Chartered Accountants*

*KPMG LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006*

66 Queen Square

Bristol

BS1 4BE

# STATEMENT OF FINANCIAL ACTIVITIES AS AT 31 MARCH 2025

| | Notes | Unrestricted Funds | Restricted Funds | **Total at 31 March 2025** | Total at 31 March 2024 |
|---|---|---|---|---|---|
| | | £000 | £000 | **£000** | £000 |
| **Income and Endowments from:** | | | | | |
| Donations and legacies | 2.2 | 2,928 | 1,549 | **4,477** | 3,809 |
| Charitable activities | 2.2 | 738 | 192 | **930** | 461 |
| Investments | 2.2 / 8.4 | 283 | 203 | **486** | 437 |
| Other | 2.2 | 85 | 53 | **138** | 263 |
| **Total** | | 4,034 | 1,997 | **6,031** | **4,970** |
| **Expenditure on:** | | | | | |
| Raising funds | 3.1 | (558) | (349) | **(907)** | **(744)** |
| Other | 3.2 | (2,486) | 61 | **(2,425)** | **(2,478)** |
| **Total** | | (3,044) | (288) | **(3,332)** | **(3,222)** |
| Net gains / (losses) on investments | 8.1 | (251) | 367 | **116** | **831** |
| **Net income** | | 739 | 2,076 | **2,815** | **2,579** |
| **Other recognised gains / (losses):** | | | | | |
| Other gains/ (losses): | | (93) | (2) | **(95)** | (38) |
| **Net movement in funds** | | 646 | 2,074 | **2,720** | **2,541** |

| | | | | | |
|---|---|---|---|---|---|
| **Reconciliation of funds:** | | | | | |
| Total funds brought forward | 11.1 | 9,685 | 5,560 | **15,245** | **12,704** |
| | | | | | |
| **Total funds carried forward** | | 10,331 | 7,634 | **17,965** | **15,245** |



# STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2025

| | Notes | Unrestricted Funds | Restricted Funds | **Total at 31 March 2025** | Total at 31 March 2024 |
|---|---|---|---|---|---|
| **Fixed Assets** | | £000 | £000 | **£000** | £000 |
| Investments | 8.1 | 4,678 | 3,804 | **8,482** | 8,367 |
| Fixed Assets | 7 | 121 | - | **121** | 159 |
| **Total Fixed Assets** | | 4,799 | 3,804 | **8,603** | **8,526** |
| **Current Assets** | | | | | |
| Debtors | 9 | 1,053 | 67 | **1,120** | 33 |
| Short term investments and deposits | 8.3 | - | - | **-** | 61 |
| Cash at bank and in hand | | 5,918 | 4,813 | **10,731** | 9,636 |
| **Total Current Assets** | | 6,971 | 4,880 | **11,851** | **9,730** |
| Creditors: Amounts falling due within one year | 10 | (1,439) | (1,050) | **(2,489)** | (3,011) |
| **Net Current Assets** | | 5,532 | 3,830 | **9,362** | **6,719** |

| | | | | | |
|---|---|---|---|---|---|
| **Total Assets less Current Liabilities** | | 10,331 | 7,634 | **17,965** | **15,245** |

| | | | | | |
|---|---|---|---|---|---|
| **Total Net Assets** | | 10,331 | 7,634 | **17,965** | **15,245** |

| | | | | | |
|---|---|---|---|---|---|
| **Funds of the Charity** | | | | | |
| Unrestricted | | 10,331 | - | **10,331** | 9,685 |
| Restricted | | - | 7,634 | **7,634** | 5,560 |
| **Total Funds** | 11.1 | 10,331 | 7,634 | **17,965** | **15,245** |

# NOTES TO THE ACCOUNTS

## 1.1 Basis of Preparation

The financial statements have been prepared under the historical cost convention with items recognised at cost or transaction value unless otherwise stated in the relevant notes to these accounts. The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011. The trust constitutes a public benefit entity as defined by FRS 102. The trustees consider that there are no material uncertainties about the Trust's ability to continue as a going concern.

In these financial statements the charity is considered to be a qualifying entity (for the purpose of FRS 102) and has applied the exemption available under FRS 102 in respect of the requirement to present a cash flow statement.

a) Parent entity

The charity is a subsidiary of the University Hospitals Dorset Foundation Trust (UHD FT), whose main place of business is at Poole Hospital, Longfleet Rd, Poole, Dorset, BH15 2JB, and whose principal purpose is the provision of healthcare. The Board of Directors of UHD FT is the Corporate Trustee of the charity. The consolidated group accounts, which include the charity, are available on the UHD FT website at https://www.uhd.nhs.uk/about-us/what-we-spend.

## 1.2 Incoming Resources

a) All incoming resources are recognised once the charity has entitlement to the resources, it is probable that the resources will be received and the monetary value of the incoming resources can be measured with sufficient reliability.

b) Intangible income

The charity had no intangible income/expenditure during the year.

c) Legacies

Legacies are accounted for as incoming resources once the receipt of the legacy becomes reasonably probable. This will be once confirmation has been received from the representatives of the estates that payment of the legacy will be made or property transferred, and once all conditions attached to the legacy have been fulfilled.

Material legacies which have been notified but not recognised as incoming resources in the Statement of Financial Activities are disclosed in a separate note to the accounts, with an estimate of the amount receivable (Note 12).

d) Debtors

Debtors are recognised when a legal or constructive obligation to pay is created, the amount can be measured reliably and it is probable that payment will be received.

## 1.3 Resources Expended & Arrangements with UHD FT Staff

Liabilities are recognised as expenditure as soon as there is a legal or constructive obligation committing the charity to that expenditure, it is probable that settlement will be required and the amount of the obligation can be measured reliably.

a) Cost of generating funds

The Trust fundraising team continues to organise fundraising, and provides the opportunity to increase income. The costs associated with fundraising, and the overhead facility costs, are recharged from UHD FT on an accruals basis, based on actual costs incurred.

b) Grants payable

Grants payable are payments made to third parties (including NHS bodies) in the furtherance of the Trust's charitable objectives of the provision of patient care and staff welfare.

They are accounted for on an accruals basis where the conditions for their payment have been met, or where a third party has a reasonable expectation that they will receive the grant. This includes grants paid to NHS bodies.

c) Management and Administrative Costs

Service provision for financial information support has been agreed. Associated costs are accounted for on an accruals basis and are recorded as recharges of appropriate proportions from UHD FT. The recharge for 2024/25 totalled £98k (2023/24 £96k).

The recharge is made up as follows:

| **Financial Services** | **2024-25** | **2023-24** |
|---|---|---|
| UHD FT Staff | 18 | 18 |
| Internal Audit | 4 | 4 |
| External Audit | 8 | 7 |
| Non Pay Costs | 18 | 18 |
| Ext NHS Finance Services | 46 | 45 |
| Indemnity insurance | 4 | 4 |
| **Total** | **98** | **96** |

Fundraising costs are also recharged to the charity from the Foundation Trust and are detailed below:

| **Fundraising costs** | **2024-25** | **2023-24** |
|---|---|---|
| Pay | 649 | 558 |
| Non-Pay | 102 | 19 |
| **Total** | **751** | **577** |

d) Staffing

The charity has no employees. Management and administrative costs are recharged as per 1.3c.

## 1.4 Structure of funds

The funds are classified and structured as below:

**Unrestricted Funds**

Unrestricted income funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds, where the donor has made known their non binding wishes or where the Trustee, at its discretion, has created a fund for a specific purpose.

**Restricted Funds**

Restricted funds are to be utilised in accordance with any specific restrictions imposed by the donor, or the specifications included in an appeal or event targeting income generation for the benefit of a particular area or service.

Where the use of a restricted fund becomes impracticable (e.g. where the terms of a restricted legacy can no longer be achieved) the Trustee may pass a special resolution reclassifying the fund as unrestricted but designated for a specific purpose. The Trustee would attempt to respect the wishes of the donor as far as is reasonably practical.

The Trust has no Endowment (Capital - Expendable or Permanent) Funds.

Analysis of the unrestricted and restricted funds can be found in Notes 11.1 & 11.2.

Details of the funds and their individual purpose can be obtained from the Annual Report along with information on the fund performance for the year.

## 1.5 Fixed Asset Investment

Investment Fixed Assets are shown at Market Value, as detailed in Note 8 to the Statement of Financial Activities.

The Trustee policy is to invest charitable funds with investments that maximise capital and are the most suitable investment type.  The long-term objective is to invest capital that will give the maximum growth on income with minimal risk.  The investment held as at balance sheet date are units within a Common Investment Fund, and are included in the Balance Sheet at the closing price at 31st March 2025.

## 1.6 Tangible Fixed Assets

**Valution**

The Charity's tangible fixed asset is revalued using professional valuations in accordance with International Accounting Standard 16 every five years. A three yearly interim valuation is also carried out. Additional valuations are carried out as appropriate.

A full asset valuation was undertaken as at 31st March 2025; and this value, together with indexation applied to buildings in line with the Valuer's advice has been included in the closing Statement of Financial Position.

The valuations are carried out primarily on the basis of Modern Equivalent for specialised operational property and Existing Use Value for non-specialised operational property.



**Depreciation**

Items of buildings are depreciated over their remaining useful economic lives on a straight line basis. The estimated useful economic life of the Resource Centre is 50 years.

**Revaluation and Impairment**

Increases and decreases in asset values arising from revaluations are reported under Other Recognised Gains/(Losses) in the Statement of Financial Activities.

## 1.6 Investment Gains and Losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or value at date of purchase if later).

Unrealised gains and losses are calculated as the difference between the closing market value and the opening value (or value at date of purchase if later). These are shown in the Statement of Financial Activities under gains on revaluation of investment assets.

Analysis of the Investment gains and losses can be found in Note 8 to the Statement of Financial Activities.

## 1.7 (Fixed) Short Term Investments

This is interest received on the main bank accounts.

Short Term Investments include stocks and equities that have been received as part of legacies made to the Charitable Funds.  In order to ensure the Charities investments are aligned to its investment policy, donated stocks and equities are disposed of as soon as it is practicable. Investments still owned at the end of the financial period are revalued, and any gain or loss on revaluation of the investment asset is shown in the Statement of Financial Activities.

## 1.8 Apportionment of Investment Income

The Fixed Asset Investment (Common Investment Fund) is revalued every month, an overall unrealised gain is apportioned over the funds (excluding Restricted), while an unrealised loss is held in a central fund until such time the investment has returned to an overall gain.

## 1.9 Pension Contributions

The charity has no employees, and therefore makes no contributions to any pension fund.

## 1.10 Prior Year Adjustments

None

## 1.11 Pooling Scheme

An official pooling scheme was registered for investments with the Charity Commission on 16th June 1998.

## 1.12 Related Party Transactions

The charity has made revenue and capital payments to University Hospitals Dorset NHS Foundation Trust (UHD FT), whose Board of Directors is the Corporate Trustee of the charity. A summary of the turnover and net surplus for the NHS Foundation Trust for 2024-25 and 2023-24 is shown in Note 15.

Arrangements are in place with the UHD FT for the completion of a monthly recharge relating to all charitable expenditure incurred by the Trust. The recharge is paid in arrears.

Details of resources expended with related parties during the year are shown in Note 3.2.

As at 31st March 2025, the Charity owed £232,956.90 to the Trust.

## 1.13 Reserves Policy

Most of the expenditure incurred by the Charity is in respect of contributions to patients, staff and the purchase of medical equipment. The policy of holding reserves is a balance between keeping a relatively small sum of money in individual funds for which specific donations have been made and planning for additional capital investment. The Trustees considered the reserves policy during 2024 and agreed that a minimum reserve target of £2 million should be retained in unrestricted funds.

## 1.14 Supporters

Organisations recognised as major supporters to the University Hospitals Dorset NHS Charitable Funds are as follows:

- Poole Hospital Cancer Treatment Trust
- Morebus
- Talbot Village Trust
- Mazars Charitable Trust
- Odinel Charitable Trust

## 1.15 Third Party Recharges

Income and expenditure relating to Third Party Recharges are included in “Other” within Incoming Resources, and expenditure is included within Grants Payable. Details of all Third Party Recharges during the year are shown in Note 2.3.

## 1.16 Trustee Remuneration

There have been no payments made during the year for the refund of expenses or remuneration to the Trustee

## 1.17 Donations Policy

Donations are receipted to the donor as they are received. All donations are allocated to the specified fund, as stated by the donor. Any restrictions on donations usage are adhered to by the Fund Managers, and the funds are classified accordingly.

Further details of the purposes of various funds can be seen within the Annual Report.



## 1.18 Activities in Furtherance of

In the furtherance of charity objectives, events have been held throughout the year by the fundraising office to generate income to the charitable funds.

Income from the fundraising events held can be seen within Operating Activities for generating funds (see Note 2.1).

All related expenditure to these fundraising events has been included within costs of generating funds and can be separately seen on the Statement of Financial Activities for the year.

## 1.19 Post Balance Sheet Events

There are no post Balance Sheet events.

## 1.20 Support Cost, Governance Cost and Cost of Generating Funds Apportionment to Trust Fund

The methodology is to apportion fundraising and administration recharges, together with investment gains and losses across all fund balances.

## 1.21 Support Cost, Governance Cost and Cost of Generating Funds Apportionment to Expense Type

Consistent with the methodology for apportioning costs to funds, the apportionment of costs to expense type includes all funds.

| **2024-25** | All funds | Governance Costs | **Total Expenditure** |
|---|---|---|---|
| | £000 | £000 | **£000** |
| Patient welfare and amenities | 1,964 | 82 | **2,046** |
| Staff welfare and amenities | 355 | 15 | **370** |
| Contributions to NHS | - | - | **-** |
| Miscellaneous | 71 | 4 | **75** |
| End of Year Commitments | (63) | (3) | **(66)** |
| Governance Costs | 98 | (98) | **-** |
| **Total** | 2,425 | - | **2,425** |

| **2023-24** | All funds | Governance Costs | **Total Expenditure** |
|---|---|---|---|
| | £000 | £000 | **£000** |
| Patient welfare and amenities | 1,594 | 64 | **1,658** |
| Staff welfare and amenities | 612 | 25 | **637** |
| Contributions to NHS | - | - | - |
| Miscellaneous | 70 | 3 | **73** |
| End of Year Commitments | 106 | 4 | **110** |
| Governance Costs | 96 | (96) | **-** |
| **Total** | 2,478 | - | **2,478** |

## 1.22 Going Concern

The Charity has significant financial resources, and Charity Fund approval commitments are included in these accounts, which therefore show the available funds.

After making enquiries, the Corporate Trustee has no material uncertainty that the Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the Annual Report and Accounts.

## 1.23 Public Benefit Entity

This is an NHS Charity, a public benefit entity, whose purposes are detailed in the introduction on page 3.

Charity Fund Applications are reviewed, and approval given (within the authorities detailed on page 28), with due regard to the commission's public benefit guidance and the purposes of the charity.

## 1.24 Judgements and Estimations

The accounts include commitments for items approved through the Charity Fund Approval process (see note 13). The values of these approvals will be based on best estimate of costs, some supported by quotations, purchase orders and costed internal recharges.

## 1.25 Donated Goods, Facilities or Services

The charity received no material donated goods, facilities or services.

Events may be held on third party sites, but costs associated with events would be recorded under cost of generating funds expenditure.

## 1.26 Volunteers

Volunteers have played a role in the running of the charity's events, as detailed on page 60 and 61.

## 1.27 Irrecoverable VAT

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

## 1.28 Taxation Liability

As a registered charity, the fund is potentially exempt from the taxation of income and gains falling within S505 of the Income and Corporation Taxes Act 1988 and S256 Taxations and Chargeable Gains Act 1992.

No tax charge has arisen in the year.

## 1.29 Cash at Bank and In Hand

Cash at bank is the sum of all coins, currency and other unrestricted liquid funds that have been placed on deposit with a financial institution. Cash in hand is the amount of money held in notes and coins not on deposit.



## 2.1 Details of Material Incoming Resources

| | Unrestricted Funds | Restricted Funds | **Total Funds 2024-25** | Total Funds 2023-24 |
|---|---|---|---|---|
| **Material incoming resources:** | £000 | £000 | **£000** | £000 |
| | | | | |
| UHD Cancer Care | 1,602 | - | **1,602** | 1,228 |
| Legacy Holding Account | - | 1,045 | **1,045** | - |
| Poole Hospital Cancer Treatment Trust | 627 | - | **627** | - |
| UHD General Fund | 493 | - | **493** | 2,209 |
| Eye Unit | 406 | - | **406** | 206 |
| Cardiac | 377 | - | **377** | - |
| CT Scanner Appeal | - | 285 | **285** | - |
| The Robert White Trust Fund | - | 103 | **103** | 143 |
| Beach Appeal - Critical Care | - | 99 | **99** | - |
| Paediatrics | 90 | - | **90** | - |
| Beach Appeal | - | 89 | **89** | - |
| Nuclear Medicine Fund | 68 | - | **68** | - |
| UHD Palliative Care | 52 | - | **52** | - |
| Christchurch Refurbishment | - | - | **-** | 52 |
| RBH Cardiac | - | - | **-** | 130 |
| Restricted- Charities Office | - | - | **-** | 70 |
| Restricted - Specialities Care Group | - | - | **-** | 119 |
| Eye Sim Appeal | - | - | **-** | 130 |
| Others | 319 | 375 | **694** | 683 |
| **Total incoming resources** | 4,034 | 1,997 | **6,031** | 4,970 |

## 2.2 Incoming Resources Received by Category

| | **Total Funds 2024-25** | Total Funds 2023-24 |
|---|---|---|
| **Description of the sources of any incoming resources by category:** | **£000** | £000 |
| Donations | **720** | 613 |
| Legacies | **3,757** | 3,196 |
| Activity Income from Fundraising Events | **930** | 461 |
| Interest / Dividends | **486** | 437 |
| Other Income | **138** | 263 |
| **Total** | **6,031** | 4,970 |

## 2.3 Income from Third Parties for Recharged Expenditure

| | **Total Funds 2024-25** | Total Funds 2023-24 |
|---|---|---|
| **Details of material Third Party recharges during the year, including Donations:** | **£000** | £000 |
| Poole Hospital Cancer Treatment Trust | 599 | - |
| Bournemouth Chest Diseases Charitable Trust | 44 | - |
| Friends of the Eye Unit | 32 | - |
| Christchurch Hospital League Of Friends | 1 | 57 |
| MNDA East Dorset- New Forest Branch | 1 | - |
| Friends of The Bournemouth Eye Unit | - | 210 |
| Tulip Appeal | - | 18 |
| **Total** | **677** | 285 |

## 3.1 Costs of Raising Funds

| | **Total Funds 2024-25** | Total Funds 2023-24 |
|---|---|---|
| | **£000** | £000 |
| Fundraising recharge (including staff recharge costs) | **630** | 537 |
| Publicity costs * | **277** | 207 |
| **Total fundraising costs** | **907** | 744 |

| | | |
|---|---|---|
| Total funds raised from events held during the year ** | **930** | 461 |

Note:

* Publicity costs are included within Total Fundraising costs within the financial statements.

** The total funds raised from events excludes donations received which are included within Donations in Note 2.2.

Further breakdown of the activities undertaken by the Fundraising Department during the year can be found in the Annual Report 2024-25



## 3.2 Other Expenditure

| | Unrestricted Funds | Restricted Funds | **Total Funds 2024-25** | Total Funds 2023-24 |
|---|---|---|---|---|
| | £000 | £000 | **£000** | £000 |
| Patient welfare and amenities | 2,042 | (78) | **1,964** | 1,594 |
| Staff welfare and amenities | 340 | 15 | **355** | 612 |
| Contributions to NHS | - | - | **-** | - |
| Miscellaneous | 102 | 67 | **169** | 166 |
| End of Year Commitments | 2 | (65) | **(63)** | 106 |
| **Total** | 2,486 | (61) | **2,425** | **2,478** |

Governance costs have been apportioned as shown in note 1.21. Further breakdown of the resources expended during the year can be found in the Annual Report 2024-25

The figure for commitments represents the movement in year, rather than the amount of new commitments made - a negative figure indicates that the commitments at the end of the year were lower than at the start.

## 3.3 Grants Made to Institutions

| | **Aggregate amount paid 2024-25** | Aggregate amount paid 2023-24 |
|---|---|---|
| **Grants paid to University Hospitals Dorset NHS Foundation Trust:** | **£000** | £000 |
| Property, Plant and Equipment, recorded in the Trust accounts | - | - |
| Expenditure for staff and patient benefit, not recorded in the Trust accounts | **2,425** | 2,478 |
| **Total** | **2,425** | 2,478 |

Details of grants paid to institutions during the year can be found in a summary of Charitable Fund Balances, which is available on request from the Trust.

## 4.1 Analysis of Governance Costs

| | Unrestricted Funds | Restricted Funds | **Total Funds 2024-25** | Total Funds 2023-24 |
|---|---|---|---|---|
| | £000 | £000 | **£000** | £000 |
| External Audit fee (inc. VAT) | 4 | 4 | 8 | 7 |
| Miscellaneous | 51 | 39 | **90** | 89 |
| **Total** | 55 | 43 | **98** | 96 |

Governance costs have been apportioned across expenditure types as shown in note 1.21.

## 4.2 Support Costs

There are no support costs, other than the governance costs reported in note 4.1. these costs have been apportioned to the funds as detailed in note 1.21.

## 4.3 Auditor Remuneration

| | **Total Funds 2024-25** | Total Funds 2023-24 |
|---|---|---|
| | **£000** | £000 |
| Statutory audit fee (exc. VAT) | **7** | 6 |
| **Total** | **7** | 6 |

## 5. Analysis of Total Resources Expended

| | Cost of Generating Funds | Cost of Activities for Charitable Objectives | Governance Costs | **Total Funds 2024-25** | Total Funds 2023-24 |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | **£000** | £000 |
| External Audit fee - statutory audit (inc.vat) | | | 8 | **8** | 7 |
| Indemnity insurance | | | 4 | **4** | 4 |
| Bought-in services from NHS | | | 86 | **86** | 85 |
| Other | 907 | 2,327 | | **3,234** | 3,126 |
| **Total** | 907 | 2,327 | 98 | **3,332** | 3,222 |

## 6. Changes in Resources Available for Charity Use

| | Unrestricted Funds | Restricted Funds | **Total Funds 2024-25** | Total Funds 2023-24 |
|---|---|---|---|---|
| | £000 | £000 | **£000** | £000 |
| Net movement in funds for the year | 646 | 2,074 | **2,720** | 2,541 |
| **Net movement in funds available for future activities** | 646 | 2,074 | **2,720** | 2,541 |



## 7.1 Tangible Fixed Assets

| | **2024/25** |
|---|---|
| **Freehold Land and Buildings:** | **£000** |
| **Valuation** | |
| Balance at 31 March 2024 | 205 |
| Additions | - |
| **Balance as at 31 March** | **205** |
| | |
| **Depreciation and Impairment** | |
| Balance at 31 March 2024 | (46) |
| Transferred by absorption 1 April 2024 | 4 |
| Depreciation charge for the year | (42) |
| **Total at 31 March** | **(84)** |
| | |
| **Net Book Value at 1 April** | **179** |
| | |
| **Net book value at 31 March** | **121** |
| | |
| **Historic cost at 31 March** | **169** |

### Valuation

The Charity's tangible fixed asset is revalued using professional valuations in accordance with International Accounting Standard 16 every five years. A three yearly interim valuation is also carried out. Additional valuations are carried out as appropriate.

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

A desktop asset valuation was undertaken as at 31st March 2025; and this value, together with indexation applied to buildings in line with the valuer's advice has been included in the closing Statement of Financial Position.

The valuations are carried out primarily on the basis of Modern Equivalent for specialised operational property and Existing Use Value for non-specialised operational property.

## 7.2 Intangible Fixed Assets

The charity has no intangible fixed assets.

## 7.3 Heritage Assets

The charity has no heritage assets.

## 8.1 Analysis of Fixed Asset Investments

| | 2024-25 | 2023-24 |
|---|---|---|
| **Fixed Asset Investments:** | **£000** | £000 |
| Opening market value | **8,367** | 7,536 |
| Net gain / (loss) on revaluation | **116** | 831 |
| **Closing market value** | **8,483** | 8,367 |

| | | |
|---|---|---|
| Historic cost | **5,850** | 5,850 |

## 8.2 Market value at 31 March:

| | Held in UK | 2024-25 Total | 2023-24 Total |
|---|---|---|---|
| | £000 | **£000** | £000 |
| Investments in a Common Deposit Fund or Common Investment Fund | 8,482 | **8,482** | 8,367 |

## 8.3 Analysis of Narrow Range Investments

| | UK Holdings | Non-UK | 2024-2025 Total | 2023-2024 Total |
|---|---|---|---|---|
| **(Fixed) Short-term Deposits:** | £000 | £000 | **£000** | £000 |
| Market value at 31 March 2024 | 59 | 2 | **61** | 82 |
| Net gain / (loss) on revaluation | (59) | (2) | **(61)** | (21) |
| **Market value at 31 March 2025** | 0 | 0 | **0** | 61 |

## 8.4 Analysis of Gross Income from Investments

| | 2024-2025 Total | 2023-2024 Total |
|---|---|---|
| **Total gross income** | **£000** | £000 |
| Other investments | **486** | 437 |
| | **486** | 437 |

Included in this total is income from non-UK Stocks and Equities amounting to less than £1k.



## 9. Debtors

Debtors are recognised when a legal or constructive obligation to pay is created, the amount can be measured reliably and it is probable that payment will be received.

| | 2024-25 | 2023-24 |
|---|---|---|
| **Amounts falling due within one year as at 31 March:** | **£000** | £000 |
| Other debtors | **1,120** | 33 |
| **Total Debtors** | **1,120** | 33 |

Included in this total are debtors relating to legacy income of £1.045m.

## 10. Analysis of Creditors

Debtors are recognised when a legal or constructive obligation to pay is created, the amount can be measured reliably and it is probable that payment will be received.

| | 2024-25 | 2023-24 |
|---|---|---|
| **Amounts falling due within one year as at 31 March:** | **£000** | £000 |
| Other creditors | **496** | 495 |
| Accruals (see note 13.1) | **1,993** | 2,516 |
| **Total creditors falling due within one year** | **2,489** | 3,011 |

## 11.1 Analysis of Funds

| | Cost Centre | Balance 31 March 2024 | Incoming Resources | Resources Expended | In Year Commitment | Gains and Losses | **Balance 31 March 2025** |
|---|---|---|---|---|---|---|---|
| **Unrestricted:** | | £000 | £000 | £000 | £000 | £000 | **£000** |
| UHD General Fund | 76109 | 3,449 | 493 | (146) | 5 | 141 | **3,942** |
| UHD Cancer Care | 76460 | 1,616 | 1,602 | (68) | (16) | 84 | **3,218** |
| PH Cardiac | 76380 | 808 | 21 | (36) | - | 37 | **830** |
| Eye Unit | 76101 | 280 | 406 | (26) | - | 27 | **687** |
| Poole Hospital Cancer Treatment | 76615 | - | 627 | - | - | - | **627** |
| Cardiac | 76385 | 109 | 377 | (5) | - | 5 | **486** |
| RBH Cardiac | 71415 | 403 | 12 | (20) | 1 | 19 | **415** |
| RBH Cancer | 71470 | 439 | 10 | (32) | 14 | 19 | **450** |
| RBH Stroke | 73450 | 225 | 5 | 15 | (25) | 10 | **230** |
| Leukaemia | 76505 | 157 | 4 | (7) | - | 7 | **161** |
| Breast Fund | 76450 | 59 | 32 | (4) | - | 4 | **91** |
| PH Stroke | 76415 | 121 | 3 | (5) | - | 5 | **124** |
| Poole Hospital Resource Centre | 72999 | 159 | - | - | - | - | **159** |
| PH Trauma | 76440 | 80 | 2 | (4) | - | 5 | **83** |
| Staff Health And Wellbeing | 76108 | 61 | 3 | (27) | 20 | 7 | **64** |
| Radiotherapy | 76470 | 66 | 45 | (5) | - | 5 | **111** |
| Paediatrics | 76475 | 31 | 90 | (2) | - | 2 | **121** |
| Stroke | 76420 | 48 | 17 | (3) | 1 | 2 | **65** |
| Dorset Breast Screening Unit | 76510 | 59 | 4 | (2) | (1) | 3 | **63** |
| Respiratory | 76375 | 52 | 10 | - | - | 2 | **64** |
| Renal Patients | 71575 | 56 | 4 | (3) | - | 3 | **60** |
| UHD Palliative Care | 73502 | 9 | 52 | (3) | - | 3 | **61** |
| Ear, Nose and Throat | 76445 | 30 | 19 | (1) | - | 1 | **49** |
| Radiology / Imaging | 76565 | 22 | 29 | (2) | - | 2 | **51** |
| Others | | 1,346 | 165 | (2,750) | (1) | (644) | **(1,883)** |
| **Total Unrestricted** | | 9,685 | 4,034 | (3,136) | (2) | (251) | **10,331** |

| | Cost Centre | Balance 31 March 2024 | Incoming Resources | Resources Expended | In Year Commitment | Gains and Losses | **Balance 31 March 2025** |
|---|---|---|---|---|---|---|---|
| **Restricted:** | | £000 | £000 | £000 | £000 | £000 | **£000** |
| The Robert White Trust Fund | 72876 | 2,646 | 103 | (205) | 161 | 206 | **2,911** |
| Restricted - Jigsaw New Build | 71499 | 1,546 | 40 | (81) | - | 69 | **1,574** |
| Legacy Holding Account | 76620 | - | 1,045 | - | - | - | **1,045** |
| CT Scanner Appeal | 76585 | 33 | 285 | (6) | - | 10 | **323** |
| Christchurch Refurbishment | 73550 | 21 | 26 | 225 | - | 12 | **285** |
| PH Ward Refurb (was Cornelia Suite Ward Fund) | 72008 | 253 | 7 | (13) | - | 11 | **258** |
| Restricted - Medical Care Group | 76305 | 81 | 47 | 136 | (65) | 9 | **208** |
| PH Breast (Was Ladybird) | 72640 | 224 | 5 | (67) | - | 10 | **172** |
| Restricted - Specialities Care Group | 76307 | 188 | 26 | (85) | - | 9 | **139** |
| Gully's Place Fund | 72801 | 92 | 46 | (14) | 1 | 5 | **131** |
| Spring Fund | 72771 | 95 | 43 | (47) | 1 | 5 | **96** |
| Beach Appeal - Critical Care | 76595 | - | 99 | (15) | - | - | **84** |
| Beach Appeal - General | 76580 | 17 | 89 | (6) | (34) | 3 | **69** |
| Restricted - Charities Office | 76102 | 91 | 5 | (36) | - | 5 | **65** |
| Others | | 273 | 130 | (140) | 1 | 13 | **276** |
| **Total Restricted** | | 5,560 | 1,997 | (354) | 65 | 367 | **7,634** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total of all Funds** | | **15,245** | **6,031** | **(3,490)** | **63** | **116** | **17,965** |

## 11.2 Details of Funds

**UHD General Fund**

Unrestricted fund to assist in the provision of patient care and staff welfare in various wards and departments of all UHD hospitals.

**UHD Cancer Care**

Any purpose relating to the treatment of cancer within the Trust.

**PH Cardiac**

To assist in the provision of patient care and staff welfare in Poole Cardiac.

**Eye Unit**

To assist in the provision of patient care and staff welfare in the Bournemouth Eye Unit.

**Poole Hospital Cancer Treatment**

To assist in the provision of patient care and staff welfare in Poole Hospital Cancer services.

**Cardiac**

To assist in the provision of patient care and staff welfare in Cardiac.

**RBH Cardiac**

Any purpose relating to the the treatment of heart conditions within the Trust.

**RBH Cancer**

Any purpose relating to the treatment of cancer within the Trust.

**RBH Stroke**

Any purpose relating to stroke care within the Trust.

**Leukaemia Fund**

To assist in the provision of patient care and staff welfare in Leukaemia.

**Breast Fund**

To assist in the provision of patient care and staff welfare in Breast Care.

**PH Stroke**

To assist in the provision of patient care and staff welfare in Poole Stroke.

**Poole Hospital Resource Centre**

Fixed asset reserve for the Resource Centre which provides information resources for patients.

**PH Trauma**

To assist in the provision of patient care and staff welfare in the trauma directorate.

**Staff Health And Wellbeing**

To assist in the provision of staff wellbeing in the trust.

**Radiotherapy**

To assist in the provision of patient care and staff welfare in Radiotherapy.

**Paediatrics**

To assist in the provision of patient care and staff welfare in Paediatrics.

**Stroke**

Any purpose relating to stroke care within the Trust.

**Dorset Breast Screening Unit**

To assist in the provision of patient care and staff welfare in DBSU.

**Respiratory**

To assist in the provision of patient care and staff welfare in respiratory.

**Renal Patients**

To assist in the provision of patient care and staff welfare in Renal.

**UHD Palliative Care**

To assist in the provision of patient care and staff welfare in Palliative Care.

**Ear, Nose and Throat**

To assist in the provision of patient care and staff welfare in Ear, Nose and Throat. .

**Radiology / Imaging**

To assist in the provision of patient care and staff welfare in Radiology / Imaging.

**The Robert White Trust Fund**

To fund the Robert White Cancer Centre and other cancer equipment and services.

**Restricted - Jigsaw New Build**

Funds held for the Jigsaw Building.

**Legacy Holding Account**

Fund for legacy accrual.

**CT Scanner Appeal**

To fund the CT Scanner Appeal.

**Christchurch Refurbishment**

To fund the Christchurch Refurbishment.

**PH Ward Refurb (was Cornelia Suite Ward Fund)**

Designated for ward refurbishment throughout Poole Hospital.

**Restricted - Medical Care Group**

To assist in the provision of patient care and staff welfare in the Medical Care Group.

**PH Breast (Was Ladybird)**

To assist in the provision of patient care and staff welfare in the Ladybird Unit.

**Restricted - Specialities Care Group**

To assist in the provision of patient care and staff welfare in the Specialities Care Group.

**Gully's Place Fund**

To assist in the provision of end of life care and palliative care for children.

**Spring Fund**

To provide support to parents and relatives who have experienced the death of a baby during pregnancy, at or just after birth.

**Beach Appeal - Critical Care**

To fund the Beach Appeal - Critical Care.

**Beach Appeal - General**

To fund the Beach Appeal - General.

**Restricted - Charities Office**

To assist in the provision of patient care and staff welfare.

**Others (all under £50,000)**

To assist in the provision of patient care and staff welfare in other departments of UHD.

## 12. Contingencies

The following contingent gains have not been included in the accounts:

| | 2024-25 | 2023-24 |
|---|---|---|
| **Contingent gains:** | **£000** | £000 |
| Outstanding Legacies | **2,052** | 2,907 |
| **Total contingent gains** | **2,052** | 2,907 |

## 13. Commitments, Liabilities and Provisions

### 13.1 Commitment Breakdown for 2024/25

| | Capital | Other | **Total** |
|---|---|---|---|
| | £000 | £000 | **£000** |
| Brought Forward Commitments as at 31 March 2024 | 555 | 1,960 | **2,515** |
| Prior Commitments spent during 2024-25 | 445 | 1,011 | **1,456** |
| Remaining prior commitment | 110 | 949 | **1,059** |
| New commitments during 2024-25 | 147 | 787 | **934** |
| **Commitments as at 31 March 2025** | **257** | **1,736** | **1,993** |

| **Large Commitments 2024/25 - Projected expenditure dates** | **CFA Number** | **Value £000** | **Estimated Expend Date** |
|---|---|---|---|
| SGRT 2 | RW Commitment | 638 | 2025/26 |
| Immunotherapy toxicity service May 23 CFC | RW Commitment | 179 | 2025/26 |
| | | | |
| Improving staff areas | CFA2023-258 | 62 | 2025/26 |
| 1x 8a clinical psychologist / 1x band 4 Research assistant | CFA2024-116 | 90 | 2025/26 |
| Hospice at Home Service | CFA2024-163 | 107 | 2025/26 |
| Youthwork service with emergency department x 2 | CFA2024-404 | 93 | 2025/26 |
| WiFi Upgrade for the whole trust | CFA2024-413 | 65 | 2025/26 |

### 13.2 Liabilities

The Trustee recognise liabilities in the accounts once they have incurred either a legal or constructive obligation to expend funds.

Commitments totalling £1,993,425 relating to grants payable, have been included in the accounts.



## 14. Indemnity Insurance

| | 2024-25 | 2023-24 |
|---|---|---|
| **Description of Cover:** | **£000** | £000 |
| Trustee Indemnity Insurance | **4** | 4 |

## 15. Connected Organisations

| | 2024-25 | | 2023-24 | |
|---|---|---|---|---|
| | **Operating Income of Connected Organisation** | **Audited Surplus/ (Deficit) for Connected Organisation** | Operating Income of Connected Organisation | Audited Surplus/ (Deficit) for Connected Organisation |
| **Name of Organisation** | **£000** | **£000** | £000 | £000 |
| University Hospitals Dorset NHS Foundation Trust | 906,264 | (81,978) | 840,441 | (32,291) |

# THANK YOU

**To the volunteers, supporters, fundraisers and groups, without whom we would not be able to provide the many benefits to our patients and staff at the Royal Bournemouth, Poole and Christchurch Hospitals.**

**We simply can't thank everyone so here are a few of our major donors and supporters:**

ASMPT

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Bournemouth Joggers

Brackenwood Open Garden

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The Cadbury Family

Erasure-ish

Gary Hargreaves

Going for Bust

Gold Accounting

Handmade with Love

Haskins

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The Grace Trust

The John Ackroyd Charitable Trust

Knit and Natter

Mazars Charitable Trust

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# University Hospitals Dorset NHS Charity

Registered Charity No. 1057366

Registered with FUNDRAISING REGULATOR

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 14 January 2026**

**Agenda item: 8.2**

| | |
|---|---|
| **Subject:** | Dorset Digital Strategy – (near) Final |
| **Prepared by:** | Beverley Bryant, Chief Digital Officer |
| **Presented by:** | Beverley Bryant, Chief Digital Officer |

| | |
|---|---|
| **Strategic themes that this item supports/impacts:** | Population & System ☒<br>Our People ☒<br>Patient Experience ☒<br>Quality Outcomes & Safety ☒<br>Sustainable Services ☒ |
| **BAF/Corporate Risk Register: (if applicable)** | None |
| **Purpose of paper:** | Decision/Approval |
| **Executive Summary:** | The Dorset Digital Strategy is a comprehensive plan aiming to transform Dorset's health and care system through digital innovation by 2030. It emphasises creating a seamless, integrated digital ecosystem that empowers staff, improves patient experiences, and leverages emerging technologies to deliver equitable, efficient, and person-centered care across all health and social care settings. |
| **Background:** | The Dorset Digital Strategy has been developed through a highly collaborative, iterative co-creation process, co-designed and co-owned by digital, clinical, and operational leaders across Our Dorset's health and care system. Every stage, from mobilisation to completion, has been shaped through engagement, evidence, and shared ownership. This approach ensures the strategy is both ambitious and grounded in real-world delivery.<br>Throughout, progress was guided by system-wide engagement and alignment with the Our Dorset vision. The result is a collectively owned, evidence-based strategy endorsed by digital leadership and system partners, ensuring shared commitment to meaningful digital transformation across Dorset.<br>The Dorset Digital Strategy focuses on the 'why' and the 'what'. Once approved by the Boards in December 2025, the next phase will be developing the roadmap for the Dorset Digital Strategy. This work will begin with a planning workshop on 22 January 2026. |
| **Key Recommendations:** | The Board is asked to approve the Dorset Digital Strategy |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality, Equity, Diversity & Inclusion ☐ |

| | | |
|---|---|---|
| | Financial | ☐ |
| | Health Inequalities | ☐ |
| | Operational Performance | ☐ |
| | People (inc Staff, Patients) | ☐ |
| | Public Consultation | ☐ |
| | Quality | ☐ |
| | Regulatory | ☐ |
| | Strategy/Transformation | ☐ |
| | System | ☐ |
| **CQC Reference:** | Safe | ☒ |
| | Effective | ☒ |
| | Caring | ☒ |
| | Responsive | ☒ |
| | Well-Led | ☒ |
| | Use of Resources | ☒ |

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | **Outcome** |
|---|---|---|
| Executive Directors | 18/11/25 | Check with TC |
| TMG | 18/11/25 | Check with TC |
| Finance and Performance Committee | 24//11/25 | The Committee endorsed the Dorset Digital Strategy with recommendation to Board to approve |

| | | |
|---|---|---|
| **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 | ☐ |

# Our Dorset Digital Strategy

## 2025–2030

### Improving Health & Care Through Digital Technology



v1.1
11th November 2025

## Table of Contents

# Chapter One - Purpose & Strategic Intent

## Becoming a Digital Pioneer

The **Our Dorset Digital Strategy** is a comprehensive plan aiming to transform Dorset's health and care system through digital innovation by 2030. It emphasises creating a seamless, integrated digital ecosystem that empowers staff, improves patient experiences, and leverages emerging technologies like AI to deliver equitable, efficient, and person-centred care across all health and social care settings.

## Strategic Vision and Context

Dorset aspires to be recognised as a digital pioneer within the NHS by 2030, where people, data, and technology work harmoniously to deliver outstanding care. The strategy addresses Dorset's diverse population of over 810,000, highlighting existing health inequalities and the need for digital tools to overcome challenges such as rural access and ageing demographics. Digital technology is positioned as essential for a resilient health and care system, not merely an optional enhancement. The strategy promotes a unified digital approach across all partners and providers, focusing on interoperability, shared priorities, and sustainable investment. AI and automation are central to this vision, supporting clinicians and enhancing care without replacing human capability.

## Strategy Development, Objectives and Themes

This strategy has been co-created with our people, not delivered to them. Over the past months, we brought together digital, clinical, and operational leaders from every part of the Dorset system to develop a shared digital ambition that genuinely reflects how care is delivered across settings. Through workshops, design sessions, and continuous engagement, we have built a common purpose rooted in local priorities, lived experience, and the expertise of those who know our services best. (See Appendix A for a summary of this co-creation process.)

The strategy sets out four strategic objectives and four themes that together provide the foundations to transform care for citizens and staff. These objectives define what we must achieve to make digital a true enabler of better outcomes, while the themes describe how we will deliver change consistently and safely across the system. These form our digital blueprint for Dorset – built on collaboration, standardisation and shared capability to support every care setting (Appendix B).

To guarantee this strategy converts ambition into measurable progress, we have defined system-wide Key Performance Indicators that will track the benefits delivered over time (Appendix C). This ensures transparency, accountability, and pace — giving confidence that Dorset is not only imagining a better digital future but is equipped to deliver it.

## Chapter Two – Enabling Care Across Settings

This chapter focuses on integrating digital systems across Dorset's varied health and social care settings to enable seamless, joined-up care. It identifies current challenges such as patchy digital maturity, inconsistent data sharing, multiple logins, and reliance on paper processes. The strategy commits to removing legacy systems, adopting modern interoperability standards, expanding electronic patient records, and embedding digital solutions into care pathways. Collaborative governance and strategic alignment are deemed essential to unify digital initiatives and data governance, ensuring privacy and ethical use. Transformation programmes like Integrated Neighbourhood Teams (INTs), a unified Electronic Health Record (HealthSet), and Future Care are key enablers for integrated, person-centred, and preventative care.

## Chapter Three – Workforce & Culture

This section highlights the critical role of a digitally capable and confident workforce in achieving the digital strategy's ambitions. It addresses challenges such as mixed staff confidence in digital skills, recruitment and retention difficulties, and dispersed leadership. It aims to cultivate digital skills at all levels, professionalise the digital workforce, and embed inclusive, accessible training. Leadership collaboration between digital, operational, and clinical teams is key to ensuring sustained, person-centred digital transformation. It also seeks to raise digital confidence across the wider health and care workforce, tackling digital exclusion and fostering a positive culture around innovation.

## Chapter Four – Digitally Enabling and Empowering Citizens

This chapter addresses the imperative to improve digital engagement and access for Dorset's citizens. Despite technological advances in other sectors, parts of the NHS remain analogue, leading to fragmented patient experiences and limited digital service adoption. It focuses on providing a unified, user-friendly digital experience through tools like the NHS App, enhancing patient access to appointments, records, and health information. The chapter further prioritises equitable digital inclusion by offering flexible alternatives and support to those with limited digital literacy or connectivity. Our aim is to empower individuals to manage their health proactively.

## Chapter Five – Modern Infrastructure Foundations

This segment underscores the importance of a resilient, secure, and scalable digital infrastructure as the backbone of modern healthcare. Challenges include aged infrastructure, legacy systems, inconsistent user experience, and cyber risks. Dorset plans to establish shared infrastructure governance, standardise procurement, adopt cloud solutions, and align infrastructure with clinical priorities to improve interoperability and user experience. It commits to improving system reliability, connectivity, and support services, while embedding robust cybersecurity frameworks, business continuity plans, and green IT initiatives to reduce environmental impact.

## Chapter Six – Data, Analytics & Insights

Data is a critical asset for enabling evidence-based decision-making, proactive care, and population health management. It emphasises enhancing data sharing and governance, developing robust data architecture leveraging cloud technologies, and advancing analytics capabilities for performance monitoring, predictive modelling, and prevention. Existing platforms like the Dorset Care Record (DCR) and Dorset Intelligence & Insight Service (DiiS) are foundational, with plans to align with national initiatives such as the Federated Data Platform (FDP). It also promotes innovation in analytics, including the use of unstructured data and AI-enabled tools, alongside active engagement with patients and communities for co-designed data solutions.

## Chapter Seven – Alignment with Other Strategies

The digital strategy aligns with a broad range of national, regional, and local policies, frameworks, and plans, including NHS England's 10-Year Plan, Department of Health and Social Care priorities, and local integrated care strategies. It maps its chapters to the NHS's "What Good Looks Like" framework, ensuring coherence with established success measures such as leadership, safety, workforce support, citizen empowerment, care improvement, population health, and foundational infrastructure.

## Digital Strategy Scope

In the past, digital plans in Dorset have been made separately by each organisation, focusing on their own needs. This has led to different systems, varied patient experiences, and made it harder to plan and work together across the county.

Now, Dorset is moving towards sharing resources and building a fully joined-up health and care system. To do this, we need one clear digital strategy that works across all services, supports the flow of patient information, and focuses on shared priorities across care settings rather than organisational boundaries.

This strategy is not about technology for its own sake. It is about harnessing digital and data to meet Dorset's challenges head-on and secure a healthier future for every community we serve.

**Core Strategy Focus**: Acute (Dorset County Hospital & University Hospitals Dorset) Community, Mental Health, Learning Disabilities (Dorset HealthCare), Integrated Care Board (NHS Dorset), and Primary Care (GP Practices).

**Strategy Interlock with Integrated Areas of Working**: Partners, such as Pharmacy, Optometry, Dental, Local Authorities (Adult & Child Social Care), Voluntary and Community Sector, Emergency Services (Ambulance, Fire, Police), County, and Regional Partners.

# Chapter Two – Enabling Care Across Settings

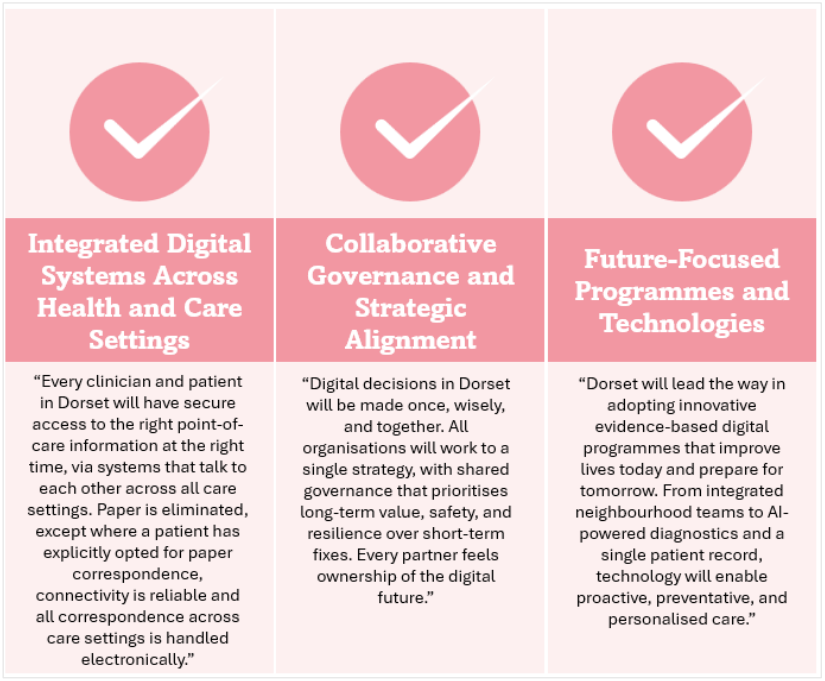
## Why This Matters

The NHS 10-Year Plan, published in July 2025, sets a bold ambition: to reinvent the NHS as a sustainable, patient-controlled, digitally advanced system focused on prevention. In Dorset, this vision must encompass a wide spectrum of care, from primary and secondary services to social care, diagnostics, prison healthcare, and voluntary groups.

Insights from the Digital Strategy Questionnaire revealed that only 8 out of 421 respondents felt digital systems supported joined-up care "extremely well." Most described disconnected experiences, especially among patients with long-term conditions as 56% of Dorset's population have one or more.

This fragmentation stems from uneven digital maturity and poor interoperability across sites, leading to incomplete records, duplicated effort, and clinical risk.

## What Dorset Aims to Achieve




## 1. Integrated Digital Systems Across Health and Care Settings

**Why:** Fragmented systems and inconsistent data sharing create gaps in care and increase risk.

Many NHS organisations, including those in Dorset, continue to rely on outdated, disconnected digital systems, hindering progress toward joined-up, patient-centred care. This challenge is compounded by the need for a flexible, digitally enabled workforce (as outlined in Chapter 3), supported by foundational investments like single sign-on and interoperability services (Chapter 5).

Fragmentation stems from suppliers' limited coordination around shared standards and the tendency to implement digital infrastructure at an organisational rather than system-wide level. The 2025 Data (Use and Access) Act now mandates common standards across health and care, aiming to ensure systems can interface seamlessly.

Despite this, staff still face daily frustrations: multiple logins, inconsistent platforms, and repetitive training across sites. These inefficiencies not only slow adoption but increase cyber risk and compromise care quality.

Dorset's strategy focuses on aligning standards, simplifying user experience, and centralising patient records to improve transitions and outcomes. Crucially, digital tools must be embedded as core to how services operate, not optional add-ons. Adoption, training, and ongoing support are as vital as the technology itself in enabling care across diverse settings.

Dorset's NHS sites vary widely in digital maturity, creating inconsistent experiences across the region. Hundreds of clinical systems are in use, many of which don't interoperate, making joined-up care difficult.

Digital tools are often treated as optional, leading to a patchwork of paper and digital processes with little standardisation. Staff face siloed data, multiple logins, and inconsistent user interfaces, which slows adoption and increases frustration.

This complexity also raises cyber risks, especially where standards haven't been adopted. Without a unified approach, digital progress remains uneven, and care delivery suffers.

### What We Will Do:

- **We will move towards a connected, interoperable digital health ecosystem** with a major emphasis on integrating Primary, Secondary and Social Care.
- **We will ensure all systems can communicate and share data effectively** by using FHIR API standards.
- **We will expand and centralise our Electronic Patient Records** to include more care settings and data to support areas of service and pathway improvement across the county.
- **We will eliminate the use of paper** in the administration of patient care.

## 2. Collaborative Governance and Strategic Alignment

**Why:** Effective digital transformation requires shared responsibility, clear objectives, and robust data governance.

Each Dorset NHS organisation has historically worked in isolation to create strategies and selected their own digital solutions, and whilst this was intended to foster innovation and responsiveness, it has led to a patchy and inefficient set of digital systems. This has resulted in limited interoperability, increased costs and difficulties in achieving consistent patient outcomes.

Career opportunities for digital staff are limited to their own organisation and clinical and operational staff working pan-Dorset require multiple devices and logins.

Within our organisations involvement of clinical and operational leaders in digital decision making have been patchy and inconsistent. Digitally enabled transformation is everybody's job and considering the process and people aspect is as important as the technologies.

### What We Will Do:

- **We will move as one 'Dorset System'** establishing cross-organisational governance to deliver digital strategy and share responsibility.
- **We will promote shared ownership and co-creation** of digital initiatives that emphasise standardised processes with clinical and operational buy in.

- **We will develop data sharing agreements** that protect privacy while enabling safe, ethical digital adoption.
- **We will ensure technology keeps pace with ambitions** for collaboration and standardised working.

## 3. Future-Focused Programmes and Technologies

**Why:** National reform demands a reimagined NHS: digital, decentralised, and preventative.

Science and technology are central to this reinvention. The NHS of the future will offer instant access, predict and prevent illness, empower frontline staff, and operate with the values of the NHS supported by a broader network of digital innovation.

The Dorset's Digital Strategy must respond directly to clinical and operational priorities. Technology should not exist in isolation, it must enable service alignment, standardised processes, and consistent ways of working across the system. Major transformation programmes are already underway to deliver the NHS 10-Year Plan, including:

- Integrated Neighbourhood Teams (INTs)
- Unified Electronic Health Record (HealthSet)

These initiatives must work in tandem: INTs driving person-centred care, and the EHR providing the digital backbone. However, challenges remain around flexibility, inclusivity, and pace of change. Addressing these will require strong interoperability, cultural alignment, and full engagement from all Dorset providers and partners.

Success also depends on the enabling roles of HR, people and culture, communications, and marketing teams, ensuring the transformation is inclusive, understood, and embedded across the system.

### Integrated Neighbourhood Teams (INTs):

Integrated Neighbourhood Teams (INTs) bring together everyone who cares for, or supports, a community. They include team members drawn from Nursing, Medical, Allied Health Professionals with Social Care, wider Local Authority Teams and the Voluntary and Community Sector.

INTs will have common purpose, vision and shared objectives, quality outcomes and access measures with a single unified leadership team. Data and technology will provide an information thread supporting collaboration and enabling INTs to deliver proactive, preventative, and personalised care closer to home, improving health outcomes and system efficiency.

In summary INTs will:

- Bring together all professionals supporting a community (nursing, medical, allied health, social care, local authority, voluntary sector).
- Use data and technology to support proactive, preventative, and personalised care closer to home, and better support collaboration across organisational boundaries.
- Operate with unified leadership, shared objectives, and common access measures.

## Unified Electronic Health Record (HealthSet)

Converging onto a single Electronic Health Record (EHR) system across Dorset and Somerset is a once-in-a-generation opportunity to transform care delivery. By uniting Dorset County Hospital, University Hospitals Dorset, Somerset NHS Foundation Trust, and Dorset HealthCare, we will improve patient experience through shared care pathways and service innovations.

This collaboration enables us to maximise digital investment, achieving economies of scale in implementation, hosting, and long-term maintenance.

Implementing a new modern EHR solution across Dorset and Somerset will:

- Align pathways between acute organisations and from acute to community and mental health, with consideration of how to integrate and standardise pathways with primary care, social care, and the voluntary community.
- Enable new pathways of care and service delivery innovations.
- Drive a focus on population health.
- Deliver parity of physical and mental health for our patients.
- Maximise the investment in digital solutions and achieve economies of scale.

This programme is a cornerstone of our regional digital strategies and a critical enabler of system-wide transformation.

# Chapter Three – Workforce & Culture

## Why This Matters

Health and care are expected to look very different in 10 years, influenced by population aging, changing workforce expectations and rapid digital advancement. This chapter outlines how Our Dorset will cultivate a digitally capable and confident workforce, recognising that effective digital transformation is fundamentally about people, not the technology.

Our staff are our greatest asset, and their ability to confidently use digital tools is crucial if we are to achieve our digital ambitions. In an increasingly technology-driven health and care environment our workforce must be equipped with the right digital knowledge, skills, leadership, and culture to meet the challenges of an ever-changing healthcare landscape.

The Digital Strategy Questionnaire insights demonstrated that staff confidence is mixed when it comes to using digital technology. Of the 421 responses to the questionnaire, only 82 staff reported being extremely confident using digital tools and 43 were not confident at all, with most falling in between. There was a strong preference for self-paced learning and in-situ training in the workplace, supported by peer-to-peer learning, with a clear demand for accessible, flexible training approaches focused on career pathways and embedding digital capability into everyday learning culture.

Our vision for a digitally enabled workforce is one where staff are confident and supported in using technology to fulfil their role.

## What Dorset Aims to Achieve

Our people are central to Dorset's digital future. To prepare the health and care workforce, we aim to:

- Build digital skills and capability from frontline to board level
- Professionalise the digital workforce and grow a sustainable talent pipeline through education, retention, and mobility
- Standardise training and improve digital and data literacy
- Drive safe innovation aligned with regulatory standards and best practice

To deliver these ambitions, we will focus on three priority areas:


## 1. Leadership and Collaboration

**Why:** Effective leadership of digitally enabled change is crucial for guiding the NHS and social care sectors through significant reforms, ensuring long-term sustainability, and unlocking widespread benefits.

When digital, clinical and operational teams are involved together in shaping and leading digital change, the outcomes are more relevant, sustainable, and impactful.

A shared governance can go some way to ensuring success but in Dorset, we are digging deeper into how roles within governance can contribute to making sure that their planned digital transformation is delivered everywhere and forever.

- **Digital Leadership** - makes sure that the chosen technologies are fit for purpose. They should own the contract and relationship with any suppliers and drive value-for-money ongoing in supplier contracts. They drive towards a changed outcome, providing the programme management rigour and discipline through to a safe transition and close-down of the legacy digital systems and contracts.
- **Operational Leadership** - prepare for and understand the impact of a switch to digital and prepare their teams to be ready for it. They drive for standardised operating procedures (SOPs), ensure staff are trained and supported and drive uptake and adoption of the digital tools, removing paper.
- **Clinical Leadership** - help ensure that digital systems improve patient safety, reduce clinical errors, and support equitable access to care. They champion the safe adoption of innovation, empowering staff to use digital tools confidently and responsibly.

Digital transformation is everybody's job and adopting a team approach to it, not just during the transition but ongoing through optimisation and transformation, is key to achieve digital systems and tools that are person-centred, ethical, safe, effective, efficient, timely, and equitable.

There are national and local shortages of Digital, Data and Technology (DDaT) professionals, limiting capacity for delivery and innovation. Unclear career pathways and training frameworks make it difficult to attract, develop, and retain talent. Clinical digital leaders are often under-supported, reducing their ability to influence change and connect clinical and digital priorities.

### What We Will Do:

- **We will embed digital leadership at all levels** ensuring that senior leaders are digitally aware and that digital leadership is present at board level.
- **We will foster shared and inclusive governance** to promote joint decision-making and co-ownership of digital initiatives ensuring all voices are heard in digital transformation.
- **We will invest in development of clinical digital leadership** to make digital core to our delivery of care in all settings.

## 2. Digital Workforce Development

**Why:** Digital, Data and Technology (DDaT) workforce development is paramount if we are to embed digital and data across our organisations. Digital professionals protect us from cyber-attacks, keep our systems up to date, manage data migrations, ensure interoperability, procure and build applications.

Our ambition for digital staff is to make Dorset an attractive destination for people to live and work. We will grow a strong, capable and skilled DDaT workforce which has the ability and agility to meet the future needs of the health and care sector, whilst having the dedicated time to continuously develop and assist patients with technology.

Chief Clinical Information Officers (CCIOs) play a key role between medical and digital teams, advocating for the benefits of digital to the clinical workforce and pushing digital potentials to improve usability for clinicians.

We will develop an Dorset-wide digital clinical leadership pipeline and position CCIOs and Chief Nursing Information Officers (CNIOs) to feel empowered to advocate for patients and carers helping contextualise digital safety risks associated with pathways, processes, tools and data, whilst sharing best practice.

### What We Will Do:

To reimagine our approaches to recruitment and retention:

- **We will partner with education and industry to build a talent pipeline** from trainees to apprentice and graduates to attract the best people to Dorset.
- **We will improve retention through career mobility** by enhancing growth and providing flexible development opportunities for staff.
- **We will create a supportive, fulfilling environment** where digital professionals feel valued and invested in through accredited career pathways and continuous learning opportunities.
- **We will embed digital risk management** and transformation principles into DDaT roles to encourage safe, sustainable change.

To champion and embed digital clinical leadership:

- **We will invest in clinical digital leadership across all our services** giving our existing clinicians a formal role in our digital team.
- **We will develop a clinical leadership pipeline** with opportunities for clinicians to receive formal and informal training and support to move into those roles.
- **We will ensure clinical digital leadership are embedded** within the future target operating model for digital services across Dorset.

## 3. Wider Health and Care Workforce Development

**Why:** Digital transformation must include all staff, not just digital professionals. Confidence and competence in using technology are essential for everyone, and we must acknowledge that resistance and negativity toward digital transformation can arise from insufficient investment to support staff with digital skills development.

The development of the wider non-digital health and care workforce is a critical component of the ongoing digital transformation within the NHS and social care sectors. The overarching goal is to empower all staff with the necessary digital skills to thrive in an increasingly technology driven environment, ensuring high-quality, personalised, and efficient patient care.

A relentless focus on digital skills and leadership at all levels is necessary to make transformation durable. Leaders must prioritise and facilitate workforce upskilling by ensuring staff have the time, funding, and accessible equipment needed for training. They need to foster a learning culture and ensure that staff have the right skills and confidence to apply new technologies successfully. This includes addressing issues of digital literacy, fear of digital systems, and unequal access to technology and training among staff.

Digital is often seen as an "add-on" rather than central, and there can be a polarised perception where it's either a panacea or a villain, hindering realistic adoption. Too often, digital tools are treated as ‘optional’ rather than an integral part of how services operate.

Low digital confidence and fear of technology remain common across the workforce. Access to IT training and tools is unequal, with many staff beyond digital professionals lacking the support they need. Digital is often perceived as optional or disruptive, rather than integral to improving care and efficiency.

### What We Will Do:

Our ambition for the wider health and care workforce is to:

**Create a digitally confident and highly skilled health and care workforce in Dorset** that is deeply integrated into a culture of continuous innovation and improvement, empowered by collaboration.

To cultivate digital confidence:

- **We will offer foundational skill support** to enhance confidence and competence with investment in digital educators and developing a network of peer digital champions.
- **We will provide tailored, ongoing digital training** and peer support to meet individual’s needs and baseline skills ensuring it is ongoing and continuous reducing fear as technology evolves
- **We will work in collaboration with our workforce colleagues to agree minimum digital skills standards for all job roles** which new starters are supported to achieve as part of their induction period and where existing staff are provided with dedicated time to maintain their digital skills development.

To make access fair and equitable:

- **We will provide equitable access to training** by providing a single point of access for learning and consistent funding policies enabling ease and equity of access at a time and place of the learner’s choosing.
- **We will tackle digital exclusion through multi-channel offers** ensuring traditional means of learning remain aligned to their needs and for those who cannot or prefer not to access digital tools for education purposes.

- **We will foster a positive, inclusive culture** around digital innovation transformation and optimisation underpinned by psychological safety, enabling staff to adopt new technologies without inherent barriers and celebrating successes.
- **We will make efforts to ensure that our diverse workforce is supported by an inclusive and accessible digital offer** which breaks down barriers and meets people where they are.

# Chapter Four – Digitally Enabling & Empowering Citizens

## Why This Matters

Despite rapid global advances in technology, the NHS remains a "20th century technological laggard," as described in the NHS 10-Year Plan. While people routinely use mobile apps, wearables, and online platforms in daily life, the NHS has yet to match this level of digital convenience.

Patients reasonably expect to book appointments, view test results, and access medical records online. These services have been available in General Practice for nearly a decade, but in secondary care, many still rely on letters or long call queues for basic information.

The Digital Strategy Questionnaire insights that patients face barriers including limited digital literacy, poor connectivity, and concerns over trust. Our staff believe that enabling patient access to records and secure digital communication are the most valuable interventions for improving patient care. Therefore, we must prioritise empowerment through simplicity, accessibility, and trust-building initiatives, with a focus on increasing adoption of the NHS App and similar platforms.

Where digital tools exist, they're often limited to a few specialties. A patient's journey may begin digitally, booking a GP appointment or receiving a test result notification, but quickly reverts to paper and manual processes, leaving them without visibility or timely updates.

This highlights the urgent need for consistent, system-wide digital transformation.

## What Dorset Aims to Achieve


### 1. Improving Experience, Access and Choice

**Why:** People and patients face uneven access to health information and inconsistent digital services. A unified, user-friendly experience is essential.

Access to health and care information for an individual is currently too convoluted, making it accessible to the most determined and digitally savvy. There is a plethora of apps available, and it is difficult for the

average person to know which ones are safe or appropriate to support their specific health and care needs.

This toolkit is focused on tools with enabling functionalities such as Patient Engagement Portals (PEPs) and the NHS App helping people and patients view and manage appointments, order repeat prescriptions, receive messages and notifications and access their health record.

Online services across the system remain uneven, with inconsistent user experiences and confusing navigation. Integration between platforms is poor, limiting personalisation and continuity of care. Accessibility and inclusivity are also limited, leaving some users unable to fully engage with digital tools.

### What We Will Do:

- **We will promote and implement new technologies** to support people to self-manage their conditions e.g. Hybrid Closed-Loop Systems.
- **We will increase the number of digitally enabled citizens** through increased accessibility and a consistent offer whilst providing them with the skills and support needed for digital inclusion and improving digital literacy.
- **We will increase the utilisation and understanding of how the NHS App will enhance user experience and choice** through convenient access to services, personalised health information and give patients the ability to access their data and make informed decisions about their care. It can provide choice based on patient satisfaction, waiting times and healthcare outcomes enabling access to the best care.
- **We will increase our adoption of trustworthy** AI to give patients access to trusted health information, helping patients articulate their health needs and preferences confidently whilst providing information on any conditions they may currently have.
- **We will transform towards a single user experience** focused on integration to the NHS APP.

## 2. Equitable Offer for All

**Why:** Digital tools must be accessible to everyone, regardless of skills, connectivity, or confidence.

We will develop our tools and services to ensure no one is left behind and that information is accessible to all in line with the Accessible Information Standard (AIS). We will tailor our services base on individual preferences for communication, capability, accessibility and need.

We are aware of the risks of digital exclusion. While digital tools can enhance care, they should not be a barrier to care. Therefore, all digital pathways and services will be designed with flexible alternatives when digital is not suitable. Digital champions and community navigators will be on hand to support patient choice utilising digital pathways where suitable

Digital literacy and access support vary widely across the system, leaving some staff and patients without the skills or help they need. The availability of digital services is inconsistent across organisations, care settings, and service types. Many tools also lack inclusive design, making them harder to use for diverse populations.

### What We Will Do:

- **We will offer information that is easy to access and use**, with clear, simple messaging (about what help is available close to home determined by their health need and disability).
- **We will increase workforce knowledge and skills around digital literacy and inclusion** with a view to consistent care offerings – messaging and signposting to appropriate services.

- **We will embed a Digital Champion programme (or equivalent) across Dorset** to increase the support available so as not to leave anyone behind.
- **We will increase our understanding of digital exclusion metrics** refining our approach with system colleagues including voluntary, community and social enterprise (VCSE) and social care.

# Chapter Five – Modern Infrastructure Foundations

## Why This Matters

A modern digital infrastructure is the catalyst for transformation and innovation in healthcare. It enables the deployment of advanced technologies, including AI and automation, supports seamless data integration, and ensures the security and reliability of digital health services. It also underpins the digital enablement of corporate services, helping streamline operations such as HR, finance, and procurement. By prioritising infrastructure development, Our Dorset can lead the way in creating a future-ready health and care system that is both innovative and resilient.

Insights from the Digital Strategy Questionnaire highlight system reliability as a recurring issue. Over 110 of 421 respondents disagreed or strongly disagreed that systems are reliable, and 58% reported that outages had affected their work. While confidence in security is strong, performance is not yet at the level required for 'silent running', where everything works smoothly behind the scenes. The strategy must commit to modernising infrastructure, ensuring fast, resilient, and integrated foundations.

In addition, Dorset is committed to implementing green IT infrastructure. This includes adopting energy-efficient technologies and practices that reduce the environmental impact of digital systems. By prioritising sustainability, Dorset can minimise its carbon footprint while maintaining high standards of performance and reliability. Green IT not only supports environmental goals but also contributes to cost savings and operational efficiency.

## What Dorset Aims to Achieve


### 1. Infrastructure as an Enabler

**Why:** The infrastructure is the foundation for any modern digital strategy and underpins both operational stability and strategic innovation.

Each organisation has historically procured its own digital solutions, creating complex demands layered over siloed infrastructure. Independent strategies and practices have embedded a wide range of technologies and configurations, making standardisation difficult and increasing the need for diverse skills and fragmented procurement. Compatibility between legacy and new systems is increasingly challenging, especially where contracts are extended and support becomes costly or unavailable.

Common platforms, including those for corporate services such as HR, finance, and procurement, will help resolve these issues by reducing duplication, enabling shared support models, simplifying integration, and creating a consistent, scalable foundation for digital transformation across the system.

What We Will Do:

- **We will establish a common, connected digital infrastructure** across all Dorset provider organisations, reducing duplication and technical debt.
- **We will ensure any infrastructure technologies are discussed and agreed via a single (cross organisational) governance** structure and overarching leadership to ensure alignment and harmonisation moving forward
- **We will standardise hardware and software procurement** to streamline maintenance, updates, reduce costs and support across the organisation while improving user experience.
- **We will, where appropriate, adopt cloud-based solutions** for data storage and applications, enhancing scalability, backup, and disaster recovery capabilities and embed an ability to innovate faster.
- **We will implement common platforms** to support our corporate services across HR, Finance, Procurement and Estates and Facilities.

## 2. Alignment with Clinical Priorities

**Why:** To ensure that that the infrastructure directly supports better patient outcomes through operational efficiency, and strategic transformation across our healthcare systems.

Staff across different organisations often lack access to shared systems, leading to delays and duplicated effort. Legacy IT and outdated technologies hinder integration, with technical debt preventing a single, up-to-date view of patient care. Regulatory and compliance requirements, while essential for safety, can slow infrastructure changes if not well planned. Inadequate data sharing means patients must repeat information and clinicians lack a complete picture. To adopt efficiency tools and AI safely, staff need confidence that these technologies are secure, regulated, and clinically sound.

What We Will Do:

- **We will develop a unified digital architecture to ensures interoperability across Dorset,** so information can move seamlessly with the patient.
- **We will prioritise clinical-led digital transformation** ensuring infrastructure decisions are driven by the needs of clinicians and patients, not just IT cycles, ensuring digital directly supports better outcomes.
- **We will modernise core infrastructure to enable single sign-on** to reduce wasted time, improve efficiency, and enhance safety by ensuring clinicians always have rapid, secure access to the tools they need regardless of where they are working.
- **We will promote digital inclusion principles to ensure infrastructure works for all patients**, including those facing digital barriers, to support equitable access to care.
- **We will promote the safe use of AI and efficiency tools** aligned with clinical workflows by embedding governance and safety processes, so Dorset can benefit from innovation without compromising trust or patient safety.
- **We will implement green IT infrastructure** adopting energy-efficient technologies and practices that reduce the environmental impact of digital systems and prioritising sustainability, whilst reducing our carbon footprint.

### 3. User Experience and Service Reliability

**Why:** A smooth, intuitive user experience reduces time spent navigating systems or seeking help. Reliable services mean fewer disruptions, allowing users to focus on their core tasks. Users are more confident in systems that are consistently available and easy to use. Positive experiences lead to higher satisfaction scores and better adoption of new technologies. When users trust the systems, they're more open to adopting new tools and workflows. This allows information technology teams to focus on strategic initiatives rather than firefighting.

Staff and patients often face inconsistent digital experiences that don't support new ways of working, with tools sometimes acting as barriers rather than enablers. Minimising downtime is critical, as planned or unplanned outages disrupt care, strain clinical workflows, and erode trust in digital systems.

Connectivity varies across organisations and care settings, making it difficult for staff to access the systems and data they need, impacting both productivity and care quality. Inconsistent mobile coverage further limits the effectiveness of integrated neighbourhood teams, forcing community staff to rely on workarounds and reducing their ability to deliver timely, joined-up care.

#### What We Will Do:

- **We will take a person and clinical-centred design approach to create** infrastructure services for staff and patients to ensure technology supports workflows rather than complicates them, improving adoption and outcomes.
- **We will establish experience-based KPIs to** measure staff and patient satisfaction with digital services to help us continually refine and deliver tools that meet expectations in practice.
- **We will enable consistent long-term investment to remove technical debt** by addressing legacy digital systems systematically, which will free up resources to invest in innovative solutions and avoid repeating cycles of short-term fixes.
- **We will deliver a seamless, consistent customer experience with reliable connectivity across every health and care setting** to allow staff to access information and tools wherever they are, ensuring patients receive joined-up care without digital barriers.
- **We will strengthen service desk and support models** to deliver a responsive, Dorset wide support offers to ensure staff have rapid assistance, helping to maintain confidence and minimise downtime.

### 4. Security, Continuity, and Support

**Why:** Essential for resilience, trust, and maintaining operational stability, staying on top of cyber threats protects data, assets, and reputation.

The growing threat landscape and complexity of digital systems make it difficult to gain full visibility and prioritise security improvements. Suppliers vary in cyber maturity and standards adoption, placing additional strain on IT teams' time and resources.

A fragmented cyber workforce with differing skills and experience leads to inconsistent security responses and risk tolerance across organisations. Legacy infrastructure, unmanaged operational technology, shadow IT, and end-of-life devices further increase vulnerability.

Staff confidence in cyber practices is low, with wide variation in awareness and education, highlighting the need for consistent training and a system-wide approach to cyber resilience.

What We Will Do:

- **We will share and standardise cybersecurity frameworks** and remediation plans and establish a dynamic approach to the management of cyber risk.
- **We will establish a shared cybersecurity operating model and technology.** By unifying our cyber approach across organisations, we improve resilience, reduce duplication, and protect against system-wide vulnerabilities.
- **We will commit to upgrading legacy systems to minimise vulnerability.** This reduces security risks and ensures all staff are working with modern, safe, and efficient tools that can integrate with future technologies.
- **We will develop and regularly test robust business continuity and disaster recovery plans.** Practicing recovery ensures Dorset can maintain critical services during any outage or attack, protecting patient care and safety.
- **Ensure our tooling, capabilities and analysis provide a mature and multi-layered security posture** that can meet evolving threats, ensure our staff are risk aware and know where to go for help, advice and guidance.
- **Promote security and privacy by design** in the building and procurement of new digital solutions (digital demand process).

# Chapter Six – Data, Analytics & Insights

## Why This Matters

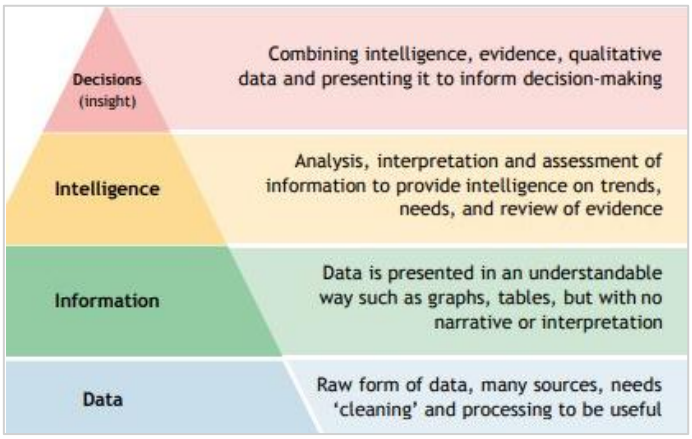
**Our data must be available to us in the Right place at the Right time:**

Data is one of the NHS's most valuable assets. When used effectively, it enables evidence-based decision-making, proactive care, and service design tailored to population needs. Dorset must become a data-driven system, embedding analytics into every aspect of health and care to improve outcomes, reduce inequalities, and support transformation.

The term "Data & Analytics" is becoming the preferred terminology within the NHS and will be used interchangeably with "business intelligence" throughout this chapter. This change emphasises that analytics is evolving into a more technical discipline, focusing not only on data collection, storage, and modelling but also on the output and reporting.

The data to insights triangle below, describes how analytical teams take raw data and turn it into intelligence which supports insightful decision making.

*Data Insights Triangle*




**Neighbourhood model of care & population health management (PHM):**

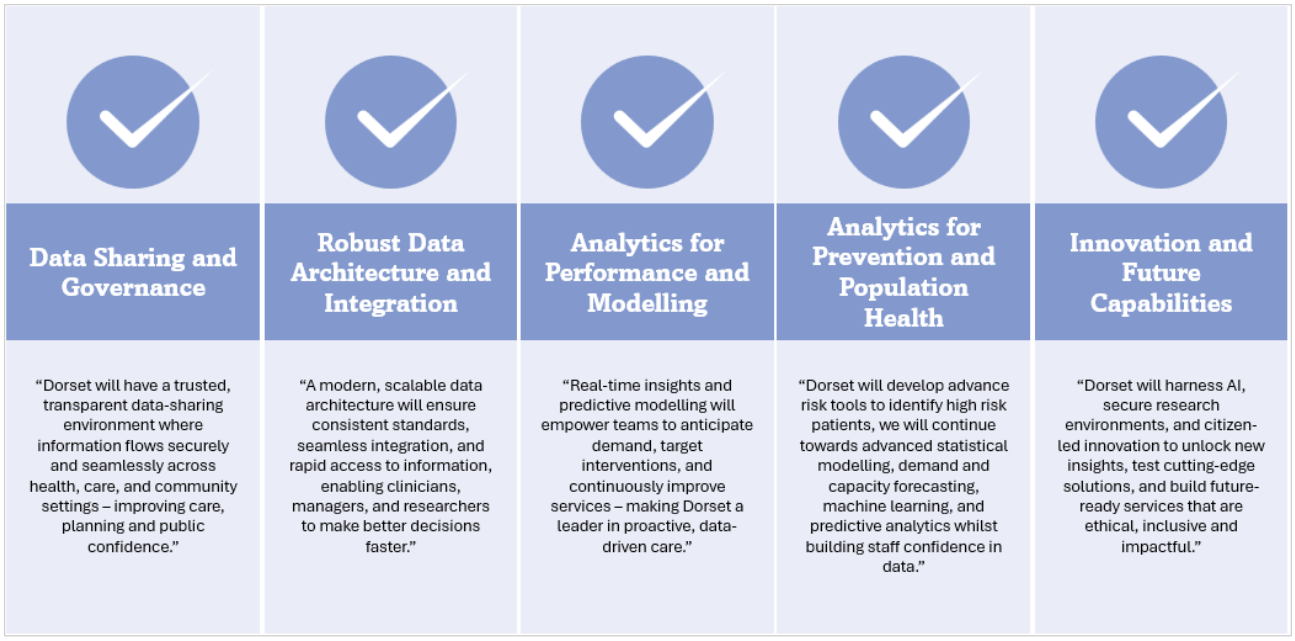
Data and analytics are fundamental in our increasingly digital world for understanding the behaviours of our communities and individuals, as well as for designing the services needed to support them.

Population Health Management (PHM) is key for ICSs like Dorset, enabling a shift from a reactive to a proactive, person-centred care. By using joined-up data and techniques like segmentation and risk stratification, we gain insights to prioritise at-risk groups for prevention, tackle health inequalities, and deliver tailored, integrated care. Effective data and analytics underpin informed decision-making and service design for our communities. The Dorset Intelligence & Insight Service (DiiS) has been driving population health in Dorset over several years and this chapter describes the developments required to embed the neighbourhood model of care across Dorset.

The following diagram shows how the PHM cycle supports the three shifts within the NHS 10 Year Plan from population needs assessments through to effective evaluation and improved outcomes. Strategic commissioning will help us approach population health more effectively, working with partners, such as hospitals and the voluntary sector. Sharing pseudonymised and anonymised data will improve

understanding of the local population and help us tailor services to meet their needs. The cycle describes how all partners within Dorset including Public Health and Local Authorities work collaboratively to deliver sustainable and cost-effective change using evidence-based interventions.

### What Dorset Aims to Achieve




## 1. Data Sharing and Governance

**Why:** Linked, high-quality data enables proactive care, strategic commissioning, and personalised services.

Dorset has a lot of data, and this will keep growing, for those in our population who are currently patients and to prevent those who are yet to be. It's important for Dorset to continue building our data-sharing culture. By linking data from primary care, hospitals, community services, mental health, local authorities, and the voluntary sector, we can improve patient and personalised care.

So far, we have made progress by establishing important clinical systems. We have created the Dorset Care Record (DCR), and the population health management system called the Dorset Intelligence & Insight Service (DiiS). These tools help us adopt digital solutions to manage patients in the community better, supporting the goal of providing care outside of hospitals.

Across Dorset information governance group works with our integrated care system to embed a culture of safe, proactive and consistent data sharing. Alongside this group, our public engagement groups such as the Digital Patient Engagement Group (DPEG), enable a transparent discussion on the purposes for data collection, the use of this data and the outcomes that result having done so. It is essential we keep sharing and accessing data from Dorset systems to support key programmes like Integrated Neighbourhood Teams (INTs) and Future Care.

### What We Will Do:

- **We will work to eliminate data silos**, strengthening data sharing across all sectors, including voluntary and social care, which will support patient journeys and service redesign, ensuring we use data safely and appropriately.
- **We will involve analysts in clinical teams or create dedicated analytical teams** to enhance data quality and improve service efficiency.

- **We will continue working with data security and protection teams across Dorset to improve our data sharing processes** and new capabilities. This will create a consistent and secure workforce, allowing us to communicate effectively about data sharing ensuring transparency on how we use and protect personal data.

## 2. Robust Data Architecture and Integration

**Why:** Scalable architecture enables timely access to linked data for care, planning, and research.

Developing a robust and scalable data architecture across Dorset and beyond is essential for enabling timely sharing of linked data sets for various purposes.

Continually advancing the integration of more data into the DiiS platform will enable a deeper understanding of population behaviours and trends, providing clinical and MDT teams with the intelligence needed to develop timely interventions and treatments both within and outside care settings.

The national data platform, the Federated Data Platform (FDP), offers the opportunity to align nationally for benchmarking and onboard rather than redevelop tools built on standardised datasets. By linking data nationally and enabling local teams, the FDP can be developed by local analytical teams to meet their needs, such as understanding acute service modelling.

### What We Will Do:

- **We will develop a robust and scalable data architecture across the ICS** leveraging cloud technologies to enable timely sharing of standardised data sets between providers, partners, and with our regional and national parties.
- **We will continue to align with the Federated Data Platform (FDP) to benchmark nationally**, avoid duplicating development of analytical tools, and empower local analytical teams to address specific needs such as acute service modelling.
- **We will increase support for operational programmes and services, including the Electronic Health Record (EHR) programme**, ensuring business and clinical needs are met through consistent data standards such as OMOP and SNOMED and improved data quality.

## 3. Analytics for Performance and Modelling

**Why:** Performance analytics support operational efficiency, early intervention, and service redesign.

Business intelligence teams across Dorset are skilled in analysing shared data and building intuitive dashboards. By sharing architecture and expertise, we can tailor insights to organisational, clinical, patient, and population needs.

Linked datasets and data-sharing systems will enable timely access to the information needed for operations, planning, and patient engagement. Enhancing performance reporting and access to near real-time data will drive productivity and service improvement, supported by BI teams.

Improving data quality is essential for routine performance management and initiatives like ‘Getting it Right First Time’ and will support the transition to a unified EHR. Strengthening performance, contract management, and productivity will help providers go beyond compliance using shared insights to better understand patient behaviours and optimise clinical resources.

### What We Will Do:

- **We will enhance real-time performance reporting and predictive modelling** to drive and deliver productivity and service improvements.

- **We will embed data-driven decision-making in operational, business, and leadership activities across all parts of Dorset**, enhancing everything from seasonal planning to targeted interventions (e.g., Falls Risk).
- **By automating more of the compliance driven data needs, we will increase focus onto information that directly supports clinical care**, transformation, and productivity, ensuring that data resources are used to deliver genuine service improvements.

### 4. Analytics for Prevention and Population Health

**Why:** Enhanced data and insight capabilities enable self-service reporting, predictive risk tools, and data-driven transformation.

The demand for more data and reporting comes from various sources, including national, regional, ICB, and local organisational levels. By enhancing the quality of analytics and delivering them more seamlessly, we can support each organisation in improving its data confidence and create a more self-service data offering. This will help reduce some demand and provide a better working experience for data teams allowing us therefore to grow and upskill our teams to meet the challenges of the future.

Through the partnership with Public Health and Local Authority analytical teams, we are best placed to support the analysis for INTs and enable place-based care. Building on the relationships already in place both operationally and across the data and analytics teams, we can work with transformation teams to embed a culture of data driven change. Underpinning this is the need for a strong focus on data quality to ensure that data driven change is informed in the most timely and accurate way possible.

#### What We Will Do:

- **We will sustain and advance the DiiS platform for population health and established data-sharing processes,** enabling a deeper understanding of population behaviours and supporting timely clinical interventions.
- **We will further develop risk stratification tools to identify high-risk patients** to inform preventative interventions, enabling clinicians to intervene earlier in patient journeys, thus reducing reliance on hospital services and supporting proactive care models.
- **We will continue to evolve from basic dashboards towards advanced statistical modelling, demand and capacity forecasting, machine learning, and predictive analytics**, to better support decision-making.
- **We will build staff confidence in using data,** allowing time for training, and utilise automated tools to significantly improve data quality, system design, and access to important care insights.

### 5. Innovation and Future Capabilities

**Why:** Future-ready systems must support AI, unstructured data, and citizen-led innovation.

Developments in data science and AI capabilities offer a greater degree of self-service than ever before. We need to be able to describe future capabilities (e.g., risk profiling, machine learning) in a way that inspires without alienating. We must continue to define and coach to instil confidence in the adoption of these emerging technologies.

While data quality and coding remain essential and must be invested in, we must also increase the focus on future possibilities, like using unstructured data, large language models and data science, without overwhelming people still grappling with basic data confidence.

National and regional research platforms, such as the Secure Data Environments for research (SDEs), offer the opportunity to share anonymised data for research projects. Governed by the Data Access

Committees (DAC), these can be academically or clinically led and can generate an income depending on the project focus and share insights back into clinical practice or population services.

### What We Will Do:

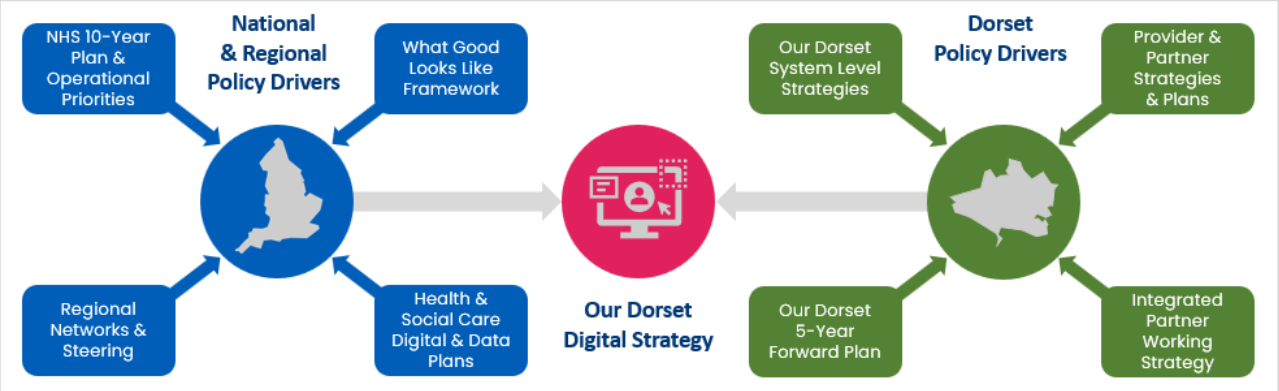
- **We will build on and expand our analytical platforms** to create a single point of entry for data insights – providing timely, high-quality data to all staff, regardless of organisation or care setting, and enabling users to search and interrogate information that supports decision-making independence and improved outcomes.
- **We will increase our active engagement with patients, citizens, and user groups.** Co-designing intuitive digital tools that embed user-centred delivery, improve basic care pathways, and ensure people can confidently interact with their own data and care plans.
- **We will expose new insights from both structured and unstructured data sources.** Unlocking the value of clinical notes, imaging, and other untapped information through advanced analytics and AI, making data accessible for real-time querying by clinicians and users.

# Chapter Seven – Alignment with Other Strategies

## Introduction

An essential part of the Dorset Digital Strategy development is understanding the broader strategic context and embedding this into the chapters. This involved translating the following strategies, plans, and guidelines into digital capabilities that Dorset needs to consider as part of its digital investments and transformation efforts.

*The Dorset Digital Strategy strategic alignment*




## The National & Regional Policy Drivers

### Department of Health & Social Care and NHS England

- Department of Health & Social Care – Health & Social Care Integration and Data Saves Lives
- NHS England - 2025/26 Priorities and Operational Planning for England
- NHS England - 10-Year Plan for England

### Regional Networks and Steering

- Health Innovation Wessex (NHS Dorset's supporting Health Innovation Network)
- Health Innovation Southwest
- NHS England Southeast 3 – Wessex Imaging Network (Internal Facing)

## The Dorset Policy Drivers

### Our Dorset System Level Strategies

- NHS Dorset - 5-Year Joint Forward Plan
- NHS Dorset - Strategic Commissioning Intentions 2026-2031 (Internal)
- Our Dorset - Integrated Care Partnership Strategy
- Our Dorset - Infrastructure (Estates) Strategy (Internal)
- Our Dorset - Clinical Digital Strategy (Internal)
- Our Dorset - Clinical Strategy 2023-2028 (Internal)

### Provider and Partner Strategies & Plans

- Bournemouth, Christchurch & Poole Council - Adult Social Care Strategy
- Dorset Council - Adult Social Care Strategy
- Dorset County & Dorset HealthCare - Federated Strategy
- University Hospitals Dorset - Digital Transformation Strategy (Internal)
- University Hospitals Dorset - Operational Plan 2024-2025
- Dorset GP Alliance - Creating Sustainable General Practice in Dorset
- Southwest Ambulance Service Trust - Strategy (Partner Working Section)

## National Health Service (NHS) & Department of Health & Social Care What Good Looks Like (WGLL)

The What Good Looks Like (WGLL) framework originated within the NHS to provide leaders, teams, and system partners with clear guidance about what "good" looks like for digital transformation across health and care settings. The framework focuses on seven success measures, which are consistent across both healthcare and adult social care settings:

- Well Led
- Smart Foundations
- Safe Practice
- Support Workforce
- Empower People
- Improve Care
- Healthy Populations

These measures were designed collaboratively by NHS England, the Department of Health and Social Care (DHSC), Local Government Association, and partners from both sectors, reflecting the drive for more joined-up, digitally mature, person-centred care.

Building on the WGLL, the NHS Digital Maturity Assessment (DMA) is a diagnostic tool used by NHS providers and integrated care systems to understand the current state of their digital services, identify strengths and gaps, and shape priorities for digital investment and improvement. The NHS Digital Maturity Assessment is explicitly structured around the seven success measures set by the WGLL framework.

The Dorset Digital Strategy Chapters can be directly mapped to the WGLL and DMA as shown below:

*How the Digital Strategy Chapters map to the WGLL and DMA*

| WGLL Success Measure | Digital Maturity Assessment | Digital Strategy Chapter |
|---|---|---|
| Well Led | Assessed via leadership and strategy | Workforce & Culture |
| Safe Practice | Reviewed via clinical safety | |
| Support Workforce | Evaluated through digital literacy/training | |
| Empower People | Measured via citizen engagement and service accessibility | Digitally Enabling & Empowering Citizens |
| Improve Care | Examined through quality and digital care pathways | Enabling Care Across Settings |
| Healthy Populations | Analysed via the use of data for population health | Data, Analytics & Insights |
| Smart Foundation | Covered via infrastructure and security | Modern Infrastructure Foundations |

# Appendices

## Appendix A

### How We Created This Strategy

The Dorset Digital Strategy has been developed through a highly collaborative and iterative co-creation process, co-designed and co-owned by digital, clinical, and operational leaders from across Dorset's health and care system.

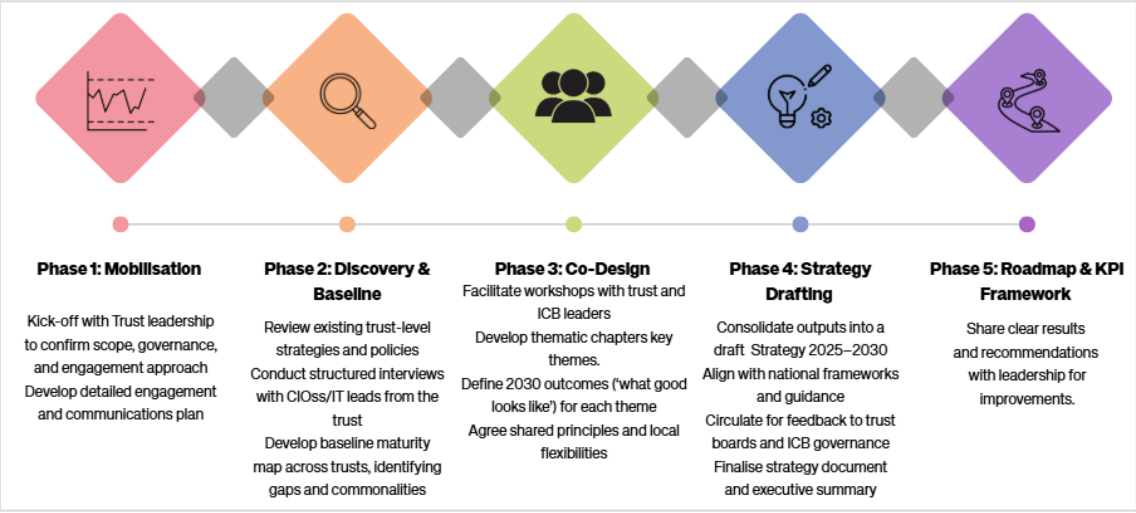
The process has ensured that every stage, from mobilisation to roadmap, has been shaped through engagement, evidence, and shared ownership. This approach brings together leaders, clinicians, and operational teams to create a strategy that is both ambitious and grounded in real-world delivery.

The work followed five structured and progressive phases:

- **Phase 1: Mobilisation**. Established scope, governance, and engagement plans through initial leadership alignment and one-to-one interviews.
- **Phase 2: Discovery & Baseline**. Reviewed existing strategies and maturity, identifying strengths, gaps, and shared priorities.
- **Phase 3: Co-Design**. Facilitated a series of five workshops with digital, clinical, and operational leaders to develop, refine, and align the strategic themes and chapters. A staff questionnaire was also conducted.
- **Phase 4: Strategy Drafting**. Splitting into multi-disciplinary chapter teams with cross organisational representation. Drafts were produced and reviewed during workshops and individual feedback loops.
- **Phase 5: Roadmap & KPI Framework.** Translated the strategy into an actionable delivery plan, defining measurable outcomes and key performance indicators for each chapter.

Throughout, progress was guided by continual feedback system-wide engagement, and alignment with the Dorset vision. The result is a strategy that is collectively owned, evidence-based, and fully endorsed by the digital leadership and system partners, ensuring a shared commitment to deliver meaningful digital transformation across Dorset.

*The phases of the Dorset Digital Strategy development*

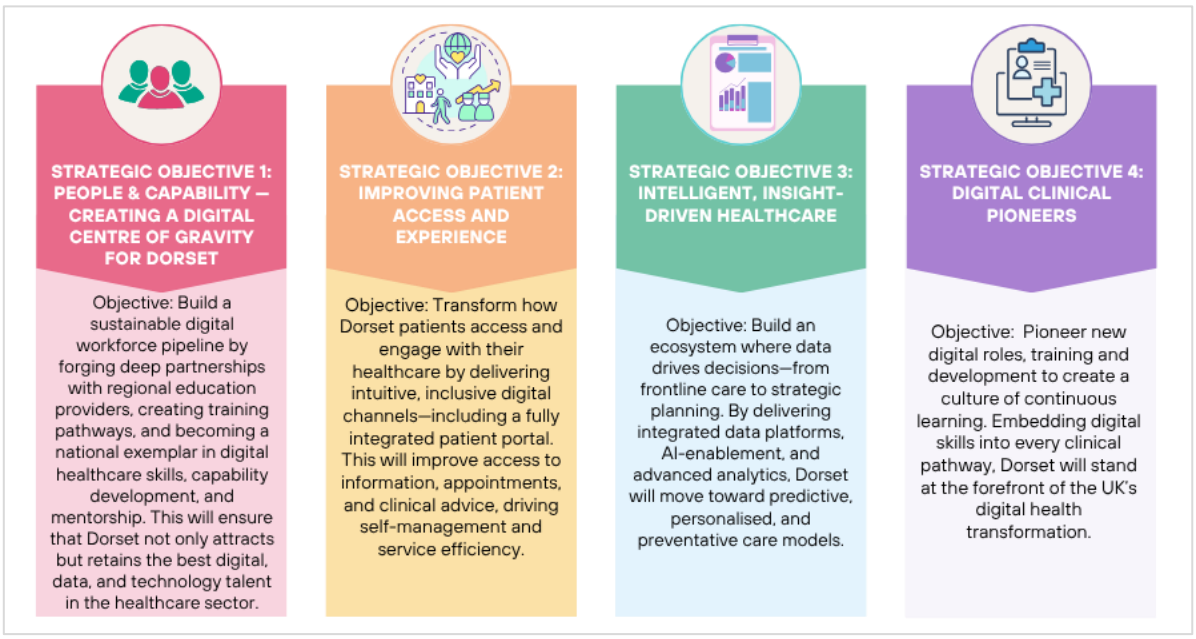


## Appendix B

### Our Strategic Objectives

Through engagement across Dorset's health and care system, four strategic objectives define our journey to 2030:

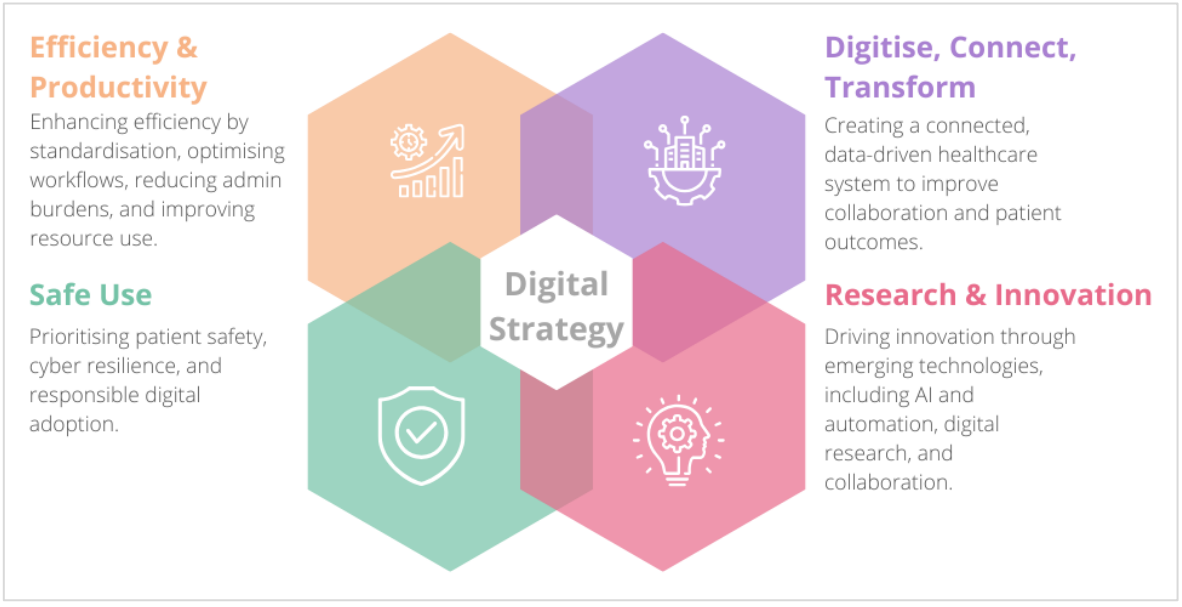
*The four strategic objectives for the Dorset Digital Strategy*




### Digital Strategy Themes

These themes are the big ideas that shape our digital plans. They give clear direction and help everyone in Dorset work in a joined-up way to deliver the strategy.

*The four strategic themes for the Dorset Digital Strategy*



## Digital Strategy Principles

These principles serve as a guide to ensure our digital plans are ethical, practical, and help us make the right decisions as we improve and deliver new digital services.

*The three strategic principles to guide the Dorset Digital Strategy*


## Digital Strategy Chapters

Each chapter focuses on a key priority or area of work. This structure will help us plan, deliver, and communicate more effectively across Dorset's health and care system.

*The seven chapter headings for the Dorset Digital Strategy*

## Appendix C- Consolidated KPI Table

### Chapter 2 – Enabling Care Across Settings

| Chapter | WGLL Theme | Strategy Outcome Theme | Strategy Chapter Outcome | Strategy Chapter Outcome KPI(s) |
|---|---|---|---|---|
| Enabling Care Across Settings | Improve Care | Integrated Digital Systems Across Settings | Every clinician and patient in Dorset will have secure access to the right point-of-care information at the right time, via systems that talk to each other across all care settings. Paper is eliminated, except where a patient has explicitly opted for paper correspondence, connectivity is reliable and all correspondence across care settings is handled electronically. | 1. Clinicians managing patient noting and correspondence digitally.<br>2. Paper limited to patient correspondence where preferred.<br>3. Uptime/reliability of connectivity in all clinical locations.<br>4. Referrals and discharge summaries between secondary and primary care handled digitally with a high level of data quality. |
| | | Collaborative Governance and Strategic Alignment | Digital decisions in Dorset will be made once, wisely, and together. All organisations will work to a single strategy, with shared governance that prioritises long-term value, safety, and resilience over short-term fixes. Every partner feels ownership of the digital future. | 5. Shadow IT and stranded IT contracts eliminated.<br>6. Annual stakeholder satisfaction scores regarding collaborative governance and decision-making. |
| | | Future-Focused Programmes and Technologies | Dorset will lead the way in adopting innovative evidence-based digital programmes that improve lives today and prepare for tomorrow. From integrated neighbourhood teams to AI-powered diagnostics and a single patient record, technology will enable proactive, preventative, and personalised care. | 7. Successful HealthSet implementation.<br>8. Delivery of a framework to allow AI and other clinically led digital innovations to persist via APIs into the HealthSet system.<br>9. Neighbourhood Teams fully digitally enabled. |

## Chapter 3 – Workforce & Culture

| Chapter | WGLL Theme | Strategy Outcome Theme | Strategy Chapter Outcome | Strategy Chapter Outcome KPI(s) |
|---|---|---|---|---|
| Workforce & Culture | Well Led<br>Safe Practice<br>Support People | Leadership and Collaboration | Digital leadership will be embedded at every level, from board to frontline, with clinical, operational, and digital leaders working together through shared governance to drive transformation across Dorset. | 10. Qualified digital leadership representation at Board-level and across all departments. (100%)<br>11. Digital leadership training standard established with a process and cohorts to build capability underway. |
| | | Digital Workforce Development | Dorset will nurture a professional, sustainable Digital, Data and Technology workforce with clear career pathways, accredited training, and opportunities for development, ensuring we attract and retain top talent. | 12. Number of digital/data professionals enrolled in accredited training schemes annually.<br>13. Retention rate for digital talent year-on-year.<br>14. Proportion of staff with advanced digital skills certification. |
| | | Wider Health and Care Workforce Development | All staff feel confident and supported in using digital tools, with equitable access to training and minimum digital skill standards, creating a culture where technology enables safe, inclusive, and high-quality care. | 15. Proportion of staff meeting minimum digital skill standards.<br>16. Number of staff participating in ongoing digital training.<br>17. Staff confidence scores for using digital tools (annual workforce survey). |

## Chapter 4 – Digitally Enabling and Empowering Citizens

| Chapter | WGLL Theme | Strategy Outcome Theme | Strategy Chapter Outcome | Strategy Chapter Outcome KPI(s) |
|---|---|---|---|---|
| Digitally Enabling and Empowering Citizens | Empower Citizens | Improving Experience, Access and Choice | Every citizen in Dorset will enjoy a simple, trusted digital front door to health and care services, offering consistent quality, seamless access, and genuine choice in how they engage with their care. | 18. Proportion of population accessing services via digital front door.<br>19. Mean time to digital service access for citizens versus analogue methods.<br>20. Patient satisfaction with range and quality of digital access options.<br>21. Proportion of patients managing conditions using digital technologies. |
| | | Equitable Offer for All | Nobody in Dorset will be excluded from digital health and care. Services, support and training will be accessible to all – regardless of skills, confidence, or connectivity – so that every citizen benefits equally. | 22. Percentage of population with access to digital health services across all demographics.<br>23. Number of digital support interventions delivered in deprived or low-connectivity areas.<br>24. Reduction rate in digital exclusion indicators – e.g., upskilling and device distribution. |

## Chapter 5 – Modern Infrastructure Foundations

| Chapter | WGLL Theme | Strategy Outcome Theme | Strategy Chapter Outcome | Strategy Chapter Outcome KPI(s) |
|---|---|---|---|---|
| Modern Infrastructure Foundations | Smart Foundations | Infrastructure as an Enabler | Infrastructure in Dorset will be recognised as a critical enabler of safe, effective and efficient care – invested in strategically to support transformation, clinical outcomes, and staff wellbeing. | 25. Percentage completion of planned infrastructure upgrades versus target milestones.<br>26. Number of infrastructure-related incidents resolved within SLA (target >95%).<br>27. Staff-reported reliability and satisfaction scores with digital infrastructure. |
| | | Alignment with Clinical Priorities | Digital infrastructure will be designed around clinical priorities and system goals, ensuring every investment directly supports better care, improved safety, and greater productivity. | 28. Clinical safety improvement rates attributable to digital investments.<br>29. Clinical team satisfaction with infrastructure support. |
| | | User Experience and Service Reliability | Staff and citizens will experience simple, seamless, and always-available digital services. Infrastructure will be intuitive, reliable, and designed to reduce frustration and duplication. | 30. Average incident response time for digital service interruptions.<br>31. Percentage uptime/availability of core digital services (target >99.9%). |
| | | Security, Continuity and Support | Resilient security, business continuity and consistent support will be embedded across all health and care settings, building public trust and ensuring uninterrupted care in both every day and exceptional circumstances. | 32. Number of cybersecurity incidents detected and positively responded to per year.<br>33. Mean time to restore critical digital services after incident (target <2 hours).<br>34. Data Security and Protection Toolkit – Standards Met across all organisations. |

## Chapter 6 – Data, Analytics & Insights

| Chapter | WGLL Theme | Strategy Outcome Theme | Strategy Chapter Outcome | Strategy Chapter Outcome KPI(s) |
|---|---|---|---|---|
| Data, Analytics & Insights | Healthy Populations | Data Sharing and Governance | Dorset will have a trusted, transparent data-sharing environment where information flows securely and seamlessly across health, care, and community settings – improving care, planning and public confidence. | 35. Number of successful cross-organisation data exchanges per month.<br>36. External audit findings on data governance robustness. |
| | | Robust Data Architecture and Integration | A modern, scalable data architecture will ensure consistent standards, seamless integration, and rapid access to information, enabling clinicians, managers, and researchers to make better decisions faster. | 37. Number of data platforms meeting interoperability standards (e.g., FHIR).<br>38. Time to on-board new datasets (mean days).<br>39. Frequency of data integration failures (target: <0.5%). |
| | | Analytics for Performance and Modelling | Real-time insights and predictive modelling will empower teams to anticipate demand, target interventions, and continuously improve services – making Dorset a leader in proactive, data-driven care. | 40. Percentage of services using real-time insights for operational decision-making.<br>41. Staff satisfaction with access to actionable data insights. |
| | | Analytics for Prevention and Population Health | Dorset will develop advance risk tools to identify high risk patients, we will continue towards advanced statistical modelling, demand and capacity forecasting, machine learning, and predictive analytics whilst building staff confidence in data. | 42. Number of active risk stratification/predictive prevention initiatives.<br>43. Uptake of advanced statistical models across departments.<br>44. Change in key population health indicators attributed to data-driven interventions. |
| | | Innovation and Future Capabilities | Dorset will harness AI, secure research environments, and citizen-led innovation to unlock new insights, test cutting-edge solutions, and build future-ready services that are ethical, inclusive and impactful. | 45. Number of AI research or citizen-led digital innovation projects in progress.<br>46. Percentage of digital services reviewed for ethical and inclusive design annually. |

## Appendix D

## Case Studies

Below gives one example of a patient with multiple morbidities and how a streamlined care system, underpinned with the right technology at the right time can influence, empower and positively impact a patient journey:

**Patient Story**

**Ella's Background and Conditions Summary**

Female | 16 years old
Lives with parents in Dorset
Scottish
Supportive family environment

- Generalised anxiety disorder with low mood symptoms
- Insomnia
- Iron deficiency anaemia (mild)
- Psychosocial stressors
- Reduced concentration and fatigue

Ella is a 16-year-old student living with both anxiety and iron deficiency, which together affect her sleep, concentration, and performance at school. Exam pressures and friendship difficulties add to her stress.

After visiting her GP, Ella is prescribed iron supplements and a low-dose anti-anxiety medication. To help her manage these treatments, she uses an NHS-approved digital medication diary, which provides reminders, tracks her symptoms, and shares progress with her care team in real time.

She also accesses NHS Talking Therapies online, allowing her to complete self-guided modules and virtual check-ins that fit around her school timetable. Her school receives secure digital updates on her wellbeing through the local NHS education portal, enabling pastoral staff to adjust deadlines and provide timely support.

By integrating digital tools across physical and mental health care, Ella's GP, counsellor, and school staff have a joined-up view of her progress. This helps them coordinate support, reduce duplication of appointments, and adapt her care plan quickly. As a result, Ella begins to sleep better, feels more confident managing her anxiety, and is better able to balance her health with her education.

Ella

**Patient Story**

**Dave's Background and Conditions Summary**

Male | 47 years old
Social housing
Afro-Carribbean heritage
No family are in the area but good community to lean on.

- COPD
- Smoker 20+years
- Current vaper
- Anxiety

Dave has recently retuned to work after a period of unemployment. He was a heavy smoker from an early age but quite about 5yrs ago following his COPD diagnosis. However, due to his recent episode of unemployment he commenced vaping as an alternative to smoking to alleviate his anxiety.

The vaping has triggered his COPD and Dave was hospitalised with a chest infection and exacerbation to his breathing difficulties. Dave is discharged with virtual support. He has been prescribed an inhaler and COPD rescue pack for future flare ups.

Dave receives support from the COPD community nursing team who will perform a virtual visit to follow up on his condition and prescribe remote management tools as part of his package of care.

Weekly virtual appointments for outpatient care are scheduled at times that are convenient for Dave. He uses his NHS App to view his appointments and care plan and get notifications or messages from his care team. Dave is asked to submit observations and answer clinical questionnaires on a scheduled basis and explained how his care team will review and monitor these which are clarified in a digital leaflet hosted by the care organisations webpages.

A digital care coordinator shows Dave how to take his vital signs and how it is directly fed into the record from integrated smart monitoring devices.

Using prescriptive algorithms, abnormal observations are automatically flagged to the teams for response with a clear standard operating pathway.

Dave

Digital confidence level

Virtual check ins

Citizen / Patient portal

Remote monitoring with integrated smart devices

## Michael
Dorset Resident

**By 2029, I will be able to...**

- Easily access support by completing the digital activities that matter to me.
- Follow consistent signposting to find information about the local digital support offer and the various places I can do to receive help.
- Access good quality Wi-Fi in my GP surgery so that I can receive help with accessing online health services and support.
- Get the care I need either from my home or a place of my choice, without the need for travel.
- Easily find information about services available to support me in my community neighbourhood.

## Sarah
Clinical

**By 2029, I will be able to...**

- Easily refer people to support with accessing healthcare-related apps so that they can engage with our online services, or alternatively, refer them to partners in voluntary groups e.g. Citizens Advice, if their need is better served by them.
- Have a strong understanding of the digital support needs in the community I serve and the tools with which to target and serve those needs.
- Understand the digital literacy ability of all of our patients with long term conditions, the potential to support them with digital tools, and have a clear view of those who need more help.
- Provide a healthcare service that I am proud to have co-designed with accessibility in mind.

## Ian
Volunteer

**By 2029, I will be able to...**

- Easily refer people to support with accessing healthcare-related apps so that they can engage with online services.
- Work in partnership with other voluntary sector organisations, using our combined resources to support our communities.
- Guide people to available local digital support e.g. device loaning, connectivity and free Wi-Fi.
- Access training on how to support the public; receive specific training and guidance on specific apps e.g. the NHS App.

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 14 January 2026**

**Agenda item: 8.3**

| | |
|---|---|
| **Subject:** | Maternity Incentive scheme assurance process year 7 |
| **Prepared by:** | Lorraine Tonge, Director of Midwifery and Neonatal services |
| **Presented by:** | Lorraine Tonge, Director of Midwifery and Neonatal Services |

| | |
|---|---|
| **Strategic themes that this item supports/impacts:** | Population & System ☒<br>Our People ☒<br>Patient Experience ☒<br>Quality Outcomes & Safety ☒<br>Sustainable Services ☐ |
| **BAF/Corporate Risk Register: (if applicable)** | None |
| **Purpose of paper:** | Decision/Approval |
| **Executive Summary**: | UHD maternity and neonatal services have continued making improvements in safety from year 6 MIS and have continuous robust assurance processes in place to monitor progress.<br><br>Assurance processes throughout the year have been followed.<br><br>All 10 safety actions criteria have been met with evidence submitted by clinical leads.<br><br>All evidence has been verified by Director of Midwifery and neonatal services with oversight from LMNS Lead midwife.<br><br>BDO auditors' assessment complete with final report to Trust Board supporting the process.<br><br>Storage of evidence is on a Microsoft teams' channel should it be required.<br><br>The report outlines each safety action and evidence provided and requests Trust Board for CEO to make declaration on its behalf by 12 noon on the 3rd of March 2026 |
| **Background:** | • Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of |

| | |
|---|---|
| | stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.<br><br>• The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund.<br><br>• The original ten safety actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS England, Royal College of Obstetricians and Gynecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC), the Maternity and Newborn Safety Investigation Programme (MNSI) and service user representatives.<br><br>• Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover their Trust's element of the contribution relating to the CNST MIS fund and this will be returned to the source of the initial CNST payment. They will also receive a share of any unallocated funds.<br><br>• Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a smaller discretionary payment from the scheme to help to make progress against actions they have not achieved.<br><br>• Such a payment would be at a lower level than the 10% contribution to the MIS fund and is subject to a cap decided annually by NHS Resolution. The balance of unallocated funds will be shared with the trusts who have achieved all ten safety actions. |
| **Key Recommendations**: | The Board is asked to approve the MIS and to make UHD's declaration to NHS resolution by the 3rd of March 2026. |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality and Diversity ☐<br>Financial ☒<br>Operational Performance ☒<br>People (inc Staff, Patients) ☒<br>Public Consultation ☐<br>Quality ☒<br>Regulatory ☒<br>Strategy/Transformation ☐<br>System ☐ |
| **CQC Reference:** | Safe ☒ |

| | | |
|---|---|---|
| | Effective | ☒ |
| | Caring | ☒ |
| | Responsive | ☒ |
| | Well Led | ☒ |
| | Use of Resources | ☒ |

| Report History: Committees/Meetings at which the item has been considered: | Date | Outcome |
|---|---|---|
| Maternity quadrumvirate | 12/12/2025 | Noted and approved through Governance processes. |
| Safety champions meeting | 19/12/2025 | To be noted and approved through Governance processes safety champions reports |
| Quality Committee | 16/12/25 | To provide assurance of process and seek Board approval to complete declaration. |
| Care group Board | 19/12/25 | To be Noted and approved through Governance processes. |

| | | |
|---|---|---|
| **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

# Maternity Incentive Scheme (MIS) Year 7 Trust Board report

Director of Midwifery and Neonatal Services – Lorraine Tonge
Clinical Director – James Balmforth
Head of Midwifery and Neonatal Services – Kerry Taylor
General Manager Women and Children – Fiona Lawson

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

## Introduction

Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund:

# The 10 safety actions

NHS Resolution

**Safety action 1**:
National Perinatal Mortality Review Tool

MBRRACE-UK

**Safety action 2:**
Data and the Maternity Services Data Set

NHS England

**Safety action 3**: Transitional care & avoiding term admissions

NHS England

**Safety action 4:** Clinical workforce planning

RCOA

Royal College of Obstetricians & Gynaecologists

**Safety action 5:** Midwifery workforce planning

Royal College of Midwives

**Safety action 6**:
Saving Babies' Lives Care Bundle Version Three

NHS England

**Safety action 7**:
Listening to women, parents and families & coproduction

NHS England

**Safety action 8**:
Training

Royal College of Obstetricians & Gynaecologists

NHS England

**Safety action 9**:
Board assurance on maternity & neonatal safety & quality issues

NHS England

**Safety action 10**:
Maternity & Newborn Safety Investigations & Early Notification Scheme reporting

MNSI

NHS Resolution

## MIS Year 7 process of assurance at UHD

### Monthly monitoring

There was continuous monitoring of MIS safety standards throughout the year with monthly assurance meetings in place.

Assurance meetings are chaired by the Director of Midwifery and Neonatal services with update, progress and any challenges presented by workstream clinical leads.

Updates on progress is provided to the Local Maternity and Neonatal System ( LMNS) care group and Trust Board throughout the year through monthly integrated performance reports.

### Evidence reviews

Evidence is gathered to demonstrate that the standards are met.
This evidence was reviewed by the DoM, and lead midwife for the LMNS (Vicky Garner) and verification is given for each standard.
BDO review the process and provide assurance to the trust Board that all assurance reviews occurred.

### Storage of evidence

All evidence is stored on a team's channel (Maternity Assurance meeting- MIS year 7 )

# MIS Y7 Compliance Overview

| Safety Action | Red | Amber | Green | Blue | Total Requirements |
|---|---|---|---|---|---|
| 1 | 0 | 0 | 0 | 7 | 7 |
| 2 | 0 | 0 | 0 | 2 | 2 |
| 3 | 0 | 0 | 0 | 6 | 6 |
| 4 | 0 | 0 | 0 | 19 | 19 |
| 5 | 0 | 0 | 0 | 12 | 12 |
| 6 | 0 | 0 | 0 | 9 | 9 |
| 7 | 0 | 0 | 0 | 4 | 4 |
| 8 | 0 | 0 | 0 | 21 | 21 |
| 9 | 0 | 0 | 0 | 9 | 9 |
| 10 | 0 | 0 | 0 | 9 | 9 |
| Total | 0 | 0 | 0 | 98 | 98 |

Key:

| | |
|---|---|
| Red | Not compliant |
| Amber | Partial compliance - work underway |
| Green | Full compliance - evidence not yet reviewed |
| Blue | Full compliance - final evidence reviewed |

*Non-mandated sctions will not be included in this table.

**Safety action 1**:
National Perinatal Mortality Review Tool

# Compliance status

Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?


Evidence provided for compliance:

- PMRT - Perinatal Mortality Reviews Summary Report
- MBRRACE Reports and Associated Evidence
- PMRT Database
- PMRT letters to all applicable families
- PMRT Board Report Q1, 25-26 and Q2 25-26 Q3 24-25 and Q4 24-25
- PMRT safety champions meetings, Quality Committee, IPR where quarterly reports are presented and discussed.
- Trust Board agenda and minutes May /September/November .

Overview:
Compliant and evidence provided for all actions 1.1 to 1.7

Section1.6 – Trust Board minutes will be added post January Trust Board meeting for full completion of storing of evidence.

**Safety action 2:**
Data and the Maternity Services Data Set

NHS England

# Compliance status

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

CNST: Safety Action 2 results for UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST for July 2025

1.

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| Birthweight DQ | 415 | 415 | 100.0 | Passed |

Pass rate: 80%

2.

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| Ethnicity DQ | 380 | 380 | 100.0 | Passed |

Pass rate: 90%

Evidence provided for compliance:

- MSDS Compliance Published Data September 2025

Overview:

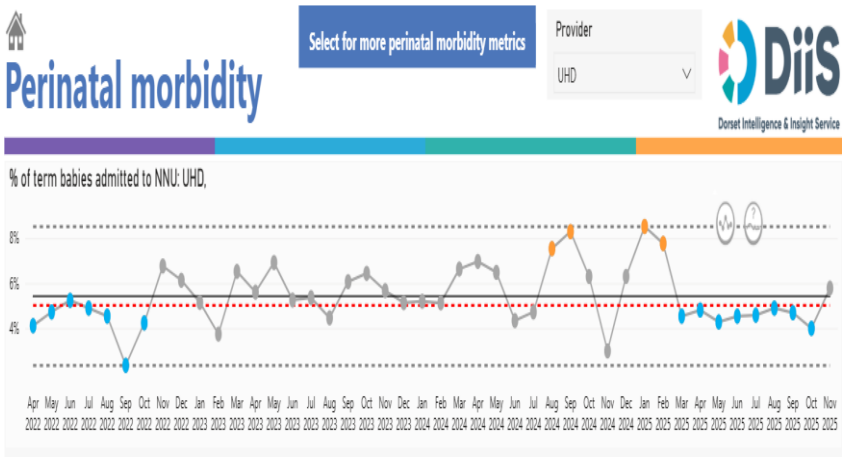
Compliant and evidence provided for all actions.

**Safety action 3**: Transitional care & avoiding term admissions

NHS England

# Compliance status

Can you demonstrate that you have Transitional Care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?




Evidence provided for compliance:

- TCU SOP
- Continuation of QI Project Avoidable term admission to NICU.
- Update on QI presentations in safety champions meeting August and May with progress made.
- Update to LMNS by Trust Board quarterly reports and presentation in November of progress made.

## Overview:

Compliant and evidence provided for all actions.

**Safety action 4:** Clinical workforce planning

# Compliance status

Can you demonstrate an effective system of clinical workforce planning to the required standard?


Evidence provided for compliance:

- The Trust data base following the criteria for employing short- and long-term locums]
- The Trust is working towards RCOG compensatory rest
- Trust monitoring compliance on consultant attendance on labour ward Audit March to May presented at safety champions and LMNS- summary in quarterly Trust Board reports.
- Anaesthetics Medical Workforce ASCA standards rotas and confirmation from maternity lead Consultant
- Neonatal Medical Workforce now meet the BAPM standards. Demonstrated in Trust Board report and risk register which reflects the year progress
- Plan for Neonatal Nursing Workforce to meet BAPM standards with agreed board QIS action plan which is recorded is recorded in Trust Board minutes and agreed by ODN and LMNS, November 2025

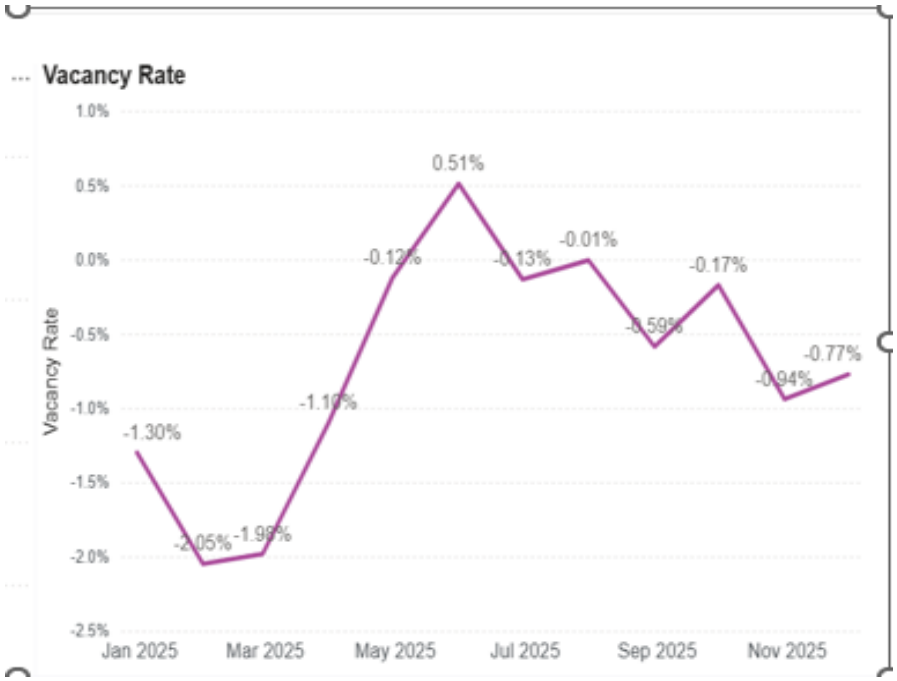
Overview:
Compliant and evidence provided for all actions 4.1- 4.20. Trust Board minutes will be added post January Trust Board meeting for full completion of storing of evidence.

**Safety action 5:** Midwifery workforce planning

Royal College of Midwives

# Compliance status

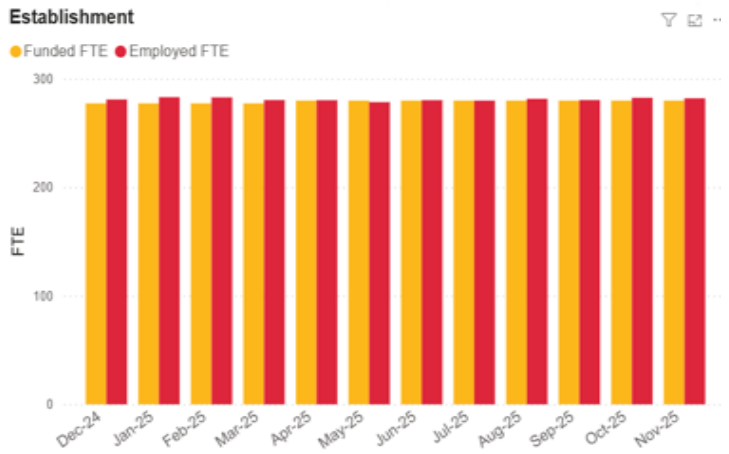
Can you demonstrate an effective system of midwifery workforce planning to the required standard?




Evidence provided for compliance:

- Midwifery 6 monthly staffing paper
- Review at people and culture committee.
- Trust board oversight and support given to recruit into maternity leave cover and over birthrate plus report.

Overview:
Compliant and evidence provided for all actions.



**Safety action 6:**
Saving Babies' Lives Care Bundle Version Three

NHS England

# Compliance status

Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version 3?

**NHSE Region:** NHSE South West

| | | Assessments | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **Review quarter:** | | Q1 2023/24 | Q2 2023/24 | Q3 2023/24 | Q4 2023/24 | Q1 2024/25 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 | Q1 2025/26 | Q2 2025/26 |
| **Assurance review date:** | | 20/09/2023 | 21/12/2023 | 20/02/2024 | 11/06/2024 | 30/08/2024 | 07/11/2024 | 25/02/2025 | 23/05/2025 29/05/2025 | 19/08/2025 | 13/11/2025 |
| Element 1 | Smoking in pregnancy | 20% | 100% | 90% | 90% | 80% | 100% | 100% | 100% | 90% | 90% |
| Element 2 | Fetal growth restriction | 45% | 70% | 65% | 75% | 70% | 95% | 95% | 90% | 80% | 95% |
| Element 3 | Reduced fetal movements | 0% | 50% | 100% | 100% | 100% | 50% | 100% | 100% | 100% | 100% |
| Element 4 | Fetal monitoring in labour | 40% | 40% | 40% | 60% | 40% | 80% | 100% | 100% | 100% | 100% |
| Element 5 | Preterm birth | 52% | 85% | 67% | 78% | 81% | 85% | 85% | 93% | 88% | 92% |
| Element 6 | Diabetes | 50% | 83% | 83% | 100% | 83% | 100% | 100% | 100% | 83% | 83% |
| All elements | All elements | 43% | 79% | 70% | 80% | 76% | 90% | 93% | 94% | 87% | 93% |

% of interventions fully implemented (LMNS Validated)

Evidence provided for compliance:

- 93 % SBL tool fully implemented within the trust and evidence from ICB of sufficient progress made in line with locally agreed improvement trajectory.
- Quarterly Trust Board reports demonstrating progress
- LMNS Board summaries to show progress.

Overview:
Compliant and evidence provided for all actions.

**Safety action 7**:
Listening to women, parents and families & coproduction

NHS England

# Compliance status

Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

## Maternity survey 2024

Published 28 November 2024

This survey looks at the experiences of 18,951 women, across 120 NHS trusts, who gave birth in February 2024 (and January 2024 for smaller trusts).

Questionnaires were sent out between May and August 2024, responses were received from 146 people at University Hospitals Dorset NHS Foundation Trust.

| | Patient Response | Compared with other trusts |
|---|---|---|
| Labour and birth | 8.4 / 10 | About the same |
| Staff caring for you | 8.7 / 10 | About the same |
| Care in hospital after the birth | 6.7 / 10 | About the same |

Evidence provided for compliance:

- Engagement with MNVP
- Terms of reference with MNVP included
- MNVP funding
- Annual CQC patient survey 2024 data and action plan

## Overview:

Compliant and evidence provided for all actions.

November 2025 , 15 -steps report with action plan to be added for completion of evidence.

**Safety action 8:** Training

NHS England

# Compliance status

## Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

| Standard | | Expected compliance | Nov-24 | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fetal Monitoring (Module 2) | Obstetric consultants | 90% | 100% | 94.40% | 94.12% | 94.44% | 94.44 | 93.33% | 100% | 100.00% | 100% | 100% | 100% | 100% | 100% |
| | All other obstetric doctors contributing to the obstetric rota | 90% | 100% | 100% | 95.65% | 100% | 100% | 100% | 94.74% | 94.74% | 100% | 100% | 100% | 85.71% | 93.75% |
| | Midwives | 90% | 99.29% | 98.20% | 97.67% | 99.23% | 98.73% | 98.80% | 99.17% | 99.22% | 99.22% | 99.59% | 99.66% | 99.62% | 98.05% |
| PROMPT (Module 3) | Obstetric Consultants | 90% | 93.75% | 89.47% | 89.47% | 94.73% | 77.77% | 100% | 100% | 100% | 100% | 100% | 93.75% | 93.75% | 100% |
| | All other obstetric doctors contributing to the obstetric rota (commenced prior to 1 July 2025) | 90% | 91.89% | 100% | 97.14% | 76.40% | 82.35% | 69.69% | 68.75% | 96.87% | 100% | 100% | 100% | 55.55% | 100% |
| | Obstetric rotational medical staff that commenced work after 1 July 2025 | a lower threshold | | | | | | | | n/a | n/a | 0% | 100% | 76% | 100% |
| | Midwives | 90% | 97.28% | 97.29% | 93.79% | 85.65% | 91.01% | 94.44% | 94.42% | 95.71% | 98.78% | 98.36% | 98.29% | 97.52% | 98.38% |
| | Maternity Support Workers | 90% | 96.59% | 96.42% | 90.24% | 79.51% | 84.88% | 94.87% | 83.52% | 94.20% | 94.18% | 90.12% | 95% | 93.97% | 96.42% |
| | Anaesthetic consultants and autonomously practising anaesthetists | 90% | 96% | 92% | 92.00% | 96% | 96% | 96% | 80.90% | 85.71 | 95% | 95% | 94.73% | 94.73% | 100% |
| | to the obstetric rota (commenced prior to 1st July 2025) | 90% | 94.11% | 100% | 100% | 90% | 85% | 90% | 68.77% | 58.06% | 82.75% | 82.75% | 100% | 100% | 90.00% |
| | Anaesthetic rotational medical staff that commenced work after 1 July 2025 | a lower threshold | | | | | | | | n/a | n/a | 0% | 50.0% | 33.33% | 75.00% |
| | Can you demonstrate that at least one emergency scenario is conducted in the clinical area? | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| | Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area? | Yes | Yes | Yes | 93.36% | 92.56% | 98.63% | 90.13% | 96% | 96% | 96.74% | 93.64% | 96.36% | 93.39% | 97.42% |
| Neonatal Basic Life Support (Module 6) | Neonatal consultants or paediatric consultants covering neonatal units | 90% | 100% | 100% | 100% | 86% | 100% | 100% | 83% | 100% | 100% | 83% | 83% | 100% | 100% |
| | Neonatal junior doctors (who attend any births) Clinical fellows | 90% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 94% | 100% | 50% | 50% | 100% | 100% |
| | Neonatal nurses (band 5 and above who attend any births) | 90% | 100% | 100% | 100% | 100% | 100% | 97% | 97% | 100% | 100% | 97% | 97% | 91% | 91% |
| | ANNPs | 90% | 100% | 100% | 100% | 94% | 100% | 100% | 100% | 100% | 100% | 100% | 93.75% | 82.00% | 100% |
| | Midwives | 90% | 97.28% | 97.29% | 90.31% | 81.39% | 80.07% | 84.90% | 92.82% | 92.99% | 90.68% | 91.39% | 94.04% | 92.97% | 95.54% |
| | Nursery Nurses | 90% | 100.00% | 100% | 50% | 50% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | All trusts must have an agreed plan in place including timescales for registered RC-trained instructors to deliver the in house basic neonatal life support annual updates and their local NLS courses | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Midwife Update Day (Module 4 & 5) | Midwives | 90% | 94.96% | 94.98% | 95.34% | 97.67% | 98.82% | 97.61% | 97.21% | 96.49% | 97.98% | 97.54% | 97.44% | 95.45% | 96.40% |

Evidence provided for compliance:

Training above 90% in the following areas:

- Fetal monitoring
- NLS
- Midwife update day
- Prompt and MDT simulation session above 90% for all staff groups except Anaesthetic team who started after 1st of July Trust Board agreed action plan in place for all outstanding to be completed within 6 months.

Overview:

Compliant and evidence provided for all staff groups.

.

**Safety action 9**:
Board assurance on maternity & neonatal safety & quality issues

NHS England

# Compliance status

Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

## Meet our Maternity and Neonatal Safety Champions

Here to support **you** in raising any concerns to ensure that parents and babies continue to receive the safest care

**Sarah Herbert**
Chief Nursing Officer
Sarah.herbert16@nhs.net

**Michael Marsh**
Non-Executive Director
Michael.marsh2@nhs.net

**Peter Wilson**
Chief Medical Officer
Peter.wilson23@nhs.net

With daily support on site from:

Lorraine Tonge
Director of Midwifery and Neonatal Services

Abi Langrish
Obstetric Lead Consultant

Kerry Taylor
Head of Midwifery and Neonatal Services

Peter McEwan
Lead Consultant Neonatologist

*If you have any urgent safety issues, please raise this with one of your leadership team*

Evidence provided for compliance:

- Evidence of safety champions NED , CNO and CMO.
- Evidence of ward to Board reporting as set out by Perinatal Surveillance oversight model.
- Evidence of safety intelligence ,listening events and reflected in Board reports and minutes.
- Evidence that the Board safety champions meetings supporting the perinatal quadrumvirate.
- Evidence of culture plan and working on improving maternity culture.

Overview:
Compliant and evidence provided for all actions.

**Safety action 10**:
Maternity & Newborn Safety Investigations & Early Notification Scheme reporting

# Compliance status

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification(EN) Scheme?

MNSI
Maternity & Newborn Safety Investigations

Evidence provided for compliance:
There has been no MNSI cases throughout 2025 and in the reporting period.

To ensure no cases have been overseen, cross check completed :

- catch up meeting with MNSI
- Review of all litigation
- Confirmation of no claims through NHS resolution.

Overview:

Compliant and cross check evidence provided for all actions.

## Conclusion

Assurance processes throughout the year have been followed.

All 10 safety actions criteria have been met with evidence submitted by clinical leads.

All evidence verified by Director of Midwifery and neonatal services with oversight from LMNS Lead midwife.

BDO auditors' assessment made with final report

Storage of evidence on Microsoft teams' channel should it be required

## Next steps

1. Director of Midwifery to present findings at safety champions meeting and Quality Committee 16/12/25.

2. Director of Midwifery to present findings and provide assurance of verification of evidence at Trust Board January 2026 .
3. To seek approval from Trust Board that assurance has been given and that the declaration can be submitted by the CEO.

1. Director of Midwifery to present findings in February 2026 and assurance at LMNS Board and completion of declaration

2. Submission of declaration form to NHS resolutions by the closing date by 12 noon on the 3rd of March 2026

# University Hospitals Dorset NHS Foundation Trust

## Internal Advisory Report - Final

### MATERNITY INCENTIVE SCHEME - YEAR 7

### DECEMBER 2025

| | |
|---|---|
| Design Opinion | N/A - Advisory |
| Effectiveness Opinion | N/A - Advisory |

# CONTENTS



| DISTRIBUTION | |
|---|---|
| **Sarah Herbert** | Chief Nursing Officer |
| **Lorraine Tonge** | Care Group Director of Midwifery |
| **Cherie Wells** | Obstetric Administration Manager |
| For information: | |
| **Pete Papworth** | Chief Finance Officer |
| **Joanne Sims** | Associate Director Quality, Governance and Risk |
| **Vicky Garner** | Lead Midwife (NHS Dorset) |

**BDO LLP APPRECIATES THE TIME PROVIDED BY ALL THE INDIVIDUALS INVOLVED IN THIS REVIEW AND WOULD LIKE TO THANK THEM FOR THEIR ASSISTANCE AND COOPERATION.**

| REPORT STATUS | |
|---|---|
| **Auditors:** | Mark Stabb, Associate Director |
| **Dates work performed:** | 4 November 2025 - 7 November 2025 |
| **Draft report issued:** | 14 November 2025 |
| **Final report issued:** | 11 December 2025 |

# Executive summary

## BAF REFERENCE: THERE IS A RISK THAT THE TRUST CANNOT ACHIEVE ITS STRATEGIC PRIORITY TO AVOID PATIENT HARM AND IMPROVE PATIENT SAFETY RESULTING IN POTENTIAL HARM TO PATIENTS, IMPACT ON OUTCOMES, EXPERIENCE AND QUALITY OF CARE, IMPACT ON REGULATORY BREACHES.

| | | | |
|---|---|---|---|
| Design Opinion | N/A - Advisory | Effectiveness Opinion | N/A - Advisory |

SCOPE

### Background

- Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.
- The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund.
- The original ten safety actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC), the Maternity and Newborn Safety Investigation Programme (MNSI) and service user representatives.
- Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover their Trust's element of the contribution relating to the CNST MIS fund and this will be returned to the source of the initial CNST payment. They will also receive a share of any unallocated funds.
- Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a smaller discretionary payment from the scheme to help to make progress against actions they have not achieved.
- Such a payment would be at a lower level than the 10% contribution to the MIS fund and is subject to a cap decided annually by NHS Resolution. The balance of unallocated funds will be shared with the trusts who have achieved all ten safety actions.
- For Year 6, the Trust reported compliance with all ten safety actions.

## Purpose

- Following on from the Year 6 submission process, we worked with the Trust to ensure systems and processes are in place for the Year 7 submission to capture the required evidence and undertake an independent review of this prior to the 2026 submission date.

## Limitations of scope

- Please note that we did not review the accuracy and validity of evidence, documentation and correspondence forming part of investigations for the audit of the MIS evidence.
- Our outcomes are strictly limited to the overarching internal controls and processes in place for recording, handling and monitoring clinical data and documentation. We do not provide assurance over any clinical judgements made within any documentation that is reviewed.
- Our findings and conclusions may not align to a CQC review of this area, as their remit is different.

## Areas reviewed

- This review has been undertaken by the BDO Associate Director to independently assess the process for the compilation of evidence supporting the Trust's self-certification.
- As part of this review, we critically analysed the evidence provided (recognising this will be at a point in time), providing challenge and requesting further supporting documentation to agree to the assertions as required.
- We assessed if there any external reports that may provide conflicting information to the Trust's proposed declaration.
- We have provided a high-level assessment of the evidence against each of the ten safety action standards to aid the Trust as it prepares to request the Board's approval of self-certification by 3 March 2026.

## AREAS OF STRENGTH

- Continued use of the audit tool provided by NHS Resolution that was designed to support Trusts on their MIS compliance journey, along with the maintenance of supporting and clearly referenced evidence folders.
- Monthly MIS Working Group meetings with attendance of nominated leads for each of the Safety Actions. Ongoing review of each safety action, documentation of progress, evidence and any potential compliance issues as they arose.
- Regular reporting of the forecasted MIS compliance position, along with mitigating action plans, to Trust Board during the year (via Quality Committee).

## UPDATE SINCE ISSUE OF DRAFT REPORT

- Following receipt of the draft report on 14 November 2025, sufficient documentation has been provided by the Trust against the six safety actions where additional evidence was felt to be required by BDO to fully satisfy compliance requirements.
- It is acknowledged that there is additional evidence that will be added to evidence folders as the Q3 reports are presented through the governance structure; these will enhance and complete the evidence

required up to the time of Board certification, the deadline for which is no later than 3 March 2026.

ADDED VALUE

- Ongoing liaison with the Trust and ICB Lead to ensure a consistent system-wide approach (and compliance) with the MIS Safety Actions.
- Sharing of Internal Audit experience / learning from previous and current MIS submissions from other Trusts

CONCLUSION

- Overall, the Trust has made strong progress in ensuring the successful and accurate submission of its Maternity Incentive Scheme year 7 self-certification and this is supported by appropriate evidence. There was early warning of potential areas of non-compliance, with mitigating actions implemented and focus given to these particular safety actions, and this is consistent with the outcomes of our work.
- A robust evidence tracking and retention process and associated reporting is fully embedded, aided by the completion of the audit tool provided by NHS Resolution. There has been ongoing liaison and review with both BDO and the ICB Lead on the completeness and relevance of the evidence in place to support the Trust's reported compliance position.
- An initial meeting was held with the Trust and ICB Lead on 6 November 2025 to triangulate the reported compliance position and review / confirm the remaining evidential requirements. A final independent assurance review of evidence and associated compliance was then undertaken on 9 December 2025 (again with the Trust & ICB Lead).
- At the time of writing, we have not been made aware of any final reports covering either 2024/25 or 2025/26 that relate to the provision of maternity services that may subsequently provide conflicting information to the Trust's declaration from the same time-period. We note the Trust has recently been subject to a CQC inspection of its Maternity Services, but as yet the formal report has not been received.
- The review has therefore demonstrated that the Trust has sufficient evidence in place to support its intended position of declaring full compliance with all ten safety actions.

# SUMMARY OF WORK UNDERTAKEN

We were provided with a copy of the Trust's Maternity Incentive Scheme Audit Tool as at 4 November 2025. This showed the following reported position against which the initial evidence was reviewed:

**Overview of progress on MIS year 7 safety action requirements**

*Mandated Safety Action Requirements:

| Safety Action | Red | Amber | Green | Blue | Total Requirements |
|---|---|---|---|---|---|
| 1 | 0 | 0 | 7 | 0 | 7 |
| 2 | 0 | 0 | 0 | 2 | 2 |
| 3 | 0 | 1 | 1 | 4 | 6 |
| 4 | 0 | 8 | 1 | 10 | 19 |
| 5 | 0 | 1 | 0 | 11 | 12 |
| 6 | 0 | 8 | 0 | 1 | 9 |
| 7 | 0 | 1 | 0 | 3 | 4 |
| 8 | 0 | 3 | 18 | 0 | 21 |
| 9 | 0 | 3 | 6 | 0 | 9 |
| 10 | 0 | 0 | 9 | 0 | 9 |
| Total | 0 | 25 | 42 | 31 | 98 |

Key:

| | |
|---|---|
| Red | Not compliant |
| Amber | Partial compliance - work underway |
| Green | Full compliance - evidence not yet reviewed |
| Blue | Full compliance - final evidence reviewed |

*Non-mandated sections will not be included in this table.

At the time of the follow up review on 9 December 2025, the updated reported position was as follows:

| Safety Action | Red | Amber | Green | Blue | Total Requirements |
|---|---|---|---|---|---|
| 1 | 0 | 0 | 7 | 0 | 7 |
| 2 | 0 | 0 | 0 | 2 | 2 |
| 3 | 0 | 0 | 2 | 4 | 6 |
| 4 | 0 | 0 | 9 | 10 | 19 |
| 5 | 0 | 0 | 1 | 11 | 12 |
| 6 | 0 | 0 | 8 | 1 | 9 |
| 7 | 0 | 0 | 1 | 3 | 4 |
| 8 | 0 | 0 | 21 | 0 | 21 |
| 9 | 0 | 0 | 9 | 0 | 9 |
| 10 | 0 | 0 | 9 | 0 | 9 |
| Total | 0 | 0 | 67 | 31 | 98 |

Key:

| | |
|---|---|
| Red | Not compliant |
| Amber | Partial compliance - work underway |
| Green | Full compliance - evidence not yet reviewed |
| Blue | Full compliance - final evidence reviewed |

**Summarised below is our analysis of the supporting documents for each of the maternity safety actions @ 9 December 2025**

| Maternity Safety Action | Required details | Evidence reviewed | Comments / Further Action required | BDO Assessment |
|---|---|---|---|---|
| Safety Action 1 | **Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?** | ▸ PMRT Table from MBRRACE (updated to 1 Dec'25)<br>▸ PMRT Raw Data @ 1 Dec'25<br>▸ PMRT Patient Letters & Feedback Form<br>▸ PMRT Meeting Minutes Jan – Sep'25<br>▸ PMRT Board Reports Q3, Q4, Q1 & Q2<br>▸ Maternity & Neonatal Quality & Safety Trust Board Reports Q4, Q1 & Q2<br>▸ Trust Board Agendas – May & Sep'25<br>▸ Safety Champion Meeting Agendas and Minutes (Apr – Oct'25) | The Maternity team are using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard. This is reported on a regular basis through the Maternity & Neonatal Quality & Safety Report to the Quality Committee (which includes the Trust maternity safety and Board level safety champions).<br>Quarterly PMRT reports are also reviewed at Safety Champion's meetings. | Evidence provided appears robust to satisfy safety action. |
| Safety Action 2 | **Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** | ▸ Final results seen on NHSE website; full compliance reported<br>▸ Screenshot of MSDS Jul'25 reported position | The Trust are submitting data to the Maternity Services Data Set (MSDS) to the required standard. Note that the Trusts data is compliant as at July 2025 as required by MIS. | Evidence provided appears robust to satisfy safety action. |
| Safety Action 3 | **Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?** | ▸ Standard Operating Procedure - Acorn Ward (Transitional Care Unit)<br>▸ ATAIN Q1 & Q2 Reports<br>▸ Maternity and Neonatal Safety Champions Meeting Agendas & Minutes<br>▸ LMNS Update Sep'25 - QI Project: Improve immediate thermoregulation and nutrition for the newborn to reduce admissions to NICU for hypoglycaemia and hypothermia.<br>▸ LMNS PQSSG Meeting Notes – Sep'25<br>▸ LMNS PQSSG Meeting Minutes - Nov'25 | Transitional Care Standard Operating Procedure (SOP) in place for new Acorn Ward (TCU). Quality Improvement work has continued linked to reducing avoidable admissions to NICU which has been shared with Safety Champions & LMNS. | Evidence provided appears robust to satisfy safety action. |

| | | | | |
|---|---|---|---|---|
| Safety Action 4 | **Can you demonstrate an effective system of clinical workforce planning to the required standard?** | <u>Obstetric Workforce</u><br>• Locum Evidence Spreadsheet 2025<br>• Confirmation Email that CEL certificate records are kept and are searchable on RCOG website and that NTN are National Training Numbers (Doctor is a Deanery Employed Training Registrar)<br>• Confirmation Email that one long term locum doctor still employed by the Trust has yearly appraisal and complies with yearly mandatory training.<br>• MatNeo Quality and Safety Board Report – Q1<br>• Board report Minutes Jun'25<br><br><u>Consultant Attendance</u><br>• Consultant Attendance Audit (Mar-May'25)<br>• Confirmation Email that there is at least one duty anaesthetist available for the obstetric unit 24 hours a day who is based on the obstetric unit. They do not have any other clinical responsibilities and they have direct phone access to the supervising consultant.<br>• Maternity & Neonatal Quality & Safety Trust Board Report Q1<br>• TB Agenda Sep'25<br>• Safety Champions Meeting Agenda & Minutes – Aug'25<br>• LMNS Safety Meeting Agenda & Minutes – Sep'25<br><br><u>Anaesthetic Workforce</u><br>• 6 weeks Anaesthetic Rotas (1 Sep – 12 Oct'25)<br><br><u>Neonatal Medical Workforce</u><br>• Consultant Rota w/c 27 Oct'25<br>• Maternity & Neonatal Quality and Safety Board Reports – Q1 & Q2 | Work has continued since last year to ensure that effective systems of clinical workforce planning to the required standards can be appropriately evidenced. | Evidence provided appears robust to satisfy safety action. |

| | | | | |
|---|---|---|---|---|
| | | ▸ Trust Board Agenda Papers – Nov'25<br>▸ Interim Company Secretary confirmation of Nov'25 Trust Board minutes content that reference BAPM compliance status<br>▸ Maternity & Neonatal Open Risk Register – Sep'25<br>▸ Risk Review Form (Risk ID 1648)<br>▸ LMNS Transformation Meeting Paper – UHD Neonatal Workforce<br>▸ LMNS Transformation Meeting Agenda & Minutes – Sep'25<br><br><u>Neonatal Nursing Workforce</u><br>▸ MatNeo Quality and Safety Board Reports – Q1 & Q2<br>▸ Trust Board Agenda Papers – Nov'25<br>▸ Interim Company Secretary confirmation of Nov'25 Trust Board minutes content that reference BAPM compliance status<br>▸ LMNS Transformation Meeting Paper – UHD Neonatal Workforce<br>▸ LMNS Transformation Meeting Agenda & Minutes – Sep'25<br>▸ Risk Review Form (Risk ID 2247)<br>▸ QIS Plan | | |
| Safety Action 5 | **Can you demonstrate an effective system of midwifery workforce planning to the required standard?** | ▸ Birthrate+ Midwifery Workforce Report – Jan'25<br>▸ Maternity & Neonatal Safe Staffing Report – Jan to Jun'25<br>▸ People & Culture Committee Agenda Papers – Aug'25 & Oct'25<br>▸ Board Agenda Papers – Sep'25 & Nov'25<br>▸ Interim Company Secretary confirmation of Nov'25 Trust Board minutes content that reference midwifery workforce as being fully funded to Birthrate Plus. | The Trust can demonstrate it has an effective system of midwifery workforce planning to the required standard, noting this is now based on its formal Birthrate+ report and outcomes. | Evidence provided appears robust to satisfy safety action. |

| | | | | |
|---|---|---|---|---|
| | | • Maternity Safety Champions Reports | | |
| Safety Action 6 | **Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?** | • Maternity & Neonatal Quality & Safety Trust Board Reports Q4, Q1 & Q2<br>• Saving Babies Lives V3.2 Board Reports (Q4, Q1 & Q2)<br>• Saving Babies Lives V3.2 LMNS Reports (Q4, Q1 & Q2)<br>• SBLV3 Element 1.1.7 improvements<br>• Agenda & Minutes LMNS PQSSG – May'25<br>• SBL Review meetings Screenshot<br>• LMNS confirmation email detailing that sufficient progress has been made towards implementing SBLv3.2, in line with the locally agreed improvement trajectory.<br>• CMO email confirmation that Trust maternity services are engaging with the LMNS and delivering all elements of the saving babies lives V3.2. | The Trust has continued to focus on demonstrating improved compliance with all the elements of the Saving Babies' Lives Care Bundle Version 3.2 (SBLv3.2). The LMNS has confirmed that sufficient progress has been made towards implementing SBLv3.2 as at the end of the required reporting period. | Evidence provided appears robust to satisfy safety action. |
| Safety Action 7 | **Listen to women, parents and families using maternity and neonatal services and coproduce services with users.** | • Co-produced CQC Maternity Survey Action Plan<br>• LMNS Board Meeting Agenda & Minutes - Aug'25<br>• Safety Champions Meeting Agenda & Minutes – Sep'25 & Nov'25<br>• Dorset MNVP Job Descriptions<br>• Contract for Provision of a Maternity and Neonatal Voices Partnership (MNVP)<br>• MNVP Budget<br>• Volunteer Involvement & Expenses Policy<br>• CQC Maternity Survey Results 2025<br>• Terms of Reference - Maternity and Neonatal Safety Champions Meeting<br>• Terms of Reference - Maternity and Neonatal Quality and Safety Meeting | Dorset MNVP in place that has a clear agenda to demonstrate engagement and seeking feedback for this safety action. | Evidence provided appears robust to satisfy safety action. |

| | | | | |
|---|---|---|---|---|
| | | ▸ Terms of Reference - Maternity/ Neonatal Services Patient Safety Meeting (Draft)<br>▸ Terms of Reference - MatNeo Policies and Procedures Group (MPPG)<br>▸ Terms of Reference - Perinatal Mortality Review Tool (PMRT) Meeting<br>▸ DMNVP Workplan 25/26 & Updates<br>▸ DMNVP Walk the Patch Overviews<br>▸ Dorset MNVP – LMNS Board Report<br>▸ Equity & Equality 5 Year Project Plan<br>▸ DMNVP 15 Steps Report | | |
| Safety Action 8 | **Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?** | ▸ Maternity Training MIS year 7 standards table for Fetal Monitoring, Prompt, Neonatal basic life support and Midwife update training compliance<br>▸ Maternity & Neonatal Quality & Safety Trust Board Report – Q2<br>▸ Training Action Plan for Board Approval contained in Q2 Maternity & Neonatal Quality & Safety Trust Board Report<br>▸ Interim Company Secretary confirmation of Nov'25 Trust Board minutes content that references Board members noting training compliance and the agreed action plan. The rotational doctors and anaesthetist, who had commenced employment in the Trust after 1 July 2025, would meet the training standard within a six-month period. This would be monitored monthly through safety champions reporting.<br>▸ Training Compliance Report @ 30 Nov'25 | Significant work undertaken on ensuring compliance levels were achieved. This included identification of staff who were required to attend training and provision of planned sessions to facilitate this, and resulted in the required compliance levels being achieved for the reporting period across the various staff groups. | Evidence provided appears robust to satisfy safety action. |
| Safety Action 9 | **Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and** | ▸ Maternity & Neonatal Quality & Safety Trust Board Reports Q4, Q1 & Q2<br>▸ LMNS Workplan<br>▸ Maternity & Neonatal IPR Oct'25 (Apr - Sep'25) | A NED undertakes the role of Board Safety Champion and minutes demonstrate there is close working with the Perinatal Leadership Team to demonstrate any quality issues are being addressed. The relevant datasets are being presented to the | Evidence provided appears robust to |

| | | | | |
|---|---|---|---|---|
| | **neonatal, safety and quality issues?** | ▸ Board Safety Champions Poster<br>▸ Maternity Safety Champions Meeting Agendas, Minutes & Reports (Jul – Sep'25)<br>▸ Trust Board Agenda Papers (Jun & Nov'25)<br>▸ Maternity & Neonatal Meeting Structure<br>▸ LMNS Revised Governance Structure<br>▸ LMNS Safety Meeting Agendas & Minutes (May, Jul & Sep'25)<br>▸ LMNS Meeting Workplan & Schedule<br>▸ Staff Feedback – Safety Champion Listening Events, Walkarounds<br>▸ Maternity Claims Reports (Q1 & Q2)<br>▸ Safety Champions Meeting Terms of Reference<br>▸ Culture Improvement Plan<br>▸ Interim Company Secretary confirmation of Nov'25 Trust Board minutes content referencing that discussions and support took place regarding improving the Maternity Neonatal culture plan. This month's focus had been on the behaviour charter with clinical leaders ensuring that they had the tools to make changes in behaviour. | Quality Committee which is triangulated with further patient safety data including incidents and complaints. Robust processes in place to provide assurance that maternity and neonatal safety and quality issues are identified, reported and acted upon. | satisfy safety action. |
| Safety Action 10 | **Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025** | ▸ MNSI Tripartite Meeting - Jul'25<br>▸ MNSI Catch Up Meeting - Oct'25<br>▸ Maternity & Neonatal Quality & Safety Trust Board Reports (Q4, Q1 & Q2)<br>▸ Maternity Claims Reports (Q4, Q1 & Q2)<br>▸ Head of Clinical Legal Services & Clinical Lead Midwife for Risk and Governance emails confirming that there have not been any EN or MNSI reportable cases in the reporting period | The Trust did not have any related Maternity & Newborn Safety Investigations (MNSI) or Early Notification (EN) referrals during the period to 30 Nov'25. | Evidence provided appears robust to satisfy safety action. |

# Appendix I - Terms of Reference

KEY RISKS

Based upon the risk assessment undertaken during the development of the internal audit operational plan, through discussions with management, and our collective audit knowledge and understanding the potential key risks associated with the area under review, are:

- There may be insufficient evidence available to demonstrate achievement of the ten maternity safety actions and that meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document issued by NHS Resolution.
- There may be reports covering either year 2024/25 or 2025/26 that relate to the provision of maternity services that may subsequently provide conflicting information to the trust's declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2026.

SCOPE & APPROACH

The following areas will be covered as part of this review:

- This review will be undertaken by the BDO Associate Director to independently assess the process for the compilation of evidence supporting the Trust's self-certification.
- As part of this review, we will critically analyse the evidence provided (recognising this will be at a point in time), providing challenge and requesting further supporting documentation to agree to the assertions as required.
- We will assess if there any external reports that may provide conflicting information to the Trust's proposed declaration.
- We will provide a high-level assessment of the evidence against each of the ten safety action standards to aid the Trust as it prepares to request the Board's approval of self-certification by 3 March 2026.

# Appendix II - Responsibilities and conformance

## Management responsibilities

The Global Internal Audit Standards (GIAS) refer to the 'board' as 'the highest-level body charged with governance, such as a board of directors, an Audit Committee, a board of governors or trustees, or a group of elected officials or political appointees.' For the Trust, 'the board' is the Audit Committee (AC) acting on behalf of the Trust Board. The AC is responsible for determining the scope of internal audit work, and for deciding the action to be taken on the outcome of our findings from our work.

The AC is responsible for ensuring the internal audit function has:

- The support of the Trust's management team.
- Direct access and freedom to report to senior management, including the Chair of the AC.
- The AC is responsible for the establishment and proper operation of a system of internal control, including proper accounting records and other management information suitable for running the Trust.

Internal controls covers the whole system of controls, financial and otherwise, established by the Trust in order to carry on the business of the Trust in an orderly and efficient manner, ensure adherence to management policies, safeguard the assets and secure as far as possible the completeness and accuracy of the records. The individual components of an internal control system are known as 'controls' or 'internal controls'.

The AC is responsible for risk management in the organisation, and for deciding the action to be taken on the outcome of any findings from our work. The identification of risks and the strategies put in place to deal with identified risks remain the sole responsibility of the Trust.

## Limitations

The scope of the review is limited to the areas documented under Appendix I - Terms of reference. All other areas are considered outside of the scope of this review.

Our work is inherently limited by the honest representation of those interviewed as part of the review. Our work and conclusion is subject to sampling risk, which means that our work may not be representative of the full population.

Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Our assessment of controls is for the period specified only. Historic evaluation of effectiveness may not be relevant to future periods due to the risk that: the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or the degree of compliance with policies and procedures may deteriorate.

## Conformance with the Global Internal Audit Standards in the UK Public Sector

This engagement has been conducted in accordance with Global Internal Audit Standards in the UK Public Sector, which encompass:

- The global Institute of Internal Auditors (IIA) *Global Internal Audit Standards* effective from January 2025
- The Internal Audit Standards Advisory Board (IASAB) *Application Note Global Internal Audit Standards in the UK Public Sector* effective from 1 April 2025.

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 14 January 2026**

**Agenda item: 9.1**

| | |
|---|---|
| **Subject:** | Risk Register Report - risks rated 15 and above |
| **Prepared by:** | Jo Sims, Associate Director for Quality Governance and Risk<br>Justine George, Risk Register Coordinator |
| **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)** | All | |
| **Purpose of paper:** | Information | |
| **Executive Summary**: | There are 207 approved risks on UHDs Risk register, of which 15 are rated as 15 and above. | |
| **Background:** | The report is provided in accordance with the UHD Risk Management Strategy.<br><br>To provide details of the risks rated 15 and above on the UHD NHS Foundation Trust risk register. | |
| **Key Recommendations**: | To review risks rated 15-25. | |
| **Implications associated with this item:** | Council of Governors | ☐ |
| | Equality, Equity, Diversity & Inclusion | ☐ |
| | Financial | ☐ |
| | Health Inequalities | ☐ |
| | Operational Performance | ☐ |
| | People (inc Staff, Patients) | ☐ |
| | Public Consultation | ☐ |
| | Quality | ☒ |
| | Regulatory | ☐ |
| | Strategy/Transformation | ☐ |
| | System | ☐ |

| | | |
|---|---|---|
| | Please select above each that applies and for all selected, explain the implications of each here | |
| **CQC Reference:** | 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 | 21/12/2025 | Discussed and noted |

| | | |
|---|---|---|
| **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

# Risk Register Report

The Risk Register report provides details of all current (approved) risks rated 15-25 to be presented at Part 1 of the Board meeting every other month.

**For the period to 31/12/2025**

# Risk Register

**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 207 approved risks on UHDs Risk register, of which 15 are rated as 15 and above.**

| **Risk Type - Population & System**<br>**Risk Category - Capacity Planning** | **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, statutory compliance and reputation |
| **Date risk raised on the risk register** | 05/02/2021 |
| **Date risk approved as 15+ risk** | 22/02/2021 |
| **Risk Rating** | 20  |
| **Risk Description** | There is a potential risk of harm to patients waiting in excess of 4 hours in ED and being cared for in an inappropriate setting. There is also a risk to organisational performance, impacting on statutory compliance and reputation. |
| **Executive sponsor** | Chief Operating Officer |
| **Controls in place** | • Compliance with National 4 hr performance Standard<br>• Performance review against metrics<br>• Daily breach analysis<br>• Efficient patient pathways and streaming process to SDEC's and UTC<br>• Link to Risk 1426(Ambulance Queues)<br>• Link to Risk 1387 and 1131 (Beds and Flow)<br>• Patient assessment form (SHINE)<br>• ED Trigger tool/ Delayed Care pathway<br>• TAD Process evoked<br>• Compliance with Trust and ED Escalation plans/SOPs<br>• Avoidable lost time and patient delay<br>• ED Primacy<br>• IPS optimisation<br>• All elements of initial assessment: TTT, TT first clinician and TT decision are all within 3 hrs of arrival<br>• Diagnostic delays standards (blood tests/x-ray and CT)<br>• Surge Management' criteria and plan<br>• External transfers procedures compliant with patient category |

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|---|---|
| | • Implementation of 4 and 12 hour escalation process and UHD ambulance divert policy.<br>• 4 hour performance metrics linked to ED escalation<br>• Escalation email/text process along with ED shift report template improvement |
| **Gaps in controls** | Gaps in assurance for sustainable delivery of 4-hour standard:<br>• SDEC pathways not in place 12 hours a day 7 days a week across all services.<br>• Revised Escalation processes (ED and wider organisation) not yet embedded.<br>• Gaps in recruitment remain a key challenge.<br>• UEC growth, MRTL numbers and industrial action could expose the Trust to reduced patient flow and performance<br>• Type 3 data from MIU and UTC remains a manual process needs to be automated for new standards<br>• Executive Enhanced support meeting has been put in place for the emergency department (Chief Medical Officer/Chief Nursing Officer & Chief Operating Officer).<br>• ED Action plan to be reviewed and recast to reduce to a smaller number of actions over 30/60/90 days.<br>• Clinical Engagement on supporting the Trust 4hour safety standard and further work on ensuring the Interprofessional standards are being followed.<br>• Revised structure, focus and workplan for the Improving Hospital Flow Group developed for TMG review on 12th September.<br>• IT ED System: Review of the operational configuration to ensure it supports the operational flow. |
| **Action plan(s)** | **Action** / **Due date**<br>System Exec meeting to review pressures, agree action and implementation plans — Closed<br>Revise and implement ED Action Plan (attached) — Closed<br>Improving Hospital Flow Programme report and actions — Closed<br>ED 4 Hour Safety Standard Implementation Plan — Closed<br>4-hour standard 60 day plan — 31/08/2023 |
| **Tolerance breach?** | Yes |
| **Target Risk Rating** | 6 |
| **Progress update** | Currently reviewing overall risk score and consolidating actions from the extensive improvement work. |

| **Risk Type - Population & System**<br>**Risk Category - Capacity Planning** | **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  |

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| **Risk Description** | Very significant demand and capacity gap in department 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** | • NHSE Business approved<br>• Local business case awaiting approval for on-going revenue costs<br>• Steering group initiated<br>• Automation project verification initiated<br>• Outsourcing<br>• Scoping NHSE consulting support<br>• Digital program on track (RBH medical staff completed validation PH staff scheduled by end of calendar year)<br>• Job planning senior BMS time is hold , appraising 12 hour work day<br>• Sickness review with OH HR (reduced to 30% from 35% staff)<br>• Recruiting to template ( loss of 2 locums end of Nov)<br>• Detailed Action Plan included in this risk maintain BAU<br>• Note: Speed of track approvals need to keep up pace to enable project delivery and maintain BAU |
| **Gaps in controls** | • Business case for additional staff has not yet been approved<br>• significant gaps in staff structure<br>• 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 | Closed |
| Report for Finance committee | Closed |
| Trust to support demand management initiative | Closed |
| Trust to review MDT requirement to reduce commitment from pathology and radiology | Closed |
| Department to implement digital pathology | 30/01/2026 |
| Department to implement AI | 30/01/2026 |
| Department to implement order comms | 30/03/2026 |
| Adress demand and capacity staffing issues in Cellular Pathology | 30/03/2026 |
| Funding Stream | 30/03/2026 |
| Trust to initiate cultural review with a view to optimising productivity in consultant body | 31/03/2026 |
| Department to accelerate BMS cut up training programmes | 30/04/2026 |
| Implementation of Automation project to modernise and streamline up to 40% of the work flow | 03/06/2026 |
| Report delays in recruitment | 30/06/2026 |
| Department to accelerate BMS reporting training programmes | 30/07/2026 |

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| **Tolerance breach?** | Yes |
| **Target Risk Rating** | 4 |

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| **Progress update** | • Automation project to modernise and streamline up to 40% of the work flow, i.e. embedding and microtomy processes, releasing 9 WTE from staffing establishment. Updated business case for funding approved and signed off. PO with suppliers and enabling work to be contracted out.<br>Following Digital Project Support Documents added to Risk:<br>1. Digital Validation Tracker 17.12.25<br>2. ODP Digital rollout plan<br>Following Automation Project Support Documents added to Risk<br>1. Automation Gantt Chart 11.12.2025<br>2. Histo Automation Implementation Group - agenda and action tracker<br>3. Cellular Pathology Automation Oversight Group -Action Notes v20251211 |

| **Risk Type - Population & System**<br>**Risk Category - Capacity Planning** | **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:<br>- medicated and monitored to manage neurodevelopment issues<br>- referred to the school age Neurodevelopmental service for advice, guidance and treatment.<br>There remains an untriaged cohort of referrals (approx. 7 months behind) and this may hold unknown risk. |
| **Executive sponsor** | Chief Operating Officer |
| **Controls in place** | • National targets in place-RTT zero tolerance 78 week waits, 65-week target<br>• Local contractual expectation (provision of service and rejection of referrals) in place<br>• Monitor of patient satisfaction via Complaints and claims<br>• Escalation process in place and compliance monitored<br>• Dorset Pathway in place and compliance monitored<br>• Workforce template agreed<br>• Monitoring of staff wellbeing through Absence, sickness & turnover<br>• Triage of referrals being received to ensure visibility of activity on eCamis & effective management of the waiting list. |
| **Gaps in controls** | • National target achievement<br>• Local contractual expectation (provision of service and rejection of referrals)<br>• Poor patient satisfaction<br>• Poor staff wellbeing<br>• Lack of capacity to triage referrals in a timely fashion. |

| | | |
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| **Action plan(s)** | **Action** | **Due date** |
| | Dedicated admin support for referral screening process | Closed |
| | Reduce backlog of un-triaged referrals | Closed |
| | Listening events & senior leadership visibility | Closed |
| | Recruitment of nurse specialist to support workforce | Closed |
| | Supporting SENCo's with regards to referrals | Closed |
| | Medical recruitment | Closed |
| | Process mapping exercise | Closed |
| | To monitor the CDC School age service transformation plan | Closed |
| | Engagement with ICB All Age Autism Pathway review | Closed |
| | Medical / AHP recruitment | Closed |
| | Review delay in uploading referrals to eCamis | Closed |
| | Medical / AHP recruitment | Closed |
| | Engagement with ICB All Age Autism Pathway review | 31/12/2025 |
| | Monitor backlogs of referrals | 31/12/2025 |
| **Tolerance breach?** | No | |
| **Target risk rating** | 3 | |
| **Progress update** | Risk remains - continue to monitor. Sustained volume of PALS and complaints related to service pressure. Continue to explore closure to routine new referrals due to size and waiting times to access a new patient appointment. | |

| **Risk Type - Population & System**<br>**Risk Category - Capacity Planning** | **Appetite = Cautious** **Tolerance = 9-15** |
|---|---|
| **Risk ID** | 2052 |
| **Risk Title** | Care of patients in non-clinical 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 Operating Officer |

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| **Controls in place** | • SOP on corridor use<br>• Ambulance handover SOP<br>• Divert procedures including dynamic conveyancing<br>• Escalation process |
| **Gaps in controls** | • Staffing is reliant on bank and agency and therefore levels not always met.<br>• Additionally, where the corridor is under the care of other agencies, there is the risk of a lack of clinical oversight from UHD. |
| **Action plan(s)** | **Action** / **Due date**<br>Decompress the Emergency Department to prevent crowding — Closed<br>Improve the facilities for patient privacy and dignity in Bournemouth corridor — 31/12/2025 |
| **Tolerance breach?** | No |
| **Target risk rating** | 3 |
| **Progress update** | Risk rating increase to 15 approved at Risk Oversight Committee 24/11/2025<br>29/12/2025 - Risk remains unchanged with usage daily. Increased staffing using Bank & use of Timely Handover Process (THP). Storm huddles in place to review plans. |

| **Risk Type - Population & System**<br>**Risk Category - Capacity Planning** | **Appetite = Cautious** **Tolerance = 9-15** |
|---|---|
| **Risk ID** | 2070 |
| **Risk Title** | Using multiple UHD Theatres for surgery which currently do not have UPS or IPS |
| **Date risk raised on the risk register** | 15/05/2024 |
| **Date risk approved as 15+ risk** | 18/09/2024 |
| **Risk Rating** | 15  |
| **Risk Description** | Currently multiple theatres across UHD do not have UPS back up and would solely rely on a diesel generator in the event of power failure. If an internal power fault occurred most theatres would lose power from their wall sockets which could result in loss of vital medical equipment such as electro surgical and various laparoscopic/robotic, such delays and loss of equipment could lead to significant harm or death to patient/s |
| **Executive sponsor** | Chief Strategy and Transformation Officer |
| **Controls in place** | • **Poole**<br>  • Barn and Level 1 theatres have UPS back up - any patients needing to continue surgery will be transferred to these areas safely<br>  • Move to open surgery if loss of stack/robotic systems<br>  • Patients are to be made safe, woken and taken to recovery area<br>  • Anaesthetic machines, theatre lights have approx 30 mins back up<br>  • No surgery will continue unless life or limb in Level 1 or Barn theatres |

| | |
|---|---|
| | • **RBH**<br>  • Move to open surgery if loss of stack/robotic systems<br>  • Patients are to be made safe, woken and taken to recovery area<br>  • Anaesthetic machines, theatre lights have approx 30 mins back up<br>  • No Surgery will continue unless life or limb |
| **Gaps in controls** | • Multiple UHD Theatres do not have UPS or localised UPS - various medical equipment would depower in a power failure if the generator was not to kick in and function, such equipment is deemed as life preserving such as electrosurgical to maintain haemostats. All equipment used for keyhole/robotic surgery would lose power under these circumstances which would require the surgeon to immediately convert to open surgery which if occurring during a perioperative bleed. |
| **Action plan(s)** | **Action** / **Due date**<br>UHD Theatres Team to investigate if a local UPS solution is available and then put it in place – Closed<br>The Surgical Care Group to escalate the risk to the Trust Board and Clinical Governance Group – Closed<br>The UHD theatre team to liaise with the estates and clinical engineering teams to put in place a permanent UPS solution (battery supplies to be installed in the theatres). – Closed |
| **Tolerance breach?** | No |
| **Target risk rating** | 4 |
| **Progress update** | Discussed at SCG gov 17/12/2025 – Theatre staff awaiting training from clinical engineering , once this is complete the risk rating can be reduced . Email to clinical engineering requesting training. |

| **Risk type - Quality (Outcome and Safety)**<br>**Risk Category - Patient Safety and Outcome  Appetite = Minimal  Tolerance = 6-10** | |
|---|---|
| **Risk ID** | 1855 |
| **Risk Title** | Lack of Breast Radiologists |
| **Date risk raised on the risk register** | 23/02/2023 |
| **Date risk approved as 15+ risk** | 21/11/2024 |
| **Risk Rating** | 20  |
| **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** | Chief Medical Officer |
| **Controls in place** | • Review of Incidents and complaints reported<br>• Weekly planning meeting to discuss previous week and week going forward<br>• Meticulous rota planning<br>• Robust and ongoing Recruitment/retention processes |

| | |
|---|---|
| | • Creation of new post to support consultant radiographers and promote succession planning<br>• Review of pressures in both clinic pathways to ensure priorities are addressed<br>• Weekend working and extra clinic in RBH<br>• Waiting list to record backlog<br>• Staff in post spreadsheet to document staff in post.<br>• Staff supporting HSU training in own time to maximise future opportunities for joint working and new staff joining the service<br>• Staff working as single practitioner in clinics where two are required |
| **Gaps in controls** | • Lack of radiology capacity to sustain service.<br>• 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.<br>• Reliance on staff who are already working extra shifts<br>• Radiologist on call rota and time off in lieu reduces available staff for sessions<br>• Inability to provide legislative axilla scanning of Melanoma patients |
| **Action plan(s)** | |

| Action | Due date |
|---|---|
| Increase Radiology capacity DBSU | Closed |
| Reduce Symptomatic Patient Backlog (Jigsaw/LBU) | Closed |
| Review of radiology on call rota | Closed |
| Update Risk weekly with numbers of cancelled clinics/slots/uncovered | 09/02/2026 |

| | |
|---|---|
| **Tolerance breach?** | Yes |
| **Target risk rating** | 2 |
| **Progress update** | Discussed at RQM slight improvement noted in staffing with the return of 1 consultant mammographer and one long term sick Radiologist who is on a phased return. To review again next month to ensure ongoing improvement and phased returner up to usual hours with a view to downgrade severity . Other work related to long term solution and short term support ongoing. |

| **Risk Type - Quality (Outcome and Safety)**<br>**Risk Category - Patient Safety and Outcome Risk  Appetite = Minimal  Tolerance = 6-10** | |
|---|---|
| **Risk ID** | 1970 |
| **Risk Title** | Lack of sufficient provision of glaucoma service |
| **Date risk raised on the risk register** | 22/09/2023 |
| **Date risk approved as 15+ risk** | 02/05/2024 |
| **Risk Rating** | 16  |
| **Risk Description** | If we do not address the workforce gaps for the provision of the glaucoma service and the outstanding review backlog then there is a risk that patients won't be seen in a timely basis leading to preventable and/or irreversible sight loss. |

<table>
<tr><td>Executive sponsor</td><td>Chief Medical Officer</td></tr>
<tr><td>Controls in place</td><td>
<ul>
<li>Dept SOP- If a patient's eye pressure is found to be high (more than 30mmHg) then they are prioritised for a review. If the Technicians have any concerns, then they will flag the patient using a separate email account. This is then prioritised.</li>
<li>Patient information - The patient is advised to present to Eye Emergency if the Technicians are really concerned and identify that the patient needs to be reviewed on the same day their pressures have been taken.</li>
<li>SOP - Technicians ask a series of questions which will inform them whether to flag the patient as a concern.</li>
<li>Timetable review for Glaucoma Nurse Specialists to enable them to support with virtual reviews.</li>
<li>Monitoring the number of overdue patients</li>
<li>Additional clinics run every weekend (8 additional clinics each weekend) - insourcing team are supporting this process</li>
<li>CD's PA time - supporting the review process and clinical outcomes</li>
<li>Risk rating is assigned to all patients being reviewed - a system helps to manage these appointments</li>
<li>LERNS and complaints monitoring</li>
<li>Admission clerk is prioritising glaucoma operations over cataract</li>
<li>Setting up POD clinics - all patients have the consultant review completed - clinics run once per week - to be increased to 2/3 clinics when senior clinicians present</li>
</ul>
</td></tr>
<tr><td>Gaps in controls</td><td>
<ul>
<li>When a patient's pressure is high, but less than 30mmHg, or they have progressive field loss, as the patient is often not aware of the field loss, they can have permanent sight loss.</li>
<li>No nurse specialist in post to help to manage the reviews</li>
<li>No additional substantive/locum glaucoma consultant in post - there should be 2 additional consultants supporting the service</li>
<li>GIRFT recommendation re LCAD (latest clinically acceptable date) - if the pt is delayed it needs to be reported</li>
<li>Lack of capacity to grade all patients</li>
<li>Backlog of emails/admin work due to the lack of PA support - admin freeze in UHD</li>
</ul>
</td></tr>
<tr><td>Action plan(s)</td><td>
<table>
<tr><th>Action</th><th>Due date</th></tr>
<tr><td>To present the plan to set up additional clinics to the directorate</td><td>Closed</td></tr>
<tr><td>Visit to Exeter</td><td>Closed</td></tr>
<tr><td>Recruit locum Glaucoma Consultant</td><td>13/10/2025</td></tr>
<tr><td>Glaucoma POD Virtual Review Clinic Model to be Implemented</td><td>31/10/2025</td></tr>
<tr><td>Ophthalmology Nurse Specialist to support with Glaucoma Virtual Reviews</td><td>05/01/2026</td></tr>
<tr><td>Monitor number of patients waiting to be reviewed/followed up</td><td>15/01/2026</td></tr>
<tr><td>Succession plan for Glaucoma Nurse Specialist</td><td>06/02/2026</td></tr>
<tr><td>Ophthalmology Nurse Specialist to commence (glaucoma module) training course.</td><td>27/02/2026</td></tr>
<tr><td>Recruit substantive Glaucoma consultants x2</td><td>01/09/2026</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>Risk rating still appropriate. Advert for recruitment back out for 6 month locum but needs to be 12 months to attract candidates- to be reviewed.</td></tr>
</table>

| Risk type - Quality (Outcome and Safety)<br>Risk Category - Patient Safety and Outcome Appetite = Minimal Tolerance = 6-10 | |
|---|---|
| **Risk ID** | 1214 |
| **Risk Title** | Risk of misdiagnosis/ incorrect treatment from use of ungoverned Point of Care devices |
| **Date risk raised on the risk register** | 10/11/2017 |
| **Date risk approved as 15+ risk** | 17/02/2023 |
| **Risk Rating** | 16 ⟷ |
| **Risk Description** | There is a high risk that mismanaged point of care devices will result in incorrect results, misinforming diagnosis and treatment and leading to patient harm. |
| **Executive sponsor** | Chief Strategy and Transformation Officer |
| **Controls in place** | • MHRA standards<br>• Compliance with national standards<br>• Service contracts<br>• Point of Care co-ordinator<br>• Contingency policy for majority tests by sending sample to the laboratory<br>• Incidents<br>• MDI procedures<br>• Medical devices policy |
| **Gaps in controls** | • Ungoverned POCT devices non-compliant with MHRA standards<br>• Non-compliance with national standards<br>• Point of Care co-ordinator - single point of failure as insufficient staffing and succession planning not in place<br>• No POC policy and standards<br>• Scope does not include point of care ultrasound |
| **Action plan(s)** | |

| Action | Due date |
|---|---|
| Quarterly EQA testing of glucose and ketone meters by Pathology | Closed |
| Audit of all Abbott blood sugar glucose and ketone equipment within service contact | Closed |
| Review training for glucose and ketone meters provided within contract | Closed |
| Support for ketone monitors training/assurance by Diabetes CNS as time allows | Closed |
| Meeting between pathology diabetes CNS to review issues | Closed |
| Ward management of quality for blood gas analysers | 31/12/2025 |

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|---|---|
| **Tolerance breach?** | Yes |

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| **Target risk rating** | 6 |
| **Progress update** | Working with Digital to assess storage requirements for data. Digital have audited the devices and is being filtered to assess the demand. Work is progressing against the actions in the A3 plan. |

| **Risk type - Quality (Outcome and Safety)**<br>**Risk Category - Patient Safety and Outcome  Appetite = Minimal  Tolerance = 6-10** | |
|---|---|
| **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 Medical Officer |
| **Controls in place** | • The team have identified Theatre 3, in Eye Outpatients, to undertake Macular injection lists as required.<br>• Appointed a fourth Macular Nurse Practitioner (training and education will be required to ensure competencies are met and signed off).<br>• Additional lists added, when staffing allows<br>• Ophthalmology ED for emergency cases<br>• 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.<br>• 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.<br>• 2 x macular coordinators reviewing patient wait times and prioritising<br>• Direct line to macular coordinators who can escalate to Clinicians<br>• Spreadsheet available for range of clinicians to review for oversight.<br>• Regular Macular meeting to focus on long waiters and agree actions required (monthly and weekly meetings)<br>• Creating a 'core team' within outpatients to work in macular<br>• Training needs identified and started to roll out. This will also support retention<br>• 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<br>• Budget to be identified to enable estates work to be completed and training to be given |

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|---|---|
| | • The 4th Macular Nurse Practitioner will require a full training program.<br>• Recruitment for replacement consultant needs to be undertaken (finance agreed) |
| **Action plan(s)** | |

| Action | Due date |
|---|---|
| Recruitment of consultant | Closed |
| Identify space for macular service | Closed |
| Recruit additional Health Care Support Workers | Closed |
| Daily review of the waiting lists for macular appointments, undertaken by the Macular coordinators | Closed |
| Weekly Macular Time Table Meeting | Closed |
| Digital improvements in macular | Closed |
| Submit A3 for Macular Workforce | Closed |
| Weekend Nurse Injection Clinics to run if required | Closed |
| Standardisation of macular clinics | Closed |
| Monitor number of patients waiting for appointment | 31/12/2025 |
| POD virtual review clinic model | 31/12/2025 |
| support recruitment and retention | 31/12/2025 |
| Increase number of patients in macular One Stop clinics | 19/01/2026 |
| Identify additional space to provide macular assessments and treatments | 30/01/2026 |
| Absence Management | 09/02/2026 |
| Ophthalmology Practitioner Training (OPT) - macular module, for all Macular Nurse Specialists | 01/05/2026 |

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| **Tolerance breach?** | Yes |
| **Target risk rating** | 9 |
| **Progress update** | Several actions have been reviewed and updated. No LERNs have been submitted so far in November and December 2025. At Risk oversight on 24/11/2025 it was accepted that risk rating is above tolerated level. |

| **Risk type - Quality (Outcome and Safety)**<br>**Risk Category - Patient Safety and Outcome Appetite = Minimal Tolerance = 6-10** | |
|---|---|
| **Risk ID** | 1378 |
| **Risk Title** | Lack of Electronic results acknowledgement system |
| **Date risk raised on the risk register** | 01/02/2021 |
| **Date risk approved as 15+ risk** | 29/11/2022 |
| **Risk Rating** | 15 |
| **Risk Description** | A lack of an electronic results acknowledgement system for requested clinical tests is a risk to patient safety and could result in missed diagnosis and suboptimal treatment. |

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| | Combined with risk register item 1197 10/2/21. Provision of a clinical service for breast site specific disease that may require radiological, cytology or histology intervention to support diagnoses. All services that may require a radiological /histological /cytology intervention and therefore subject to an amended report. System does not alert requesting physician of change.<br>Risk involves Surgery, Radiology, Pathology, and Informatics. |
| **Executive sponsor** | Chief Medical Officer |
| **Controls in place** | • Teams based notifications standards<br>• External regulatory compliance standards<br>• Compliance with GMC guidance re: the responsible clinician<br>• Clinical in-patient worklist procedures<br>• Health of the ward procedures<br>• Royal College standard regarding referrers responsibilities<br>• IT strategy<br>• LERN policy |
| **Gaps in controls** | • No effective single user interface for clinicians to manage their core care processes. |
| **Action plan(s)** | **Action** / **Due date**<br>Referrer awareness / Closed<br>App / Closed |
| **Tolerance breach?** | Yes |
| **Target risk rating** | 4 |
| **Progress update** | The Task and Finish Group is meeting weekly to move the Trust to paperless requesting and reporting. The pilot areas have progressed well but a couple of areas now need focus<br>(1) Standing orders - where the same patient has multiple tests<br>(2) Bulk orders - where multiple patients have the same test<br>(3) Equipment - look at the equipment Trust wide to support the roll out.<br><br>This will progress in January. End of March target remains to achieve paperless at this time |

| **Risk type - Quality (Outcome and Safety)**<br>**Risk Category - Infection Prevention and Control** **Appetite = Minimal** **Tolerance = 6-10** | |
|---|---|
| **Risk ID** | 2246 |
| **Risk Title** | Inability to access a second obstetric theatre |
| **Date risk raised on the risk register** | 14/09/2025 |
| **Date risk approved as 15+ risk** | 24/11/2025 |

| | |
|---|---|
| **Risk Rating** | 15  |
| **Risk Description** | Emergency obstetric patients needing to access an operating theatre in a timely fashion for Category 1 and 2 deliveries where there is concern regarding maternal or fetal wellbeing, manual removal of placenta, perineal repair, post partum haemorrhage. If we do not provide this service, there will be risk to maternal and fetal life. |
| **Executive sponsor** | Chief Medical Officer |
| **Controls in place** | • Triaging potential emergency cases<br>• Ongoing monitoring of patient whilst awaiting theatre<br>• Alerting elective surgical teams to consider where lists can be paused during core working hours<br>• Flow chart from Protocol to risk assess and summon a second emergency obstetric team to theatres is in place and agreed by maternity, obstetrics, theatres and anaesthetics (displayed in Labour ward/ maternity theatres/fishbowl)<br>• An additional emergency team to be compiled from CEPOD and existing obstetric theatre team where available<br>• Staff training, skills and drills<br>• Consider moving patient to main theatre if both maternity theatres are occupied<br>• Escalation to Clinical Site Team |
| **Gaps in controls** | • Unpredictability of obstetric emergencies. Obstetric emergencies can arise quickly and may escalate quickly from Cat 2 to Cat 1 making triaging very dynamic<br>• Numbers of appropriate staff/skill mix might not be available to compile a second emergency team<br>• Awareness for CEPOD team of the urgency/ priority of the obstetric cases<br>• There are only 2 obstetric theatres. If there is an elective patient using one theatre and one patient using the 2nd theatre in an emergency, there is no other theatre for a 2nd emergency case<br>• Obstetric teams do not have oversight of elective lists in main theatres<br>• Physical and clinical risks for moving a patient |
| **Action plan(s)** | |

| Action | Due date |
|---|---|
| Protocol to risk assess and summon a second emergency theatre team for obstetrics | Closed |
| Improve Obstetric staff education and awareness regarding the above protocol | Closed |
| Ongoing collection of data through LERN submission | Closed |
| Theatre capacity review | 28/11/2025 |
| Improve anaesthetic staff education and awareness regarding the above protocol | 30/11/2025 |
| Review communication tools for contacting CEPOD team | 24/12/2025 |
| Improve theatre staffing to facilitate formation of a second emergency obstetric team | 08/01/2026 |
| Improve theatre staff education and awareness regarding the above protocol | 30/01/2026 |

| | |
|---|---|
| **Tolerance breach?** | Yes |

| | |
|---|---|
| **Target risk rating** | 5 |
| **Progress update** | Risk rating of 15 approved at Risk Oversight 24/11/2025. Additional action plan entries to be added. 24/12/2025 - Risk grading to remain the same as no changes. Staff encouraged to submit Datix's for the inability to access a second obstetric theatre. |

| **Risk type - Quality (Outcome and Safety)<br>Risk Category - Infection Prevention and Control Appetite = Minimal Tolerance = 6-10** | |
|---|---|
| **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 foetal 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** | Chief Medical Officer |
| **Controls in place** | • LERNS – 12 Patient Safety events raised since March 2025<br>• Scan tracker in place to log and monitor workflow<br>• General ultrasound examinations being conducted by outsourcing company (they do not offer obstetric services)<br>• Substantive staff being offered bank shifts and Wait List Initiative (WLI) at weekends to increase capacity<br>• Prioritisation of those areas measured for Maternity Incentive Scheme (MIS) audits.<br>• Radiology management team in discussion with radiologists to look at supporting enhanced practice for sonographers to help with staff retention long term<br>• 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<br>• Limited numbers of substantive staff with obstetric competencies mean there is little appetite for more sessions in obstetrics.<br>• 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. |
| **Action plan(s)** | |

| Action | Due date |
|---|---|
| Insourcing support for obstetrics | Closed |
| Align Preceptorship SOP | Closed |
| Upskilling of substantive staff | 01/09/2026 |
| Sonographer enhanced practice. | 01/09/2026 |

| | |
|---|---|
| **Tolerance breach?** | Yes |
| **Target risk rating** | 6 |
| **Progress update** | Notified that NHS England and the Royal College of Obstetricians and Gynaecologists have become aware of a potential safety concern regarding the use of Intergrowth Estimated Fetal Weight (EFW) charts in maternity services that requires immediate action. US leads assessing impact this will have on service with regards to increasing numbers/repeat scans in coming months.<br>One student sonographer expected to qualify in spring 2026 now will not qualify until summer 2026.<br>Insourcing support not yet agreed beyond December 2026.<br>Latest round of sonographer job adverts have not resulted in any suitable candidates. |

| **Risk type - Quality (Outcome and Safety)**<br>**Risk Category - Infection Prevention and Control  Appetite = Minimal  Tolerance = 6-10** | |
|---|---|
| **Risk ID** | 1397 |
| **Risk Title** | Provision of 24/7 Haematology/ Transfusion Laboratory Service |
| **Date risk raised on the risk register** | 13/11/2020 |
| **Date risk approved as 15+ risk** | 23/07/2025 |
| **Risk Rating** | 15 ⬌ |
| **Risk Description** | Lack of experienced Biomedical scientists to provide robust out of hours on call service for haematology and transfusion.<br>If this continues, this could lead to inability to provide emergency blood within safe timeframe for patients with major haemorrhage |
| **Executive sponsor** | Chief Medical Officer |
| **Controls in place** | • Onboarding 2 x locums for Poole<br>• Planning to redistribute the staffing evenly across the rota's, now that the cross-site consultation is completed<br>• Proactive ongoing recruitment to maximise opportunities<br>• Additional mitigation is for Band 7's to backfill shifts but this impacts on supervision, training & quality activity<br>• Ongoing staff support to optimise retention<br>• Sickness and absence procedures<br>• JACIE, MHRA and UKAS accreditation standards.<br>• laboratory closure OOH procedures<br>• SOP in place at both sites for service delivery<br>• SOP and Flow chart for obtaining flying squad blood |
| **Gaps in controls** | • Lack of establishment to support robust and sustainable model to ensure patient safety |

| | | |
|---|---|---|
| **Action plan(s)** | **Action** | **Due date** |
| | Review residual risk | Closed |
| | Recruitment and retention of staff | Closed |
| | Completion of OOH action tracker Oct 22 | Closed |
| | Table top exercise testing Blood Transfusion Contingency Plan | Closed |
| | Establishment of Robust Out of Hours Service | 30/03/2026 |
| **Tolerance breach?** | Yes | |
| **Target risk rating** | 1 | |
| **Progress update** | One locum has passed competencies and is now doing 2 nights per week to support the OOH rota. Second locum's progress has been delayed due to sickness but will also be able to join the OOH roster. Numbers at RBH seem to be stabilising and the situation does appear to be due to improve come the New Year. Anticipate an opportunity to assess decreasing the risk in Feb/Mar review. | |

| **Risk Type - Sustainable Services Risk**<br>**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** | 16  |
| **Risk Description** | There is a risk that the Trust cannot achieve its strategic priority to return to a financial surplus by 2026/27.<br>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.<br>• Dedicated financial support in place including additional variance analysis and reporting.<br>• Scheme of delegation, Standing Financial Instructions, and other finance policies and procedures in place.<br>• Monthly reporting to Trust Management Group, Finance and Performance Committee and Board highlighting risks and mitigating actions.<br>• Patient First 'driver' and 'watch' metrics agreed and monitored monthly.<br>• Alignment of approved nursing templates, e-roster templates, and budgeted establishment.<br>• Enhanced vacancy and non pay controls implemented to support financial recovery.<br>• Financial planning with system partners<br>• Efficiency Improvement Programme in place with oversight by Finance and Performance Committee. |

| | |
|---|---|
| | • QIA policy and process in place.<br>• Regular contract performance meetings with commissioners.<br>• Weekly MTP meetings.<br>• Regular System triple lock meetings. The trust is not authorised to approve new investments above £25k, subject to triple lock process.<br>• Detection control NHSE regulatory assessment (Risk Of Non Delivery Assessment (RONDA))<br>• Weekly escalation of the efficiency position to the executive team. Exec lead EIP meetings with each care group to challenge the recurrent and non recurrent nature of schemes. |
| **Gaps in controls** | • • Weaknesses in temporary staffing controls and roster management. Mitigation: Temporary staffing controls and roster management mitigation: External review of TSO, re-establishment of e-roster steering board, new e-form in development for approval of nursing/ HCA agency (Lead = CPO).<br>• Weaknesses in the alignment of medical job plans, medical staff rotas and financial budgets. Mitigation: Alignment of medical job plans, medical staff rotas and financial budgets Mitigation: Medical staffing Patient First corporate project (Lead = CMO).<br>• Weakness in high cost drugs spend controls by holding these in a non-directorate cost centre. Mitigation: High cost drugs spend controls mitigation: Harmonise legacy reporting processes to single data source, reporting spend at Care Group level improving accountability (Lead = CFO)<br>• At present the trust has not identified sufficient savings / opportunities to deliver the full year efficiency improvement programme and financial outturn requirements. |
| **Action plan(s)** | **Action** \| **Due date**<br>Medium Term Financial Sustainability \| 31/03/2026 |
| **Tolerance breach?** | Yes |
| **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 type - Sustainable Services**<br>**Risk Category - Information Technology Appetite = Cautious Tolerance = 9-15** | |
|---|---|
| **Risk ID** | 1950 |
| **Risk Title** | The Trust Electronic Patient Record (EPR) will be unsupported from April 2027 and is not fit for purpose |
| **Date risk raised on the risk register** | 01/08/2023 |
| **Date risk approved as 15+ risk** | 04/10/2023 |
| **Risk Rating** | 15  |

<table>
<tr><td>Risk Description</td><td>There is a risk that the Trust EPR is going to be unsupported with no planned replacement and the current solution is not fit for purpose for UHD and the wider Dorset System. There is a risk that this impacts on patient flow (1872), patient safety and results acknowledgement (1378), clinical engagement and staff morale.</td></tr>
<tr><td>Executive sponsor</td><td>Chief Digital Officer</td></tr>
<tr><td>Controls in place</td><td>The Electronic Health Record Programme (EHR) is moving forward where UHD will partner with Somerset and Dorset to procure a new system that will replace all the current key IT systems.<br><br>The majority of the trust IT systems that make up the EPR ecosystem have the following controls in place:<br>• Underpinning legal contracts with software suppliers<br>• Immutable backups (i.e. cannot be affected by malware)<br>• Staff training programmes<br>• Active Information Asset Owners who undertake appropriate audits in line with the Data Security and Protection Toolkit<br>• UHD wide Business Continuity Plan<br>• Dedicated Subject Matter Experts in the clinical applications who maintain them in their optimal state<br>• Teams of people working to ensure that the underlying IT Infrastructure is maintained in an optimal state</td></tr>
<tr><td>Gaps in controls</td><td>• Substantial gaps in the functionality of our EPR ecosystem relating to the management of the workflow of diagnostic results and reports and assured clinical transactions generally (e.g. therapy input and interprofessional referrals).<br>• No effective single user interface for clinicians to manage their core care processes.<br>• Local departmental Business Continuity Plans are not yet in place</td></tr>
<tr><td>Action plan(s)</td><td><table><tr><th>Action</th><th>Due date</th></tr><tr><td>Option appraisal</td><td>Closed</td></tr><tr><td>Business continuity Plan</td><td>Closed</td></tr><tr><td>EPR internal mitigation</td><td>Closed</td></tr></table></td></tr>
<tr><td>Tolerance breach?</td><td>No</td></tr>
<tr><td>Target risk rating</td><td>6</td></tr>
<tr><td>Progress update</td><td>Commercial conversations have now commenced with [redacted] to support the extension to the end of June 2028 when the EHR comes in. These negotiations should be concluded in January to lock in that support. The EDM continues to be the plan for a business continuity solution.</td></tr>
</table>

**Risk Heat Map- UHD**

| UHD | | | | | | |
|---|---|---|---|---|---|---|
| **Current Risk Grading** | | No Harm (1) | Minor (2) | Moderate (3) | Major (4) | Catastrophic (5) |
| Likelihood | Almost Certain (5) | 1 | 9 | 4 | 1 | 0 |
| | Likely (4) | 2 | 21 | 22 | 5 | 1 |
| | Possible (3) | 2 | 27 | 46 | 9 | 4 |
| | Unlikely (2) | 0 | 6 | 30 | 9 | 2 |
| | Rare (1) | 0 | 0 | 2 | 3 | 1 |

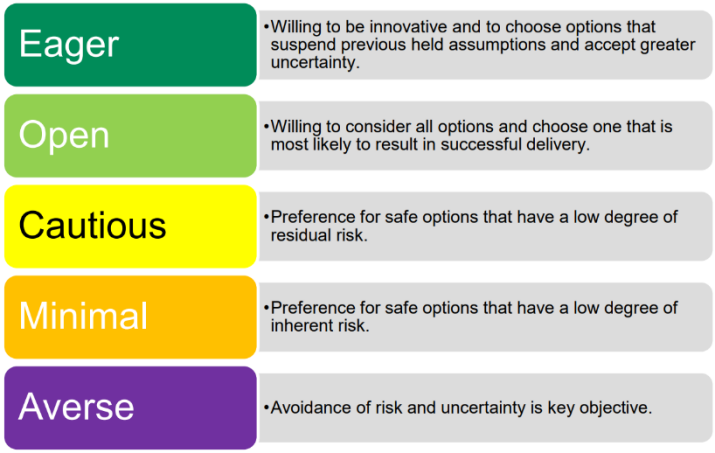
**Current Risk score by month – rolling year (at the point of report date – taken as preceding month)**

| Current Risk Score– UHD total | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Very Low (1-3) | 4 | 3 | 4 | 6 | 6 | 5 | 6 | 5 | 5 | 5 | 5 | 4 |
| Low (4-6) | 72 | 73 | 74 | 71 | 72 | 72 | 75 | 71 | 79 | 79 | 75 | 70 |
| Moderate (8-10) | 111 | 107 | 99 | 96 | 94 | 93 | 92 | 92 | 93 | 95 | 96 | 87 |
| Moderate (12) | 38 | 42 | 41 | 40 | 45 | 46 | 44 | 44 | 43 | 36 | 32 | 31 |
| High (15 -25) | 20 | 19 | 21 | 19 | 19 | 19 | 19 | 14 | 14 | 15 | 14 | 15 |
| **Total number of risks under review** | 245 | 244 | 239 | 232 | 236 | 235 | 236 | 226 | 234 | 230 | 222 | 207 |

## 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 |
|---|---|---|---|---|---|
| **Workforce Risk** | Staff Experience Risk | Cautious | 1-8 | 9-15 | Chief People Officer |
| **Workforce Risk** | Leadership and Talent Management Risk | Cautious | 1-8 | 9-15 | Chief People Officer |
| **Workforce Risk** | Recruitment and Retention (Staff Offer) Risk | Cautious | 1-8 | 9-15 | Chief People Officer |
| **Workforce Risk** | Workforce Risk | Cautious | 1-8 | 9-15 | Chief People Officer |
| **Workforce Risk** | People Function Risk | Cautious | 1-8 | 9-15 | Chief People Officer |
| **Population and System Risk** | Capacity Planning Risk | Cautious | 1-8 | 9-15 | Chief Operating Officer |
| **Population and System Risk** | Partnership Working Risk | Open | 1-10 | 12-20 | Chief Strategy and Transformation Officer |
| **Quality (Outcome and Safety) Risk** | Infection Prevention and Control Risk | Minimal | 1-5 | 6-10 | Chief Nursing Officer |
| **Quality (Outcome and Safety) Risk** | Patient Safety and Outcome Risk | Minimal | 1-5 | 6-10 | Chief Nursing Officer AND Chief Medical Officer |
| **Quality (Outcome and Safety) Risk** | Research Innovation and Development Risk | Open | 1-10 | 12-20 | Chief Medical Officer |
| **Quality (Outcome and Safety) Risk** | Health and Safety Risk | Averse | 1-3 | 4-6 | Chief People Officer |
| **Quality (Outcome and Safety) Risk** | Legal and Governance Risk | Averse | 1-3 | 4-6 | Chief Executive |
| **Quality (Outcome and Safety) Risk** | Regulatory Risk | Averse | 1-3 | 4-6 | Chief Nursing Officer |
| **Sustainable Services Risk** | Financial Management Risk | Cautious | 1-8 | 9-15 | Chief Finance Officer |
| **Sustainable Services Risk** | Counter Fraud Risk | Averse | 1-3 | 4-6 | Chief Finance Officer |
| **Sustainable Services Risk** | Financial Reporting Risk | Minimal | 1-5 | 6-10 | Chief Finance Officer |
| **Sustainable Services Risk** | Revenue Funding and Cash Management Risk | Cautious | 1-8 | 9-15 | Chief Finance Officer |
| **Sustainable Services Risk** | Information Governance and Security Risk | Cautious | 1-8 | 9-15 | Chief Informatics Officer |
| **Sustainable Services Risk** | Supply Chain Risk | Cautious | 1-8 | 9-15 | Chief Finance Officer |
| **Sustainable Services Risk** | Physical Assets Risk | Cautious | 1-8 | 9-15 | Chief Strategy and Transformation Officer |
| **Sustainable Services Risk** | Business Continuity Risk | Cautious | 1-8 | 9-15 | Chief Operating Officer |
| **Sustainable Services Risk** | Information Technology Risk | Cautious | 1-8 | 9-15 | Chief Informatics Officer |
| **Patient Experience Risk** | Patient Experience Risk | Minimal | 1-5 | 6-10 | Chief Nursing Officer |

## Risk Appetite Scales




## Risk type and category definitions

| | |
|---|---|
| **Workforce 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 Experience Risk | To ensure the Trust provides a safe environment for staff where all feel respected, valued and included at work |
| Leadership and Talent Management Risk | To ensure that the Trust has processes to support a well led workforce |
| Recruitment and Retention (Staff Offer) Risk | To ensure that the Trust recruits and retains the best people |
| Workforce Risk | To ensure that the Trust maintains a sustainable workforce that is adaptable and organised 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. |
| Capacity Planning 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 maintain patient safety and 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 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. |
| 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 and Outcome Risk | To ensure the Trust has effective processes in place for monitoring patient safety and outcomes, including learning from patient safety incidents and audit findings |
| Research Innovation and Development Risk | To ensure the Trust has an effective research and innovation strategy and a robust structure in place for research governance |
| Health and Safety Risk | To ensure that the management of Health and Safety and is designed to prevent harm to patients, staff, visitors, and volunteers. |
| Legal and Governance Risk | To ensure that the Trust controls and manages legal risk in accordance with Risk Appetite and operates an effective Corporate Governance Framework |
| Regulatory Risk | To ensure the Trust has effective processes in place for monitoring performance and progress against regulatory quality standards. |

| | |
|---|---|
| **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 is accurate and complete, including waste reduction programme, and enables the Trust to manage its financial position appropriately, on an ongoing basis |
| Counter Fraud Risk | 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. |
| Financial Reporting Risk | To ensure that financial information reported externally is correct, true, and fair and does not contain material misstatement. Also, to ensure that the tax position of the Trust is understood, appropriately managed, and reported correctly |
| Revenue Funding and Cash Management Risk | To ensure that the Trust's funding sources are adequately managed, held in the required state and available as the business requires |
| Information Governance and Security Risk | 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.<br><br>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. |

| | |
|---|---|
| Supply Chain Risk | To ensure that the selection, ongoing management, and termination of third-party suppliers are managed appropriately to protect the Trust's patients, assets, operations and finances. |
| 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. |
| Business Continuity Risk | To ensure the Trust is able to maintain key patient services during, as well as after, significant failures of systems, cyber-attacks or security breaches, failure of critical and important third-party suppliers or an environmental disaster, such as a fire or flood, impacts to workforce supply |
| 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.<br>• Peripheral element of treatment or service suboptimal<br>• Informal complaint/inquiry | • Overall treatment or service suboptimal<br>• Single failure to meet internal standards<br>• Minor implications for patient safety if unresolved<br>• Reduced performance rating if unresolved<br>• Breech of statutory legislation<br>• Elements of public expectation not being met<br>• Loss of 0.1–0.25 per cent of budget<br>• Claim less than £10,000<br>• Loss/interruption of >8 hours<br>• Minor impact on environment | • Treatment or service has significantly reduced effectiveness<br>• Repeated failure to meet statutory or contractual standards<br>• Major patient safety implications if findings are not acted on<br>• Challenging external recommendations/ improvement notice<br>• 5–10 per cent over project budget<br>• Local media coverage – long-term reduction in public confidence<br>• Loss of 0.25–0.5 per cent of budget | • Major injury leading to long-term incapacity/disability<br>• Non-compliance with national standards with significant risk to patients if unresolved<br>• Multiple complaints/ independent review<br>• Low performance rating<br>• Uncertain delivery of key objective/service due to lack of staff<br>• Enforcement action<br>• Multiple breeches in statutory duty<br>• Improvement notices<br>• National media coverage with <3 days service well below reasonable public expectation<br>• Non-compliance with national 10–25 per cent over project budget<br>• Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget<br>• 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<br>• Gross failure to meet national standards<br>• Multiple breeches in statutory or regulatory duty<br>• Prosecution<br>• National media coverage with >3 days service well below reasonable public expectation.<br>• Incident leading >25 per cent over project budget<br>• Non-delivery of key objective/ Loss of >1 per cent of budget<br>• Loss of contract / payment by results<br>• Claim(s) >£1 million<br>• Permanent loss of service or facility<br>• 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**<br>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 |

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 14 January 2026**

**Agenda item: 9.2**

| | |
|---|---|
| **Subject:** | Integrated Performance Report (Safety, quality, experience, workforce and operational performance) |
| **Prepared by:** | Executive Directors, Adam Morris, Mark Major, Judith May, David Mills, Irene Mardon, Jo Sims and Adrian Tron. |
| **Presented by:** | UHD Chief Officers |

| | |
|---|---|
| **Strategic themes that this item supports/impacts:** | Population & System ☒<br>Our People ☒<br>Patient Experience ☒<br>Quality Outcomes & Safety ☒<br>Sustainable Services ☒ |
| **BAF/Corporate Risk Register: (if applicable)** | BAF Risks 1-7<br><br>Trust Integrated Performance report for November 2025 - Appendix A |
| **Purpose of paper:** | Assurance |
| **Executive Summary**: | November saw a continued increase of anticipated pressures typically associated with winter, against a backdrop of a challenged wider system with regards to No Criteria Position (NCtR). Despite the pressure we have maintained an improved length of stay; increased our use of SDECs to pull from Emergency Departments and avoid admission and continued to increase referrals to hospital at home. In addition, and following collaborative work with our Ambulance Partner SWAST, we have also improved our ambulance handover times.<br><br>Our elective position remains strong with sustained performance around our diagnostic services and improvement in our delivery of the cancer standards. Our focus is currently on reducing the number of patients waiting over 52 weeks for treatment.<br><br>The National Oversight Framework Q2 segmentation was published in November. UHD has been placed into segment 3 by NHSE, with a rank of #71/134 acute and specialist providers and an average metric score of 2.37 (previous quarter 2.36). A summary of the segmentation by domain is included within the IPR.<br><br>**Proactive Management of Risks**<br>We are actively mitigating the potential impacts of constrained patient flow across our key domains: |

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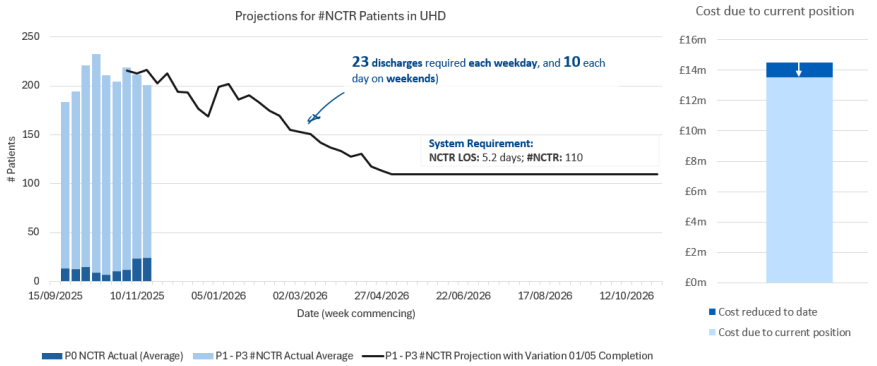
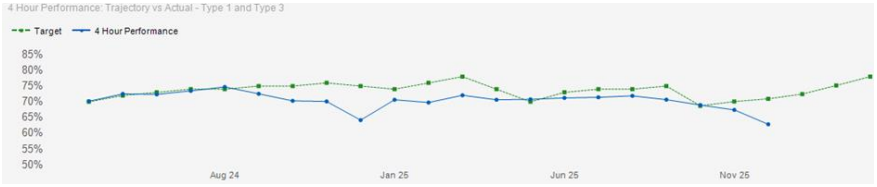
| | • Quality & Safety: Our priority is to safeguard patient safety and experience. We are implementing targeted flow initiatives to minimise the risk of increased waiting times and protect our elective procedure rates from cancellation.<br>• Financial: We are maintaining financial discipline by managing capacity escalation costs. Our focus remains on delivering our elective and cancer recovery programme efficiently to mitigate any financial and patient waiting times impact risk from activity shortfalls.<br>• People & Wellbeing: Protecting our workforce is paramount. Our winter planning prioritises sustainable rostering and the wellbeing support needed to manage demand without over-reliance on high-cost temporary staffing.<br>• Strategic Performance: Our elective recovery programme remains on track, demonstrating our resilience. We are strategically balancing capacity to protect this progress while responding to urgent care needs, thereby safeguarding our reputation for both planned and emergency care.<br><br>**Forward Look: Prepared and Focused**<br>We recognise the challenging operational environment that winter brings and the impact that seasonal viruses have for both patients and staff. We have a winter plan guided by our Trust strategic deployment reviews and we are confident that our focused actions and continued prioritisation will ensure we maintain stability and delivery against our key objectives through the coming months. |
| **Background:** | The integrated performance report (IPR) includes a set of indicators covering the key aspects of the Trust's performance relating to safety, quality, experience, workforce, and operational performance.<br><br>As part of our commitment to the CQC Well-Led Framework, we continue to develop the format and content of the IPR by:<br>• Extending best practice use of Statistical Process Control (SPC) Charts.<br>• Maintaining and updating the indicators that are most relevant to our patients.<br>• Greater focus on key indicators as part of our Patient First roll-out programme linked to the Trust Strategic priorities and the Trust refreshed Strategy Deployment Review process. Metrics that are part of the National Oversight Framework are denoted in bold in the metrics summary tables.<br>• Providing SPC training to operational leads who compile the narrative against the data included within the report.<br><br>We recognise as a Trust Board that behind every single metric discussed in this paper there is a patient. |
| **Population & Systems**<br><br>**Urgent & Emergency Care**<br><br>**(2 Alerts, 1 Advise, 3 Assure)** | **Strategic goal: To meet the national constitutional standards for Planned and Emergency care, supporting reducing inequalities in outcome and access and improving productivity and value.**<br><br>**Alert (1): No Criteria to Reside:**<br>Little improvement in the No Criteria to Reside position for Nov 25, which continues to impact the wider system with a growing number of delays impacting patients on pathways 1-3. The number of |

patients on pathway 2 is significantly higher than the same reporting period in 25/26 and are taking an average of 20 days to discharge. There is high correlation with ambulance handovers and patients over 12 hours within the Emergency Department. A set of improvement actions have been agreed with partners, focussing on reducing delay and increasing discharges. The Dorset system has agreed an improvement trajectory to reduce NCtR to 110 by the end of April 2026 with clear targets by responsible organisation.




**Alert (2): Performance against the 4-hour Organisational standard:**

The Trust's position against the standard was finalised at 67.4%, failing to meet the improvement trajectory of 70.07%.

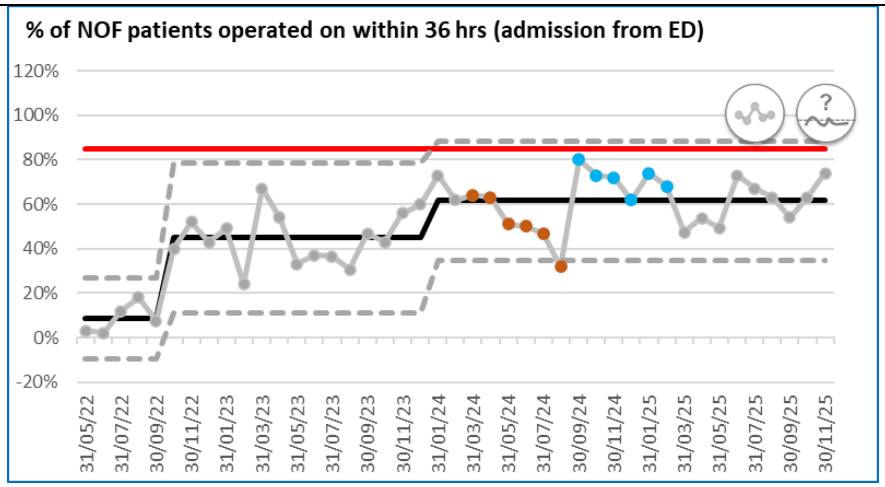



The Emergency Department has plans to run a suite of improvement cycles scheduled for 8th December 26 running in parallel to the cultural improvement plan. The cycles are focussed on underlying processes - SDEC / Streaming; Rapid Assessment (RAT); Ambulatory Care (ACA) with a broader PDSA focussed on effective escalation. The flow programme 'Care Coordination, is focussed on ward processes that underpin patient flow and early discharge, aligning with the FutureCare programme and the Transfer of Care (TOC) hub.

**Advise (1): Trauma: November performance for time to theatre for fractured neck of femur (#NoF) patients saw 74% of patients operated on within 36 hours from ED admission.**

Performance improved 11.4% and is above the process mean for the second consecutive month. The target continues to fall within the process limits indicating it is achievable.

90.5% achieving surgery within 36 hours of being fit for surgery.



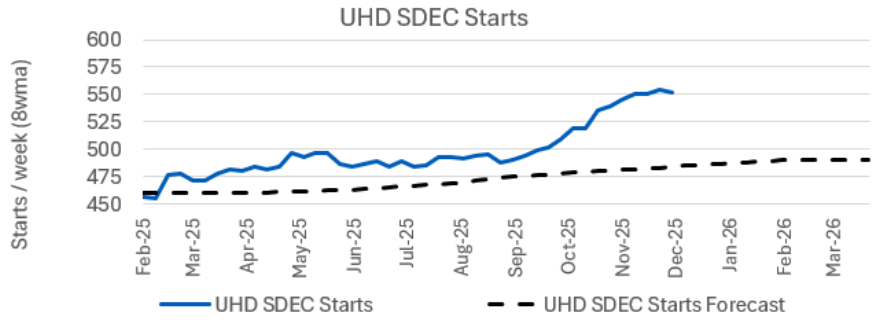

The key areas of focus to further improve this position are:

- Improving trauma theatre start times using data for procedure times and raising awareness of the Live on the Day Theatre Tool with the Trauma Wards
- Optimising the responsiveness from T&O with theatres, noting theatre staffing shortfalls at Poole.
- Continued focus on maximising trauma theatre efficiency and mitigating periods of escalated service demand.
- Looking to embed protected 1st patient on the theatre list to improve start times.

**Assure (1): Ambulance Performance**:
Sustained improvement in handover times since June 2025 with further improvement at RBH site driving further reduction in average handover time to meet the 27 min trajectory.

**Assure (2): Alternatives to Admission:**
The number of Same Day Emergency Care (SDEC) starts has continued to demonstrate a week-on-week increase since the beginning of September, alongside an increase in Hospital at Home (H@H) seen through October and November 25 (91% occupancy).

**Assure (3): Non-Elective Length of Stay (LOS):**
Despite the current NCtR position, our non-elective length of stay continues to be below 2025/26.




**Population & Systems**

**Planned Care including Cancer standards**

**Advise (1) Cancer Waiting Times**

62 Day performance in October 2025 was 72.2%, achieving a 7.8% improvement from September 2025. This fell slightly short of the Trust Operational Plan (72.4%) but is a notable improvement towards the March 2026 national recovery target (75%).

**(4 Advises, 2 Assures)**

**Advise (2) RTT waits >65 weeks were eliminated with the exception of 1 corneal graft wait. The percentage of >52 week waits as a proportion of the waiting list (2.7%) however, has increased**

The percentage of patients waiting >52 weeks in November lies within the process control limits with the target sitting outside of these. Intervention in December is required to reduce the variance to the target. Planned interventions include:

- Outsourcing orthopaedic and other high volume surgical lists to ISP providers to reduce waits on admitted lists and recover orthopaedic capacity lost following the business continuity incident in November.
- Bringing forward ERF allocations from Q4 to December and creating opportunities for high volume outpatient clinics

**Advise (3) The % of patient waiting >52 weeks for Community Health (neurodevelopmental) services remains high**

Three new consultants have been in place during Q3, however the priority for this additional capacity to date has been to manage time critical follow up patients and high priority patients. Patients from the long-waiter cohort are expected to be booked into appointment slots from Q4.

**Advise (4) 18-week Referral to Treatment (RTT) performance continues to demonstrate special cause improvement; however, the variance from the operational plan trajectory increased to 2%.**

In November, RTT performance was adversely impacted by a significant reduction of the total waiting list this month (-2,127) as a result of the Q3 validation sprint, reducing the denominator. Nevertheless, the Trust has continued to deliver fewer patients waiting for diagnosis or treatment, exceeding the operational plan (3.7k below plan). Over three quarters of patients are now receiving a first OPA or diagnostic test within 18 weeks of referral; this also exceeds the March 2026 plan trajectory (73%).

The Planned Care Improvement Group has oversight of the improvement projects supporting elective performance.

| Planning requirement | Oct 25 | November 2025 | |
|---|---|---|---|
| Referral to treatment 18-week performance | 64.1% | 63.6% ↓ | National standard 92% trajectory 65.6% Nov 25 |
| Eliminate >65 week waits | 4 | 1 ↓ | Plan trajectory 0 by Nov 25 |
| Reduce >52+ weeks | 1639 | 1713 ↑ | Plan Trajectory 1.6% 828 by Nov 25 |
| Reduce Waiting List size | 65,111 | 62,984 ↓ | Plan Trajectory 66,662 Nov 2025 |
| Waits for first activity <18 weeks | 75.0% | 76.1% ↑ | Plan trajectory 72.3% Nov 2025 |

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| | **Assure (1) Cancer Waiting Times**<br><br>FDS performance in October 2025 achieved 77.8%, which is above the national standard (75%) and the Trust's Operational Plan (78.75%).<br><br>**Assure (2) Cancer Waiting Times**<br><br>The 31 Day performance in October 2025 was 96.6%, achieving the 96.0% national standard. This standard has achieved for 9 consecutive months. |
| **Population & Systems**<br><br>***Health Inequalities and Primary Prevention***<br><br>***(1 Assure)*** | **Assure (1) The DM01 (Diagnostic) standard performance was 1.8% of patients waiting more than 6 weeks for a diagnostic test, achieving the operational planning ambition (5%).**<br><br>Standard: No more than 1% of patients should wait more than 6 weeks for a diagnostic test.<br><br>**November 2025** / **Total Waiting List** / **< 6 weeks** / **> 6 weeks** / **Performance**<br>UHD / 10,529 / 185 / 10,344 / **1.8%**<br><br>Diagnostic waiting times performance remains strong, with the Trust performing in the top decile nationally and waits over 13 weeks are also now showing a sustained reduction. |
| **Population & Systems**<br><br>**Operational Productivity**<br><br>***(2 Advise, 1 Assure)*** | **Advise (1) Capped theatre utilisation (80.5%) improved in November but remains below the operational plan trajectory**<br><br>This metric is not changing significantly, and performance is showing normal variation, rather than improvement. The target sits outside of current process control limits.<br><br>November's performance was impacted by a reduction in activity in the Derwent (Orthopaedics) Unit during the business continuity incident in month.<br><br>The 3 key actions are:<br>• Improve Gynaecology list planning following successful recruitment into Admission team roles. Improvement evidenced in November.<br>• Clinician booking profiles under review within Head & Neck services to promote list optimisation. Notable improvement in month > 3% overall.<br>• Trauma & Orthopaedics directorate areas of focus: recovery of previous improvement seen in October prior to the business continuity incident, through reducing cancelations on the day, reducing loan equipment, and accurate theatre scheduling.<br><br>**Advise (2) The Trust's achievement of the British Association of Day Surgery (BADS) day surgery rate (85%) remains variable.**<br><br>The latest published data is August 2025 and the Trust is performing at 84%, an improvement compared to July. Contributing to this position is an improvement in Arthroplasty day case rate. |

Two key actions:

- All BADS procedures are being listed as day case by default to improve the data capture of procedures.
- Embedding laparoscopic hysterectomy and vagina repair surgery day case pathways across both sites.

**Assure (1) The Trust has delivered 115.3% (provisional value weighted activity) year to date compared to the same period in 2019/20.**

Activity is above the operational plan trajectory (108.2%). The month 5 (latest nationally reported data) estimated 25/26 Implied Productivity Growth compared to month 4 2024/25 is 4.0%, placing UHD as having the 4th highest productivity growth in the South West Region.

***Maternity (1 Advise)***

**Advise (1): There are 3 areas currently identified for focus**

- Workforce –sickness rates
- Readmitted babies to hospital within first 30 days of life
- Pre- birth optimisation :
  1. % of babies before 30 week's gestation who receive magnesium sulphate within 24 hours prior to birth and
  2. % of babies born <34 week's gestation who receive full course of steroids within 1 week of birth.

Improvement actions are detailed within the IPR.

***Infection Prevention and Control: (2 Alert, 6 Advise)***

**Quality, Safety, & Patient Experience Key Points**

**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): Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia:** 2 cases of hospital associated MRSA bacteraemia in November
- **Alert (2) Clostridioides *difficile* cases**: 10 cases of hospital associated *C.diff* cases were reported and investigated in November.
- **Advise (1) *E.coli* bacteraemia:** 11 cases of *E.coli* bacteraemia were reported and investigated in November
- **Advise (2) *Klebsiella* bacteraemia**: 2 cases reported in November
- **Advise (3) Pseudomonas bacteraemia:** 6 cases reported in November
- **Advise (4) Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia:** A decrease in cases compared to the previous month

| Organism | Dec-24 | Jan-25 | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MRSA | 3 | 1 | 0 | 2 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 2 |
| MSSA | 5 | 3 | 7 | 8 | 4 | 4 | 6 | 2 | 6 | 5 | 5 | 3 |
| C Diff | 14 | 4 | 6 | 8 | 10 | 11 | 5 | 8 | 13 | 8 | 12 | 10 |
| E Coli | 14 | 18 | 14 | 19 | 18 | 12 | 14 | 12 | 7 | 7 | 12 | 11 |
| Kleb | 7 | 8 | 5 | 8 | 3 | 6 | 3 | 4 | 4 | 3 | 2 | 2 |
| Pseudo | 3 | 4 | 2 | 0 | 3 | 2 | 1 | 2 | 2 | 2 | 4 | 6 |
| Outbreaks | 4 | 5 | 5 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 |

- **Advise (6): Outbreaks/cohort of infectious disease:** Nil COVID-19 outbreaks

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| ***Clinical Practice Team***<br><br>***(1 Advise)***<br>***(1 Assure)*** | **Clinical Practice Team:**<br><br>**Falls prevention & management**:<br>**Advise (1)**: Inpatient falls remain within expected variation. November 2025 rate: **6.3 per 1,000 bed days**. Three inpatient falls resulted in moderate or greater physical harm, equating to **0.1 per 1,000 bed days**.<br><br>**Assure (1)**: PSIRF SWARM reviews completed for all moderate+ harm falls; no new Trust-wide learning identified. Falls Steering Group: Monthly meetings scheduled from January 2026 to embed new structure.<br><br>**VTE Prophylaxis Prescribing:** Reporting on this metric has now gone live with a Cosmos report available trustwide and Patient First scorecard metric. |
| ***Patient Experience***<br><br>***(4 Advises)*** | **Strategic goal: Every team is empowered to make improvements using patient (or user) feedback, in order that all patients at UHD receive quality care, which results in a positive experience for them, their families and/or carers.**<br><br>**Patient Experience and Engagement Team Overview:**<br><br>**Patient Experience (inc. PALS and Complaints) performance November 2025**<br><br>**Advise (1) The number of open complaints over 35 days** is currently at 32. This continues to be in part due to delays in receiving content and statements along with approval from the staff involved in the complaints and outstanding information needed. The complaints team continue to prioritise, with further measures to reduce the number of outstanding complaints in place.<br><br>**Advise (2) Average complaint response timescale** August 2025 was a 33.72 working day average for a final response.<br><br>**Advise (3) – increased demand on PALS service** – PALS service are experiencing a month on month increase in workload, there was a decrease in opened PALS cases in November due to a high level of sickness within the PALS team.<br><br>**Advise (4) Friends and Family Test (FFT) T**he volume of FFTs being received has shown a decrease this month, UHD continues to see a sustained high satisfaction score. The Trust's overall positive score remains above the upper control limit. |
| ***Nurse Staffing: (2 Advise, 2 Assure)*** | **Care Hours per Patient Day (CHPPD):**<br><br>**Advise (1)** Nov 2025 CHPPD remained stable at 4.8 for Registered Nurses/Midwives combine and all Registered and non- registered care staff 7.8.<br><br>The overall percentage rota fill rate against planned staffing (day and night all nursing/care staff) was 94.4%<br><br>**Red Flag Reporting:**<br>**Assure (1)** 5 Red Flags on Adult in patient wards for November 2025. 2 (40%) Omission of Fundamental Care, 1 (20%) for RN |

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| | Shortfall of 8hrs or greater than 25% versus shift demand, 1 (20%) Unable to Provide Enhanced Care, and 1 (20%) for delay in providing planned medications or pain relief.<br><br>**Workforce Controls:**<br>**Advise (2)** Red flag data is triangulated with other quality and safety information in preparation for unannounced assurance visits to in-patient wards.<br>**Assure (2)** Ongoing review shows no impact on care delivery or safety due to the current workforce controls. |
| ***Workforce Performance:*** | **Strategic goal: To significantly improve staff experience, engagement, and retention.** |
| ***CPO Headlines*** | In M08 UHD was 132.7 whole time equivalents (wte) behind the total workforce in month plan; 9933.9 wte usage against a plan of 9801.2wte.<br><br>M08 substantive workforce was 141.2wte behind plan of 9035 wte.<br><br>Bank usage increased for the fourth month in a row in M08, adverse variance above plan by 52wte. Bank spend increased to 8.92% of the total pay bill, which is the highest spend this financial year to date.<br><br>Agency usage reduced in M08 to 85.5wte, against a plan of 146wte. In line, agency spend also reduced and was 0.91% of the total pay bill.<br><br>Resident doctors' Industrial Action in M08 has resulted in a marked increase in Medical Bank spend YTD from £9.7M in M07 to £11.3M YTD in M08 and further Industrial action is planned for M09. |
| ***HR Operations - (1 Alert, 1 Advise)*** | **Alert – Resident Doctor Industrial Action:** The British Medical Association (BMA) have announced that Resident Doctors in England will strike in December. The five-day strike will run from 7am on 17 December until 7am on 22 December. Industrial action planning meetings have commenced, in anticipation of the industrial action commencing.<br><br>**Advise – Consultant and SAS Job Planning:** As at 3 December, 89.2% of consultants and 75.9% of SAS doctors had signed off job plans for the 2025/26 job planning round. Whilst this is not in line with the 95% requirement (by 1 October), marginal progress has been made month on month. Care Group team job planning completion is 54.3%, with a trajectory of 85.7% completion by January. |
| ***Blended Education & Training*** **(2 Advises)** | **Advise** Oliver McGowan training being allocated to all staff from January 2026 with the aim to meet NHSE requirement of 30% compliance by March 2026. All clinical patient facing staff to complete Tier 2 face to face training, non-clinical staff to complete Tier 1 webinar, all staff to complete the eLearning first, compliance now available on Cosmos. |

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| | **Advise** BEAT/VLE licence expiry March 2026, possibility of procuring a new VLE and adding in EHR and IT training across Dorset. |
| ***Workforce Systems***<br><br>***(1 Advise 1 Alert)*** | **Advise** – This month, just over 18 rosters were not finalised within the required timeframe compared to 40 in the previous month resulting in the pay files being submitted late.<br><br>**Alert** – Due to issues with team capacity the deadline of March 2026 for the medical rostering part of the Clinical Workforce Programme is at risk. Additional resource directly from Healthrota (rostering platform owners) is currently being investigated. |
| ***Resourcing***<br><br>***(1 Alert, 1 Advise)*** | **Advise** - The Trust's Right to Work position has strengthened with the approval and publication of the new Maintaining Right to Work Compliance SOP, providing clear standards and controls. This now gives a consistent framework for managers and Recruitment, reducing compliance risk and supporting faster, more reliable pre-employment checks.<br><br>**Alert -** The Immigration Skills Charge will rise by 32% from 16 December, significantly increasing the cost of skilled worker sponsorship. The Recruitment Team has proactively processed all eligible visa extensions up to April 2026 ahead of the increase, generating an estimated cost avoidance of £24,320 for the Trust. |
| ***Temporary Staffing (1 Alert,)***<br><br>***Occupational Health (3 Advise)*** | **Alert -** The use of Agency Band 3 workers to support Enhanced Therapeutic Observations remains high mainly within the Medical Care Group. The data available does not capture the governance controls and use of Security for direct patient care.<br><br>Work is underway to assess and mitigate impact of NHSE directive to remove by end of January. This is likely to result in unintended consequences of increased demand in Agency Registered Mental Health to ensure appropriate support for patients.<br><br>**Advise** - Occupational Health received 133 management referrals in November of these 57% were offered an appointment within 10 days of the referral being consented. The average time for a pre-placement to be cleared was 5 days.<br>The staff MSK service received 63 new referrals in November 2/3rds of the referrals were for staff who perform manual roles in the trust.<br><br>**Advise** - Health kiosks have been installed in RBH, PH and Christchurch staff restaurants to support staff with monitoring their health.<br><br>**Advise** - PSC received 60 referrals in November 2025 of which 50% were offered an appointment within 2-weeks. Pre-assessment screening identified 85% reporting high stress, 63% with symptoms of burnout, 48% with probable depressive disorder, 27% with suicidal ideation, 63% with |

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| | poor sleep and 18% with probable PTSD. 20% reported as signed-off work by their GP. |
| **Organisational Development**<br><br>***(3 Advise)*** | **Advise - FTSU** 295 staff have raised a concern with the FTSU team since April 2025. The greatest theme that staff raised to the FTSU team was relating to behaviours (150 staff; 51%) followed by process and systems (90 staff; 30%).<br><br>**Advise - Team** - TED Community of Practice launched for team leaders to have a safe space to share and learn. Masterclasses for TED team leaders and coaches booked to build capability and knowledge. Work being undertaken to design offer of support to those teams working through transition.<br><br>**Advise - EDI** The Transgender Memorial Event hosted by the PRIDE Network on 20th November to honour lives lost to anti-transgender bigotry and violence. The Pro-Ability Network marked 'Positively Purple' with a webinar featuring speaker Jamie McAnsh and a range of visibility activities. A bespoke listening event hosted for DEN members, to deepen understanding of the current concerns of Global Majority staff and call for action. |
| **Trust Finance Position**<br><br>**(2 Alerts, 1 Advise, 2 Assures)** | **Strategic goal: To return to recurrent financial surplus from 2026/27**<br><br>**Alert (1): Revenue Position**<br>At the end of November, the Trust reported a deficit of £6.4 million, being £28,000 better than plan.<br><br>Following considerable work across the ICS, including engagement with NHS England, the Trust now has a detailed plan to recover the year-to-date deficit and deliver within the full year budget. This includes non-recurrent funding from NHS England to mitigate the financial impact of ceasing the planned Wholly Owned Subsidiary. This plan requires the acceleration of identified efficiency schemes currently expected to deliver in 2026/27, a further tightening of workforce controls including a considerable reduction in bank expenditure, together with a range of smaller mitigations.<br><br>However, the Trust is currently experiencing significant operational pressures, including caring for 224 patients who no longer require acute care (90 more than the ICS agreed trajectory) which are putting significant pressure on the forecast outturn. As such, there remains considerable risk in the delivery of the full year plan.<br><br>**Alert (2): Efficiency Improvement Programme**<br>Efficiency improvement delivery to the end of November is £0.6 million behind plan. The trust has identified savings opportunities of £55 million, however when adjusted to reflect the risk of delivery in year, this is reduced to £53.6 million.<br><br>Whilst this represents an improvement in month of £0.7 million; it remains £16 million short of the full year savings requirement. Further enhancing of local controls following a detailed review of the national 'grip and control' checklist in September has, and will continue to support improvements in this forecast, and NHS England undertook a deep dive on our efficiency programme in |

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| | October, to provide additional external assurance and to learn from the output of similar reviews undertaken elsewhere in the South West. We expect to receive full feedback from NHS England in December.<br><br>**Advise (1): Capital Programme**<br>The Trust has reported capital expenditure of £83.9 million, being £19.7 million below plan year to date. Whilst the Trust is currently forecasting delivery of the programme within the capital funding envelope, there remains considerable risk in this. Specifically, the agreed purchase of Wessex Fields has put pressure on the local CDEL and work is underway to secure additional funding and re-prioritise/ re-profile existing schemes to accommodate this additional commitment. Conversely, there is a risk of slippage against a small number of national programmes, and work is ongoing to accelerate these and open conversations regarding any potential reprofiling opportunities.<br><br>**Assure (1): Public Sector Payment Policy**<br>In relation to the timely payment of supplier invoices, the Trust is currently delivering performance of 95.2%, ahead of the national standard of 95%. This has further improved in November following the summer leave period which had impacted the timely authorisation of invoices, and we continue to target support to areas with slow invoice approvals to ensure performance remains above the target in future months.<br><br>**Assure (2): Cash**<br>As at November 2025 the Trust is holding a consolidated cash balance of £73.6 million which is fully committed against the Trust's reconfiguration programme. This current balance represents 31 days of operating expenditure. |
| **Sustainable Services**<br><br>**Digital**<br><br>**(2 Assure, 1 Advise)** | **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**<br><br>A task and finish group involving clinical and operational leads supporting the development of a standard operating procedure for Advice and Guidance pathways and the roll out of the use of the Consultant Connect solution. Dermatology has been live for some time. In November Urology, Gastro & Rheumatology went live and in December Cardiology and Gynaecology have now also gone live. The next specialties are being worked up to progress this.<br><br>**Advise (2) Did not attend or missed appointment rates are above the Trust's 5% target at 5.7%.**<br><br>Whilst the increasing trend is not statistically significant at this point, action will be taken to understand the trends at specialty level and |

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| | to evaluate in December the impact of DNA prediction, which has been employed through the DrDoctor portal in some services.<br><br>**Assure (1) ICE for Ordering vs paper - agreed locations to start pilot by 20th October and feedback.**<br><br>The Task and finish group continues to work up the Add On process and the Blood Transfusion process. However, within the pilot we are in week two and E3, SDEC Ward 2 all show a slight reduction in electronic requesting at the beginning of week 2. This collates with equipment issues/resolution (took 5 days to resolve). The remaining areas in the pilot, which equates to 8 other areas, all show an increase in electronic requesting. The action plan to move to 95% electronic requesting by end of March is still correct.<br><br>An additional element of this project is that we have now turned off 14 areas who were previously receiving paper reports so we now have a total of 29 paperless areas. 40% of paper now turned off for reporting. |
| **Key Recommendations :** | Members are asked to note the content of the report. |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality, Equity, Diversity & Inclusion ☒<br>Financial ☒<br>Health Inequalities ☒<br>Operational Performance ☒<br>People (inc Staff, Patients) ☒<br>Public Consultation ☐<br>Quality ☒<br>Regulatory ☒<br>Strategy/Transformation ☒<br>System ☒ |
| **CQC Reference:** | Safe ☒<br>Effective ☒<br>Caring ☒<br>Responsive ☒<br>Well Led ☒<br>Use of Resources ☒ |

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | |
|---|---|---|
| Finance & Performance Committee (Operational / Finance Performance) | 15/12/2025 | The Committee noted the report. |
| Trust Management Group | 23/12/2025 | The Group noted the report. |
| Quality Committee | 16/12/2025 | The Committee noted the report. |

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| **Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)** | Commercial confidentiality<br>Patient confidentiality<br>Staff confidentiality<br>Other exceptional reason | ☐<br>☐<br>☐<br>☐ |

University Hospitals Dorset
NHS Foundation Trust

# Integrated Performance Report

**Reporting month:** November 2025

**Meeting Month :** December 2025

# Contents

University Hospitals Dorset
NHS Foundation Trust

# Executive Summary

University Hospitals Dorset
NHS Foundation Trust

November saw a continued increase of anticipated pressures typically associated with winter, against a backdrop of a challenged wider system with regards to No Criteria Position (NCtR). Despite the pressure we have maintained an improved length of stay; increased our use of SDECs to pull from Emergency Departments and avoid admission and continued to increase referrals to hospital at home. In addition, and following collaborative work with our Ambulance Partner SWAST, we have also improved our ambulance handover times.

Our elective position remains strong with sustained performance around our diagnostic services and improvement in our delivery of the cancer standards. Our focus is currently on reducing the number of patients waiting over 52 weeks for treatment.
The National Oversight Framework Q2 segmentation was published in November. UHD has been placed into segment 3 in the September 2025 NHSE ranking, with a rank of #71/134 acute and specialist providers and an average metric score of 2.37 (previous quarter 2.36)

**Proactive Management of Risks.**
We are actively mitigating the potential impacts of constrained patient flow across our key domains:

- **Quality & Safety:** Our priority is to safeguard patient safety and experience. We are implementing targeted flow initiatives to minimise the risk of increased waiting times and protect our elective procedure rates from cancellation.
- **Financial**: We are maintaining financial discipline by managing capacity escalation costs. Our focus remains on delivering our elective and cancer recovery programme efficiently to mitigate any financial and patient waiting times impact risk from activity shortfalls.
- **People & Wellbeing:** Protecting our workforce is paramount. Our winter planning prioritises sustainable rostering and the wellbeing support needed to manage demand without over-reliance on high-cost temporary staffing.
- **Strategic Performance:** Our elective recovery programme remains on track, demonstrating our resilience. We are strategically balancing capacity to protect this progress while responding to urgent care needs, thereby safeguarding our reputation for both planned and emergency care.

**Forward Look: Prepared and Focused**
We recognise the challenging operational environment that winter brings and the impact that seasonal viruses have for both patients and staff. We have a winter plan guided by our Trust strategic deployment reviews and we are confident that our focused actions and continued prioritisation will ensure we maintain stability and delivery against our key objectives through the coming months.

***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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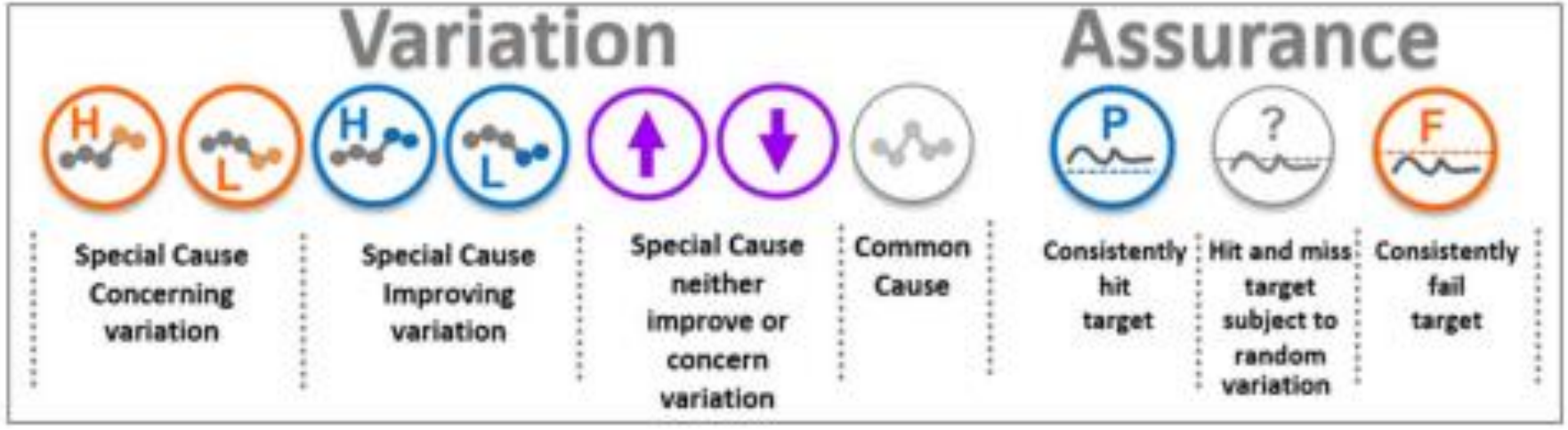


**Special Cause Concern** - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance. (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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## 2025/26 IPR Matrix

| VARIATION | ASSURANCE: Pass - the target sits within the process limits and will be achieved if no change (P) | ASSURANCE: "Flip flop" - the target may or may not be achieved (?) | ASSURANCE: Fail - the target sits outside the process limits and will not be achieved without change (F) | No Target |
|---|---|---|---|---|
| special cause variation , IMPROVEMENT (H / L) | 31 day cancer standard | | | Ambulance handovers<br>- average handover time UHD |
| common cause or normal variation no significant change observed (same) | % Patients waiting <18 weeks for 1st attendance<br>UHD - % waiting over 6 weeks | Faster Diagnosis Standard (FDS) 28 days<br>In Month Sickness Absence *<br>Mortality Reviews<br>HSMR In Month - UHD (Source: HED)<br>SHMI – Summary Hospital Level Mortality Indicator * | RTT Performance against trajectory for 18 week standard (92%)*<br>% Patients waiting >52 weeks (1% std) against trajectory *<br>62 day cancer standard *<br>4 hour safety standard *<br>Theatre utilisation (capped)<br>Number of Early Resolutions<br>% of total complaints closed within 35 days | Under 18's RTT pathways<br>Patients >12hrs in dept *<br>Vacancy Rate at end of each month<br>Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays *<br>hospital assocoiated infections - MRSA<br>hospital assocoiated infections - CDiff<br>hospital assocoiated infections - E Coli<br>Number of complaints per 1000 contacts for clinical services<br>Number of Complaints Received |
| special cause variation , DETERIORATION (H / L) | | | | Community Health Services SITREP % over 52 weeks |

# National Oversight Framework

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UHD has been placed into **segment 3** of the NHS Oversight Framework (NOF) in the September 2025 NHSE ranking, with a rank of #71/134 acute and specialist providers and an average metric score of 2.37 (previous quarter 2.36)

*Scores and ranks are refreshed quarterly (1 is best)*

| Domain | Domain Score (September 2025) | Segment | Direction of Travel since last segmentation | Prevoius score (initial segmentation July 2025) |
|---|---|---|---|---|
| Access to Services | 2.68 | 3 | ⟷ | Domain score 2.68 / Segment 3 |
| Effectiveness and Experience of Care | 2.43 | 3 | ⟷ | Domain score 2.44 / Segment 3 |
| Patient Safety | 2.40 | 2 | ⟷ | Domain score 2.49 / Segment 2 |
| People and Workforce | 2.22 | 2 | ⟷ | Domain score 2.13 / Segment 2 |
| Finance and Productivity | 1.20 | 1 | ⟷ | Domain score 1.07 / Segment 1 |

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# Population & System

**Mark Mould**
Chief Operating Officer

**Operational Leads:**
Judith May – Director of Operational Performance and Oversight
Mark Major – Deputy Chief Operating Officer
Abigail Daughters – Group Director of Operations – Surgery
Lisa Clarke – Group Director of Operations – Women's, Children, Cancer and Support Services
Adam Morris – Interim Group Director of Operations – Medical

**Committees:**
Finance and Performance Committee

# Performance at a Glance

## Population & System

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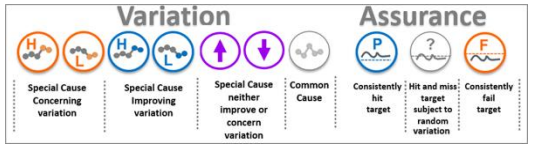


### UHD Elective Care

| KPI | Latest month | Measure | Target | Variation | Assurance |
|---|---|---|---|---|---|
| RTT Total Waiting List Size | Nov 25 | 62984 | 66662 | | |
| **RTT Performance against trajectory for 18 week standard (92%)** | **Nov 25** | **63.6%** | **65.6%** | | |
| Patients waiting >52 weeks | Nov 25 | 1713 | 828 | | |
| **% Patients waiting >52 weeks (1% std) against trajectory** | **Nov 25** | **2.7%** | **1.2%** | | |
| Patients waiting >65 weeks | Nov 25 | 1 | 0 | | |
| % Patients waiting <18 weeks for 1st attendance | Nov 25 | 76.1% | 72.3% | | |
| **Under 18's RTT pathways** | **Nov 25** | **4717** | **-** | | |
| UHD - Total Diagnostic Waiting List | Nov 25 | 10529 | - | | |
| **UHD - % waiting over 6 weeks** | **Nov 25** | **1.8%** | **5.0%** | | |
| UHD - % waiting over 13 weeks | Nov 25 | 0.3% | | | |
| **Community Health Services SITREP % over 52 weeks** | **Nov 25** | **64.6%** | **-** | | |
| **Faster Diagnosis Standard (FDS) 28 days (75% std)** | **Oct 25** | **78.8%** | **78.8%** | | |
| 31 day standard (96% std) | Oct 25 | 96.6% | | | |
| **62 day standard (85% std)** | **Oct 25** | **72.2%** | **85.0%** | | |
| Trauma Admissions | Nov 25 | 369 | - | | |
| % of NOF patients operated on within 36 hrs (admission from ED) | Nov 25 | 74.0% | 85.0% | | |
| % Outpatient appointments with procedures | Nov 25 | 22.4% | | | |
| UHD - Total Outpatient - Virtual (%) | Nov 25 | 15.8% | 25.0% | | |
| UHD Outpatient DNA rate | Nov 25 | 5.7% | 5.0% | | |
| Theatre utilisation (capped) | Nov 25 | 80.5% | 85.0% | | |
| UHD Theatre case opportunity | Nov 25 | 11.1% | 15.0% | | |

### UHD Urgent and Emergency Care

| KPI | Latest month | Measure | Target | Variation | Assurance |
|---|---|---|---|---|---|
| Arrival time to initial assessment | Nov 25 | 20 | 15 | | |
| Clinician seen <60 mins % | Nov 25 | 26% | - | | |
| Patients >12hrs from DTA to admission | Nov 25 | 358 | 0 | | |
| **Patients >12hrs in dept** | **Nov 25** | **1246** | **-** | | |
| **4 hour safety standard** | **Nov 25** | **67.4%** | **70.1%** | | |
| Ambulance handovers - average handover time UHD | Nov 25 | 26.6 | - | | |
| Ambulance handovers - average handover time RBH | Nov 25 | 28.5 | - | | |
| Ambulance handovers - average handover time Poole | Nov 25 | 24.5 | - | | |
| Ambulance handover >60mins breaches | Nov 25 | 61 | | | |
| Ambulance handovers | Nov 25 | 4423 | - | | |
| Bed Occupancy (capacity incl escalation) | Nov 25 | 94% | 85% | | |
| Stranded patients: Length of stay 7 days | Nov 25 | 532 | - | | |
| Stranded patients: Length of stay 14 days | Nov 25 | 335 | - | | |
| Stranded patients: Length of stay 21 days | Nov 25 | 233 | 108 | | |
| Non-elective admissions | Nov 25 | 6692 | - | | |
| > 1 day non-elective admissions | Nov 25 | 3981 | - | | |
| Same Day Emergency Care (SDEC) | Nov 25 | 2711 | - | | |
| Conversion rate (admitted from ED) | Nov 25 | 29.1% | 30.0% | | |

# Elective Access - RTT

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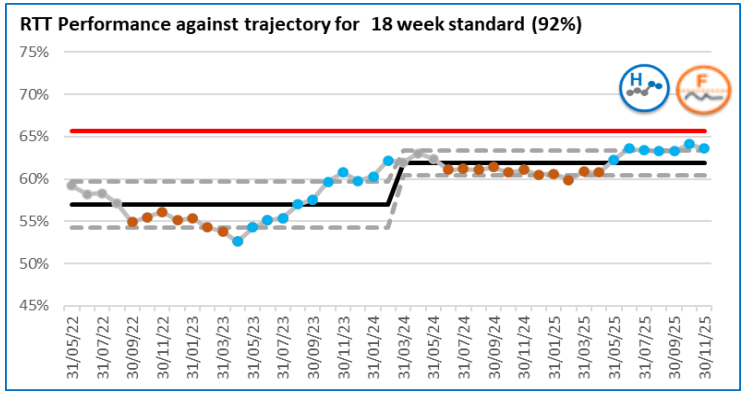
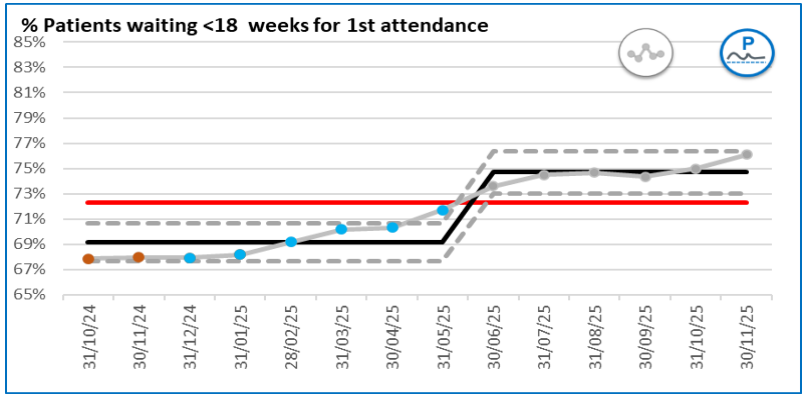
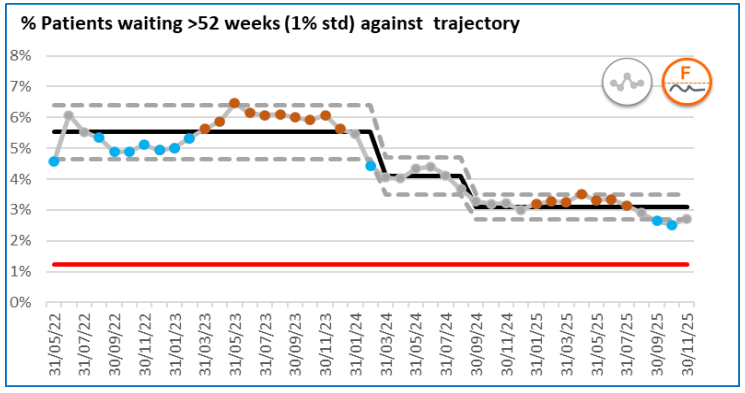
| November 25 |
|---|
| 63.6% |
| Variance/Assurance |
| H F |
| Targeting (Internal) |
| 65.6% |
| Business Rule |
| Full CMS |



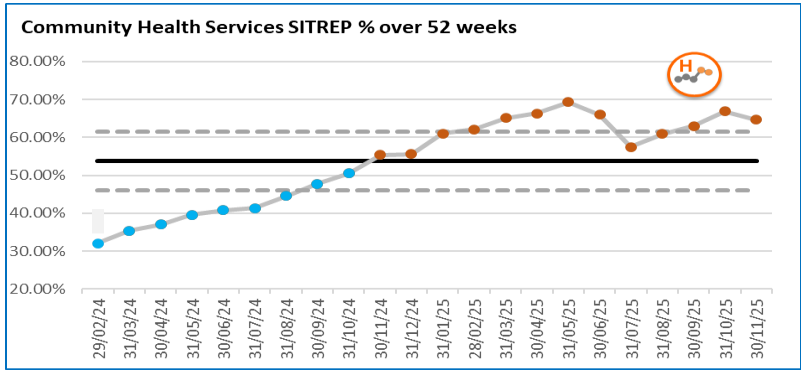

| November 25 |
|---|
| 76.1% |
| Variance/Assurance |
| P |
| Targeting (Internal) |
| 72.3% |
| Business Rule |
| Note performance |




| November 25 |
|---|
| 2.7% |
| Variance/Assurance |
| F |
| Targeting (Internal) |
| 1.2% |
| Business Rule |
| Full CMS |




| November 25 |
|---|
| 64.6% |
| Variance/Assurance |
| H |
| Targeting (Internal) |
| |
| Business Rule |
| Note performance |




## Summary

RTT performance maintains special cause improvement since June 2025, whilst November performance is below plan by 2%; adversely impacted by a significant reduction of the total waiting list this month (-2,127) though WL validation (3.7k below plan)
76.1% of patients received either a first OPA or diagnostic test within 18 weeks of referral; exceeding the March 2026 plan trajectory (73%). This has resulted in a significant increase to the admitted waiting list. The drive to increase outpatient activity for longwaiters has also resulted in a similar increase in admitted waits for patients waiting >52 weeks. An overall increase of 74 >52ww is within process limits but above target.
The Trust was successful in eliminating waits >65 weeks except for 1 patient waiting a corneal graft.
>52 weeks for Community Health (neurodevelopmental) services is above the upper process control limit and requires intervention.

## Actions

- Bring forward plans to reduce the number of 52-week breaches by reallocating ERF funding from Q4 to Q3.
- Increase validation of the waiting list in line with the national 'validation sprint' Q3 initiative, maintaining an increase in removals >5% above baseline levels.
- Submit bid for additional national funding to reduce 52 week waits and RTT performance.
- Implement changes following recent clinic template standardisation audit to increase clinic slot capacity; due to complete in December 2025.
- Review demand management for neurodevelopmental services.
- Maintain 95% of elective activity during industrial action in December.



## Assurance & Timescale for Improvement

Planned Care Improvement Group providing oversight and weekly performance huddle in place.
Timescales:

- Elimination of all 65 week waits by end December
- Reduce variation to plan for % of waiting list >52 week waits, to 0 by end March 2026 and return to RTT performance planned trajectory by December 2025.
- Currently exceeding March 2026 target for waits for 1st activity and no known risks.
- Increase bookings for patients waiting neuro-developmental assessment.

# Elective Access - Cancer

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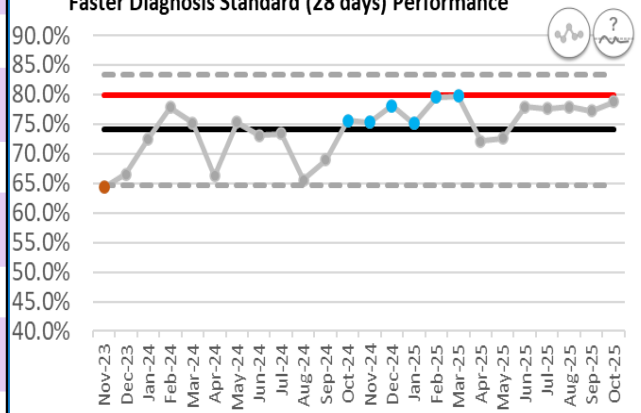
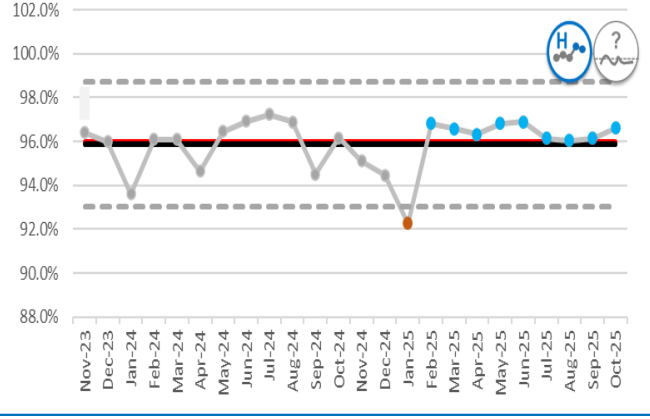
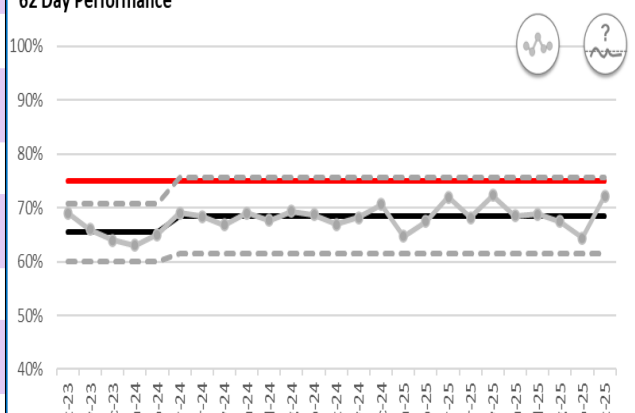
| Oct 25 | Faster Diagnosis Standard (28 days) Performance |
|---|---|
| 78.8% |  |
| **Variance/ Assurance** | |
| **Targeting (Internal)** | |
| 78.75% | |
| **Business Rule** | |
| Note performance | |



| Oct 25 | 31 Day Performance |
|---|---|
| 96.6% |  |
| **Variance/ Assurance** | |
| **Targeting (Internal)** | |
| 96.0% | |
| **Business Rule** | |
| Note performance | |



| Oct 25 | 62 Day Performance |
|---|---|
| 72.2% |  |
| **Variance/ Assurance** | |
| **Targeting (Internal)** | |
| 72.8% | |
| **Business Rule** | |
| Full CMS | |



## Summary

**FDS** Performance for Oct-25 was above the national standard (75%) and the Trust's Operational Plan (78.75%). The process is showing common cause variation, suggesting that the variation is inherent to the current system and no special cause is influencing the data. Performance was above the mean for 5 consecutive months.

**31 Day** Oct-25 performance achieved the 96.0% national standard for the ninth consecutive month, achieving 96.6%. The SPC chart indicates special cause improvement, signifying a statistically significant upward shift in the process mean and evidence of sustained improvement.

**62 Day** Oct-25 performance fell slightly short of the Trust operational plan (72.8%) and the national recovery target (75%). The SPC chart shows common cause variation, suggesting that the variation observed is inherent to the current process, however the target is within the process limits and therefore achievable.

## Actions

- **Colorectal** – clinical audit underway until Jan 26 with the cancer alliance and Colorectal nursing team to support moving to the best practice timed pathway.
- **Breast** – additional Radiology Saturday sessions to support Breast Radiologist shortages where possible.
- **Urology** – Targeted actions identified to improve the diagnostic pathway for Prostate patients who require active monitoring which will enable Urology to meet the 62D standard.
- **Skin** – an extension in Q4 of the summer insourcing plan with 18 weeks to provide additional fast track and treatment capacity.
- **Gynaecology –** treatment capacity shifting to pre 62 days following a focused reduction of the over 62 Day PTL.
- **All sites** – investment in pre-op assessment capacity to support 62D improvement.

## Assurance & Timescale for Improvement

- On track to meet the 80% target for the 28 Day Faster Diagnosis Standard by March 2026.
- A 7.6% improvement in 62D performance from September was delivered, ensuring progress towards the March 26 target.
- 9 consecutive months of achieving the 31 Day standard, with no known risks for the remainder of 2025/2026.
- The over 62 Day PTL has remained below 220 patients throughout 2025/2026 with the end of November position reporting 173 patients. A trajectory is in place by tumour site to reduce this by 50% by March 2026.

# Health Inequalities and Primary Prevention

## Diagnostic Access , RTT Under 18's waiting and Smoking Referrals

University Hospitals Dorset
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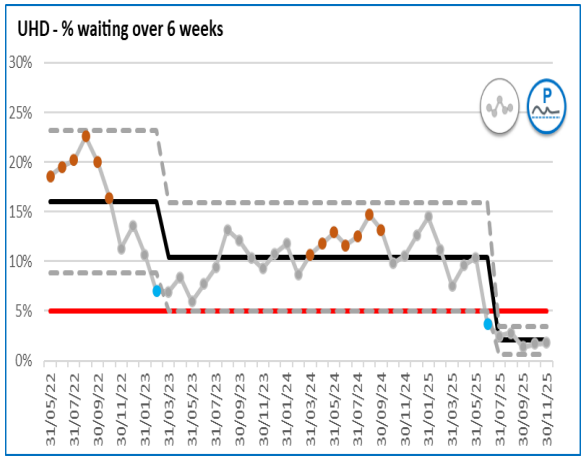
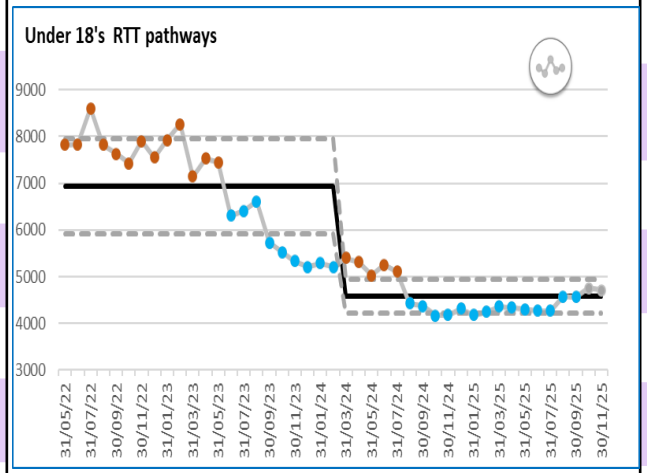
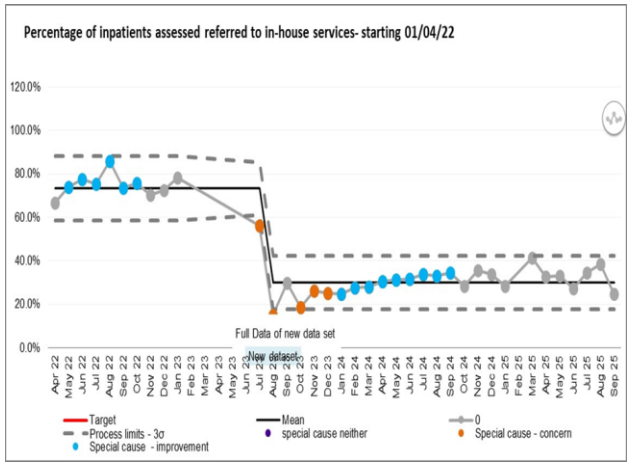
| Nov 25 |
|---|
| 1.8% |
| **Variance/ Assurance** |
| **Targeting (Internal)** |
| 5% |
| **Business Rule** |
| Note Performance |




| Nov 25 |
|---|
| 4,717 |
| **Variance/ Assurance** |
| **Targeting (Internal)** |
| **Business Rule** |




| Sep 25 |
|---|
| 24.6% |
| **Variance/ Assurance** |
| **Targeting (Internal)** |
| **Business Rule** |

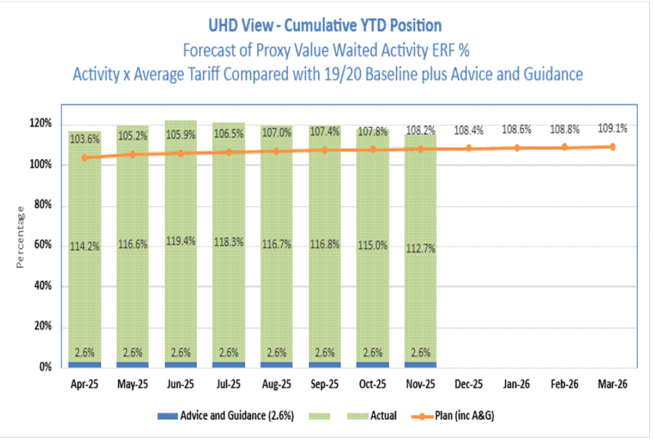



| Summary | Actions | Assurance & Timescale for Improvement |
|---|---|---|
| There is consistent achievement of the Trust DM01 (Diagnostics) target. Performance in November was just 0.8% above the national constitutional standard, with the Trust remaining closest of all Trusts in the South-West region to the national standard and in the top decile nationally.<br><br>The RTT waiting list for patients <18 yrs demonstrates common cause variation but remains within process control limits and is 0.1% above the RTT performance for all age groups.<br><br>The average weeks waiting at the point of treatment for people in IMD 1-2 (most deprived) shows a +1 week variation compared to people from IMD 3-10 in the second month of the Quarter. Children within the 20% most deprived groups, on average have 2 weeks less to wait compared to adults. This is an improvement. No variation exists in the total waiting list when analysing by ethnicity. However, children from community minority groups are waiting an average of 8 weeks. In contrast, waiting times for White British children is on average 11 weeks.<br><br>UHD Tobacco Service –The latest data remains September - referrals 390, with 76% of patients seen following referral.<br>28 Day Quit Outcomes – Sep 2025 –24.6% | Diagnostics:<br>• Increase capacity for Cystoscopy in the short term to clear backlog<br>• Continue use of 18 Weeks Support for endoscopy pending opening of the new Endoscopy build in 2026. | Recover cystoscopy >13 week breaches by end December 2025<br><br>The target for DM01 performance has been achieved for six consecutive months and now the aim is to continue with sustainable improvement below 5% for the rest of 2025/26. |

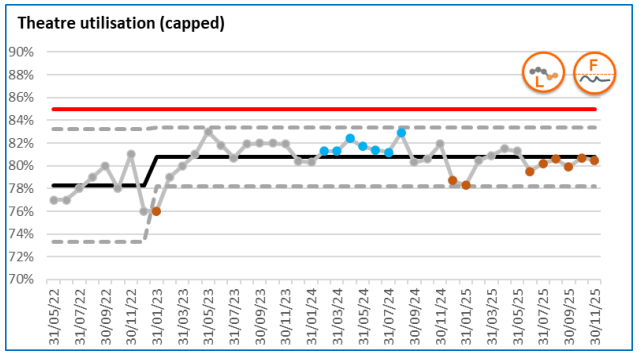
# Operational Productivity

University Hospitals Dorset
NHS Foundation Trust

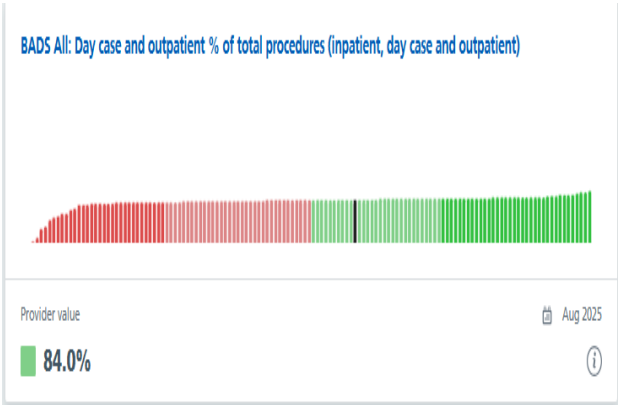
| Nov 25 |
|---|
| 115.3% YTD |
| **Variance/ Assurance** |
| **Targeting (Internal)** |
| 108.2% |
| **Business Rule** |
| Note Performance |




| Nov 25 |
|---|
| 80.5% |
| **Variance/ Assurance** |
| **Targeting (Internal)** |
| 85% |
| **Business Rule** |
| Verbal CMS |




| July 25 |
|---|
| 84% |
| **Variance/ Assurance** |
| **Targeting (Internal)** |
| **Business Rule** |




British Association of Day Case Surgery – BADS
Procedures included updated October 2025 nationally

## Summary

- Year to date 115.3% (value weighted) elective activity has been delivered compared to the 2019/20 baseline period. This is above the operational plan trajectory (108.2%).
- Capped theatre utilisation is below trajectory and the national target (85%), whilst notable improvements have been made amongst some specialities in month, overall performance reduced by 0.2%. Contributing factors:
  - Reduced utilisation impacted by cancellations: patients unfit, acute medical reasons; prioritisation of emergency cases, patient DNAs; and 15 patients no longer required the procedure
  - A business continuity incident at RBCH impacted Derwent with loss of activity and short notice movement of capacity to daycases.
  - Hospital flow and capacity challenges; appropriate bed not available or day case ward capacity prioritised for OPS/medical patients
- Daycase rates are below the 85% target at 84%, noting latest data reported is August 2025, and an improvement on July position
- The month 5 (latest nationally reported data) estimated 25/26 implied productivity growth compared to month 5 2024/25 is 4.0%, placing UHD as having the 4th highest productivity growth in the South West Region.

## Actions

Theatre improvement programme – key areas of focus:

- Reducing cancellations by specialities, particularly for pooled lists
- List profiling Elective activity and Emergency activity accurately
- Continued Clinician booking profiles under review within Head & Neck services to promote list optimisation. Notable improvement in month > 3% overall
- Gynaecology focus - accurate theatre scheduling, list management and earlier list booking
- Optimisation of pre-op assessment capacity
- Winter plan and Hospital Flow programmes in place to manage winter pressures on capacity and flow.

- All BADS procedures are being listed as day case by default to improve the data capture of procedures.
- Implementation of a single pathway for Laparoscopic hysterectomies.

## Assurance & Timescale for Improvement

The Planned Care Improvement programme provides oversight to elective activity, and Theatre Improvement and Daycase programmes.

Theatre improvement programme relaunched in September 2025 and A3 improvement plans developed for each specialty performing below the national target to affect delivery of the planned capped theatre utilisation target. Chief Operating Officer review of the programme is to take place in Q3.

Aiming to improve the BADS day case rate – Quarter 3, with a focus on reducing variation.

# Urgent and Emergency Care

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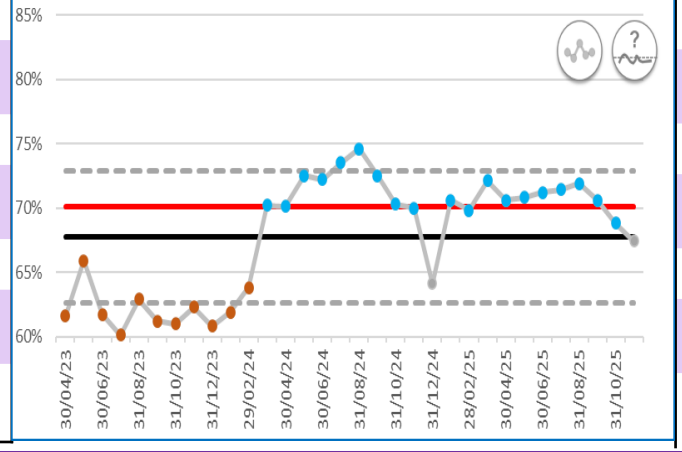
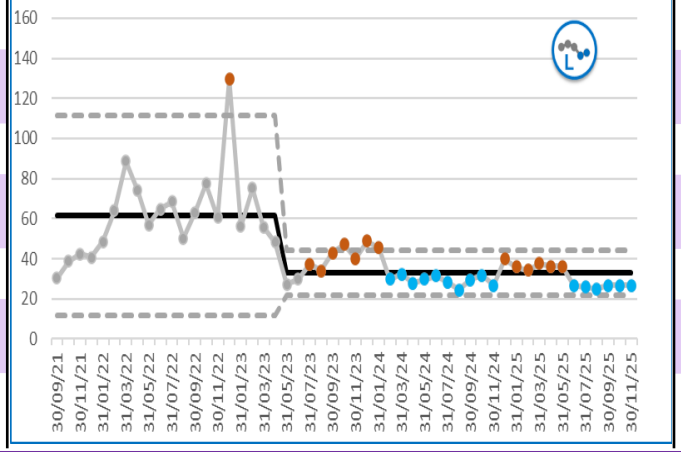
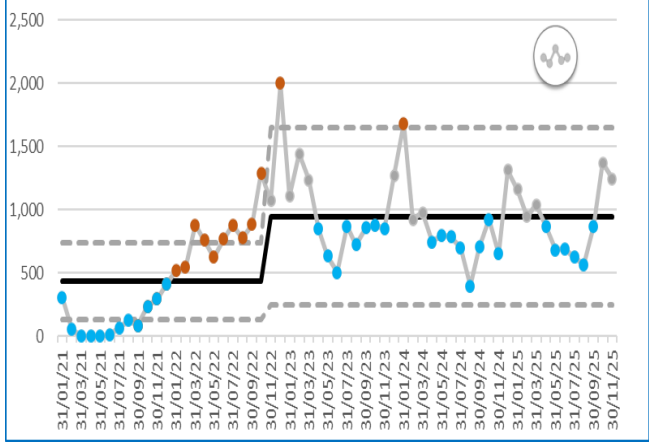
| Nov 25 | 4 hour safety standard |
|---|---|
| 67.4% |  |
| **Variance/ Assurance** | |
| **Targeting (Internal)** | |
| 68.7% | |
| **Business Rule** | |
| Note performance | |

| Nov 25 | Ambulance handovers - average handover time UHD |
|---|---|
| 26.6 minutes |  |
| **Variance/ Assurance** | |
| **Targeting (Internal)** | |
| **Business Rule** | |
| Note performance | |

| Nov 25 | Patients >12hrs in dept |
|---|---|
| 1,246 |  |
| **Variance/ Assurance** | |
| **Targeting (Internal)** | |
| **Business Rule** | |
| Verbal CMS | |

## Summary

- The Trust's position against the standard was finalised at 67.4%, failing to meet the improvement trajectory of 70.07%. The national target (78%) remains outside of process control limits, therefore will not be achieved without change or intervention to underlying processes.
- Average handover time is improving and one data points from demonstrating special cause improvement. Following the implementation of the Timely Handover Process (THP) the target falls within process limits. BH site is now below 30 mins driving further improvement to an average of 27 mins. THP however demands that the trust has sufficient occupancy to maintain outflow to avoid corridor care.
- Number of patients within the department for more than 12 hours has risen sharply with target within process limits. There is strong correlation between the bed occupancy associated with increased No Criteria to Reside (NCtR). In addition, a lack of community provision of acute mental health beds and high prevalence of patients presenting with mental health difficulties, has contributed to the increase.

## Actions

- Cultural plan continues to be progressed across the departments in parallel to improvement plans.
- Four improvement cycles scheduled for 8th Dec – SDEC, RATs, ACA and escalation focusing on process – streaming earlier in pathway, fewer hand-offs, timelier seen times.
- Executive supported bi-weekly enhanced meetings.
- Ongoing focus on NCtR recovery actions including increasing social worker provision and focus on pathway 1. System commitment to increasing P1 provision that will also benefit P2 pathway. .
- System have signed up to an improvement trajectory to deliver <110 by end of March 2026 with clear targets per pathway and responsible organisation.
- Work continues with the wider system to embed the Mental Health Action card. Meeting scheduled w/c 15th Dec 26.
- Surgical SDEC plan in progess to address reduction in starts, supported by FutureCare Porgramme.

## Assurance & Timescale for Improvement

- Revised 4-hour improvement trajectory outturning 78% compliance by March 2026.
- All driver metrics linked to underlying processes are aligned to outturn 78% by March 2026.
- Continued increase in SDEC starts through Nov 25.
- Hospital @ Home increased occupancy to 91% (6% increase vs Oct).
- Sustained improvement against ambulance handover average of 30 mins with BH site improvement driving handover time to 27 mins and achieving trajectory..
- NCtR trajectory requires 23 weekday discharges and 10 per weekend day to deliver 110 by end of April 26.
- Non-elective LOS remains below same period 25/26

University Hospitals Dorset
NHS Foundation Trust

# Our People

**Melanie Whitfield**
Chief People Officer

**Operational Leads:**
Irene Mardon- Deputy Chief People Officer

**Committees:**
People and Culture Committee

# Performance at a Glance
## Our People

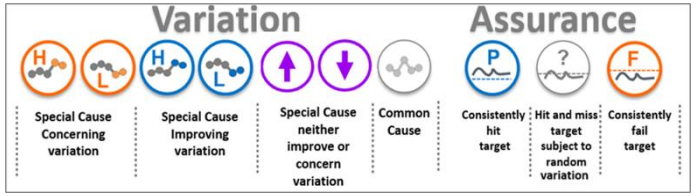
University Hospitals Dorset
NHS Foundation Trust

### UHD Workforce

| KPI | Latest month | Actual | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Vacancy Rate at end of each month | Oct 25 | 6.6% | 7.5% | | | 7.1% | 4.7% | 9.5% |
| **In Month Sickness Absence** | **Nov 25** | **5.3%** | **4.0%** | | | **4.9%** | **3.9%** | **5.9%** |
| Mandatory Training Compliance at end of each month | Nov 25 | 87.6% | 90.0% | | | 88.5% | 87.1% | 89.8% |
| Agency Pay as Proportion of Total Pay | Nov 25 | 0.7% | 3.2% | | | 3.4% | 2.2% | 4.6% |
| | | | | | | | | |

### NHS Staff Survey Results will be reported annually

- "Staff engagement score >7/10"
- "I would recommend my organisation as a place to work" > 62% by March 2024
  National Education and Training Survey overall satisfaction score



# Workforce monitoring - Actual vs plan / Vacancy Rate

University Hospitals Dorset
NHS Foundation Trust

## Operational Plan Monitoring

| Staff Type | Plan/Actual | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Substantive | Actual | 9098.1 | 9070.4 | 9085.4 | 9039.3 | 9106.2 | 9094.1 | 9145.1 | 9176.2 | | | | |
| | Plan | 9086.0 | 9099.0 | 9072.3 | 9064.3 | 9055.3 | 9095.4 | 9057.3 | 9035.0 | 9012.7 | 8990.3 | 8968.0 | 8968.0 |
| Bank | Actual | 643.3 | 647.5 | 669.5 | 678.2 | 651.2 | 627.6 | 636.0 | 672.2 | | | | |
| | Plan | 609.0 | 591.0 | 564.0 | 565.0 | 560.0 | 640.9 | 630.5 | 620.2 | 609.9 | 599.5 | 589.2 | 589.2 |
| Agency | Actual | 135.8 | 148.1 | 129.3 | 83.4 | 87.8 | 90.7 | 101.4 | 85.5 | | | | |
| | Plan | 158.0 | 135.0 | 135.0 | 136.0 | 135.0 | 139.0 | 141.0 | 146.0 | 151.0 | 144.0 | 128.0 | 116.7 |

| Staff Type | Plan/Actual | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Staff | Actual | 9877.2 | 9866.1 | 9884.2 | 9800.9 | 9845.2 | 9812.3 | 9882.5 | 9933.9 | | | | |
| | Plan | 9853.0 | 9825.0 | 9771.3 | 9765.3 | 9750.3 | 9875.3 | 9828.8 | 9801.2 | 9773.5 | 9733.9 | 9685.2 | 9673.9 |

**October 25**

6.6%

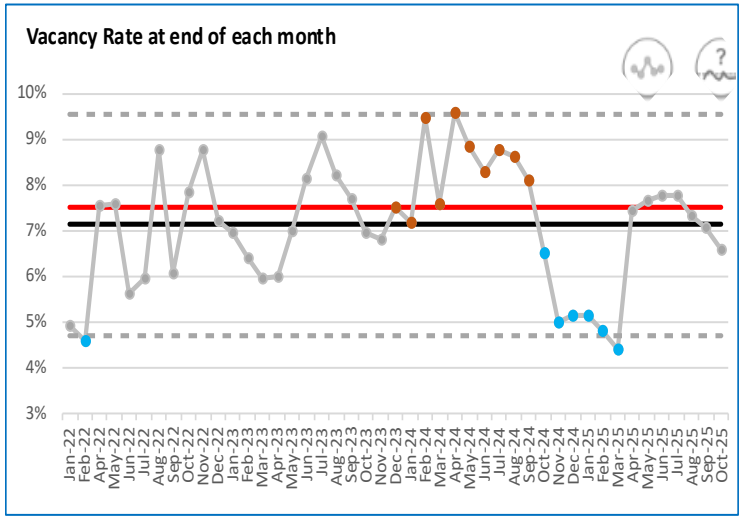
**Variance/ Assurance**

**Targeting (Internal)**

7.5%

**Business Rule**

Verbal CMS




## Summary

In M08 UHD was 132.7wte behind the total workforce in month plan: 9933.9wte usage against a plan of 9801.2wte.
Vacancy rates have reduced to 6.6%
Time to Hire continues to fall week-on-week and has reduced by 6.5 days over the last two reporting periods, now at 51.56 days against the 30-day target.
Current Workforce Controls and Vacancy Review Panel (VRP) processes are not delivering the expected impact, with limited influence on vacancy demand.
The A&C recruitment pipeline remains high, with 36.88 WTE in external recruitment, and progress against the 25/26 A&C reduction target is significantly behind plan. Only 27% (36.04 WTE) of the required reduction has been achieved with four months remaining, limiting the Trust's ability to deliver the planned workforce and financial savings trajectory.

## Actions

Continue strengthening SLAs for shortlisting and interview scheduling as further progress is constrained by slow employment-check processing. Continue to implement system-supported checks, tighten SLAs
and monitor performance against new KPIs to close the gap.
A redesign of the VRP process is underway to strengthen governance, improve the quality of submissions, and ensure the controls support tighter workforce and financial management.

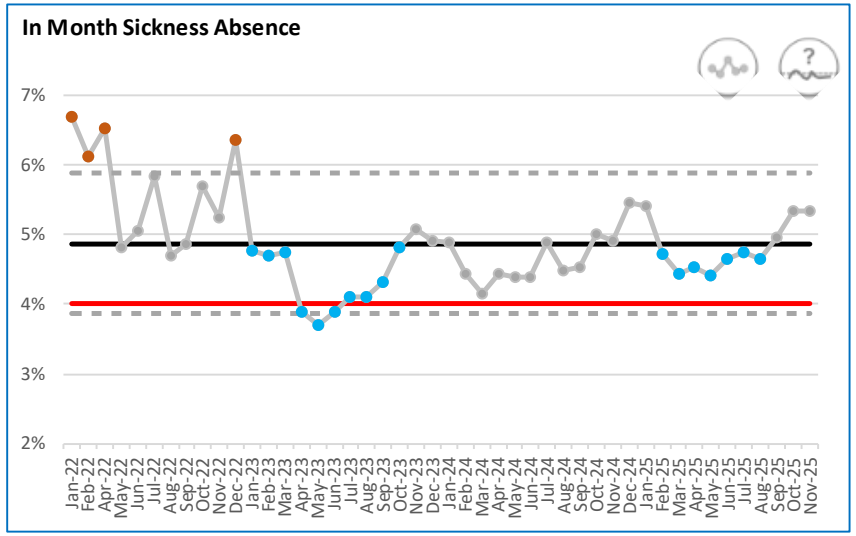
## Assurance & Timescale for Improvement

Ongoing monitoring against revised H2 trajectory.
Mapping of further workforce considerations (i.e., CDC expansion, 4.5% bank to substantive conversion for inpatient areas and recruitment against approved business cases) and impact on M12 planned v forecast position.
Regular review and updating of risks aligned to achieving 25/26 operating plan and escalations at appropriate Care Group Boards. SDR meetings and Sustainability Services Meetings

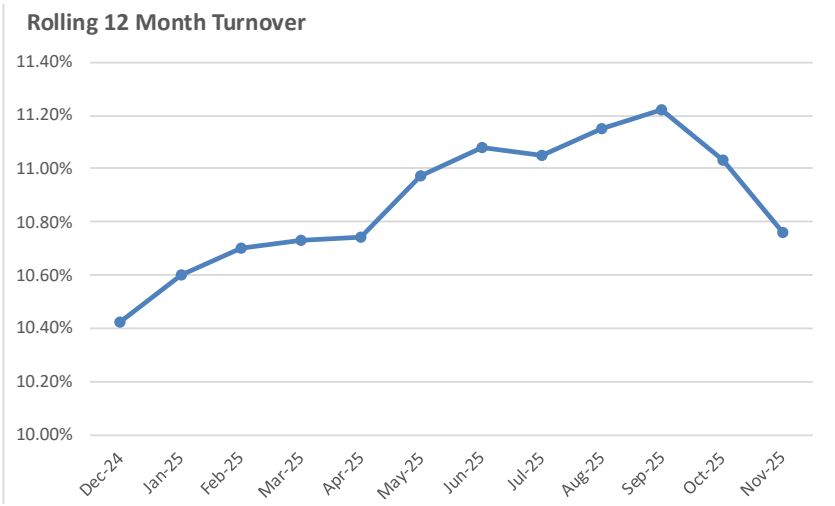
# Sickness Absence Rate / Turnover

University Hospitals Dorset
NHS Foundation Trust

| November 25 |
|---|
| 5.3% |
| **Variance/ Assurance** |
| **Targeting (Internal)** |
| 4.0% |
| **Business Rule** |
| Verbal CMS |




| November 25 |
|---|
| 10.8% |
| **Variance/ Assurance** |
| N/A |
| **Targeting (Internal)** |
| 10% |
| **Business Rule** |
| Verbal CMS |




## Summary

M08 sickness absence rate (5.3%) is higher than M08 2024 (4.9%). The top three reasons for sickness absence are anxiety/stress/depression/other psychiatric illness, back problems and other musculoskeletal problems.

Short term sickness absence equates to 3.37% of absence, with long term sickness absence (over one month) accounting for 1.96% of absence.

The Operations function had the highest percentage of sickness absence in M08 (6.89%) with the majority of absence within the estates and ancillary groups.

Fit for the Future: The 10 Year Health Plan for England sets out the target for NHS bodies to reduce sickness absence rates to 4.1%.

Rolling turnover for M08 (10.8%) is broadly in line with M08 2024 rolling rate of 10.6%.

## Actions

HR Business Partners are working in collaboration with Care Groups/Corporate/Operations functions to undertake a structured A3 'Patient First' deep dive into areas of high sickness absence. This approach will provide a clear diagnosis of underlying causes and enable the development of focused, evidence-based and prioritised action plans tailored to each service. Findings and proposed interventions will be reviewed through Care Group and corporate governance routes, with the aim of achieving a sustained reduction in sickness absence across the Trust. Relating wider factors such as good attendance management, alignment with temporary staffing rates, training and education and efficiency of processes, will also be part of a structured deep dive.

Turnover data will be further analysed to understand trends, reasons and onward employer destination.

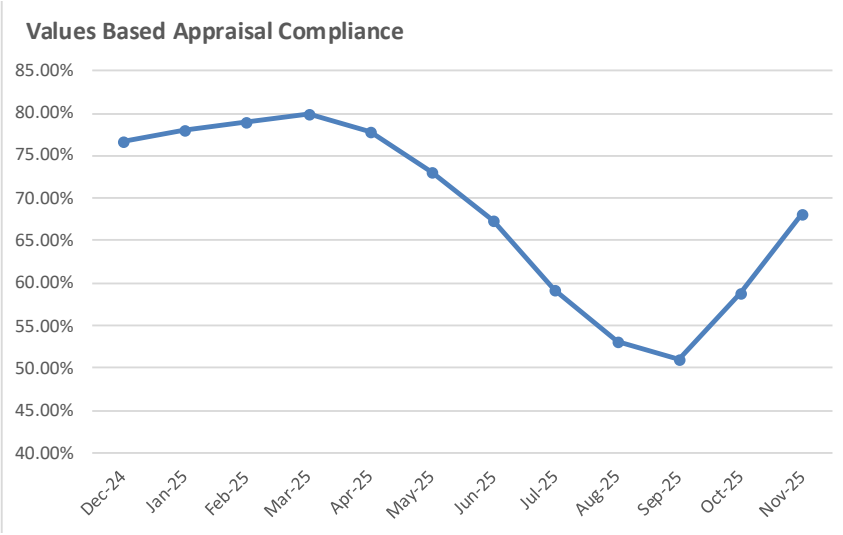
## Assurance & Timescale for Improvement

A reduction of sickness absence is not typically expected during the winter period, given the seasonal increase in flu and other related pressures. Trends will be monitored with this seasonal context in mind. A3 plans will be developed during M9 with clear plans and trajectories in place by M10.

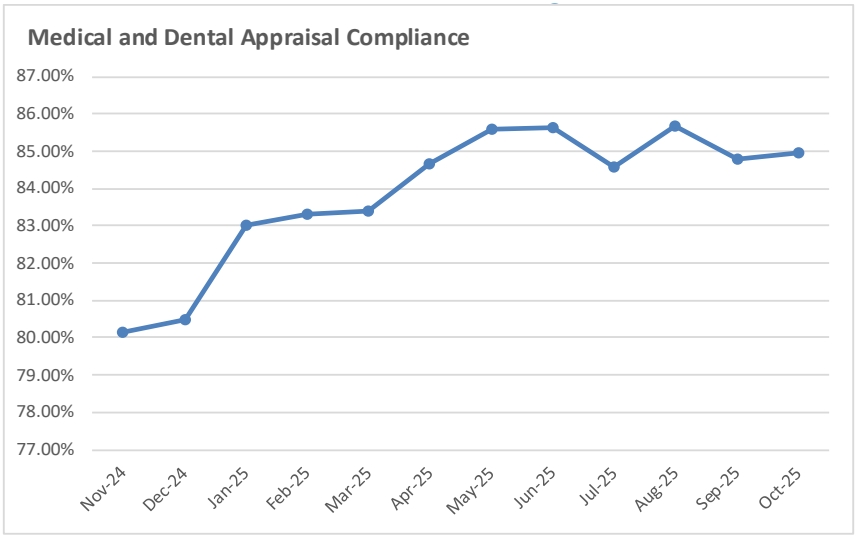
# Appraisal Rates

University Hospitals Dorset

| November 25 |
| --- |
| 68.1% |
| **Variance/Assurance** |
| N/A |
| **Targeting (Internal)** |
| 90% |
| **Business Rule** |
| Full CMS |




| November 25 |
| --- |
| 84.8% |
| **Variance/Assurance** |
| N/A |
| **Targeting (Internal)** |
| 90% |
| **Business Rule** |
| Full CMS |




| Summary | Actions | Assurance & Timescale for Improvement |
| --- | --- | --- |
| Following a period of decline, appraisal rates have been improving across September - December. As of 3.12.25 the compliance is 68.5%. We are aware that operational challenges account for low compliance in certain areas, primarily clinical teams. | All teams to ensure all staff have protected time to ensure compliance is always achieving the 90% target structured appraisal is completed.<br>Focus on values-based appraisal through a Trust-wide improvement project in 2026.<br>Appraisal essentials sessions continue to be offered monthly, with good uptake and representation from across the care groups.<br>Q4 deep dive on Staff Survey results for appraisal questions to better understand wider staff experience and make informed improvements as a result. | Q4 All trust teams to ensure improvement in levels achieving compliance rate enabling all staff to have had an appraisal.<br>Monitoring monthly compliance to enable us to be proactive and responsive in our support offer.<br>Continuing with monthly 'Appraisal Essentials' sessions and monitoring attendance.<br>Continuing to publish guidance and signposting to support in our internal comms. |

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
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
## Quality Outcomes & Safety

University Hospitals Dorset
NHS Foundation Trust

| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Patient Safety Incidents (All) per 1,000 beddays | Nov 25 | 36.90 | - | | | 37.11 | 30.65 | 43.57 |
| Patient Safety Incidents (Moderate +) per 1,000 beddays - Closed only | Nov 25 | 0.40 | - | | | 0.45 | 0.06 | 0.84 |
| Medication Incidents (All) per 1,000 beddays | Nov 25 | 4.90 | - | | | 4.98 | 3.20 | 6.77 |
| **Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays** | **Nov 25** | **0.60** | **-** | | | **0.32** | **0.05** | **0.60** |
| Inpatient Falls (Moderate +) per 1,000 beddays | Nov 25 | 0.10 | - | | | 0.16 | -0.04 | 0.37 |
| **Hospital Associated Infections - MRSA** | **Nov 25** | **2** | **-** | | | **0** | **-1** | **2** |
| Hospital Associated Infections - MSSA | Nov 25 | 3 | - | | | 4 | -1 | 9 |
| **Hospital Associated Infections - C Diff** | **Nov 25** | **10** | **-** | | | **8** | **-1** | **17** |
| **Hospital Associated Infections - E Coli** | **Nov 25** | **11** | **-** | | | **10** | **0** | **20** |
| Hospital Associated Infections - Kleb | Nov 25 | 2 | - | | | 4 | -3 | 11 |
| Hospital Associated Infections - Pseudo | Nov 25 | 6 | - | | | 2 | -2 | 5 |
| Hand Hygiene Compliance | Nov 25 | 94.8% | - | | | 96.3% | 94.3% | 98.3% |
| Infection Control Mandatory Training Compliance | Nov 25 | 89.9% | - | | | 89.5% | 88.9% | 90.1% |

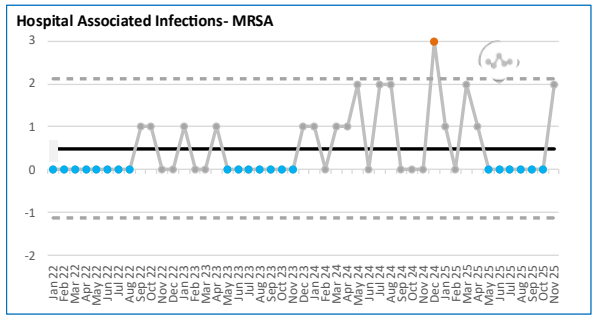
**NHS Staff Survey Results will be reported annually**

- **Improved NHS Staff Survey culture questions by 5% - raising concerns sub-score**

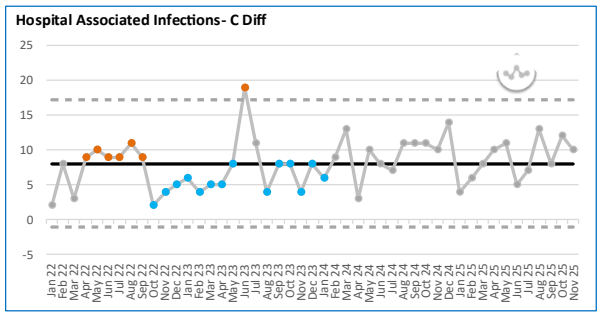
# Hospital Associated Infections

University Hospitals Dorset
NHS Foundation Trust

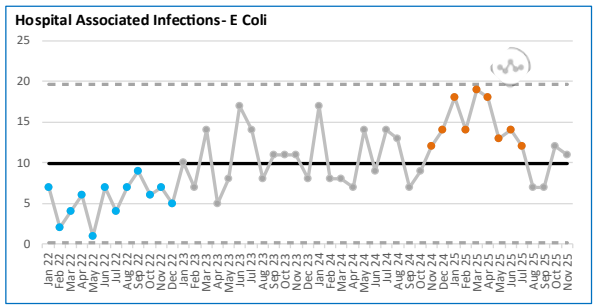
| November 25 |
|---|
| 2 |
| Variance/ Assurance |
| |
| Targeting (Internal) |
| - |
| Business Rule |
| N/A |




| November 25 |
|---|
| 8 |
| Variance /Assurance |
| |
| Targeting (Internal) |
| - |
| Business Rule |
| N/A |




| November 25 |
|---|
| 6 |
| Variance /Assurance |
| |
| Targeting (Internal) |
| - |
| Business Rule |
| N/A |




## Summary

November 2025:
Hospital associated MRSA bacteraemia – 2
Hospital associated MSSA bacteraemia – 3
*Clostridiodes difficile* hospital associated cases - 10
*Escherichia coli* bacteraemia cases – 11
*Klebsiella* cases – 2
*Pseudomonas* cases – 6
COVID-19 outbreaks – 1 (1 Bay closed)

## Actions

Decolonisation protocol for Neonates under review following x1 case in November
Neonatal unit supported with education and HH improvements
Review of IPC infection matrix for supporting clinical decision making at ward and site team level
Ongoing ward Hand Hygiene audits
PSIRF review for MRSA bacteraemia in Neonate
MSSA cases under investigation – initial review likely linked to peripheral lines.
Gram-negative bacteraemia – ongoing reviews in progress

## Assurance & Timescale for Improvement

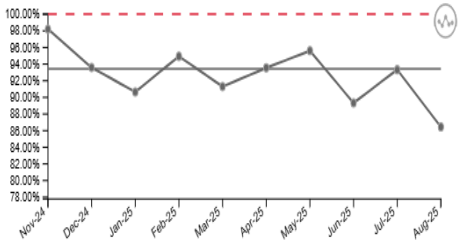
Respiratory panel LFD testing in ED has made a difference in admission prevention of sub-acute patients. Currently in use in admission units.
Monitoring of Influenza and respiratory infections ongoing
Learning shared at the monthly care group IPC meetings.
IPC team have developed an IPC resource pack currently on pilot in T&O.
Catheter improvement programme addressing catheter insertion and ongoing care.

# eMortality Consultant Review Compliance
# HSMR < 100

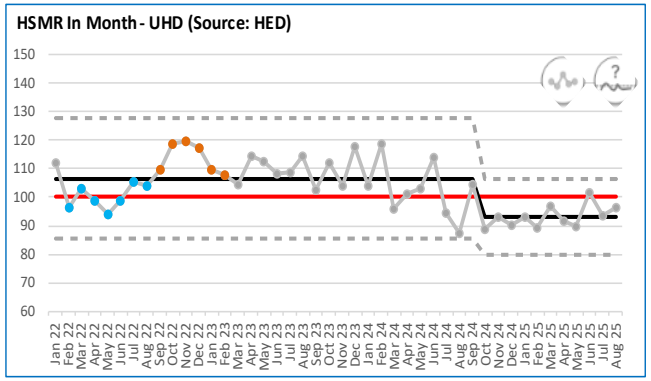
University Hospitals Dorset
NHS Foundation Trust

| August 25 |
|---|
| 86.4% |
| Variance/ Assurance |
| Targeting (Internal) |
| 100% |
| Business Rule |
| Full CMS |

Mortality Reviews

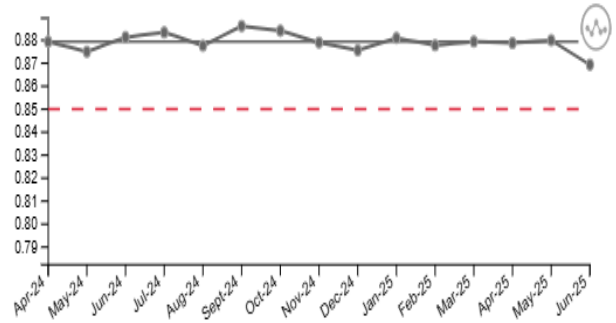



| August 25 |
|---|
| 96.5 |
| Variance /Assurance |
| Targeting (Internal) |
| 100 |
| Business Rule |
| N/A |




| June 25 |
|---|
| 0.87 |
| Variance /Assurance |
| Targeting (Internal) |
| 1 |
| Business Rule |
| Verbal CMS |

SHMI – Summary Hospital Level Mortality Indicator

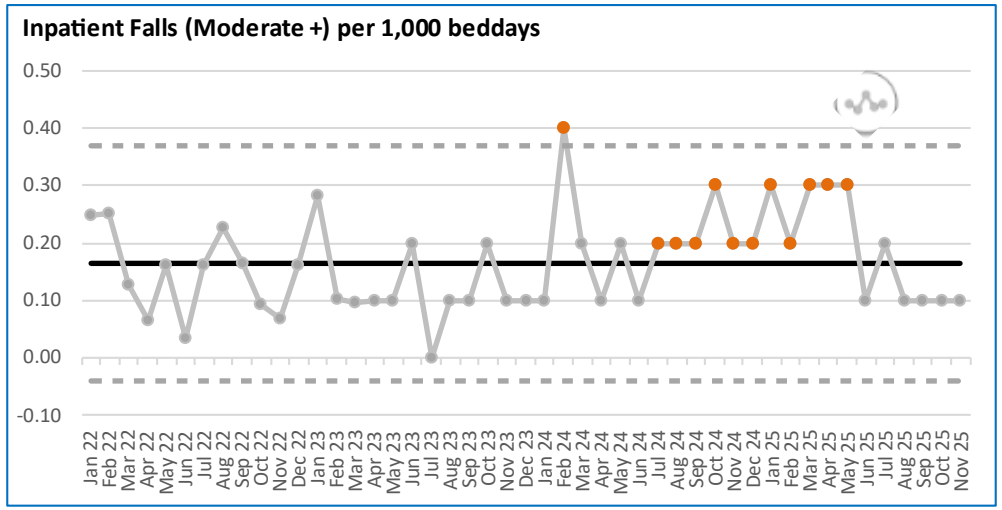



| Summary | Actions | Assurance & Timescale for Improvement |
|---|---|---|
| E-Mortality review compliance remains below target at 86.4% | Continued education and engagement of consultants<br>Working to ensure that the reviews are completed by the most appropriate team for learning e.g. ITU<br>Ongoing issues around identifying the correct consultant delay reviews. | Significant improvement noted already, particularly in medicine. Barriers to surgical teams are being worked through with good effect by working with individuals with lower compliance |
| HSMR in month remains within range. Regularly below target of 100 since October 2024 with expected variation. In month HSMR for August 2025 has remained below 100 and within expected variation.<br>SHMI remains below target and stable at 0.87. | Audit of mortality coding in progress to review codes and accuracy.<br>HED alerts reviewed through newly developed standardised process to ensure any concerns are identified.<br>A continued upward trend in HSMR in month will warrant further review. | UHD is in the top 15 trusts of the 119 trusts included in the SHMI reporting. |

# Patient Safety – Falls

University Hospitals Dorset
NHS Foundation Trust

| November 2025 |
|---|
| 0.10 |
| Variance/ Assurance |
| |
| Targeting (Interna) |
| - |
| Business Rule |
| N/A |




## Summary

Statistical process control remains within expected variation. In November 2025, the overall inpatient falls rate was **6.3 per 1,000 bed days, which is within expected limits.**

**Three inpatient falls** resulted in moderate or greater physical harm, equating to **0.1 per 1,000 bed days - within expected variation**.

**Nine falls** (4%) were initially classified as moderate harm or above but were later **downgraded** following SWARM review or negative scan results.

**94% of all falls were recorded as Low or No Harm,** while 4% were submitted without a harm level—predominantly during afternoo

## Actions

**PSIRF Learning:** SWARM reviews completed for all falls incidents causing moderate or greater harm; no new Trust-wide learning identified. LERNs remain pending Matron sign-off and final Duty of Candour completion.
**Falls Steering Group meeting:** December not quorate due to care group-wide attendance. Monthly meetings have been forward-scheduled from January 2026 to re-establish the new structure.
**Falls Policy Review:** UHD Falls Policy and SOPs on lying and standing BP and Red WZF are under review for approval by the Falls Steering Group before submission to PPG.
**L&S BP:** eObs functionality to record lying and standing BP readings in line with RCP guidelines is nearly complete. Teaching materials on conservative management of postural hypotension are currently being drafted.

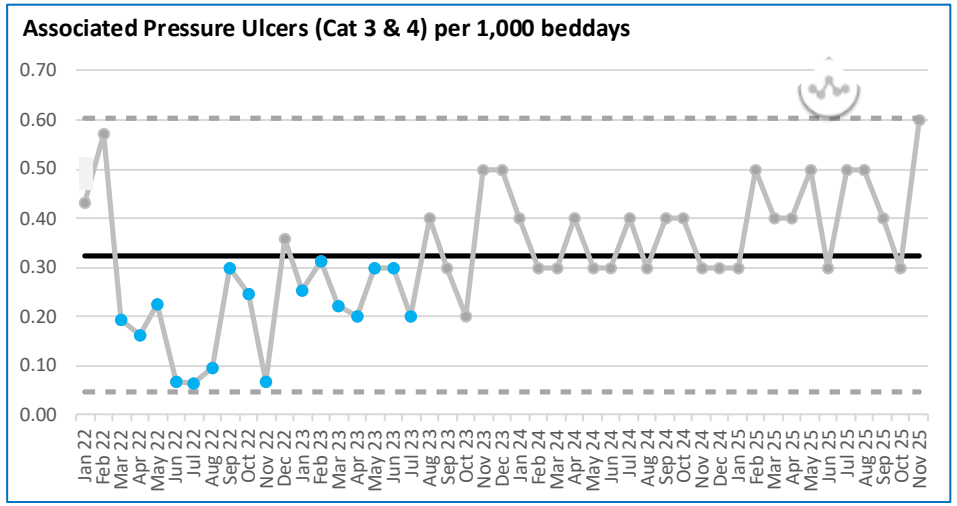
## Assurance & Timescale for Improvement

- **Falls Steering Group:** Monthly meetings scheduled from January 2026 to embed new structure.
- **Assessment Redesign:** Falls and Safer Activity assessments in PDSA planning stage; small-scale implementation targeted for March–April 2026.
- **Digital Integration:** eObs functionality for lying/standing BP recording to launch February 2026, aligned with Safer Activity work.
- **Footwear Initiative:** Promotion of patients' own footwear during February 2026 Safer Activity launch to reduce reliance on non-slip socks.
- **Walking Aid Access:** Improvements currently on hold.
- **Post-Fall Response:** Updated Grab Pack including post-fall debrief/huddle launching January 2026.

# Patient Safety – Pressures Ulcers

University Hospitals Dorset
NHS Foundation Trust

| November 2025 |
|---|
| 0.60 |
| Variance/ Assurance |
| |
| Targeting (Internal) |
| |
| Business Rule |
| N/A |




## Summary

Statistical process control remains within usual variation during November 2025.

- Category 3: 17 patients acquired 17 pressure ulcers
- Category 4: 0 patients acquired a Category 4

This equates to a rate of 0.6 per 1,000 bed days.

## Actions

- The Trustwide aSSKINg bundle has been rolled out across the Medical Care Group with plans to implement this within Surgical Care Group in January 2026.
- A total of 160 Registered Nurses have attended face to face pressure ulcer prevention training during 2025,
- The Skin Integrity Group will launch the 'Be a Zero Hero' campaign in January 2026 as part of Fundamentals of care (relating to zero pressure for pressure ulcer prevention)
- Ward walk rounds have been conducted to launch the Moisture or Pressure differential diagnosis tool (RBH)
- Dome booked for information day on 27th January 2026
- Standard Operating Procedure for investigation of hospital acquired pressure damage at final stages of development and review

## Assurance & Timescale for Improvement

Learning response significant harms

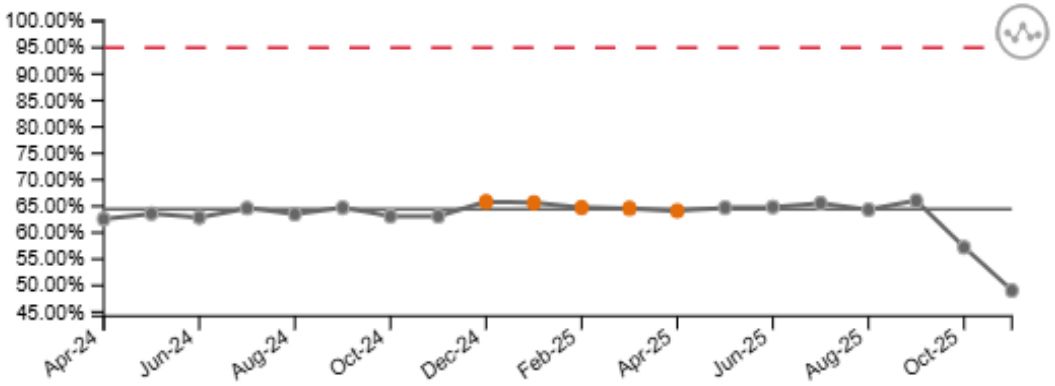
- Incidents where patients have acquired Category 4 pressure damage have been escalated for further investigation by way of an After Action Review
- Incidents of significant harm (Category 3) will be reviewed by way of a Multi-disciplinary Team Meeting to review case and ensure learning is shared

# Patient Safety – VTE Prophylaxis

University Hospitals Dorset
NHS Foundation Trust

| November 2025 |
|---|
| 49.1% |
| **Variance/ Assurance** |
| |
| **Targeting (Internal)** |
| 95% |
| **Business Rule** |
| Full CMS |

VTE Prophylaxis Prescribing Compliance




## Summary

- VTE risk assessment is mandated in EPMA and Trust achieves national mandated target of 95% however there is no electronic mandation 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

## 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
- Developing Patient Information Videos
- Training update Videos for staff
- Raised on RISK register
- VTE on SDR reporting with actions for improvement.
- TG attend Specialty Governance groups

## Assurance & Timescale for Improvement

- RCA reporting of all hospital acquired thrombosis
- Reporting into thrombosis group
- PSIRF
- VTE Thematic review to begin

University Hospitals Dorset
NHS Foundation Trust

# Perinatal Quality Surveillance

## Maternity and Neonatal Dashboard

| | Provider | UHD | | | |
|---|---|---|---|---|---|
| MetricName | Latest Date | Value | Target | Variation | Assurance |
| No. of women delivered (all births) | Oct 25 | 333 | | | |
| No. women delivered (unregistrable baby/babies only) | Oct 25 | 8 | | | |
| Number of women delivered (multiple births where at least one unregistrable and one registrable) | Oct 25 | 0 | | | |
| Number of babies born | Oct 25 | 342 | | | |
| No. of registrable babies born | Oct 25 | 334 | | | |
| Total number of bookings | Oct 25 | 366 | | | |
| % bookings completed <10 weeks gestation | Oct 25 | 79.2% | 65% | | |
| % of women on continuity of carer pathway by 29 weeks' gestation | Oct 25 | 6.27% | | | |
| % of Black and Asian women on continuity of carer pathway by 28 weeks' gestation | Oct 25 | 81.8% | | | |
| % of women (IMD-1) placed on a continuity of carer pathway | Oct 25 | 0% | | | |
| % of babies receiving breast milk at first feed | Oct 25 | 81.4% | 72% | | |
| % babies receiving breast milk at discharge from midwifery care to HV/GP (10 - 28 days PN) | Oct 25 | 74.4% | | | |

### 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 ,10 weeks
- Avoidable term admissions to Neonatal unit **ATAIN** slight increase noted this month

### Key Areas of Focus

- **Workforce –sickness** rates and staff morale
- Readmitted babies to hospital within the first 30 days of life- well-being clinic now commenced in November
- Apgar score less than 7 at 5 minutes
- Babies below 34 week's gestation who have their umbilical cord clamped on or after one minute of birth

# Perinatal Quality Surveillance

## Maternity and Neonatal Dashboard

| MetricName | Provider Latest Date | UHD Value | Target | Variation | Assurance |
|---|---|---|---|---|---|
| Maternal death - number of deaths of women during or up to 1 year following the end of pregnancy (irrespective of place/circumstances of death) | Nov 25 | 0 | | | |
| Number of women admitted to ITU associated with birth up to 28 days post-natal (any birth, not including any other trust birth) | Nov 25 | 0 | | | |
| % of term babies admitted to NNU | Nov 25 | 5.78% | 5% | | |
| % of babies <3rd birthweight centile, born >37+6 weeks | Nov 25 | 20% | | | |
| No. of Hypoxic-Ischemic Encephalopathy (HIE) incidents | Nov 25 | 0 | | | |
| % of babies born < 32 weeks gest. age with Germinal matrix/ intraventricular haemorr. / Post haemorr. Vent. Dil. / Cystic peri. leuk. | Nov 25 | 0% | | | |
| Rate per 1,000 babies born at term with an Apgar score <7 at 5 minutes (CQIMApgar) | Nov 25 | 20.1 | 13 | | |
| No. of still births per month | Nov 25 | 0 | | | |
| No. of neonatal deaths < 28 Days | Nov 25 | 1 | | | |
| Annual rate of stillbirths per 1,000 births - rolling 12mths | Nov 25 | 4.01 | 2.5 | | |
| Rate per 1,000 of live birth babies who died within 28 days of birth - rolling 12mths | Nov 25 | 3.20 | | | |

# Perinatal Quality Surveillance

## Maternity and Neonatal Dashboard

| MetricName | Provider Latest Date | UHD Value | UHD Target | UHD Variation | UHD Assurance |
|---|---|---|---|---|---|
| % of babies who died below 32 weeks gestation, or 44 weeks post-menstrual age (whichever occurs sooner)(rolling 12-month period) | Nov 25 | 10% | | | |
| % infants born outside of a NICU: singleton 27 weeks' gestation or multiples <28 weeks' gestation or birthweight <800g any gestation | Nov 25 | 0% | | | |
| % babies born <34 weeks' gestation who receive full course of AN steroids within 1 week of birth | Nov 25 | 36.6% | 55% | | |
| % of babies born before 30 weeks' gestation who receive magnesium sulphate within the 24 hours prior to birth | Nov 25 | 75% | 90% | | |
| % of babies born below 34 weeks' gestation who have their umbilical cord clamped at or after on minute after birth | Nov 25 | 66.7% | 75% | | |
| % of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5-37.5oC and measured within one hour of birth | Nov 25 | 79.6% | 80% | | |
| % of babies born below 34 weeks of gestation who receive their own mother?s milk in the first 2 days of life | Nov 25 | 53.8% | 60% | | |
| % of women smoking at booking | Nov 25 | 7.51% | | | |
| % of women smoking at delivery (previous month) | Nov 25 | 5.41% | 6% | | |
| % of women with a CO measurement at time of booking | Nov 25 | 96.5% | 95% | | |
| % of women with a CO measurement at time of 36 weeks' gestation | Nov 25 | 93.9% | 95% | | |
| Midwifery sickness rate (% FTE days absent) | Nov 25 | 8.39% | 3% | | |
| Midwifery turnover - % midwives leaving (rolling 12-month period) | Nov 25 | 8.14% | | | |
| Midwife vacancy rate | Nov 25 | 2.78% | | | |

# Maternity and Neonatal Care

University Hospitals Dorset
NHS Foundation Trust

| CQC Maternity Ratings UHD Assessment 2019 and Oct 2022. | OVERALL | SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL LED |
|---|---|---|---|---|---|---|
| | Inadequate | Inadequate | GOOD | OUTSTANDING | OUTSTANDING | Inadequate |

## 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 Maternity Safety Self -Assessment and Ockendon 1 requirements**
- **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 | Matters for Board information and awareness | Progress in achievement of maternity improvement plan |
|---|---|---|
| **MBRRACE reportable cases:**<br><br>There was one neonatal death in November which was reportable to MBRRACE and will follow the PMRT process.<br><br>**MNSI**<br><br>There were no new MNSI cases in October 2025 and no ongoing or outstanding MNSI cases. | **Patient Safety Incident Response Framework** (PSIRF) has been implemented in maternity.<br><br>In November there was no new incidents requiring escalation through PSIRF.<br><br>Ongoing After -action review<br><br>L159852- 6.2 L Major Obstetric Hemorrhage (MOH) following a Cat 2 EMCS (Emergency caesarean section) and Hysterectomy in theatre, then transfer to ITU.<br>After Action Review (AAR) carried out by the Patient safety team in October. Feedback and questions have been received from the patient and her partner. Currently graded as 'Moderate physical harm' pending review.<br><br>**Top incidences LFPSE:**<br><br>• Term admission to NICU 3.9%<br>• PPH –27.7 per 1000<br>• Insufficient number of healthcare professionals<br><br>**Safety champions reviews this month:**<br><br>• Monthly safety champions report | CQC action plan -<br>**Advise**<br>Recent inspection in September – Awaiting draft report – initial recommendations action plan in place for baby abduction/security and safe staffing rosters.<br><br>Maternity incentive scheme year 7 -<br>Release of year 7 in April. Standards increased –assurance processes continue ICB mid-point assessment –on target to achieve MIS .<br><br>Insight and 3-year delivery plan -<br>**Assure**<br>Actions for year 3 in place progress being made<br><br>2024 CQC Maternity Survey results published, and the results show continuing improvement since 2022. 2025 survey expected in December.<br><br>Staff survey shown overall staff satisfaction -action plan in place for each area to individualize the improvements in 2025.<br>Staff survey for 2025 closed end of November –good maternity response rate<br><br>Culture improvement plan – Focus on behaviour charter work underway with perinatal leadership team in updating plan for 2025/2026 |

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 | Nov 25 | 94.1% | - | | | 92.5% | 90.2% | 94.8% |
| Complaints Received | Nov 25 | 82 | - | | | 70 | 35 | 105 |
| Mixed Sex Accommodation Breaches | Nov 25 | 0 | - | | | 7 | -11 | 25 |

**Survey Results will be reported annually**

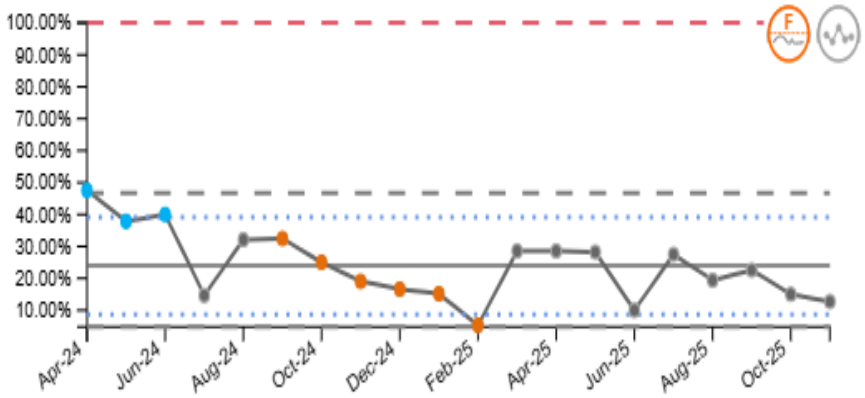
- To increase Have Your Say Survey feedback rates by 30%
- 5% improvement in employees who see patient care as a top priority for UHD

# Patient Experience

University Hospitals Dorset
NHS Foundation Trust

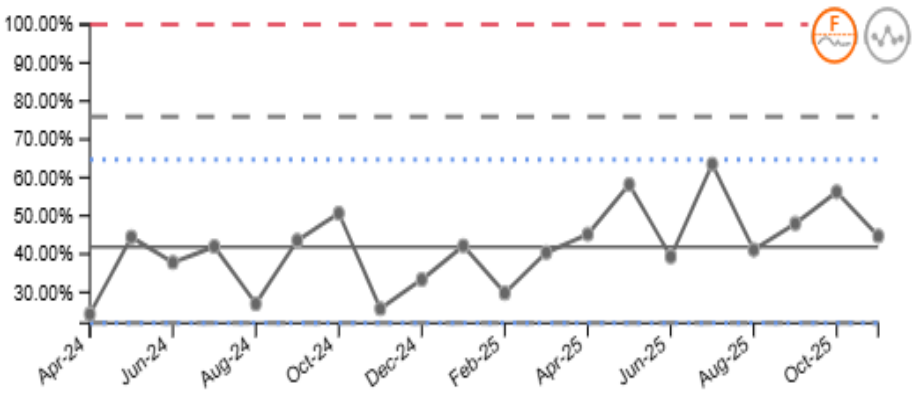
| November 25 |
|---|
| 12.8% |
| Variance/ Assurance |
| F |
| Targeting (Internal) |
| 100% |
| Business Rule |
| Verbal CMS |

% of Early Resolutions closed within 10 days



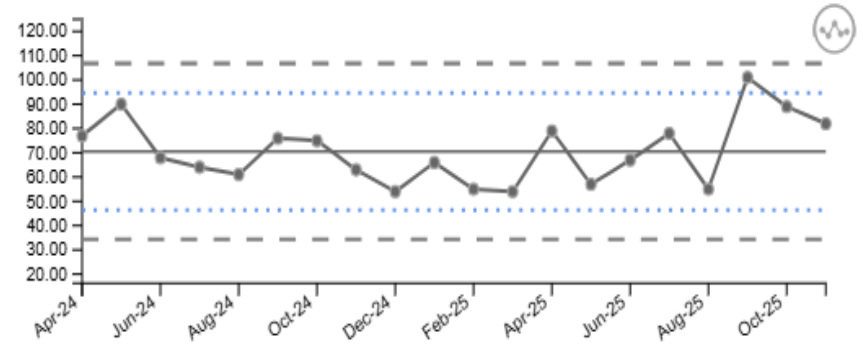

| November 25 |
|---|
| 44.7% |
| Variance/ Assurance |
| F |
| Targeting (Internal) |
| 100% |
| Business Rule |
| Full CMS |

% of total complaints closed within 35 days



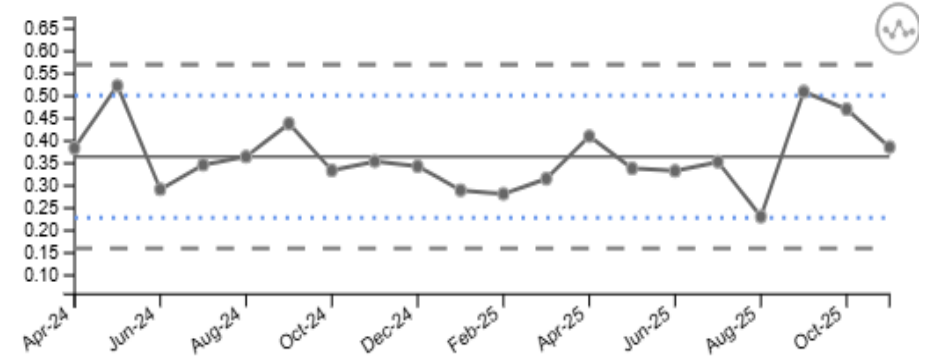

| November 25 |
|---|
| 82 |
| Variance/ Assurance |
| Targeting (Internal) |
| - |
| Business Rule |
| Note Performance |

Number of complaints received




| November 25 |
|---|
| 0.39 |
| Variance/ Assurance |
| Targeting (Internal) |
| - |
| Business Rule |
| Verbal CMS |

Number of complaints per 1000 contacts for clinical services




| Summary | Actions | Assurance & Timescale for Improvement |
|---|---|---|
| PALS concerns received = 463<br>Formal complaints = 41<br>Early Resolution Complaints = 41<br>Average Complaint response time = 33.72 days | Decrease in number of PALS concerns logged in month due to sickness absences in the team.<br>Focus on reducing complaint response timescales continues | Complaints manager continues to meet weekly with the care groups to discuss the open complaints and any assistance needed to progress them. |

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 | Forecast Outturn Plan | Forecast Outturn Actual | Forecast Outturn Variance |
|---|---|---|---|---|---|---|---|---|---|---|
| Revenue Control Total | Nov-25 | 1,324 | 1,347 | 23 | (6,453) | (6,425) | 28 | 0 | (13,605) | (13,605) |
| Capital Control Total | Nov-25 | 13,203 | 11,435 | 1,768 | 103,582 | 83,886 | 19,696 | 180,441 | 180,441 | 0 |
| Efficiency Programme | Nov-25 | 6,936 | 4,329 | (2,607) | 39,270 | 38,707 | (563) | 69,625 | 53,613 | (16,012) |
| Cash Balance | Nov-25 | 66,591 | 73,602 | 7,011 | 66,591 | 73,602 | 7,011 | 74,976 | 74,976 | 0 |
| Better Payment Practice Code | Nov-25 | 95.0% | 96.7% | 1.7% | 95.0% | 95.2% | 0.2% | 95.0% | 95.0% | 0.0% |

# Efficiency Improvement Programme

University Hospitals Dorset
NHS Foundation Trust

| November 25 |
|---|
| 77% |
| **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 | (5,625) | 2,850 | (2,776) | (8,551) | 4,428 | (4,123) | 52% | 4,760 | 56% | 1,858 | 2,405 | (4,288) | 50% |
| Medical | (8,064) | 6,411 | (1,653) | (12,524) | 9,324 | (3,200) | 74% | 9,836 | 79% | 5,887 | 1,487 | (5,150) | 59% |
| WCCSS | (7,507) | 5,270 | (2,237) | (11,318) | 8,267 | (3,051) | 73% | 8,576 | 76% | 5,169 | 459 | (5,690) | 50% |
| Operations | (1,282) | 2,856 | 1,574 | (1,875) | 3,413 | 1,538 | 182% | 3,447 | 184% | 1,153 | 142 | (580) | 69% |
| Corporate | (2,615) | 4,405 | 1,790 | (3,875) | 5,841 | 1,966 | 151% | 5,888 | 152% | 3,144 | 254 | (477) | 88% |
| Trust Wide | (11,515) | 16,275 | 4,760 | (23,497) | 21,701 | (1,796) | 92% | 21,764 | 93% | 8,577 | 322 | (14,598) | 38% |
| Dorset wide schemes | (2,662) | 640 | (2,022) | (7,986) | 640 | (7,346) | 8% | 640 | 8% | 0 | 0 | (7,986) | 0% |
| **UHD** | **(39,270)** | **38,707** | **(564)** | **(69,625)** | **53,613** | **(16,012)** | **77%** | **54,911** | **79%** | **25,787** | **5,069** | **(38,769)** | **44%** |

## Summary

Efficiency improvement delivery to the end of November is £0.6 million behind plan. The trust has identified savings opportunities of £54.9 million, however when adjusted to reflect the risk of delivery in year, this is reduced to £53.6 million. Whilst this representing an improvement in month of £0.7 million; it remains £16.0 million short of the full year savings requirement.

## Actions

Further enhancing of local controls following a detailed review of the national 'grip and control' checklist in September has, and will continue to support improvements in this forecast. NHS England undertook a deep dive into our efficiency programme in October, to provide additional external assurance and to learn from the output of similar reviews undertaken elsewhere in the South West. We expect to receive full feedback from NHS England in December.

## 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.

# Financial Management – YTD Variance to budget

University Hospitals Dorset
NHS Foundation Trust

| November 25 |
|---|
| (£13,605) |
| **Variance/ Assurance** |
| F |
| **Targeting (Internal)** |
| £0 |
| **Business Rule** |
| Full CMS |

| Summary I&E | Year to date | | | Unmitigated Forecast | | |
|---|---|---|---|---|---|---|
| | Budget | Actual | Variance | Budget | Forecast | Variance |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Patient Care Income | 559,357 | 565,378 | 6,021 | 836,927 | 845,949 | 9,022 |
| Other Operating Income | 36,700 | 38,021 | 1,321 | 54,428 | 58,221 | 3,792 |
| Charitable Income | 2,496 | 2,214 | (282) | 3,488 | 3,224 | (264) |
| **Total Income** | **598,552** | **605,613** | **7,060** | **894,843** | **907,393** | **12,550** |
| Employee expenses | (401,992) | (402,283) | (292) | (600,908) | (606,747) | (5,839) |
| Clinical supplies expenses | (48,136) | (49,726) | (1,590) | (71,991) | (73,670) | (1,679) |
| Drugs expenses | (59,919) | (60,795) | (876) | (88,575) | (88,884) | (310) |
| Purchase of healthcare and social care | (9,958) | (14,271) | (4,313) | (13,547) | (19,925) | (6,378) |
| Depreciation and amortisation expense | (23,700) | (23,955) | (255) | (36,005) | (36,005) | (0) |
| Clinical negligence expense | (12,599) | (12,488) | 111 | (18,898) | (18,059) | 839 |
| Premises & fixed plant | (22,428) | (21,605) | 823 | (34,378) | (33,305) | 1,073 |
| Other operating expenses | (18,514) | (25,739) | (7,225) | (105,636) | (81,974) | 23,662 |
| **Operating Expenses** | **(597,245)** | **(610,861)** | **(13,616)** | **(969,937)** | **(958,569)** | **11,368** |
| Net finance costs | (8,735) | (8,569) | 167 | (11,603) | (11,140) | 463 |
| Other adj to control total basis | 975 | 7,392 | 6,417 | 86,698 | 48,712 | (37,986) |
| **Control Total Surplus/ (Deficit)** | **(6,453)** | **(6,425)** | **28** | **0** | **(13,605)** | **(13,605)** |

| November 25 |
|---|
| £180,194 |
| **Variance/ Assurance** |
| P |
| **Targeting (Internal)** |
| £180,194 |
| **Business Rule** |
| Verbal Update |

| Capital | Year to date | | | Forecast | | |
|---|---|---|---|---|---|---|
| | Budget | Actual | Variance | Budget | Actual | Variance |
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Estate Schemes | 12,586 | 6,975 | 5,611 | 19,139 | 19,139 | 0 |
| IT Schemes | 5,689 | 5,468 | 221 | 10,844 | 10,844 | 0 |
| Medical Equipment | 3,336 | 479 | 2,857 | 6,053 | 6,053 | 0 |
| **Total Operational CDEL** | **21,611** | **12,922** | **8,689** | **36,036** | **36,036** | **0** |
| **Total Donated Assets** | **1,098** | **1,098** | **0** | **1,540** | **1,540** | **0** |
| DDP - Digital Pathology | 203 | 203 | 0 | 203 | 203 | 0 |
| ELR - Elective Recovery | 86 | 90 | (4) | 1,891 | 1,891 | 0 |
| EPR - Front Line Digitisation | 876 | 339 | 537 | 2,784 | 2,784 | 0 |
| NHP - FBCa / Enabling / FBCB | 10,397 | 10,234 | 163 | 33,498 | 33,498 | 0 |
| NHP - NHP - FBCA & Enabling Works | 9,028 | 9,028 | 0 | 30,327 | 30,327 | 0 |
| NHP - NHP - FBCB | 1,369 | 1,206 | 163 | 3,171 | 3,171 | 0 |
| SOL - Renewables - Solar Partnership Schem | 14,818 | 8,425 | 6,393 | 21,141 | 21,141 | 0 |
| STPW1 - Beach & PH Theatres (ESL & C2) | 0 | 0 | 0 | 0 | 0 | 0 |
| UEC - Urgent Emergency Care | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total Central PDC** | **80,873** | **69,866** | **11,007** | **142,618** | **142,618** | **0** |
| **UHD Capital Total** | **103,582** | **83,886** | **19,696** | **180,194** | **180,194** | **0** |

## Summary

**I&E :** The Trust reported deficit is £6.4 million at Month 8, £28,000 better than plan. However, the unmitigated forecast is a deficit of £13.6 million.
The Trust now has a detailed plan to recover the year-to-date deficit and deliver within the full year budget – noting the risk to delivery posed by the significant operational pressures the trust is currently experiencing.
**Capital :** The Trust reported capital expenditure of £83.9 million, being £19.7 million lower than plan year to date. We are forecasting delivery of the programme within the funding envelope but there remains risk within this, due to the agreed purchase of Wessex fields having put pressure on the local CDEL.

## Actions

**I&E :** The plan requires acceleration of identified efficiency schemes currently expected to deliver in 2026/27, a further tightening of workforce controls including considerable reduction in bank expenditure, together with a range of smaller mitigations.

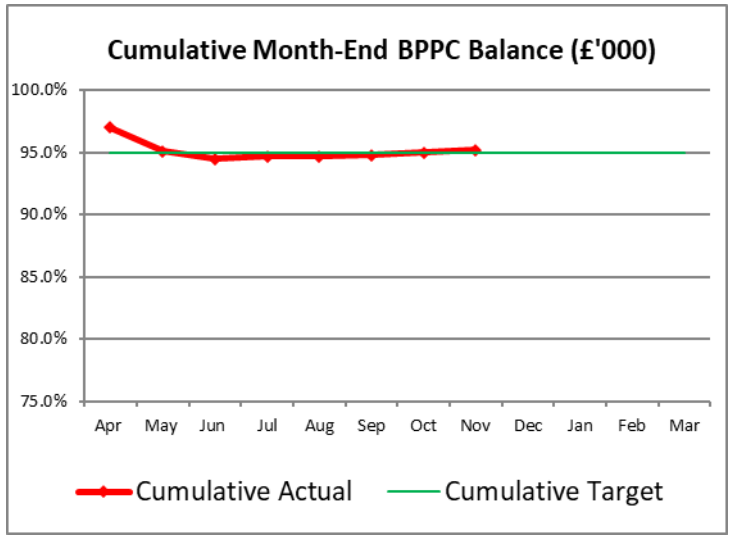
**Capital :** Work is underway to secure additional capital funding and to re-prioritise / re-profile existing schemes to accommodate this additional commitment. Work is ongoing to accelerate national programmes and agree potential reprofiling opportunities

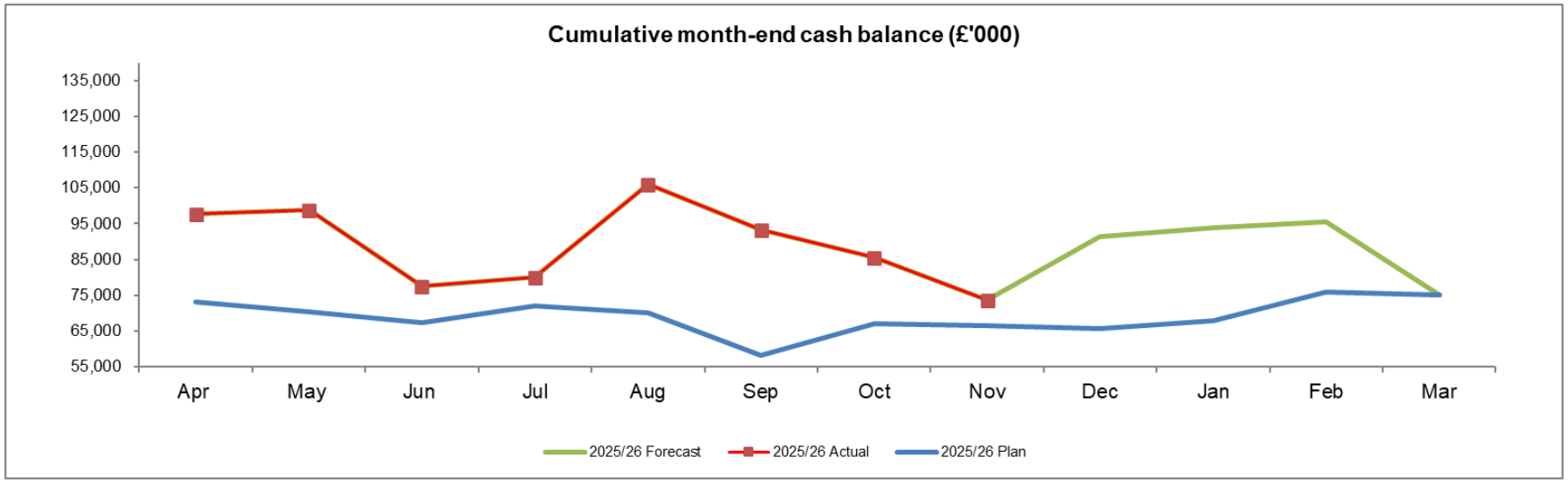
## Assurance & Timescale for Improvement

**I&E :** The actions listed including non recurrent funding from NHS England to mitigate the financial impact of ceasing the Wholly Owned Subsidiary mean the Trust has a detailed plan to deliver within the full year budget. However, the Trust is currently experiencing significant operational pressures, including caring for 224 patient who no longer require acute care (90 more than the ICS agreed trajectory). There remains considerable risk, therefore, in the delivery of the full year plan
**Capital** : Ongoing work with partners in Dorset, together with Regional Capital team and National Programme leads to explore options, to be concluded by December 2025

# 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 currently delivering performance of 95.2%, above the national standard of 95% and was above target within November showing further signs of recovery.<br>**Cash :** As at October 2025 the Trust is holding a consolidated cash balance of £73.6 million which is fully committed against the Trust's reconfiguration programme. This current balance represents 31 days of operating expenditure. | **Public Sector Payment Policy :** It is anticipated that this will be maintained above the target, with ongoing support to areas with slow invoice approvals to ensure performance moves above the target in future months.<br>**Cash :** With the increasing system and regional focus on the forecasting of cash flow we are strengthening our internal processes around the forecasting and internal reporting of cash flow for future months | **Public Sector Payment Policy :** It is expected that the actions ongoing to support BPPC performance will result in performance above the target 95% to the end of the financial year.<br>**Cash** : ongoing work with system partners to identify and implement best practice cash flow forecasting and reporting mechanisms, to be complete by December 2025 |

University Hospitals Dorset
NHS Foundation Trust

# Sustainable Services

## Digital

**Beverley Bryant**
Chief Digital Officer

## 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% | Dec 26 | | This is to monitor move of A&G to Consultant Connect | | | |
| | | | | | | | | |
| ICE for Ordering vs paper | | 95% | Mar 26 | | This is move of ICE to paperless requesting | | | |
| ICE results acknowledgement | Jan 00 | 90% | Mar 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 | | | | | | | |
| | | | | | | | | |

| Summary | Actions | Assurance & Timescale for Improvement |
|---|---|---|
| DNA rates (5.7%) remain below the process mean however the lower process limit is above the target and there is some evidence of an increasing trend in the data, but this is not yet statistically significant. | Evaluation of the Trust's pilot of DrDoctor DNA predictor to take place in Quarter 3 prior to full roll out.<br>Monitoring to of DrDoctor data to support evidence of ongoing reduction in DNA. | 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 meeting has taken place to review current status and analysis of postage and printing spend. | Productivity leads to support workflow and cost reviews in the specialties to identify potential areas for transition to digital.<br>Comms being created to promote this project. | This is a project under Transforming and Valuing Administration. |
| Advice & Guidance is the take up of Consultant Connect as the new process for A&G through ERS. Currently there are 6 specialties live with consultant connect. | Dermatology have been live for some time. In November Urology, Gastro & Rheumatology went live. And in December Cardiology and Gynaecology have now also gone live. The next specialties are being worked up to progress this. | Advice & Guidance Task & Finish Group progressing this project. |
| ICE Ordering and Results Acknowledgement – Single Task & Finish Group to focus on moving this to electronic only. | Week two of the pilot and E3, SDEC Ward 2 all show a slight reduction in electronic requesting at the beginning of week 2. This collates with equipment issues/resolution (took 5 days to resolve). The remaining areas in the pilot which equates to 8 other areas all show an increase in electronic requesting. | Task & Finish Group for ICE Paperless Reporting and Reporting to Monitor and Track this. Overall target for paperless reporting & requesting by end March 2026. |
| No of Attendances Streamed away via NHS S&R Tool – need to clarify the metrics we intend to monitor for this change. | NHS S&R is now fully live and deployed so need to confirm metrics for monitoring. | The Task and finish group has now been stood down as this is in Business as Usual |

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 14 January 2026**

**Agenda item: 10.1**

| | |
|---|---|
| **Subject:** | 2024 - 25 Annual In-Patient Establishment Review |
| **Prepared by:** | Vivian Alividza -Deputy Chief Nurse |
| **Presented by:** | Vivian Alividza – Deputy Chief Nurse |

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| **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 1056 (9) Inability to provide a fully established nursing workforce in accordance with the agreed establishment template (currently under review) | |
| **Purpose of paper:** | Information | |
| **Executive Summary**: | The report highlights safe staffing for in-patient wards and provides an update on ensuring compliance with national staffing level guidance outlined by the NQB. | |
| **Background:** | Recommendations in this report link to the statutory requirements from the National Quality Board 2016 (NQB) on ensuring safe, sustainable, and productive staffing. It also encompasses the Developing Workforce Safeguards guidance NHSE (2018) and the RCN Nursing Workforce Standards assessed as part of CQC safe and well-led domain. | |
| **Key Recommendations**: | It is recommended that the report and recommendations of the 2025/26 establishment review are noted and considered as part of budget setting. | |
| **Implications associated with this item:** | Council of Governors | ☐ |
| | Equality, Equity, Diversity & Inclusion | ☐ |
| | Financial | ☒ |
| | Health Inequalities | ☐ |
| | Operational Performance | ☒ |
| | People (inc Staff, Patients) | ☒ |
| | Public Consultation | ☐ |
| | Quality | ☒ |
| | Regulatory | ☒ |
| | Strategy/Transformation | ☒ |
| | System | ☐ |

| CQC Reference: | | |
|---|---|---|
| | 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<br>Trust Management Group | | Noting<br>Review of asks made by care groups as part of the establishment reviews. |

| 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 | ☐ |

# 1. Purpose

The purpose of this paper is to conduct an annual review of nursing staffing levels to ensure they are safe and sustainable, in accordance with the national safe staffing guidelines. This review is part of the annual process that fulfils expectation 1 and 2 of the National Quality Board NQB (2018) requirements for Trusts in relation to safe nurse staffing and fulfils some requirements outlined in the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) which sets out to support providers to deliver high quality care through safe and effective staffing. This review also meets standards outlined in the RCN Nursing Workforce Standards (May 2021).

The establishment reviews are carried out in accordance with the Developing Workforce Standards, and employ evidence-based tools, such as the Safer Nursing Care Tool (SNCT) to assess patient acuity and dependency, against patient ratios, while applying professional judgment.

All ward establishments and nurse staffing levels are continuously reviewed during this yearly (October 2024 - November 2025) period as ward functions, specialty and acuity/dependency levels have continued to fluctuate due to operational challenges and on-going service reconfiguration.

# 2. Background

In 2016, the National Quality Board (NQB) issued guidance on NHS nurse staffing levels, advocating a triangulated approach that considers patient's needs, acuity, and risks. This method helps Boards make informed staffing decisions beyond simple staff-to-patient ratios.

The NQB guidance states that providers:

- Must deploy sufficient suitably competent, skilled and experienced staff to meet the care and treatment needs safely and effectively
- Must have a systematic approach to determining the number of staff and range of skills required to meet the needs of the people using the service to always keep them safe
- Must use an approach that reflects current legislation and guidance where it is available.

Within the NQB framework, expectation 1 sets out the need to ensure that all establishment reviews include the following key factors:

- Use of a validated/accredited decision support tool
- Professional judgement
- Patient factors
- Ward factors
- Nursing staff factors

- Nursing care activities

Organisations are expected to be compliant with the recommendations in these reports and are subject to review on this as part of the CQC inspection programme under both the 'safe' and 'well led' domains. It is recommended that at least two Shelford Safe Nursing Care Tool (SNCT) audits are undertaken to ensure that a full data cycle is collated. This is to allow for richness in the data and for variances to be considered as part of the analysis.

The SNCT is a licensed evidence-based methodology which is NICE (2014) endorsed and nationally recognised as a reputable decision support tool for safe staffing decisions. The tool enables indicative nursing establishments to be calculated. The methodology for this process is a combination of:

- Patient acuity and dependency assessment scores (Levels of Care)
- Accurate data collection
- Nursing multipliers
- Consideration of nurse sensitive indicators and resource requirements

Whilst there are clear links between patient outcomes, staff well-being and nurse staffing levels, there are intentionally no prescribed minimum staffing levels. The delivery of safe nurse staffing is therefore entrusted to be delivered locally, through national guidance as detailed above.

## 3. Establishment Review Methodology

In 2023 UHD established a systematic, triangulated methodological framework to reviewing in-patient staffing levels on an annual basis linked to aligning legacy organisations, to budget setting and staffing requirements.

The adult inpatient Safer Care Nursing Tool (SNCT) has been fully implemented across all inpatient services within UHD, with the most recent data gathered over a 4-week period in September 2025, prior to completion of this review.

Decision support tools such as those for measuring acuity and dependency, help managers determine safe, sustainable staffing levels and remove reliance on subjective judgments. Professional consensus suggests that no single tool meets every ward need, therefore NHSE recommend combining methods. When used with Nurse Sensitive Indicators/Quality Indicators, it is a reliable method against which to deliver evidence-based workforce plans.

In line with NQB recommendations and building on work previously undertaken across UHD, further work was conducted to identify, correct and reconcile gaps in establishments across the Trust. The data review across all inpatient wards in September 2025 included:

- Workforce metrics
- SNCT scoring; safe care tool incorporated into Healthroster
- Professional/specialist considerations
- Quality indicators/nurse sensitive indicators

- Environmental considerations, e.g. ward layout
- Care Hours Per Patient Day (CHPPD)
- Temporary staffing use
- Red Flags raised when staffing levels were not safe

Professional Judgement is included in workforce reviews to confirm appropriate nurse staffing levels. This consultative approach to the determination of nurse staffing requirements is a bottom-up approach used to determine ward staffing requirements, based on the judgement of experienced nurses to agree the number and grade of staff required to provide care on a specific ward. This is discussed at the nursing workforce reviews alongside the quality indicators and finance and workforce indicators.

As well as considering the acuity and dependency of the patients cared for by the ward (SNCT), other factors which can affect staffing requirements are discussed and include:

- The layout and design of the ward – wards with multiple single rooms or bays may require higher staffing capacity and capability
- Line of sight of patient and 1:1 enhanced care or bay cohort nursing.
- The number of housekeepers and other support staff available – employing ward clerks and housekeepers on wards can assist nurses, midwives and care staff by undertaking tasks not directly related to patient care.
- Patient throughput – high throughput needing more staff to help maintain patient flow.
- The provision of supervisory time required by the Ward Manager to undertake the management requirements of the post, together with the amount of time required to support, supervise and mentor students and newly appointed staff.

The annual establishment review was carried out from September - November 2025 utilising annual data from October 2024 -November 2025), with initial meetings taking place in each Care Group. A detailed spreadsheet with ward-by-ward findings, providing information on the current ward establishments broken down by shift (day/night), and assessing against registered/unregistered ratios; CHPPD; nurse to patient ratios and acuity from Safecare.

In line with the Transforming for Care, several wards continue to be reconfigured in response to the new build and ward moves, therefore light touch reviews will be completed once ward moves occur in phase 2 and phase 3.

Emergency Departments (ED), critical care units and maternity wards do not use the SNCT. A specialised tool has been developed for ED, maternity utilise the Birth Rate Plus, while critical care units use the critical care acuity scoring system. All these wards follow the relevant guidelines to ensure quality care.

The Care Hours per Patient Day (CHPPD) is a nationally recognised method of measure for available staffing capacity. Lord Carter (2016) indicated CHPPD is a key marker for patient safety, as part of the unwarranted variation review in English acute hospitals. It is a mandated

monthly report and provides local and central information regarding the average amount of care delivery time each patient receives a day.

## 4. Review Findings

The Establishment Review Complete Data (appendix two) - summarises the current and proposed staffing levels across in-patient wards, including:

- Registered and unregistered staff on each shift by ward.
- Registered and unregistered skill mix ratio
- Registered nurse (RN) to patient ratio
- Total (registered and unregistered) nurse to patient ratio
- Shelford SNCT calculated CHPPD based on recommended staffing
- Model Hospital reported CHPPD for July 2024 (latest available data), for benchmarking and comparison of the registered, unregistered and combined staffing data for UHD, Peer (CQC Good) Median and Provider (Acute Trust) Median

The inpatient review was conducted against a backdrop of transformation moves expected in Phase 2 and 3 of the Transforming Care Programme. It included a total of 45 in-patient wards, excluding Critical Care and the Emergency Department. It should also be noted that there were some key ward reconfigurations and refurbishments, and some ward moves since the bi-annual review, and these wards will have a light touch review in Spring 2026 as part of the bi-annual establishment review.

### Registered nurse to patient ratios

The ward registered nurse (RN) to patient ratios across the care groups range from 1:2 to 1:9 during the day, reflecting the specialty and overall staffing model. The average RN to patient level is set to achieve 1:4 to 1:6 in 28 (64%) of wards during the day with 17 wards meeting a ratio of 1:7 to 1:9. The wards on or above the 1:7 ratio, on one or more shift, are Ward 5, 22, B1, B3, B4, Kimmeridge, Brownsea, Lytchett, Portland and Derwent.

The night RN: patient ratio is between 1:5 and 1:9, except for 4 wards (B4, Ward 23, Ward 24, Kimmeridge) that have a 1:10 – 1:12 ratio. Wards with lower RN: patient ratios (as noted in some older people services) require on-going monitoring to ensure there is no further reduction in the RN ratio.

Planned staffing ratios at night require regular oversight to ensure the model is sufficient to provide safe and effective care for patients. Managing the workload at night and weekends emerged as an area that continues to need action for several wards in the medical and surgical care groups.

Rising acuity of patients, and escalation areas has increased the pressure on ward staffing resource both during the day and at night.

## Registered Nurse to Healthcare Support Workers

UHD wards were reviewed against the Shelford recommended best practice benchmark of 70:30 registered to healthcare support workers (HCSW) ratios and 60:35 as the minimum wards should ideally not fall below unless planned as the model of care.

16 wards are rostered between 60:35 and 70:30, while 28 wards are below 60:35 ratio. A number of these wards are established to utilise band 4 RNA workforce, however feedback from the wards has highlighted challenges with training, recruitment and retention.

5 wards (Coronary Care Unit, Cardiology Investigation Unit, Sandbanks – oncology, and Acute Medical Units) are rostered at the 70:30 ratio, reflecting the higher level of specialism, where patient acuity demands a greater proportion of registered nurses compared to HCSWs. In these wards where the acuity and intensity of patients has increased, and treatment and medication regimes are complex, further reduction in the overall skill-mix of registered to unregistered staff is not appropriate to maintain safe staffing levels and ensure adequate supervision.

The support of band 4 roles continues to be designed in as part of a model of care across wards linked to the further development of apprenticeship opportunities. This has also provided a role in which to appoint future cohorts of nursing associates who have qualified and registered with the NMC.

Continued focus will be placed on reviewing the overall balance between the registered and unregistered workforce to ensure that any modifications align with planned changes to models of care and are supported by an appropriate equality impact assessment (EQIA) and evaluation.

### Care Hours Per Patient Day

CHPPD is a measure that can be used at both ward and service level or be aggregated to Trust level. It provides a view of all professions that deliver care in a ward-based setting and differentiates registered clinical staff from non-registered clinical staff. This ensures skill-mix is well-described, that nurse-to-patient ratio is considered when deploying the clinical professionals to provide the planned care, and that this is reflected alongside an aggregated overall actual CHPPD.

The planned total CHPPD in the medical care group range from 3.8 – 12, the surgical care group range from 5.0 -15.9 and Women Children Cancer Support Services (WCCSS) 4.4 -14. and average at 12, comparable with Model Hospital data.

Actual CHPPD levels vary significantly throughout the year and are closely linked to patient numbers and variations in patient acuity. For instance, increased staffing to support patients requiring enhanced care will raise the overall CHPPD attributed to a ward.

## Quality Indicators

Quality data indicators were reviewed and triangulated at the establishment review meetings. 12 months of data was considered looking for trend and triangulation of data during census completion to review impacts/harm due to reduced staffing levels. Pressure ulcer, falls, medication incidents, red flags and workforce KPIs were reviewed in line with budgeted establishments.

In line with the safer staffing requirements, red flags are reported where there is a shortfall of more than eight hours or 25% of registered nurse time available compared with the actual requirement for the shift or where fewer than two registered nurses are present on a ward during any shift. There remain 16 open red flags in Networked medicine (reviews pending), and 14 red flags in Specialist Medicine.

Ongoing work to improve the review of red flags with ward leaders and matrons across the care groups at the daily staffing meetings.

## Acuity and Dependency

The ongoing development of pathways continues to demonstrate an evidenced increase in the complexity, acuity, and dependency of patients cared for in general ward beds, which is also associated with length of stay. Information on patient acuity and dependency is captured through the 'Safe Care' functionality within Healthroster and is used in real time to inform daily staffing meetings**.** Ward leaders and matrons reported an increase in the acuity and complexity of patient presentations across several pathways, resulting in increased staffing requirements.

UHD has continued to see an increase in the complexity of patients particularly in relation to mental health needs including dementia and patients remaining in the acute settings for prolonged lengths of time whilst awaiting appropriate placements. We have also seen a significant rise in the episodes of violence and aggression experienced in our clinical areas which creates additional needs for staffing support. This continues to have an impact on the ability to support the additional enhanced care needs that arise for these groups of patients particularly across key specialties

Wards on the Bournemouth site are often able to care for patients within eyesight observations (cohort) due to the layout of the wards, compared to Poole site where the layout of the wards present significant challenge in the ability to cohort patients or develop enhanced care bays.

The management of additional enhanced care needs extends beyond the definition of patients requiring formal mental health support. Increased numbers of patients with challenging behaviour or needing 1:1 presence brings additional pressures to ward establishments but are necessary to keep the environment safe for all patients.

This care is frequently supported by HCSWs; however, changes to immigration legislation and natural attrition across care groups have resulted in a number of vacancies within HCSW establishments. As part of efforts to reduce reliance on temporary staffing, wards are reviewing and addressing their HCSW vacancies.

Recruitment and retention actions are included below.

- A blended approach to recruitment of HCSWs (central and local recruitment drives)
- A recruitment tracker in the medical and surgical care groups with a pipeline report
- Learning and development: New HCSW forum to be launched in January 2026, a forum for shared learning and development

**Headroom and supervisory ward leader**

Headroom was reviewed post-merger in 2021 to align the legacy organisations. A further amendment was agreed at Trust Management Group in 2024 and subsequently in 2025. Headroom at UHD has since been amended from 17.7% to 22% in October 2025 to reflect a breakdown of 14.7% leave, 3% sickness, 3% study leave, and 1.5% parenting leave. The new allowances were used to calculate staffing requirements for this review, using the Shelford SNCT calculator.

Band 7 management / clinical time. There are several models in place across the NHS that advocates non-clinical time for the Band 7 Clinical Leader to focus on their management responsibility. UHD ward leaders are often counted in the numbers to mitigate gaps in staffing, this was discussed at the establishment reviews, in particular the impact on quality indicators, and appraisal compliance.

**Establishment Review Recommendations**

The focus of this establishment review has been on the nursing establishments to maintain safe staffing. However, it was apparent that some of the nursing budget has been used to support non-nursing services that impact on patient activity and flow.

The following recommendations are made to ensure future establishments reviews give due consideration to this, increase in acuity and complexity of presentations and patient safety. See appendix 1 for the full list of posts funded within care group and total investment requested.

**Medical Care Group**

A care group review of the Band 6 uplift in acute admission areas, CCU & Stroke Unit is required with a recommendation the uplift is re-instated to ensure consistent 24-hour cover at Band 6.

The Stroke Unit and OPAU reported that the Band 6 uplift had been removed, adding a budgetary risk into the establishment. These areas require a Band 6 Nurse-in-charge 24 hours a day with the associated budget uplift; uplift costs to cover annual leave, sickness and study leave have been applied at Band 5 not Band 6 level as required.

Ward 23 sought additional investment to increase their HCSWs to a 2:2 model to provide an additional HCSW at night; this was highlighted due to an increase in dependency in this ward since the transfer of cardiology to the Royal Bournemouth site.

Additional staffing investments were reviewed as part of budget setting by the care group and funding agreed as follows:

- Ward 1- Increase to second HCSW on the night
- Wards 3 and 14 Increase to 4th HCSW on the Late
- CCU uplift to be returned to the band 6 line
- Stroke -increase additional HCSW on LD
- AMU PH following template review in March - Band 6 uplift was put into band 5 line- AMU as an admissions ward will require band sizes on duty to coordinate the ward- Additional 2.04 WTE and 0.52 of bank
- AMU RBH- Same as above B6- additional 1.84 band six needed- Will pick up SDEC request separately as should relate to BC - AMU should also have 3 Band 7 plus a practice educator role- ask is to reduce band 5 line to top up band 7.
- Kimmeridge - Additional RN on the night (use bank budget)

**Surgical Care Group**

Ward 12 requested 1 additional HCSW (LD Mon-Fri), to support activity on the ward previously modelled to reduced activity over the weekend however the activity over the weekend has remained consistently high.

Ward 16 review identified an additional registered nurse on the day shift to support an increasing number of nurse transfers off the ward. Additionally, the headroom was removed as part of the review in 2023, but Band 6 cover has been maintained resulting in a cost pressure to the Care group.

Ward B2 review identified that there was skill mix gap therefore have requested based on the ward quality indicators a HCSW on the night shift to support with the delivery of the fundamentals of care, and observations.

SAU RBH – Band 5 increase to 2.62 WTE to streamline the establishment to 5=2 on each shift and match the day and night shift.

**Women Children Cancer and Support Services**

In light of the transformation within WCCSS, no changes to the establishments were requested, as the current establishment meets the service's needs. It was noted that a light-touch review will be undertaken following the moves and changes to the environment and layout.

## Cross-cutting recommendation

Continued training on the use of the Shelford SNCT and Safecare Allocate to increase staff understanding and confidence when completing the acuity and dependency audits.

Improvement work focused on strengthening the review of red flags with ward leaders and matrons across care groups during daily staffing meetings.

All rosters and templates require review using a consistent process and aligned with the corporate minimum standards and best practice guidance.

## 5. Conclusion

The Board can be assured that robust processes are in place to monitor and address staffing concerns in real time, supporting safe and effective patient care.

To note findings of this annual ward establishment review and the Trust position in relation to adherence to the monitored metrics on nurse staffing levels.

Although the review has identified areas for investment and budget alignment it is important to note that the senior nursing team did not find any areas where the current staffing position was deemed to be unsafe.

To support the continued Trust wide commitment and momentum on actions to fill vacancies in the HCSW workforce and further reduce the reliance on agency and bank against the backdrop of rising acuity, emergency and elective recovery.

# Appendix 1: RAG review of Care Group Asks & Financial cost.

**RAG rating**:

- **Red** – priority for investment 2026/27
- **Amber** - further scrutiny/review at Care group level
- **Green** - identified from within Care group current funded establishments.

**Medicine:**

| Ward | Ask | Rationale | RAG rating |
|---|---|---|---|
| Ward 23 – Networked Medicine | HCSW on the night shift | There has been an increase in patient dependency since the transfer of cardiology to the Royal Bournemouth site. | |
| Stroke - Networked Medicine | Re-instatement of the Band 6 uplift | The headroom was removed as part of the review in 2023, but Band 6 cover has been maintained resulting in a cost pressure to the Care group. | |
| OPAU -OPS | Re-instatement of the Band 6 uplift | The headroom was removed as part of the review in 2023, but Band 6 cover has been maintained resulting in a cost pressure to the Care group. | |
| RACE -OPS | Re-instatement of the Band 6 uplift | The headroom was removed as part of the review in 2023, but Band 6 cover has been maintained resulting in a cost pressure to the Care group. | |
| Ward 1- Specialist Medicine | HCSW on night shift | Currently funded for x1 HCSW on night shifts. Increase to a 2nd HCSW on night shift requiring 2.4WTE (73.5). | Funding identified within Care Group |
| Ward 3 – Specialist Medicine | HCSW on late shift | Increased activity on late shifts requiring an increase of 0.515 WTE | Funding identified within Care Group |
| Ward 14 - Specialist Medicine | HCSW on late shift | Increased activity on late shifts requiring an increase of 0.515 WTE | Funding identified within Care Group |
| CCU – Networked Medicine | Re-instatement of the Band 6 uplift | Realignment of the Band 6 headroom removal – 1.57WTE from Band 5 line, currently as a cost pressure of £20,288. | Funding identified within Care Group |

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|---|---|---|---|
| Stroke – Networked Medicine | HCSW on long day | Additional HCSW on long day -2.62 WTE. Increased acuity following changes to pathways in 2024. Introduction of SDEC resulted in admission of higher acuity patients. | Funding identified within Care Group |
| Ward 4 -OPS | Band 6 | Discrepancy in Band 6 line, funded for 2 and 3 in post. Realignment of Band 6 line to cover 3.0WTE in post, from Band 5 line -£4,711.87 | Funding identified within Care Group |
| AMU Poole - OPS | Band 6 | The headroom was removed as part of the review in 2023, but Band 6 cover has been maintained resulting in a cost pressure to the Care group. | Funding identified within Care Group |
| AMU RBH -OPS | Band 6 | The headroom was removed as part of the review in 2023, but Band 6 cover has been maintained resulting in a cost pressure to the Care group. | Funding identified within Care Group |
| Kimmeridge - OPS | Band 5 | Uplift to night staffing to 3RNs due to challenges including patient numbers and ward environment – layout of the ward greatly compromises visibility. This is 2.75 WTE | Funding identified within Care Group |
| **Total funded by Medical Care Group = £245,710.83** | | | |
| **Total investment requested = £215, 597.84** | | | |

**Surgery:**

| Ward | Ask | Rationale | RAG rating |
|---|---|---|---|
| Ward 12 | HCSW increase on Saturday and Sunday | To maintain safe staffing, aligned with activity levels. | Funding identified within Care Group |
| Ward 15 | B5 uplift to a B6 post | The headroom was removed as part of the review in 2023, but Band 6 cover has been maintained resulting in a cost pressure to the Care group. | Funding identified within Care Group |
| Ward 16 | HCSW at night and B5 uplift to B6 | Considerable increase in nurse transfer of patients off the ward impacting staffing levels, and HCSW to align to staff ration of 3WTE on night shifts | Funding identified within Care Group |
| B2 | HCSW increase on a long day | To maintain safe staffing, aligned with activity levels. | Funding identified within Care Group |
| SAU RBH | Baand 5 - 2.62 WTE | Band 5 increase to 2.62 WTE to streamline the establishment to 5=2 on each shift and match the day and night shift. | Funding identified within Care Group |
| **Total funded by Surgical Care Group = 259, 817** | | | |

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 14 January 2026**

**Agenda item: 10.1**

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|---|---|
| **Subject:** | Equality Quality Impact Assessment Oversight Panel |
| **Prepared by:** | Judith May, Director of Performance and Oversight<br>Alan Betts, Director of Integration<br>Jo Maple-Roberts, Transformation Workforce Lead |
| **Presented by:** | Sarah Herbert, Chief Nursing Officer |

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|---|---|---|
| **Strategic themes that this item supports/impacts:** | Population & System<br>Our People<br>Patient Experience<br>Quality Outcomes & Safety<br>Sustainable Services | ☐<br>☐<br>☐<br>☒<br>☐ |
| **BAF/Corporate Risk Register: (if applicable)** | All | |
| **Purpose of paper:** | Information | |
| **Executive Summary**: | This report provides a summary of the EQIAs completed for Productivity and Efficiency Improvement Schemes, Transformation and workforce over the last quarter.<br><br>49 QIAs have been completed in this period.<br><br>In most cases, the EQIA section was completed with 'No Change' identified to the service and minimal risk, such that the level of risk did not trigger the requirements for a full equality analysis.<br><br>Only 1 EQIA has met the threshold for review by the EQIA panel showing risk above 9, however the panel identified further work required on the mitigations to provide appropriate assurance. | |
| **Background:** | The UHD Form and EQIA process follows the NHS Dorset System Quality Equity and Equality Impact Assessment (SQEEIA) format and adheres to the National EQIA guidance. | |
| **Key Recommendations**: | To note the number of EQIA's being completed across the Trust | |

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| | To note the ongoing process of oversight and scrutiny |
| **Implications associated with this item:** | Council of Governors ☐<br>Equality, Equity, Diversity & Inclusion ☒<br>Financial ☒<br>Health Inequalities ☒<br>Operational Performance ☒<br>People (inc Staff, Patients) ☒<br>Public Consultation ☐<br>Quality ☒<br>Regulatory ☐<br>Strategy/Transformation ☒<br>System ☐ |
| **CQC Reference:** | Safe ☒<br>Effective ☐<br>Caring ☐<br>Responsive ☐<br>Well-Led ☒<br>Use of Resources ☐ |

| **Report History: Committees/Meetings at which the item has been considered:** | **Date** | **Outcome** |
|---|---|---|
| Quality Committee | 16/12/2025 | The Committee noted the report |

| | |
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| **Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)** | Commercial confidentiality ☐<br>Patient confidentiality ☐<br>Staff confidentiality ☐<br>Other exceptional reason ☐ |

## QUALITY IMPACT ASSESSMENT Q2 REPORT

### Introduction

This report provides a summary of the EQIAs completed for Productivity and Efficiency Improvement Schemes, Transformation and Workforce changes over the last quarter.

### Productivity and Efficiency Schemes

### Number of EQIAs

- 39 EQIAs were completed in 2024/25 and in 2025/26 572 schemes have been identified. An increase of 42 schemes since last report shared in September 2025. 119 schemes 25/26 have an agreed alternative approach to quality impact assessment through 'other assurance' documentation related to pharmacy and procurement schemes. 44 remain in draft awaiting final signature and approval and 85 fully completed an increase from the previous 66 reported at the last QIA meeting in September. Of those where a EQIA has been completed the highest risk score reported was 8. 29 schemes do not yet have an EQIA started and 295 schemes are transactional and therefore don't require an EQIA.

### Schemes which identified risks requiring mitigation

- In the Medical Care Group, the Dermatology private work scheme was reviewed in October. The scheme identified a risk score of 4 due to the lack of UHD space for the private work to be an income generation scheme. A risk rating of 2 includes the hesitance of staff willing to engage with private practice, however this can be mitigated once the correct environment is created.

- Surgical Care Group EQIAs included CDC income. The CDC QIA details risks of 8, 6 and 4 due to activity not exceeding plan, workforce and recruitment challenges.

- Operations - Further completed EQIAs include admin vacancy removal, uniform dispensers, hand towels & voucher promotion. No significant risks identified.

- The types of schemes within WCCSS include Specialist Palliative Care bed remodelling, iron supplements in child health and child health., radiology and therapies staffing reviews. The Child Health staffing review did not identify any risks to bring to EQIA panel as the service has managed without the posts over a period of time. Within Therapies, the EQIA for staffing WTE reduction remains in edit as another staff budget review took place on 29th October and further staffing CIP was approved and transacted on 5th November. The previous EQIA has been revised to reflect the additional WTE and

finances transacted - no additional risk has been identified however the risk score range between 4-8, reduced to 3-4 with mitigation.

**EQIA decisions**

- The EQIAs demonstrated an assessment of impact of the cost improvement plans on quality, access and experience or performance. In most of cases the EQIA section was completed with 'No Change' identified to the service and minimal risk, such that the level of risk did not trigger the requirements for a full equality and quality analysis.
- WCCSS presented an EQIA to the panel relating to the closure of hospice beds in the East of Dorset, showing risk of 15, 12 and 9 which can be mitigated to 10, 9 and 6.The panel felt the EQIA didn't reflect the detail required around the service changes and therefore the strength of the mitigations. A decision was made that additional was work required on the EQIA to enable exec sign off.

## Transformation

As part of the Reconfiguration Gateway Review process, EQIA's have to be completed for Gateway 2 which is normally 6 months from the move date. Depending on the size and scale of the move, some services that do not have gateway reviews just complete as part of the Go/No Go process. The EQIA form is included as part of the Go/No go checklist. Care Group sign off is required prior to submission to Gateway 2 panel or prior to Go/No go sign off.

Learning from the phase 2 moves of the Transformation indicated that further training is required for those completing EQIA's to ensure risks and mitigations are highlighted. The training was completed in October with attendance from all Care Groups.

**Number of new EQIA's**

At this current time there have been two additional EQIAs completed, one for endoscopy which has not highlighted any areas of concern however confirmation is awaited from the Medical Care Group that they have signed this off. There is also a draft EQIA for the Oncology move taking place February 26 but further review is required by the care group to ensure adequate mitigations to the impact identified.

## Workforce Planning

**Number of EQIA's**
13 EQIA's were completed as part of phase two transformation for services moving to or impacted by moves to the BEACH building.

The EQIA's completed were from CrCu, CrCu therapies, Maternity, NICU, CSMT, Emergency Department, Obstetric theatres, MSK therapies, Radiology, paediatric therapies, housekeeping, catering and Stroke early supported discharge. At this point in the workforce planning process all services completing a workforce plan were required to complete an EQIA, however following a review it was agreed that an EQIA would only be required on identification of a negative impact/risk associated with transformation.

**Schemes covered**
The workforce EQIA supports workforce plans where it has been identified that reconfiguration/transformation will result in a negative impact/risk to an area of quality. (i.e. impact of change of location, implementation of cross site working, demand and capacity). Examples of impacts/risks identified:

- Change of base location – staff retention
- Cross site working within working day – loss of capacity, delay in patient care, patient/carer experience, environmental impact
- Staff morale/experience
- Impact of patient experience – delays in assessment/review
- Safety standards – increased side room capacity, lack of visibility

For phase three of the Transforming Care Together (TCT) programme five EQIA's have been completed to date (anaesthetics, ENT, OMF, Pre-assessment and cancer informatics) and were reviewed as part of the sign off process.

With 31 workforce plans still to progress through the workforce planning sign off process it is anticipated that further EQIA's will be submitted where there is an identified risk to service delivery following reconfiguration/transformation within the current financial envelope.

**Progress made**
The EQIA panel undertook a review of historic EQIA's and identified the need for widespread training to ensure thorough and robust completion of EQIA's. A session was held in October and the recording shared widely with the care groups.

There has also been work undertaken to ensure the governance process outlined within the EQIA policy are embedded at care group level, to ensure the appropriate level of scrutiny and support has been provide before EQIA's come to panel for exec sign off.

**Future Steps**
The decision was made at the EQIA panel to combine transformation and workforce EQIA's where there is overlap to reduce duplication but also to review impact in the whole.

In addition to ensure robust oversight on the impact of the transformation work as we approach the phase 3 move the decision was made to increase the frequency of the review panel. This will start from January.

University Hospitals Dorset
NHS Foundation Trust

# PATIENT SAFETY REPORT TO QUALITY COMMITTEE 6/1/26

| ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise | |
|---|---|
| **Report from:** | Patient Safety Report – November 25 |
| **Presented by:** | Natasha Sage – Head of Patient Safety |
| **Agenda:** | CGG 18/12/25<br>QC 6/1/26 |
| **ALERT**<br><br>*Each Alert raised should indicate the current actions and mitigations that have been taken. The Alert should also include details of leads and timescales for actions where relevant.* | The PSII declared in April (L148355 / PSII 2504-08) has now been confirmed as a Never Event (December 2025). The final report clarified that the foreign object was included in the formal count at the start of the procedure, which was not clear at the time of initial reporting. This brings UHD's total Never Events for the current year to four, the same as the number reported in 2024/25.<br><br>A new PSII (PSII 2512-13) was commissioned in December. This investigation focuses on an individual patient event aligned with the PSIRF priority theme of **post-partum haemorrhage**.<br><br>Additionally, a new thematic review on **VTE prophylaxis** was initiated in December. This review will consolidate all improvement work undertaken to date. Key lines of enquiry include:<br>• Review of policies versus practice<br>• Patient information and engagement<br>• Identification of contributory factors<br>• Governance and data analysis |
| **ASSURE** | • **Falls:** Rates remain within standard variation; notable improvement in moderate harm falls over last 6 months linked to thematic review and improvement program.<br>• **Pressure Ulcers:** Rates stable; new PSIRF-aligned prevention toolkit launching soon.<br>• **VTE:** Risk assessment compliance >95%; slight improvement in prophylaxis prescribing.<br>• **Mental Health:** Significant drop in LERNs reported; unclear if due to workstreams or attribution issues.<br>• **Diagnostics:** ICE filing introduced to improve reporting; outpatient improvement program underway.<br>• **Deteriorating Patients, Post-Partum Haemorrhage, NICU admissions, Stillbirth:** Highlight reports presented at PSIRF Oversight |
| **ADVISE** | **Current PSII caseload**:<br>• 5 investigations, including 2 Never Events (wrong site surgery) and one thematic review.<br>**Duty of Candour Process:** |

| | |
|---|---|
| | • Review and standardisation of apology letter approval process and toolkit in progress<br><br>**PSIRP Review:**<br>• Collaborative workshop planned to identify key themes for next iteration; PSIRF templates under review.<br><br>**Risk Management Strategy:**<br>• Updates underway to align with new Risk Oversight Committee and Good Governance Institute guidance. |
| **Review of Risks** | No new risks |
| **Celebrating Outstanding** | Throughout 2025, the UHD Safety Crew successfully hosted learn at lunch sessions. Thank you to all presenters and staff who participated—whether live or via the intranet catch-up links. We are currently finalising the 2026 session line-up and look forward to continuing these valuable opportunities for shared learning and engagement in the year ahead. |

## Patient Safety Activity – as at end November 2025

| Patient Safety Incident Investigations | |
|---|---|
| PSII commissioned/ reported on STEIS (in month) | 1 |
| Total PSII on caseload | 5 |
| Of which are Never Event | 2 |
| Of which are MNSI investigated | 0 |
| Trust closure confirmed (in Month) | 1 |
| **Thematic review** | |
| Thematic Review commissioned in month | 0 |
| Total Thematic review on caseload | 1 |
| Trust closure confirmed (in Month) | 0 |

## PSII cases for monitoring:

| LERN ref & PSII ref | STEIS ref | Care Group | Theme | Update | Target date |
|---|---|---|---|---|---|
| L141254 PSII 2411-06 | 2025/84 | Medical | Unexpected death | Due at Oversight in December | Dec 25 |
| L148355 PSII 2504-08 | 2025/2103 | Surgical | Retained object | Due at Oversight in December | Dec 25 |
| L152070 PSII 2507-10 | 2025/3715 | Surgical | Never Event- Wrong site surgery | Action planning stage | Dec 25 |
| L153399 PSII 2507-11 | 2025/4038 | Surgical | Never Event- Wrong site surgery | Due at Oversight in December | Dec 25 |
| L157265 PSII 2509-12 | 2025/6264 | Medical | Mental Health Management | ToR held, information gathering | Mar 26 |

## Thematic review for monitoring:

| Thematic review reference | Care Group | Theme | Update |
|---|---|---|---|
| TR2501-04 | WCCSS | Term admission to NICU | Awaiting care group sign off |

## Completed report signed off at November Oversight meeting:

| LERN ref & PSII ref | STEIS ref | Care Group | Theme |
|---|---|---|---|
| L150440 PSII 2506-09 | 2025/3476 | Surgical | Never Event- retained object |

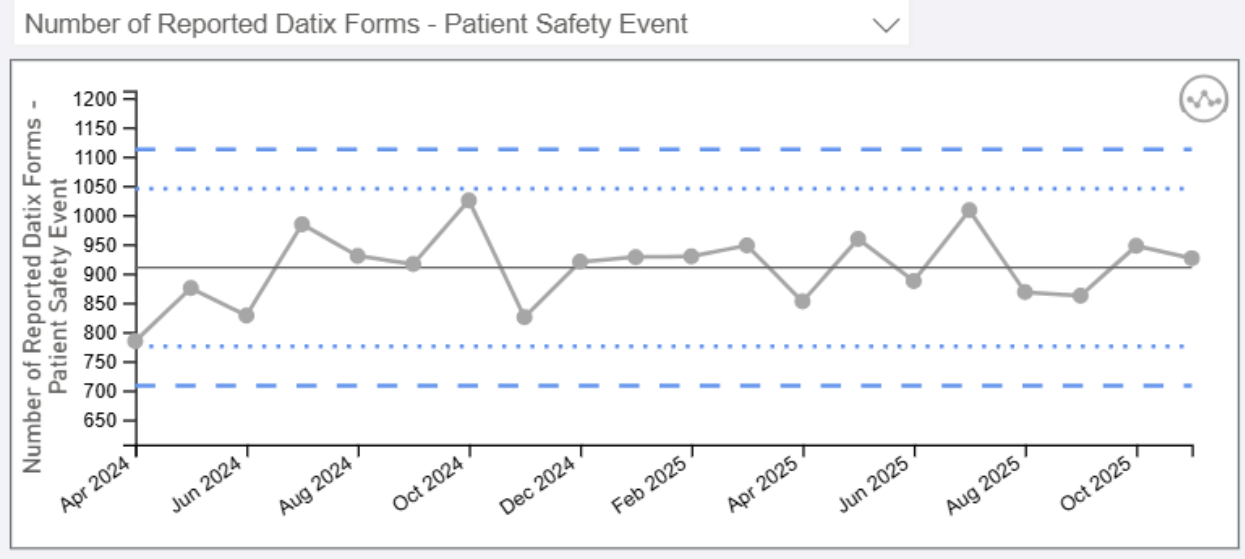
## Never Events by Date reported on STEIS (Month and year) and Care Group 25/26

| UHD | 24/25 | Apr 25 | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan 26 | Feb | Mar | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Surgical CG | 2 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| Medical CG | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| WCCSS CG | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 4 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |

There was one never event reported in June (retained swab in gynae/theatres) and two never events reported in July; one wrong site injection in theatres and the other wrong site injection in ophthalmology (via an insourcing company).

### LERN forms:

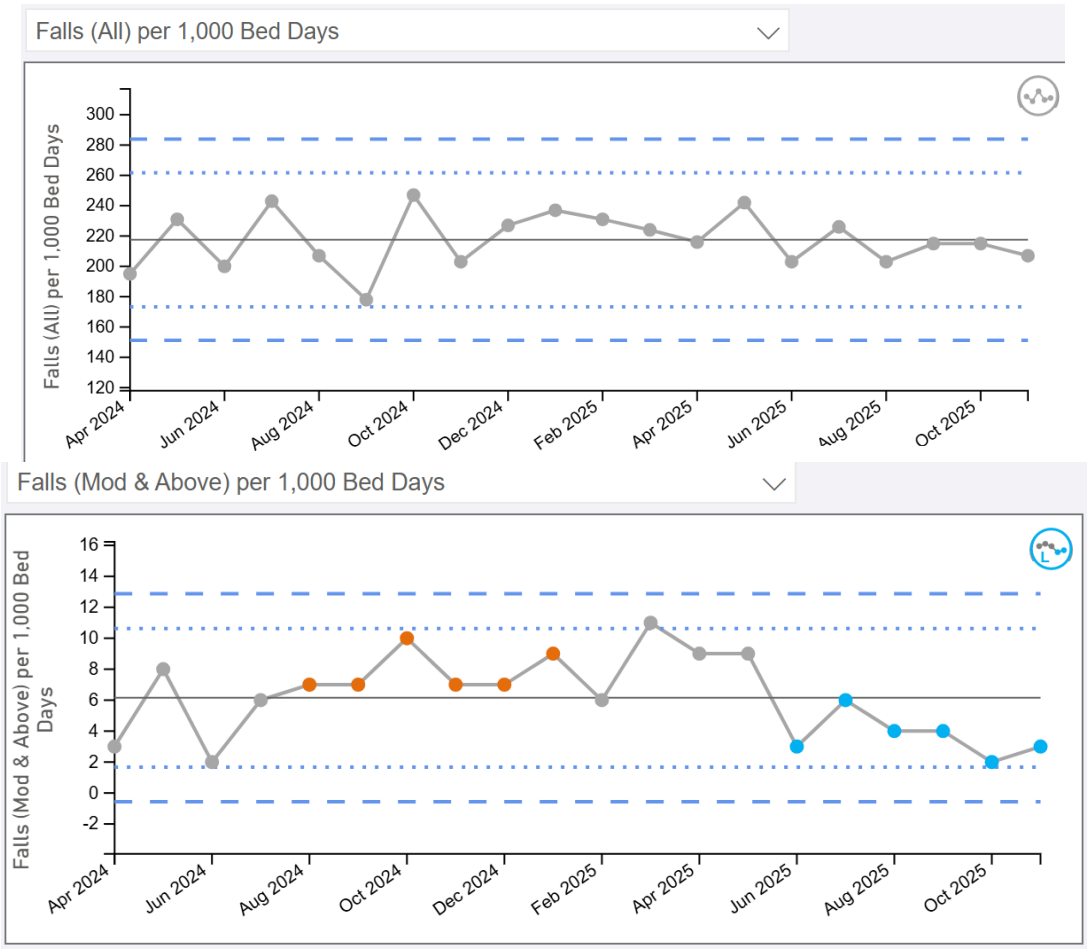
The number of patient safety events reported remains within standard variation
Data from Cosmos




### LERNS by patient safety theme

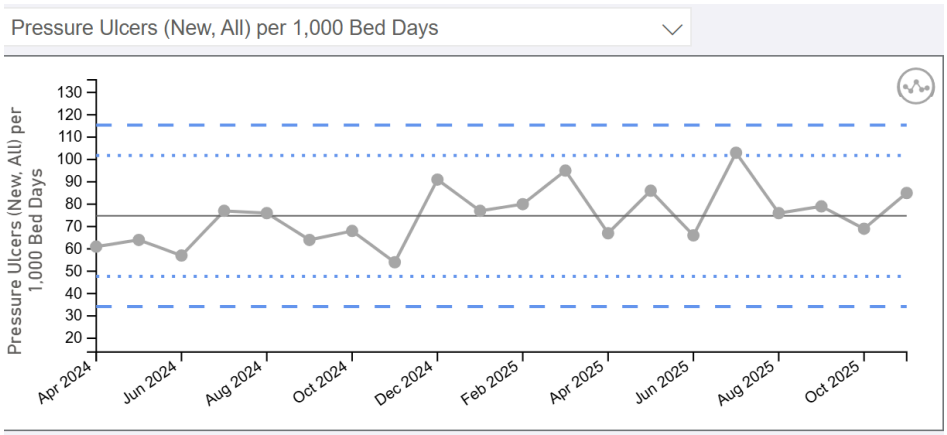
The patient safety theme is chosen at the time of reporting and can be updated by the ‘reviewer’ of the LERN. There is a delay in validating the theme against the LERN description. It is possible for a ‘reviewer’ to add a theme to an ‘Other’ safety event form.

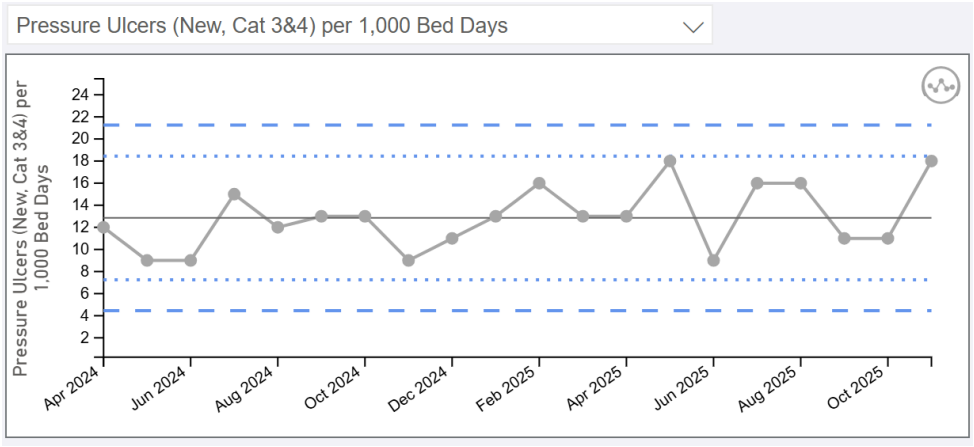
**Falls**:
Data from Cosmos pulled through from Datix




The number of falls per 1000 bed days remains within standard variation. The number of moderate or above harm falls per 1000 bed days also remains within standard variation; however, a statistical improvement has been made over the last six months. This coincides with the learning from the thematic review and the improvement program on the Older Peoples Assessment Unit.

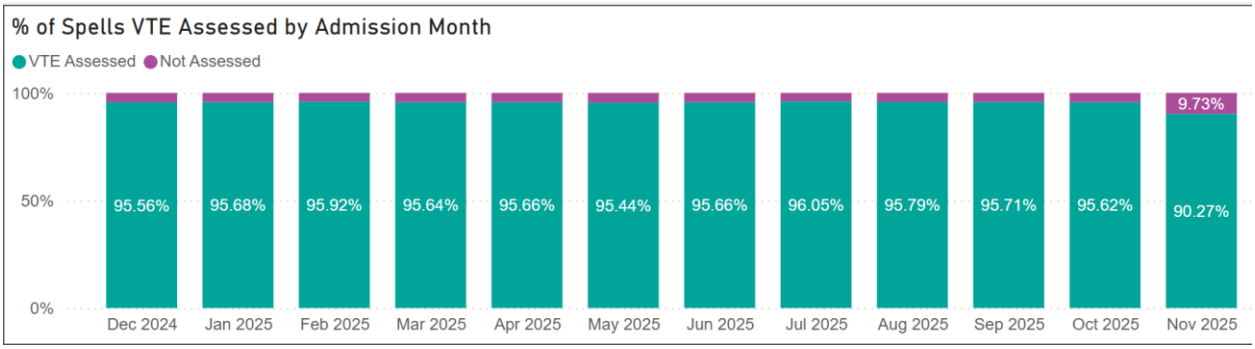
**Pressure Ulcers**
Data from Cosmos pulled through from Datix





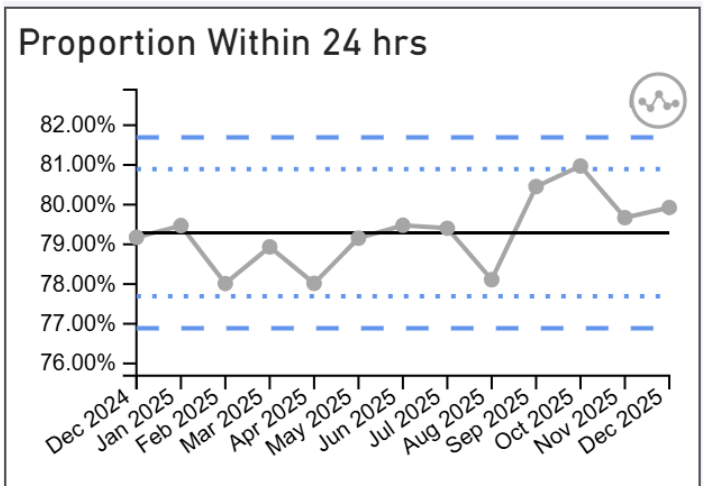

The number of pressure ulcers per 1000 bed days remains within standard variation. The number of Category 3, 4 and combined (essentially, with harm) per 1000 bed days also remain within standard variation. The tissue viability team are working through the pressure ulcer prevention thematic review action plan and will soon launch a new PSIRF aligned process and toolkit to support clinical teams to prevent pressure ulcers and learn when they occur.

**VTE:**
Data from Cosmos
Risk Assessment:



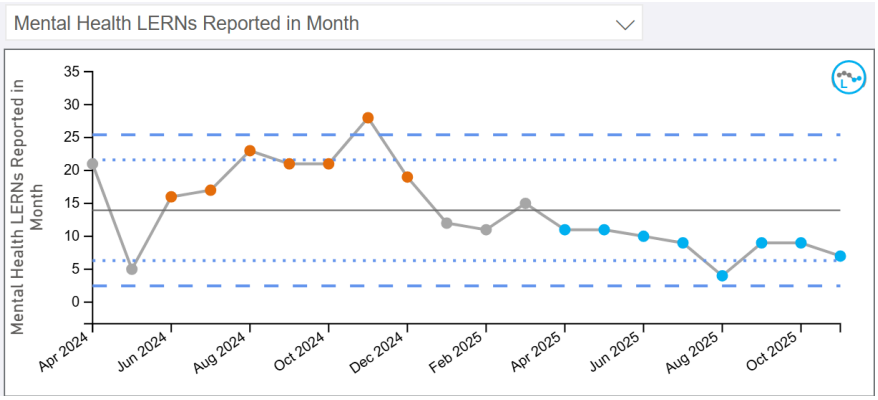

VTE risk assessments continue to remain above 95% completion. The most recent month has not been validated.

Prescribed:

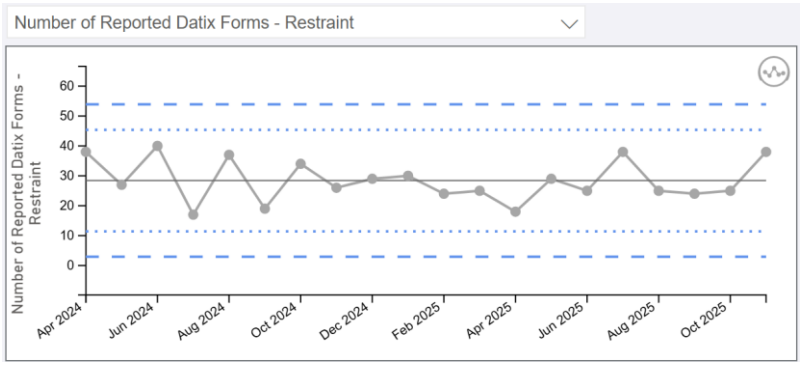



There is an increase in the number of patients prescribed VTE prophylaxis within 24 hours although this improvement is not statistically significant at this time.

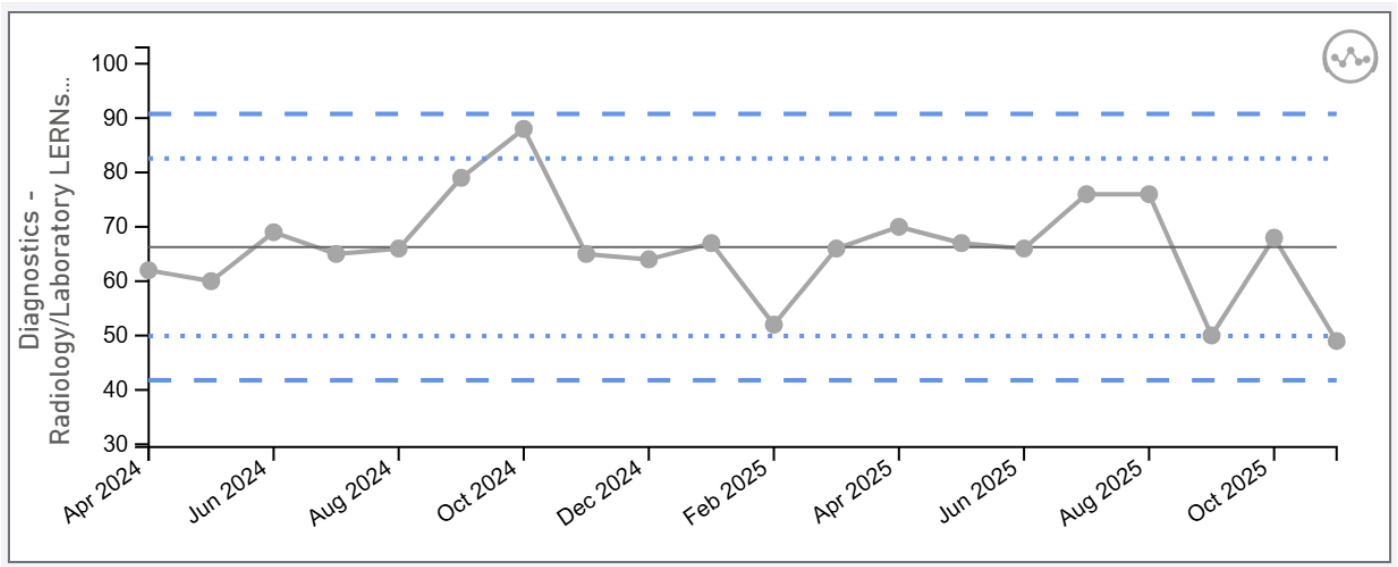
**Mental Health**
Data from Cosmos pulled through from Datix




The number of LERNs reported regarding mental health has significantly decreased. It is not clear if this is because of the Mental Health workstreams or staff not attributing the event to a patient's mental health management. The number of restrictive interventions remains within standard variation.




**Diagnostics**:
Data from Cosmos pulled through from Datix




Staff may use the diagnostics theme for a number of different incident types including laboratory and radiology incidents. ICE filing has been introduced to 'close the loop' on reporting and this continues to be embedded. There is an Outpatient Improvement Programme which comprises of six projects which will reduce the risk of patients coming to harm including: advice and guidance, standardisation of bookings, clinic space utilisation, improved patient access, follow up standardisation and electronic patient check in. A harm review tool is also being developed to identify whether patients have been harmed, or are at risk of harm, as well as helping to avoid future harm whilst waiting for clinical treatment.

## Deteriorating Patients:
Highlight report for PSIRF Oversight

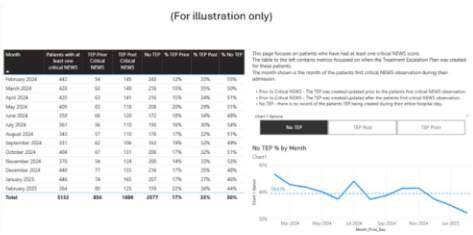
| Deteriorating Patient Group | | | Reporting Month | October -2025 |
|---|---|---|---|---|
| **Project Goal: -**<br>• To provide structured governance for all the deteriorating patient (DP)pathways.<br>• To re-establish sepsis and AKI groups to report into DPG alongside CCOT and Martha's Law groups.<br>• To oversee DP related safety incidents to identify and respond to themes.<br>• To ensure that learning from deteriorating patient incidents is embedded across all specialties.<br>• To ensure national audits are identified and actioned.<br>• To support education around responding to deteriorating patients and management of sepsis and AKI | **Exec Sponsor:** | Peter Wilson | **Project Status** | |
| | **SRO**<br>**RO** | Michelle Scott, Jess Wiggins, Jo Sims, | **Is the project on schedule?** | **Y/N** |
| | **PM** | | **Statistical improvement?** | **Y/N** |

**Driver Metrics and/or:**

**Separate workstreams for each subgroup working on A3s to describe the goals and driver metrics These are likely to include the following:**

Compliance to DP policy
Appropriate escalation based on NEWS score
Outcomes following NEWS alerts
NEWS compliance
TEP compliance
Sepsis metrics – time to antibiotics, sepsis policy compliance
AKI – fluid balance monitoring compliance
BEAT mandatory training compliance
eObs training compliance

(For illustration only)

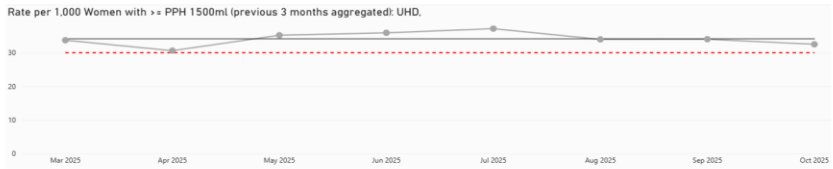


| ALERT - Description | Actions/Mitigation taken by project | Support requested from TMG? |
|---|---|---|
| • Currently no sepsis team therefore no capacity for audit and education. No trust sepsis policy<br>• AKI – Adam Kirk to re-establish AKI group and support AKI nurse<br>• CCOT – staffing issues, unclear what service will look like following reconfiguration<br>• Martha's Rule – IT support required to meet national requirements on eObs<br>• Deteriorating patient policy requires ratification at PPG | • Funding identified for sepsis nurse and recruitment process in progress. Sepsis A3 to be developed and sepsis policy underway (MS)<br>• A3 in progress. Policy out for review<br>• Current work to improve visibility and understand how this can be implemented in ED<br>• Further modifications required prior to ratification and formal launch of pathway and flowchart. | Expedite job matching process |
| **ADVISE - Description** | **Actions/mitigation taken by project** | **Support requested from TMG?** |
| • Short-term Recognition, Response and Escalation group formed to support governance around DP | • KG/KH to lead group, incorporating trust IV fluid management workstream, supporting roll out of e-obs in CH and governance around this. Working with teams to look at escalation and early identification of deterioration. | |
| **ASSURE – Description** | | |
| • First meeting of new Deteriorating Patient group planned for January with all workstreams to update on progress<br>• Resus group to report into DP group for shared learning and information | | |

## Post Partum Haemorrhage
Highlight report for PSIRF Oversight

| Improvement programme/project title: Post partum haemorrhage >1500mls | | | Reporting Month | December 2025 |
|---|---|---|---|---|
| **Project Goal: UHD to consistently be below the national target of 30 per 1000 for reported post partum haemorrhages over 1500mls.** | **Exec Sponsor:** | Sarah Herbert | **Project Status** | |
| | **SRO/Project lead:** | Bernadette Chubb | **Is the project on schedule?** | **Y** |
| | **Report author:** | Suzie Warwick | **Statistical improvement?** | **Y** |

**Driver Metrics, Milestones & workstreams:**




| | Key milestones | Delivery | Projects/workstreams |
|---|---|---|---|
| 1 | Deep dive reviews to identify themes | | |
| 2 | Formal weekly review group of PPH's | | |
| 3 | PPH relaunch week | | |
| 4 | Policy update/review | | |
| 5 | PPH medication cupboards in all labour rooms | | |
| 6 | PPH emergency trolleys | | |
| 7 | Proforma's in all birthing rooms | | |
| 8 | SIMS training involving MDT | | |

- Post partum haemorrhage co-ordinator to be identified at the beginning of each shift
- MF review tool for reviews

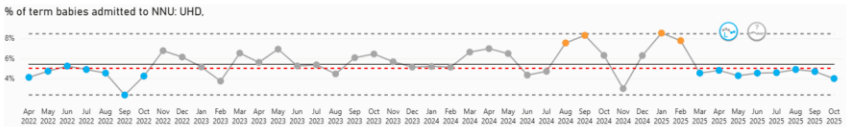
- Identified that UHD are demonstrating improvement in the number of PPH's >1500mls recorded.
- Thematic review to be undertaken to outline improvement areas.

| ALERT – Description | Actions/Mitigation taken by project | What support is requested? |
|---|---|---|
| Identified PPH's were consistently above national targets.<br>Discrepancy between data sources (Diis data / SCR data)<br>PSII declared for 6L PPH in October. | • PPH relaunch<br>• Policy review / update<br>• Drug cupboards/proformas/trolleys | To identify a lead for stillbirth thematic review |
| **ASSURE – Description** | | |
| • Current mitigations identified from themes collated during deep dive.<br>• Key messages being shared through prompt/safety messages / LW 60 seconds / risky business / hot topics<br>• Highlighting good practice / cases for learning | | |
| **ADVISE – Description** | **Actions/Mitigations taken by project** | **What support is requested?** |
| Although UHD can evidence that there has been a decrease in the number of post partum haemorrhages, it has been recognised that, the ones there have been, have been more severe overall with a higher volume of blood loss or less optimal outcome for the patient. | PPH's being reviewed in a timely manner to identify themes and areas for improvement. | SIMS training involving all teams (theatre, obstetrics etc) |

## Term admission to NICU
Highlight report for PSIRF Oversight

| Improvement programme/project title: Term admission to NICU | | | Reporting Month | December 2025 |
|---|---|---|---|---|
| **Project Goal: To reduce the number of term babies born requiring admission to the Neonatal Intensive Care Unit (NICU) and to reduce the separation time between baby and mother.** | **Exec Sponsor:** | Sarah Herbert | **Project Status** | |
| | **SRO/Project lead:** | TBC | **Is the project on schedule?** | Y |
| | **Report author:** | Suzie Warwick | **Statistical improvement?** | Y |

**Driver Metrics, Milestones & workstreams:**




- Identified improvement – consistently below national target for 8 consecutive months (March – October 25)
- Thematic review completed and actions have been identified – this will feed into the projects / workstreams

| | Key milestones | Delivery | Projects/workstreams |
|---|---|---|---|
| 1 | To undertake a thematic review | Completed | |
| 2 | To review the recommendations and create SMART actions | Completed | |
| 3 | Completion and implementation of all actions from the thematic review | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |

| ALERT – Description | Actions/Mitigation taken by project | What support is requested? |
|---|---|---|
| Identified UHD was consistently above national targets at the end of 2024 | • Working group set up by ATAIN leads<br>• Weekly high-level meetings implemented in addition to monthly ATAIN review meetings. | Ongoing engagement |

**ASSURE – Description**

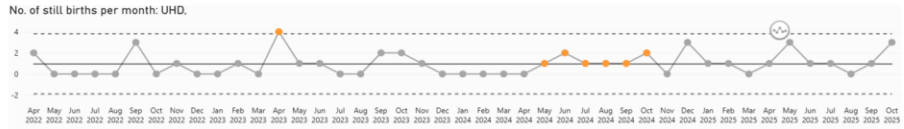
- Well attended monthly Avoiding Term Admissions Into Neonatal units (ATAIN) meetings, with leads receiving protected time for the review process.
- UHD have been below the national and regional target for 8 consecutive months.
- Bedside CPAP has been successful in helping 3 out of 4 babies avoid admission to NICU and therefore avoided separation between baby and mother.

| ADVISE – Description | Actions/Mitigations taken by project | What support is requested? |
|---|---|---|
| Ongoing implementation of bedside CPAP.<br>Ongoing projects and workstreams in line with the thematic review findings. | Ongoing work within the projects and workstreams | Ongoing engagement |

## Stillbirth
Highlight report for PSIRF Oversight

| Improvement programme/project title: Stillbirths | | | Reporting Month | December 2025 |
|---|---|---|---|---|
| **Project Goal: To meet the MBRRACE national targets and standards for stillbirths each quarter and document in the quarterly reports (currently Q2).** | **Exec Sponsor:** | Sarah Herbert | **Project Status** | |
| | **SRO/Project lead:** | TBC | **Is the project on schedule?** | N |
| | **Report author:** | Suzie Warwick | **Statistical improvement?** | N |

**Driver Metrics, Milestones & workstreams:**




- Action Tracker
- MF review tool for reviews

- Identified increase in the number of stillbirths within UHD and exceeding national targets
- No key milestones or workstreams currently identified – thematic review to be undertaken to outline improvement areas

| | Key milestones | Delivery | Projects/workstreams |
|---|---|---|---|
| 1 | Start date | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| | End date – close or BAU | | |

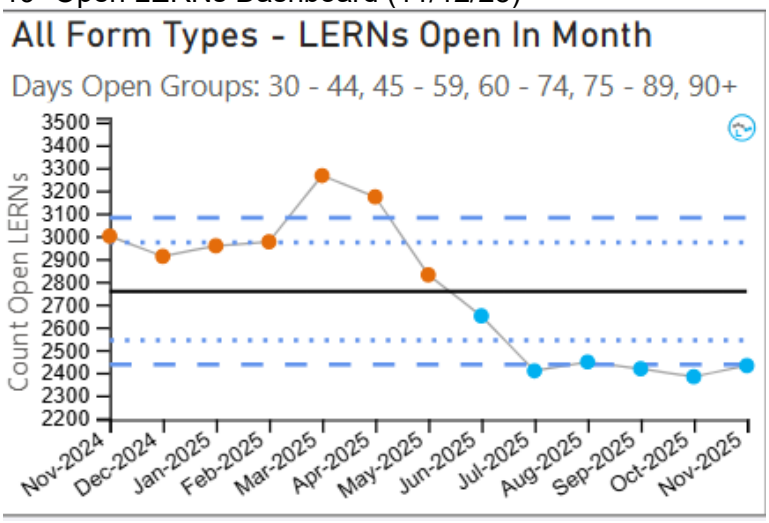
| ALERT – Description | Actions/Mitigation taken by project | What support is requested? |
|---|---|---|
| Identified at the end of 2024/2025 there was an increase in the number of stillbirths within UHD. | Escalated to trust board and LMNS. | To identify a lead for stillbirth thematic review. |

**ASSURE – Description**

- PMRT ensures detailed monthly reviews of all cases in a timely manner.
- Peer reviewed with DCH.
- Themes are being identified and potential themes observed which can be used to outline milestones and workstreams.
- Meeting MIS year 7 safety action 1 PMRT.
- Some stillbirths are MBRRACE reportable but do not meet criteria for PMRT review eg MTOP (medical termination of pregnancy)

| ADVISE – Description | Actions/Mitigations taken by project | What support is requested? |
|---|---|---|
| Potential theme was identified around missed urinalysis results | OWL (organisational wide learning) report was created and shared Trust Wide | Ongoing monitoring |

**Open LERNs:**
Data from Cosmos PBI119- Open LERNs Dashboard (11/12/25)




Improvement in reducing the number of open LERNs has been sustained for six months in a row, with significant progress in no and low harm patient safety events and restraint forms.

Number of LERNs open longer than 30 days by care group (11/12/2025)

Open LERNs - By Days Open, Care Group and Directorate

Days Open Groups: 30 - 44, 45 - 59, 60 - 74, 75 - 89, 90+

| Care Group | 30 - 44 | 45 - 59 | 60 - 74 | 75 - 89 | 90+ | Total |
|---|---|---|---|---|---|---|
| ⊞ Medical | 139 | 85 | 83 | 63 | 377 | 747 |
| ⊞ Surgical | 43 | 35 | 34 | 37 | 259 | 408 |
| ⊞ Corporate | 25 | 11 | 6 | 12 | 202 | 256 |
| ⊞ WCCSS | 52 | 33 | 35 | 19 | 91 | 230 |
| ⊞ Operations | 11 | 6 | 4 | 5 | 81 | 107 |
| ⊞ Not Stated | 8 | 2 | 4 | 2 | 69 | 85 |
| ⊞ External | 4 | 2 | 2 | 1 | 34 | 43 |
| Total | 282 | 174 | 168 | 139 | 1113 | 1876 |

Unsurprisingly, the majority of open LERNs are more than 90 days old. WCCSS have continued to close a significant number of LERNs in the last month and have less open than the Corporate Directorate. Support is available to theme and close historic LERNs via the patient safety team.

Number of LERNs open longer than 30 days by LERN form (11/12/2025)

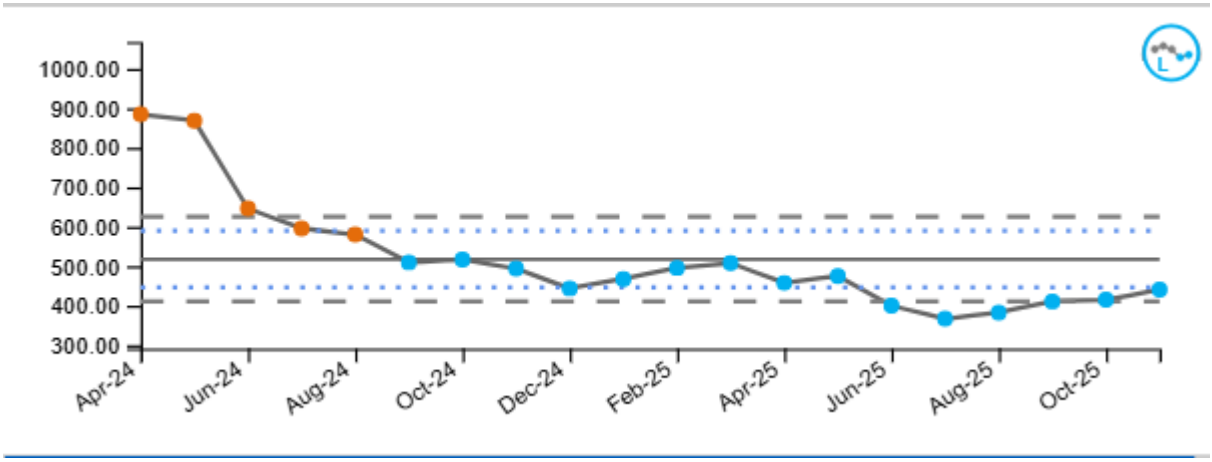
Open LERNs - By Form Type and Severity

Days Open Groups: 30 - 44, 45 - 59, 60 - 74, 75 - 89, 90+

| Form Type, Severity | 30 - 44 | 45 - 59 | 60 - 74 | 75 - 89 | 90+ | Total |
|---|---|---|---|---|---|---|
| ⊟ Patient Safety | 146 | 116 | 100 | 74 | 431 | 867 |
| Fatal | | 1 | | | 1 | 2 |
| Low | 36 | 33 | 32 | 18 | 124 | 243 |
| Moderate | 15 | 6 | 9 | 4 | 16 | 50 |
| No harm | 86 | 68 | 53 | 47 | 269 | 523 |
| Not Stated | 4 | 6 | 5 | 3 | 14 | 32 |
| Severe | 5 | 2 | 1 | 2 | 7 | 17 |
| ⊟ Staff/Ext and Other | 118 | 47 | 58 | 55 | 475 | 753 |
| Low | 21 | 3 | 8 | 9 | 101 | 142 |
| Moderate | 10 | 4 | 2 | 6 | 17 | 39 |
| No harm | 76 | 35 | 44 | 35 | 322 | 512 |
| Not Stated | 9 | 5 | 4 | 4 | 35 | 57 |
| Severe | 2 | | | 1 | | 3 |
| ⊞ Issues | 15 | 11 | 9 | 10 | 202 | 247 |
| ⊞ Restraint | 3 | | 1 | | 5 | 9 |
| Total | 282 | 174 | 168 | 139 | 1113 | 1876 |

There is a balance to be struck between prioritising the learning where it is known that harm has occurred, and the length of time it takes to review and close high harm incidents. The most frequently reported incident type is patient safety; therefore, it stands to reason that there is the most outstanding. It is also important to balance patient and staff safety. Needlestick injuries are required to remain at moderate harm until it can be determined that no blood-borne disease has been acquired. Work continues to support closure of Issues forms, which are confidential due to the nature of the event.

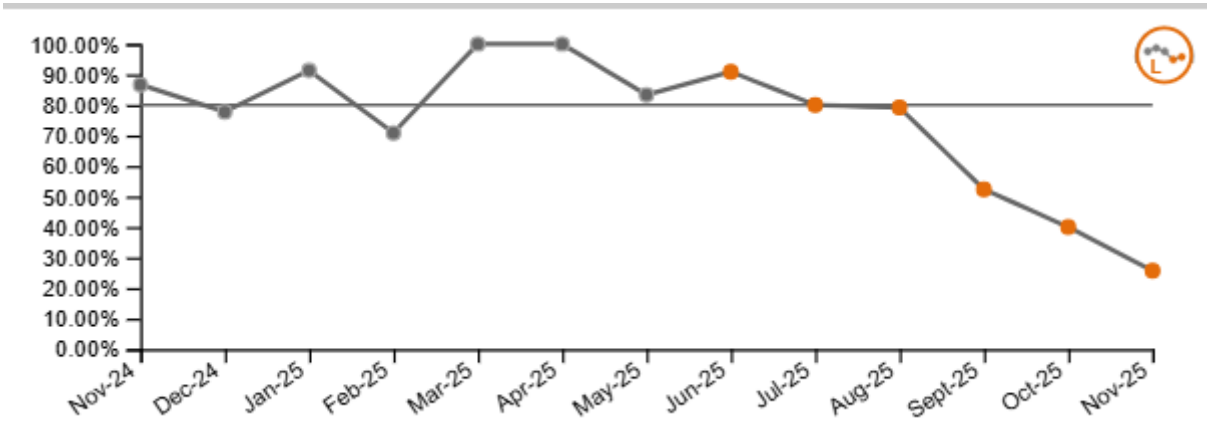
**Breaching Actions**
Data from Patient First scorecard




Sustained improvement continues to address the number of overdue actions across all levels of harm. Thank you to all the staff responsible for implementing these actions and closing them on Datix.

## Duty of Candour compliance
Data from the Patient first scorecard

Statutory duty of candour (DoC) compliance is now derived directly from LERN forms. Compliance will always be lower in recent months as the measure is when a formal letter of apology has been shared with the patient or family and it takes time to identify leads, write letters and upload to Datix.




Data from Cosmos PBI122 (Duty of Candour). Correct on 11/12/2025.

Duty of Candour Compliance by Reported Month and Combined Harm

| Combined Harm | Nov-2024 | Dec-2024 | Jan-2025 | Feb-2025 | Mar-2025 | Apr-2025 | May-2025 | Jun-2025 | Jul-2025 | Aug-2025 | Sep-2025 | Oct-2025 | Nov-2025 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Fatal | 100.0% | | 100.0% | | 100.0% | | 100.0% | | 100.0% | 100.0% | 100.0% | 100.0% | 0.0% |
| Severe | 100.0% | 100.0% | 100.0% | 40.0% | 100.0% | 100.0% | 71.4% | 100.0% | 100.0% | 100.0% | 60.0% | 33.3% | 42.9% |
| Moderate | 81.8% | 75.0% | 88.2% | 78.9% | 100.0% | 100.0% | 87.5% | 88.9% | 73.3% | 72.2% | 46.7% | 38.9% | 22.2% |
| **Total** | **86.7%** | **77.8%** | **91.3%** | **70.8%** | **100.0%** | **100.0%** | **83.3%** | **90.9%** | **80.0%** | **79.2%** | **52.4%** | **40.0%** | **25.7%** |

This new tool enables teams to identify the LERNs that are not compliant and address the requirements in a timely manner. We must not lose sight that we are counting patients that have come to harm within our care that require an apology, information and support.

This tool is also identifying LERNs that have been recorded as moderate harm or above, but other DoC status' such as 'professional', 'not applicable' or 'to be assessed' have been selected. This was not visible for oversight previously. The consequence of this is the number of 'total LERNs' that require statutory duty of candour is increasing as the status is being reviewed and amended.

The new BI tool updates daily and there will continue to be a short-term challenge as teams identify the LERNs and work out responsibility between departments to ensure the apology is delivered both verbally and in writing.

Back to report | DUTY OF CANDOUR COMPLIANCE SUMMARY BY CARE GROUP AND DIRECTORATE

| Care Group | Compliance | Total LERNs | Compliant | Non Compliant |
|---|---|---|---|---|
| **Corporate** | **100.0%** | **2** | **2** | **0** |
| **External** | | **0** | | |
| **Medical** | **71.9%** | **167** | **120** | **47** |
| Emergency & Urgent Care | 56.0% | 25 | 14 | 11 |
| Networked Medicine | 66.7% | 15 | 10 | 5 |
| OPS and Acute Care | 85.7% | 84 | 72 | 12 |
| Specialist Medicine | 55.8% | 43 | 24 | 19 |
| **Not Stated** | **0.0%** | **3** | **0** | **3** |
| **Operations** | | **0** | | |
| **Surgical** | **65.3%** | **75** | **49** | **26** |
| Anaesthetics | 63.6% | 11 | 7 | 4 |
| Head and Neck | 80.0% | 5 | 4 | 1 |
| Surgery | 52.8% | 36 | 19 | 17 |
| Trauma & Orthopaedics | 82.6% | 23 | 19 | 4 |
| **WCCSS** | **73.0%** | **37** | **27** | **10** |
| Cancer Care | 66.7% | 3 | 2 | 1 |
| Child Health | 50.0% | 4 | 2 | 2 |
| Gynaecology | 73.3% | 15 | 11 | 4 |
| Mat Neo | 100.0% | 5 | 5 | 0 |
| Pathology | | 0 | | |
| Pharmacy | | 0 | | |
| Radiology | 66.7% | 9 | 6 | 3 |
| Research | | 0 | | |
| Therapies | 100.0% | 1 | 1 | 0 |
| **Total** | **69.7%** | **284** | **198** | **86** |

Work is ongoing to address patient and family engagement. A new working group has been set up under the Quality and Safety Strategy and are devising an A3.

**Learning Response tools**
Data from Datix

| | Dec 2024 | Jan 2025 | Feb 2025 | Mar 2025 | Apr 2025 | May 2025 | Jun 2025 | Jul 2025 | Aug 2025 | Sep 2025 | Oct 2025 | Nov 2025 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal reflection (72 hours) | 44 | 55 | 58 | 57 | 60 | 68 | 70 | 76 | 68 | 51 | 84 | 47 | 738 |
| Team reflection ( 72 hours) | 30 | 41 | 41 | 30 | 49 | 39 | 32 | 49 | 32 | 44 | 31 | 25 | 443 |
| Clinical case review ( 1 month) | 9 | 13 | 14 | 13 | 9 | 9 | 10 | 11 | 9 | 11 | 9 | 5 | 122 |
| Pressure Ulcer Event Review ( 14 days) | 11 | 11 | 14 | 7 | 5 | 5 | 6 | 8 | 14 | 7 | 4 | 13 | 105 |
| AAR (20 days) | 5 | 9 | 7 | 14 | 8 | 5 | 4 | 8 | 5 | 6 | 6 | 5 | 82 |
| MDT review ( 1 month) | 0 | 7 | 3 | 3 | 5 | 8 | 4 | 5 | 8 | 5 | 4 | 8 | 60 |
| FALLS SWARM ( 5 days) | 12 | 13 | 8 | 13 | 5 | 8 | 2 | 3 | 4 | 1 | 2 | 2 | 73 |
| Timeline (14 days) | 6 | 9 | 3 | 4 | 5 | 9 | 5 | 13 | 4 | 7 | 4 | 4 | 73 |
| Thematic review ( 6 months) | 5 | 0 | 1 | 6 | 8 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 23 |
| SWARM huddle ( 5 days) | 2 | 1 | 0 | 0 | 2 | 3 | 1 | 1 | 0 | 3 | 3 | 1 | 17 |
| SMART action plan | 0 | 0 | 1 | 1 | 4 | 3 | 2 | 4 | 1 | 1 | 1 | 0 | 18 |
| PSII (6 months) | 1 | 0 | 0 | 1 | 1 | 1 | 1 | 0 | 1 | 0 | 1 | 0 | 7 |
| M&M Discussion | 1 | 2 | 1 | 0 | 1 | 1 | 0 | 3 | 1 | 0 | 2 | 3 | 15 |
| Total | 126 | 161 | 151 | 149 | 162 | 159 | 137 | 181 | 147 | 137 | 152 | 114 | 1776 |

The above table presents the learning response tool chosen to identify the learning by the reported date of the event. The tools available are being reviewed as part of the PSIRP review and the ability to gain assurance that the most appropriate tool was used, is being developed.

## Learning from investigations closed in November 2025.

<table>
<tr><th>Theme</th><th>Synopsis</th></tr>
<tr><td>L150440- Never Event- retained object</td><td>

**Summary of incident**

The patient had been admitted to hospital for an elective hysteroscopy and endometrial biopsy procedure following complaints of post-menopausal bleeding while on continuous combined hormone replacement therapy (HRT).

Following the procedure, the final count was being performed by the theatres staff nurse and the theatre support worker, and it was noted that a small 10cm x 7.5cm swab was missing.
The patient had already been transferred out of the operating room and into the recovery area at the time that this was discovered.

The surgeon was notified of the missing swab immediately upon discovery and went to the recovery area to examine the patient. The patient had not yet regained full consciousness following the anaesthetic and it was noted that she still had an airway adjunct in place.

All efforts were made to protect the patient's privacy and dignity while the surgeon examined the patient in the recovery area to locate the missing swab. The swab was found inside the patient's vagina and was removed.

**Areas for improvement**

- UHD would benefit from the development of a more robust system for the sign-out process which will account for any contributing organisational or human factors and ensure it can protect both the patients and the staff regardless of circumstance.
- It was acknowledged that, as a result of the learning and actions from the previous Patient Safety Incident Investigation (PSII) which has recently been completed in relation to retained swabs, a piece of work is currently being undertaken within theatres to develop and improve the WHO checklist to ensure the policies, processes, and protocols are aligned, more prescriptive, and provide structure and clarity of timings for the sign-out process, staff who are required to be present at this time, and to ensure that an appropriate 'time out' is held.
- It is important that the theatre team maintain open communication throughout the procedure, and if any item is removed from the trolley following the count this needs to be well and effectively communicated to the team for awareness, and to highlight and allow for its inclusion within the count.
- It was agreed that the overall responsibility of ensuring accurate completion of the WHO checklist lies with everyone in the room; but also acknowledged that this checklist is not always given the focus it requires due to additional time pressures.
- There needs to be wider education to ensure all theatre staff are aware of the reasons why they are required to complete the WHO checklist, and the importance of it, which will steer away from the concept that it is solely a paper exercise.

**Areas of good practice**

- Excellent adherence to the WHO checklist in the sign-out process.
- Prompt recognition of the missing swab and effective escalation by the theatre team which allowed for timely patient examination, swab identification, and removal.
- Duty of candour was provided promptly to the patient when she had fully regained consciousness.

**Learning points for sharing/recommendations/follow-up**

1. To consider implementing a "Stop Before Sign-Out" initiative as an immediate safety action to ensure that everyone is able to focus on the patient safety element of the sign-out process ensuring accurate completion of the checklist, encourage teamwork within this task, and to raise awareness of the importance of this.
2. To include the findings from this review and allow them to feed into the ongoing piece of work already in profess within theatres to develop and improve the WHO checklist to ensure the policies, processes, and protocols are aligned, more prescriptive, and provide more structure and clarity.
3. To co-ordinate and allow opportunities for theatres staff to attend Human Factors training.
4. To co-ordinate and allow opportunities for theatres staff to attend Duty of Candour training.
5. To link the learning from this incident to that of the previous retained swab PSII as the learning and action plan from that investigation has relevance to this event.

**Type of learning response used: PSII 2506-09** **Datix: L150440** **STEIS No: 2025/3476**

</td></tr>
<tr><td>L151176- Choking</td><td>

**Summary of incident**

Patient due to be discharged to his care home after medical assessment. There was a long delay in hospital transport in ED (Emergency Department) of many hours and also no down stream beds available. Patient choked on sandwich provided in department and went into cardiac arrest. CPR (Cardiopulmonary Resuscitation) commenced and ED consultant in attendance. Evidence of choking so suction commenced and forceps used to remove sandwich. Return of Spontaneous Circulation (ROSC) obtained but poor outcome and patient moved to resus where decision was made to withdraw care. The patient had a community Do Not Attempt Resuscitation (DNAR) and Treatment Escalation Plan (TEP) in place not for escalation to Intensive Therapy Unit (ITU).

**Areas for improvement**

- It is important to ensure **high-risk information** is clearly handed over at each step in the patient journey*
- Had it been known that the patient had level 7 regular easy to chew food and normal fluids he would likely still have had the sandwich, but he would have been more closely supervised with his food.
- In the 4 interactions following the SALT assessment in 2024, there was no documented unsafe swallow or reference to additional supervision.
- Patients attending the Emergency department from other Care Providers would benefit from a front sheet in the folder with succinct points on first page including risks and important information.
- This patient had an extended length of stay within the emergency department awaiting transport home.
- Patients with dementia can go to the discharge lounge, the criteria does not extend to wandering patients as the area is small and it is staffed by a small team who would not be able to manage them safely. All other patients with dementia are accepted.
- There are different types of assessments and care plans included in patients EPR records that are not easily visible or accessible, but it is unrealistic for ED to search through EPR to look for assessments that may not be there.
- There is not an obvious link between Alert flags and the corresponding care plans
- There is no transport service overnight leading to delays in discharge
- Further information is needed from SWAST.
- Implementation of criteria for a SALT ALERT flag was considered, however the team advised it is not possible to have an ALERT flag for all patient with feeding risks because of the sheer volume of assessments they carry out. They need a threshold for the patients that need an ALERT and those that are advisory. This patient likely met an advisory rather than an alert threshold.

**Areas of good practice**

Response and resuscitation coordination.

**Learning points for sharing/recommendations/follow-up**

- Add ALERT flag to AGYLE when swallow risk is known and audit flags added monthly for 3 months then quarterly
- Before feeding any patient with a history of stroke:
  - Assess for feeding or swallowing risks (e.g., dysphagia) by
  - Asking the patient directly if they are aware of any swallowing difficulties or special feeding requirements.
- If the patient cannot communicate or is unsure,
  - Contact the care home or responsible healthcare provider to confirm any feeding precautions or dietary plans.
  - Document findings in Agyle notes
  - Patients identified as having a feeding risk - ensure there is an alert flag added to AGYLE for future awareness.
- For nursing staff Dysphagia education module on the BEAT VLE platform. This module covers the International Dysphagia Diet Standardisation Initiative (IDDSI) framework, specifically food texture levels 3 to 7, to ensure consistent knowledge and application in patient care.
- Disseminate Learning through Governance Structure

**Type of learning response used: After Action Review** **Datix: L151176**

</td></tr>
</table>

<table>
<tr>
<td>L155236-<br>Medication</td>
<td>
<table>
<tr><th>Summary of incident</th><th>Areas of good practice</th></tr>
<tr>
<td>A decision was made to thrombolyse a patient who had become acutely unwell with a confirmed Pulmonary Embolism (PE). The patient's blood pressure had fallen to 76/40 mmHg and their oxygen saturations had dropped.<br>Staff on Ward 2 experienced difficulties in initiating the thrombolysis process, as this treatment is not routinely administered on the ward. No clear or accessible guidance (e.g. flowcharts or step-by-step protocols) was available at the time.<br>Attempts to source the thrombolytic medication from ward stock and neighbouring areas were unsuccessful. There was no pharmacist present on the ward, and pharmacy support was not immediately accessible.<br>The Critical Care Outreach Team was contacted; however, the on-call registrar was occupied in Resus with an intubated patient, resulting in further delay.<br>Subsequently, a member of the Ward 2 team located a pharmacist in the corridor and explained the situation. The pharmacist promptly obtained the necessary information and arranged for the thrombolytic medication to be supplied and delivered to Ward 2.<br>The patient received the thrombolytic treatment approximately 90 minutes after the initial decision to proceed.</td>
<td>The Registrar and Consultant on Ward 2 provided clear senior decision-making and remained present throughout the patient's care.<br>Once contacted directly, the pharmacist acted promptly to verify dosing, collect the medication, and deliver it to the ward.<br>Ward 2 staff demonstrated persistence and commitment under pressure, ensuring the patient received timely treatment despite systemic barriers.<br>The patient was successfully transferred to CCU for ongoing monitoring following thrombolysis, in line with best practice.<br>The Ward Sister appropriately raised a LERN and participated in reflective review, showing a proactive approach to patient safety.</td>
</tr>
<tr><th>Areas for improvement</th><th>Learning points for sharing/recommendations/follow-up</th></tr>
<tr>
<td>• The existing PE thrombolysis guideline is lengthy and lacks accessible visual aids (e.g., flowcharts or quick-reference tools), leading to confusion about the correct pathway and level of care.<br>• Unclear procedures for obtaining Alteplase from pharmacy and confusion existed around ward stock availability and the difference between in-hours vs. out-of-hours procurement processes.<br>• Acknowledgement of impact on staff involved and the need to provide support to them.</td>
<td>• Update the Pulmonary Embolus Guideline to include a concise flowchart for thrombolysis management, indicating escalation points, ward responsibilities, and transfer criteria.<br>• Education for staff on the correct in-hours and out-of-hours processes for obtaining thrombolytic drugs, ensuring rapid access in emergencies.<br>• Share this case in Ward 2 huddles, Medical Care Group Governance, and Pharmacy Governance meetings to highlight teamwork, escalation challenges, and resilience.<br>• Continue to support ward staff following this and similar incidents, acknowledging the emotional and operational pressures involved.</td>
</tr>
<tr><td colspan="2">Type of learning response used: After Action Review Datix: L155236</td></tr>
</table>
</td>
</tr>
<tr>
<td>L159697-<br>Diagnostics</td>
<td>
<table>
<tr><th>Summary of incident</th><th>Areas of good practice</th></tr>
<tr>
<td>Patient attended the Emergency Department following a fall at home with reports of right hip and right sided rib pain. A 'trauma' CT scan was carried out and reported "no bony injuries". The patient was admitted under the medical team for 20 days where he received inpatient physiotherapy. The patient was discharged home.<br><br>The patient followed up with his GP where he reported that he had had no further falls but was still struggling with severe right hip pain during attempts to mobilise and weight bear. It was also noted that the patient displayed shortening and rotation of the right leg – signs which indicate a fractured hip. The GP advised the patient to return to the Emergency Department for an Xray.<br><br>Patient re-attended to the Emergency Department as advised. CT scan was carried out and reported a potential hip fracture, and a subsequent Xray was done which confirmed a fracture to the right hip.</td>
<td>• Duty of Candour was carried out promptly.<br><br>• Imaging was completed and reported timely.<br><br>• Risk assessments and appropriate therapy assessments were completed safely.<br><br>• It was recognised that the patient had two further inpatient falls during the initial admission – the post falls checklists were completed and risk assessments updated following both falls with no concerning aspects or injuries to note. The patient was mobilising independently following both falls.</td>
</tr>
<tr><th>Areas for improvement</th><th>Learning points for sharing/recommendations/follow-up</th></tr>
<tr>
<td>• The clinical history given on the initial 'trauma' CT scan request focused mainly on concerns regarding the chest, with hip mentioned minimally suggesting less concern here .<br><br>• The fracture was subtle due to minimal displacement. It was not easily visible in all planes and there was also movement artefact in the pelvis.<br><br>• There was no documentation within the medical notes to evidence a review of the continuing pain in patients' hip which was escalated by the therapy and nursing teams.</td>
<td>1. Undisplaced/minimally hip fractures do not always present with the classic signs of a fracture such as leg shortening and rotation.<br>2. Identification of hip fractures on x-ray and CT relies on displacement of the fracture to make them visible on x-rays. Minimally displaced fractures are therefore difficult to see on x-ray and CT, and these tests can be false negative in up to 20% of x-rays and 10% of CT scans. MRI is most sensitive with a false negative rate of 1%.<br>3. If a patient has a normal x-ray or CT but is still not weightbearing or still in significant pain, consider an MRI scan.</td>
</tr>
<tr><td colspan="2">Type of learning response used: Clinical Case Review Datix: L159697</td></tr>
</table>
</td>
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## Patient safety team activity

### Duty of Candour Process

The duty of candour letter process is currently under review and will be updated alongside the supporting toolkit. This work aims to standardise the production of high-quality letters of apology across the organisation.

### Patient Safety Incident Response Plan (PSIRP)

The current PSIRP is being reviewed, with work underway to identify key themes for consideration in the next iteration of the plan. A collaborative workshop will be scheduled to support this process.

### PSIRF Templates

As part of the review, all existing PSIRF templates are being assessed to ensure they effectively support learning and contribute to a continuous improvement oversight loop.

**Assurance and Oversight**
To provide organisational assurance regarding PSIRF priorities, highlight reports will be presented at the PSIRF Oversight meeting every two months. The latest highlight reports are included within this update.

**Datix and IT Integration**
The Patient Safety team is working with Datix and IT to ensure continuity of email notifications when the UHD email relay is switched off and Microsoft implements changes to its authentication process.

**Risk Management Strategy**
The risk management strategy is being updated to reflect recent process changes, including the establishment of the Risk Oversight Committee sub-board group and guidance from the Good Governance Institute.

**Learning from Restraint Incidents**
Ongoing work is focused on improving learning from restraint incidents. A fortnightly Restraint Rapid Review has been introduced to review all restraint cases from the preceding two weeks. This multidisciplinary process aims to triage incidents, agree on appropriate learning responses, and collate themes for improvement.

**Collaborative Data and Learning Initiatives**
The team continues to work closely with Tissue Viability, Falls, Maternity, and IPC teams to enhance data collection from Datix and strengthen processes for learning from incidents.

Other regular Patient safety team activity include:

- Ongoing training for duty of candour, LERN reporting, LERN reviewing, PSIRF learning responses, risk register training, After action review facilitation, ad-hoc patient safety training. More info/ dates: https://intranet.uhd.nhs.uk/uploads/quality-risk/documents/training/2025_training_dates_v3.pdf
- Working with the fundamentals of care workstreams
- Supporting care groups implementation of PSIRF
- Pulling together the UHD PSIRF oversight agenda and documentation for shared learning
- Answering Freedom of Information requests
- Validating LERNs (almost 2000 per month)
- Implementing risk management strategy

## Healthcare Services Safety Investigation Branch (HSSIB) reports –November 2025

| Title | Findings/recommendations | Hyperlink |
|---|---|---|
| Electronic patient record (EPR) systems – thematic review | The review found that EPR systems could contribute to the risks of patient care being missed, delayed or incorrect. These risks were persistent despite national recommendations and actions seeking to mitigate them.<br>HSSIB had a number of findings under the following headings:<br>• Choosing an EPR system capable of meeting the needs of an organisation<br>• Implementing an EPR system that meets the needs of users<br>• Seeking feedback and ongoing EPR system optimisation<br>• Supporting safe selection and procurement of an EPR system<br>• Supporting safe implementation of an EPR system<br>• Supporting ongoing optimisation of an EPR system | Electronic patient record (EPR) systems – thematic review |

University Hospitals Dorset
NHS Foundation Trust

**BOARD OF DIRECTORS - PART 1 MEETING**

**Meeting Date: 14 January 2026**

**Agenda item: 10.1**

| | |
|---|---|
| **Subject:** | Guardian of Safe Working- Quarterly report |
| **Prepared by:** | Paul Froggatt, Julie Mantell, Nicola Craig |
| **Presented by:** | Paul Froggatt, Peter Wilson |

| | | |
|---|---|---|
| **Strategic themes that this item supports/impacts:** | Population & System<br>Our People<br>Patient Experience<br>Quality Outcomes & Safety<br>Sustainable Services | ☐<br>☒<br>☐<br>☒<br>☐ |
| **BAF/Corporate Risk Register: (if applicable)** | | |
| **Purpose of paper:** | Information | |
| **Executive Summary**: | Good levels of exception reporting, as expected across acute specialties. There has been an increase in the number of exception reports at both sites, however Poole has seen an increase of 69 reports, compared to the previous quarter. It is not unusual to see a higher rate of reporting in this quarter but of note an increase of reporting from more senior resident doctors is noted. In addition, there were a total of 14 Immediate Safety Concerns for the Trust, mostly related to hours worked. | |
| **Background:** | Resident doctors are employed by the trust as per 2016 TCS. A mandatory component is the role of the GoSW and the preparation of quarterly & annual reports regarding exception reports & the resident doctors forum (JDF) | |
| **Key Recommendations**: | GoSW to liaise with RDs & Care Group Leads to ensure timely escalation of any safety concerns. | |
| **Implications associated with this item:** | Council of Governors<br>Equality, Equity, Diversity & Inclusion<br>Financial<br>Health Inequalities<br>Operational Performance<br>People (inc Staff, Patients)<br>Public Consultation<br>Quality<br>Regulatory<br>Strategy/Transformation<br>System | ☐<br>☐<br>☐<br>☐<br>☐<br>☐<br>☐<br>☐<br>☐<br>☐<br>☐ |

| CQC Reference: | | |
|---|---|---|
| | 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 | 05/01/2026 | 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

# GUARDIAN OF SAFE WORKING REPORT

## 1st July to 30th September 2025

## UNIVERSITY HOSPITALS DORSET

**CONTENTS:**

**GSW Summary**

Apologies there is no GSW summary available at this time.

**Resident Doctor Forums**

There were two Resident Doctor Forums during this period.

**22nd July – this meeting was quorate**:

July strike action was raised – there were no concerns or comments from RDF

Exception Reporting: UHD had started the new process for exception reporting i.e. under 2 hrs were dealt with automatically through Medical Staffing meaning no supervisor approval was needed. Haem and oncology had asked for these not to be processed automatically and for these to be referred back to dept. Kristie Hancock advised that UHD has gone early with the 2hr process – is not mandatory until September. Peter Wilson wanted to ensure the the Trust worked with one process rather than depts working differently to others. Dr Poynter advised that she will liaise with Rachel Ford to ensure there are no delays in payment approval processes.

Health and Wellbeing: RDs wanted to have more communication relating to health and wellbeing. It was advised that there are lots of posters around and communications in the Bulletin and Brief. Julie Mantell advised that will look to provide more communication relating to Health and Wellbeing. It was also suggested that this could be supported by the Doctors Mess and including in WhatsApp updates by the RDC (Resident Doctor Committee).

Study Budget/Allowance for F2: Discussions were had around the changes to Foundation F2 study course and budget provision. Dr Poynter clarified the process at the the time and that any queries should be addressed to the FPDs (Mihye Lee and Craig Prescott).

2025-26 Resident Doctor Committee Representatives: A call has been put out for doctors who are interested in forming the next Resident Doctor Committee and Representatives.

Strike Action: Peter Wilson finished by stating that resident doctors who are coordinating the strike action on both sites to feel free to contact him directly for any issues or concerns they may have.

**8th September – this was cancelled as was poorly attended.**

**25th September**: An extraordinary RDF meeting was held with attendance from Resident Doctors across both sites to discuss the 10 Point Plan. To discuss the points individually and to inform our Trust feedback.

**University Hospitals Dorset: Poole Hospital**

**High level data**

Number of doctors / dentists in training (total): 214.4

Number of doctors / dentists in training on 2016 TCS (total): 214.4

Amount of time available in job plan for guardian to do the role: 1 PAs/4hrs per week

Admin support provided to the guardian (if any): 0.13 WTE

**Exception reports**

| Speciality | Exceptions raised 1st July to 30th September 2025 | Exceptions raised outside of 14 days from event | Outcome agreed (*not closed*) | Number of exceptions closed | Number of exceptions outstanding |
|---|---|---|---|---|---|
| **Colorectal/Upper GI** | 16 | 0 | 0 | 12 | 4 |
| **Emergency Medicine** | 19 | 0 | 0 | 16 | 3 |
| **ENT** | 1 | 0 | 0 | 1 | 0 |
| **General Medicine** | 90 | 0 | 0 | 84 | 6 |
| **General Surgery** | 27 | 4 | 0 | 27 | 0 |
| **Haematology/Onc** | 29 | 0 | 0 | 28 | 1 |
| **OPS** | 78 | 0 | 0 | 73 | 5 |
| **Respiratory** | 4 | 1 | 0 | 3 | 1 |
| **Vascular** | 2 | 0 | 0 | 2 | 0 |
| **Women's Health** | 2 | 0 | 1 | 1 | 0 |
| **Total** | **268** | **5** | **1** | **247** | **20** |

*(Source: Allocate and HealthRota)*

Five exceptions which were entered in error have been included in the exceptions closed figures (2 for OPS, 2 for Upper GI and 1 for General Medicine).

Two exceptions were rejected and included within the exceptions closed figures (2 for General Medicine).

## Brief Overview of Exception Reports Raised

There was total of 268 exception reports raised for the quarter 1st July to 30th September 2025. This has increase by 69 compared to the last quarter.

There were eight patient safety concerns raised during this quarter, this is a decrease of four from the previous quarter figure of twelve. Interestingly 5 were from within the surgical directorate.

| Rota/Dept | Number of ISCs Raised | Grade | Reasons |
|---|---|---|---|
| General Medicine | 1 | FY1 | Inadequate Supervision |
| General Medicine | 1 | FY2 | Difference in hours worked |
| OPS | 1 | Junior Clinical Fellow | Difference in hours worked |
| Colorectal | 2 | FY1 | Unable to take breaks |
| Colorectal | 1 | FY1 | Inadequate clinical exposure/experience |
| General Surgery | 1 | FY1 | Difference in hours worked |
| Colorectal | 1 | FY1 | Difference in hours worked |

## Exception Reports – Previous Quarter Comparisons

| Speciality | Exceptions raised 1st April to 30th June 2025 | Exceptions raised 1st July to 30th September 2025 |
|---|---|---|
| **Colorectal/Upper GI** | 19 | 16 |
| **Emergency Medicine** | 15 | 19 |
| **ENT** | 1 | 1 |
| **General Medicine** | 35 | 90 |
| **General Surgery** | 24 | 27 |
| **Haematology/Oncology** | 29 | 29 |
| **Liaison Psychiatry** | 1 | 0 |
| **OPS** | 73 | 78 |
| **Respiratory** | 1 | 4 |
| **Vascular** | 0 | 2 |

| | | |
|---|---|---|
| **Women's Health** | 1 | 2 |
| **Total** | **199** | **268** |

## Reasons for Exceptions Raised

Over 92% of reports raised were in relation to staff working over their contracted hours, this remains as the key reporting reason. These reports were raised by 72 doctors during this period.

| Working over contracted hours | Access to Education | Shift Pattern | Service Support | Natural Breaks/Rest |
|---|---|---|---|---|
| 247 | 9 | 1 | 3 | 8 |

*(Source: Allocate)*

## Reporting Grades for this Period

Interestingly more higher grades are beginning to exception report which historically had been predominantly Foundation grades.

| FY1 | FY2 | GP/ST1/2 | Trust SHO | IMT1/CT1/ST1 | IMT2/CT2/ST2 | IMT3/CT3/ST3 | ST4+ |
|---|---|---|---|---|---|---|---|
| 118 | 38 | 8 | 70 | 12 | 11 | 10 | 1 |

*(Source: Allocate)*

## Outcome Types Agreed

| Overtime payment | Time off in lieu | No further action | Created in error | Request for more info | Work Schedule Review/Pattern | Outcome Still Awaited |
|---|---|---|---|---|---|---|
| 138 | 102 | 2 | 5 | 0 | 0 | 21 |

*(Source: Allocate)*

## Fines

There were no fines this quarter.

## Vacancies – Doctors in Training

| Department | Number of vacancies |
|---|---|
| **Anaesthetics** | 1 |
| **Diabetes & Endo** | 1 |
| **ENT** | 2 |
| **Gastro** | 1 |
| **OPS** | 1 |

*(Source: Medical Staffing)*

**Locum Bookings via Bank**

The below table indicates the number of shifts and hours worked through the bank during this period, identifying whether increase / decrease from the previous quarter.

| Locum bookings (Bank) by department | | | | |
|---|---|---|---|---|
| **Specialty** | **Number of shifts requested** | **Number of shifts worked** | **Number of hours requested** | **Number of hours worked** |
| **Anaesthetics** | 13 ↑ | 6 ↓ | 154 ↑ | 66 ↓ |
| **Emergency Medicine** | 703 ↑ | 542 ↑ | 6,494 ↑ | 4,991 ↑ |
| **ENT** | 105 ↑ | 84 ↑ | 900 ↑ | 705 ↑ |
| **General Surgery** | 33 ↑ | 17 - | 347 ↓ | 177 ↓ |
| **Maxillo-facial Surgery** | 48 ↓ | 43 ↓ | 315 ↓ | 295 ↓ |
| **Medicine** | 299 ↑ | 223 ↑ | 2,955 ↑ | 2,223 ↑ |
| **Obstetrics and Gynaecology** | 7 ↓ | 7 ↓ | 49 ↓ | 49 ↓ |
| **Oncology** | 104 ↓ | 90 ↑ | 965 ↓ | 843 ↑ |
| **Orthopedic Surgery** | 445 ↓ | 352 ↓ | 4,227 ↓ | 3,341 ↓ |
| **Paediatrics** | 61 ↑ | 40 ↑ | 670 ↑ | 451 ↑ |
| **TOTAL** | **1,818 ↑** | **1,404 ↑** | **17,075 ↑** | **13,140 ↑** |

*(Source Temp Staffing Office)*

During this quarter there was a decrease of 1% in the overall number of locum shifts from 1803 to 1818 during this quarter.

There has been a notable decrease in Obstetrics and Gynaecology from 32 to 7 shifts requested (78% decrease).

There has been a continued increase within Emergency Medicine from 688 to 703 shifts (2% increase). The most significant increases have been within Anaesthetics from 8 to 13 shifts (62% increase) and Paediatrics from 26 to 61 (135% increase).

The most unfilled shifts were within Anaesthetics (54% unfilled) and General Surgery (48% unfilled).

The table below shows a different aggregation in which the grades for locum shifts were requested.

| Locum bookings (Bank) by Grade | | | | |
|---|---|---|---|---|
| **Grade** | **Number of shifts requested** | **Number of shifts worked** | **Number of hours requested** | **Number of hours worked** |
| **F1** | 2 ↓ | 1 ↓ | 25 ↓ | 13 ↓ |
| **F2** | 4 ↓ | 0 ↓ | 30 ↓ | 0 ↓ |
| **ST/CMT1/2** | 1,439 ↓ | 1,106 ↓ | 13,241 ↓ | 10,147 ↓ |
| **ST3+** | 373 ↑ | 297 ↑ | 3,779 ↑ | 2,981 ↑ |
| **TOTAL** | **1,818 ↑** | **1,404 ↑** | **17,075 ↑** | **13,140 ↑** |

*(Source Temp Staffing Office)*

Continuing the previous quarters trend, the majority of shifts (79%) have been requested at ST/CMT 1/2 grades.

There has been a slight increase in the number of shifts worked from 75% between April and June to 77% in July to September.

| Locum Bookings (Bank) by Reason | | | | |
|---|---|---|---|---|
| **Reason** | **Number of shifts Requested** | **Number of shifts worked** | **Number of hours Requested** | **Number of hours Worked** |
| **Annual Leave** | 153 ↑ | 113 ↑ | 1,315 ↑ | 953 ↑ |
| **Covering Absent Colleagues** | 71 ↑ | 51 ↑ | 701 ↑ | 520 ↑ |
| **Deanery Vacancy** | 46 ↓ | 41 ↓ | 465 ↓ | 423 ↓ |
| **Escalations** | 30 ↓ | 10 ↓ | 273 ↓ | 88 ↓ |
| **Industrial Action** | 322 ↑ | 235 ↑ | 3,295 ↑ | 2,461 ↑ |
| **LTFT Cover** | 23 ↓ | 18 ↑ | 255 ↓ | 190 ↑ |
| **Maternity/Paternity Leave** | 19 ↑ | 16 ↑ | 121 ↑ | 92 ↑ |
| **Service Demand (e.g winter pressures)** | 169 ↓ | 149 ↓ | 1,644 ↓ | 1,430 ↓ |
| **Sickness** | 151 ↓ | 84 ↓ | 1,419 ↓ | 756 ↓ |
| **Study Leave** | 40 ↑ | 27 ↑ | 358 ↑ | 238 ↑ |
| **Trust vacancy** | 755 ↑ | 632 ↑ | 6,931 ↑ | 5,787 ↑ |
| **Urgent Clinical Need** | 34 ↓ | 23 ↓ | 262 ↓ | 162 ↓ |
| **WLI (Waiting List Initiative)** | 5 ↑ | 5 ↑ | 39 ↑ | 39 ↑ |

| | | | | |
|---|---|---|---|---|
| **TOTAL** | **1,818 ↑** | **1,404 ↑** | **17,075 ↑** | **13,140 ↑** |

*(Source Temp Staffing Office)*

This quarter, the notable increases have been for Study Leave which have increased by 67% from 24 to 40 shifts and Maternity/Paternity Leave by 46% from 13 to 19 shifts.

Industrial Action shift requests did not feature in the previous quarters list of reasons.

Whilst there have been significant decreases in Escalations of 75% from 119 to 30 shifts and Urgent Clinical Need by 88% from 291 to 34 shifts.

The highest percentage of shifts unfilled were for Escalations and Sickness.

**Locum Bookings via Agency**

| | | |
|---|---|---|
| **Grade** | **Number of shifts requested** | **Number of shifts worked** |
| **FY1** | 0 - | 0 - |
| **FY2** | 0 - | 0 - |
| **ST1/2 - CT1/2** | 14 ↓ | 14 ↓ |
| **ST3 +** | 8 ↓ | 3 ↑ |
| **TOTALS** | **22 ↓** | **17 ↓** |

*(Source Temp Staffing Office)*

**University Hospitals Dorset: Royal Bournemouth Hospital**

**High level data**

Number of doctors / dentists in training (total): 204.6

Number of doctors / dentists in training on 2016 TCS (total): 204.6

Amount of time available in job plan for guardian to do the role: 1 PAs/4hrs per week

Admin support provided to the guardian (if any): 0.13 WTE

**Exception reports**

| Speciality | Exceptions raised 1st July to 30th September 2025 | Exceptions raised outside of 14 days from event | Outcome agreed (not closed) | Number of exceptions closed | Number of exceptions outstanding |
|---|---|---|---|---|---|
| **Acute** | 4 | 0 | 0 | 4 | 0 |
| **Cardiology** | 6 | 0 | 0 | 6 | 0 |
| **Colorectal** | 12 | 1 | 0 | 7 | 5 |
| **Diabetes and Endocrine** | 3 | 0 | 0 | 2 | 1 |
| **Emergency Medicine** | 11 | 0 | 0 | 11 | 0 |
| **General Medicine** | 11 | 0 | 0 | 9 | 2 |
| **General Surgery** | 1 | 0 | 0 | 1 | 0 |
| **Haematology/Onc** | 5 | 0 | 0 | 5 | 0 |
| **OPS** | 23 | 0 | 0 | 22 | 1 |
| **Psychiatry** | 2 | 2 | 0 | 0 | 2 |
| **Respiratory** | 16 | 0 | 0 | 14 | 2 |
| **Upper GI** | 7 | 0 | 0 | 6 | 1 |

| | | | | | |
|---|---|---|---|---|---|
| **Urology** | 11 | 0 | 0 | 9 | 2 |
| **Vascular** | 15 | 2 | 0 | 13 | 2 |
| **Women's Health** | 1 | 0 | 0 | 1 | 0 |
| **Total** | **128** | **5** | **0** | **110** | **18** |

*(Source: Allocate and HealthRota)*

**Brief Overview of Exception Reports Raised**

There was a total of 128 exception reports raised during the quarter 1st July to 30th September, an increase of 19 compared to the previous quarter.

Two exceptions which were entered in error have been included in the exceptions closed figures (1 for Urology and 1 for Vascular). Five exceptions which were rejected have been included in the exceptions closed figures, 1 for Emergency Medicine, 2 for Vascular, 1 for Urology and 1 for Upper GI.

**Patient Safety Concerns Raised**

There were eight patient safety concerns raised during this quarter, decreasing from sixteen in the previous quarter. Of note 6 of the PSCs were within the surgical directorate.

| Rota/Dept | Number of ISCs Raised | Grade | Reasons |
|---|---|---|---|
| Respiratory | 1 | Trust SHO | Difference in hours worked |
| Colorectal | 3 | FY1 | Unable to take breaks |
| Colorectal | 1 | FY2 | Difference in hours worked |
| Upper GI | 1 | FY1 | Difference in hours worked |
| Urology | 1 | FY2 | Difference in hours worked |
| Emergency Medicine | 1 | FY2 | Difference in hours worked |

**Exception Reports – Previous Quarter Comparisons**

| Speciality | Exceptions raised 1st April to 30th June 2025 | Exceptions raised 1st July to 30th September 2025 |
|---|---|---|
| Acute | 0 | 4 |
| Cardiology | 11 | 6 |
| Colorectal | 9 | 12 |
| Diabetes and Endocrine | 2 | 3 |
| Emergency Medicine | 1 | 11 |
| Gastroenterology | 2 | 0 |
| General Medicine | 11 | 11 |
| General Surgery | 0 | 1 |
| Haematology/Onc | 1 | 5 |
| OPS | 9 | 23 |
| Palliative Care | 6 | 0 |
| Psychiatry | 3 | 2 |
| Respiratory | 4 | 16 |
| Stroke | 1 | 0 |
| Upper GI | 29 | 7 |
| Urology | 15 | 11 |

| | | |
|---|---|---|
| **Vascular** | 4 | 15 |
| **Women's Health** | 1 | 1 |
| **Total** | 109 | 128 |

## Reasons for Exceptions Raised

The main reason for exceptions being raised during this quarter was for doctors working over their contracted hours totalling 87% of the reports; a theme which follows the pattern of the previous quarter.

| Working over contracted hours | Access to Education | Shift Pattern | Service Support | Natural Breaks/Rest |
|---|---|---|---|---|
| 111 | 5 | 0 | 0 | 12 |

*(Source: Allocate and HealthRota)*

## Reporting Grades for this Period

| FY1 | FY2 | GP/ST1/2 | Trust SHO | IMT1-2 | ST1/ST2/CT1/CT2 | IMT3/ST3/CT3+ |
|---|---|---|---|---|---|---|
| 69 | 23 | 3 | 15 | 16 | 0 | 2 |

*(Source: Allocate and HealthRota)*

## Outcome Types Agreed

| Overtime payment | Time off in lieu | No further action | Created in error | Request for more info | Work Schedule Review/Pattern | Outcome Still Awaited |
|---|---|---|---|---|---|---|
| 45 | 59 | 5 | 2 | 0 | 0 | 17 |

*(Source: Allocate and HealthRota)*

## Vacancies

| Department | Number of vacancies |
|---|---|
| **Anaesthetics** | 2 |
| **Cancer Care** | 1 |
| **ED** | 2 |
| **OMF** | 5 |

| | |
|---|---|
| **Ophthalmology** | 2 |
| **OPS** | 1 |
| **Orthodontics** | 1 |
| **Stroke** | 1 |

*(Source: Medical Staffing)*

## Fines

There were no fines this quarter.

## Locum Bookings Via Bank

| **Locum bookings (Bank) by department** | | | | |
|---|---|---|---|---|
| **Specialty** | **Number of shifts requested** | **Number of shifts worked** | **Number of hrs requested** | **Number of hrs worked** |
| **Anaesthetics** | 11 ↓ | 10 ↓ | 133 ↓ | 120 ↓ |
| **Emergency Medicine** | 686 ↑ | 507 ↑ | 6,388 ↑ | 4,739 ↑ |
| **General Surgery** | 181 ↑ | 136 ↑ | 1,861 ↑ | 1,428 ↑ |
| **Medicine** | 585 ↑ | 394 ↑ | 5,805 ↑ | 4,079 ↑ |
| **Obstetrics and Gynaecology** | 178 ↑ | 144 ↑ | 1,779 ↑ | 1,434 ↑ |
| **Oncology** | 2 ↑ | 2 ↑ | 20 ↑ | 20 ↑ |
| **Ophthalmology** | 2 ↓ | 2 ↓ | 9 ↓ | 9 ↓ |
| **Orthopedic Surgery** | 177 - | 141 - | 1,362 ↓ | 1,084 ↑ |
| **Urology** | 27 ↑ | 24 ↑ | 233 ↑ | 200 ↑ |
| **TOTAL** | **1,849** | **1,360** | **17,589** | **13,112** |

*(Source Temp Staffing Office)*

The above table highlights the number of shifts and hours worked, compared to the previous quarter figures.

There was an increase of 31% in the number of shifts requested from 1415 to 1849 with 74% of these worked during the quarter. The majority of the number of increased shifts requested have been in Emergency, General Surgery, Medicine, O&G.

The notable increases in number of shifts requested have been in Medicine from 404 to 585 shifts (45% increase), Obstetrics and Gynaecology from 113 to 178 (58% increase) and Urology from 15 to 27 shifts (80% increase).

Most departments have seen increases, except within Anaesthetics which has decreased by 63% from 30 to 11 shifts and Ophthalmology by 60% from 5 to 2 shifts.

The most unfilled shifts were within Emergency Medicine (26% unfilled) and Medicine (33% unfilled).

The table below shows a different aggregation in which the grades for locum shifts were requested. Continuing the previous quarters trend, the majority of shifts (77%) have been requested at ST/CMT 1/2 grades.

| Locum bookings (Bank) by Grade | | | | |
|---|---|---|---|---|
| **Grade** | **Number of shifts requested** | **Number of shifts worked** | **Number of hours requested** | **Number of hours worked** |
| **F1** | 11 ↑ | 3 ↑ | 111 ↑ | 25 ↑ |
| **F2** | 24 | 13 | 162 | 76 |
| **ST/CMT1/2** | 1,430 ↑ | 1,108 ↑ | 13,475 ↑ | 10,570 ↑ |
| **ST3+** | 384 ↑ | 236 ↑ | 3,842 ↑ | 2,441 ↑ |
| **TOTAL** | **1,849** ↑ | **1,360** ↑ | **17,589** ↑ | **13,112** ↑ |

*(Source Temp Staffing Office)*

There was a decrease in the number of shifts with 74% between July and September compared to 82% between April and June.

| Locum Bookings (Bank) by Reason | | | | |
|---|---|---|---|---|
| **Reason** | **Number of shifts Requested** | **Number of shifts worked** | **Number of hours Requested** | **Number of hours Worked** |
| **Annual Leave** | 115 ↑ | 89 ↑ | 1,079 ↑ | 844 ↑ |
| **Civil Duty** | 11 ↑ | 9 ↑ | 105 ↑ | 86 ↑ |

| | | | | |
|---|---|---|---|---|
| **Covering Absent Colleagues** | 55 ↑ | 39 - | 566 ↑ | 420 ↑ |
| **Deanery Vacancy** | 193 ↑ | 163 ↑ | 1,912 ↑ | 1,619 ↑ |
| **Escalations** | 13 ↓ | 8 ↓ | 121 ↓ | 73 ↓ |
| **Industrial Action** | 353 ↑ | 201 ↑ | 3,593 ↑ | 2,226 ↑ |
| **LTFT Cover** | 15 ↓ | 14 ↓ | 188 ↓ | 175 ↓ |
| **Maternity/Paternity Leave** | 32 ↑ | 22 ↑ | 357 ↑ | 237 ↓ |
| **Service Demand (e.g winter pressures)** | 122 ↓ | 101 ↓ | 1,020 ↓ | 831 ↓ |
| **Sickness** | 191 ↓ | 119 ↓ | 1,724 ↓ | 1,097 ↓ |
| **Study Leave** | 3 ↓ | 3 ↓ | 29 ↓ | 29 ↓ |
| **Trust vacancy** | 397 ↑ | 286 ↑ | 3,615 ↑ | 2,611 ↑ |
| **Urgent Clinical Need** | 345 ↓ | 302 ↓ | 3,248 ↓ | 2,829 ↓ |
| **WLI (Waiting List Initiative)** | 4 ↓ | 4 ↓ | 36 ↓ | 36 ↓ |
| **TOTAL** | **1,849 ↑** | **1,360 ↑** | **17,589 ↑** | **13,112 ↑** |

*(Source Temp Staffing Office)*

This quarter, the biggest bank locum bookings increase has been for Trust Vacancy raising from 196 to 397 shifts (103% increase) and Deanery Vacancy rising from 120 to 193 shifts (61%).

The notable decreases have been for Study Leave from 16 to 3 shifts (81% decrease) and 13 to 4 shifts (69% decrease).

The highest percentages of shifts worked were for LTFT at 93% then Study Leave and WLI with 100% shifts worked.

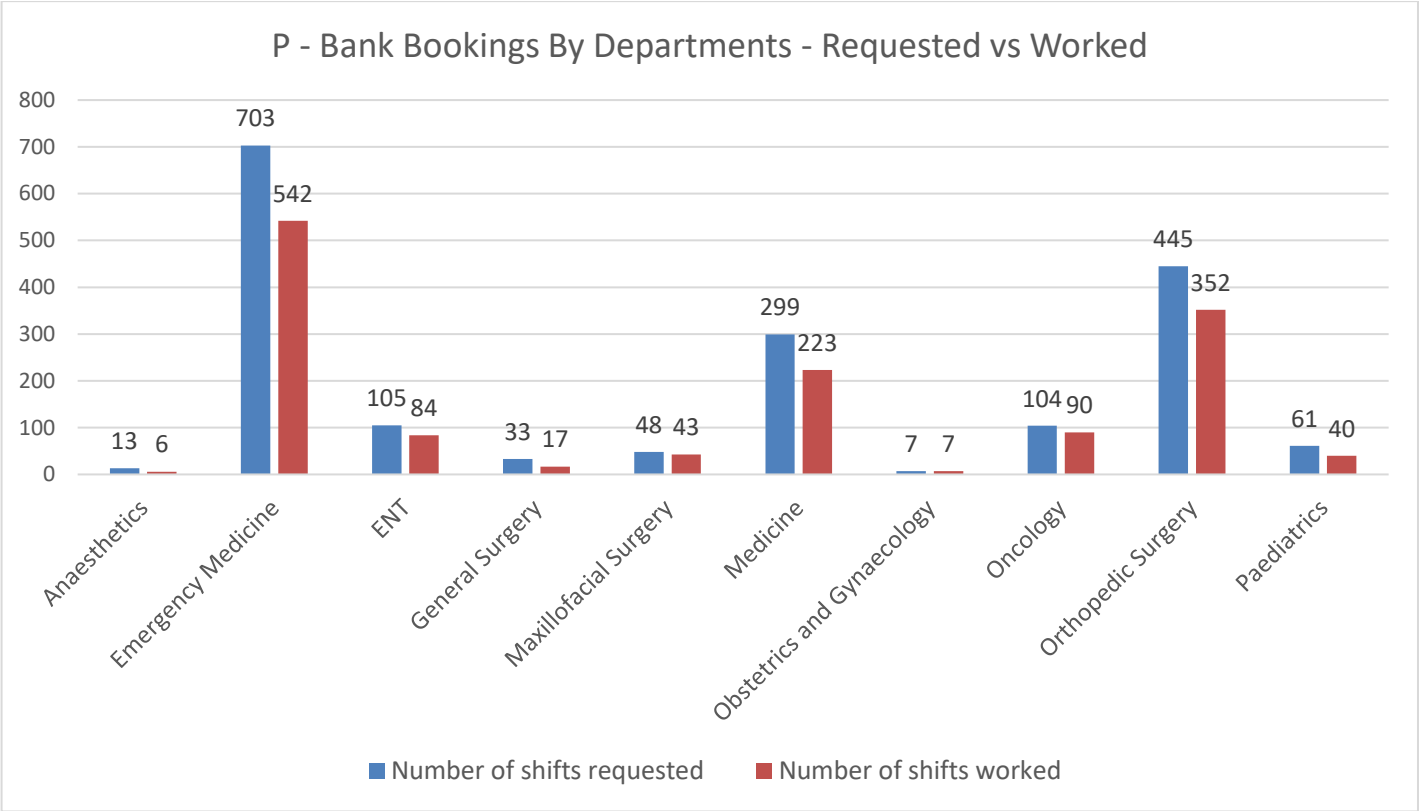
### Locum Bookings via Agency

| **Locum bookings by Grade** | | |
|---|---|---|
| **Grade** | **Number of shifts requested** | **Number of shifts worked** |
| **FY1** | 0 - | 0 - |
| **FY2** | 0 - | 0 - |
| **ST1/2 - CT1/2** | 0 - | 0 - |
| **ST3+** | 0 - | 0 - |
| **TOTAL** | **0 -** | **0 -** |

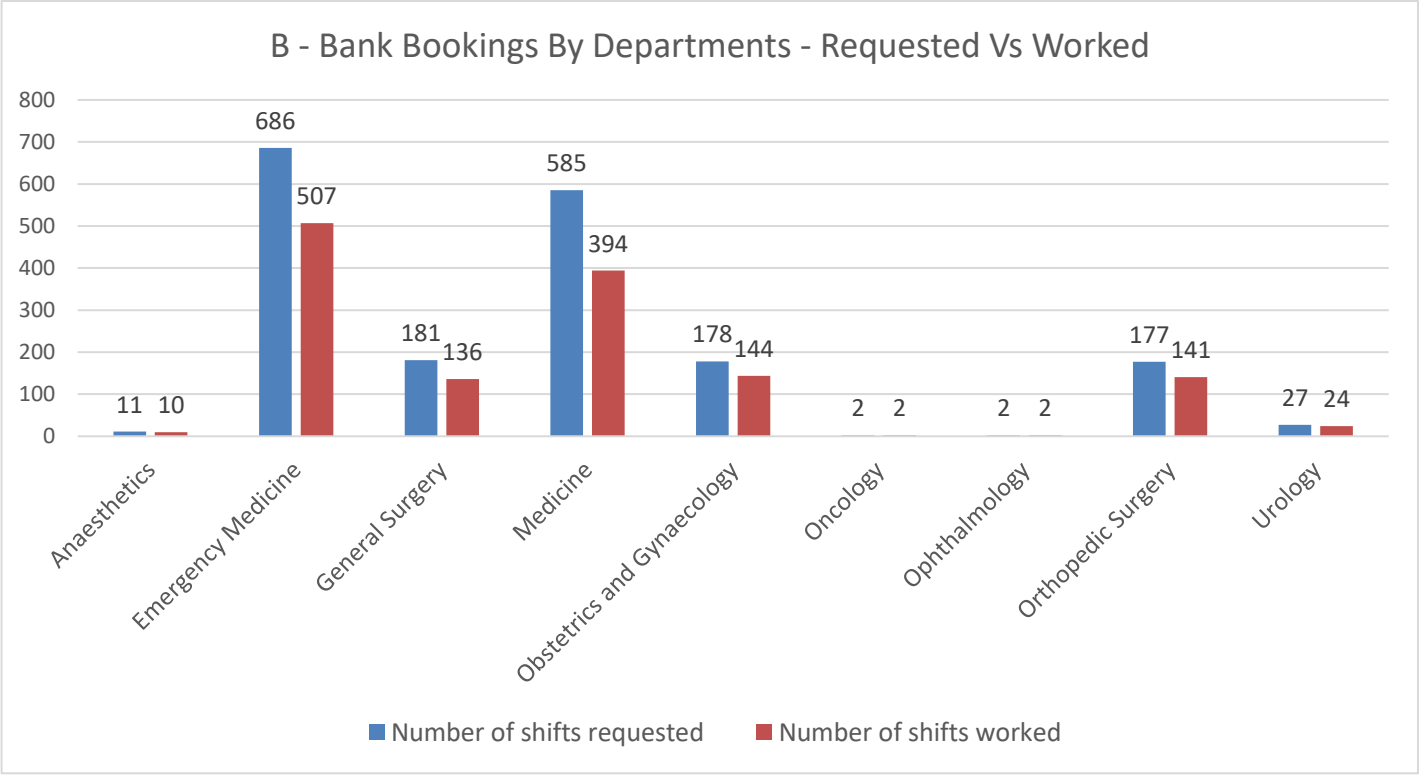
*(Source Temp Staffing Office)*

**Visual Data Representations**

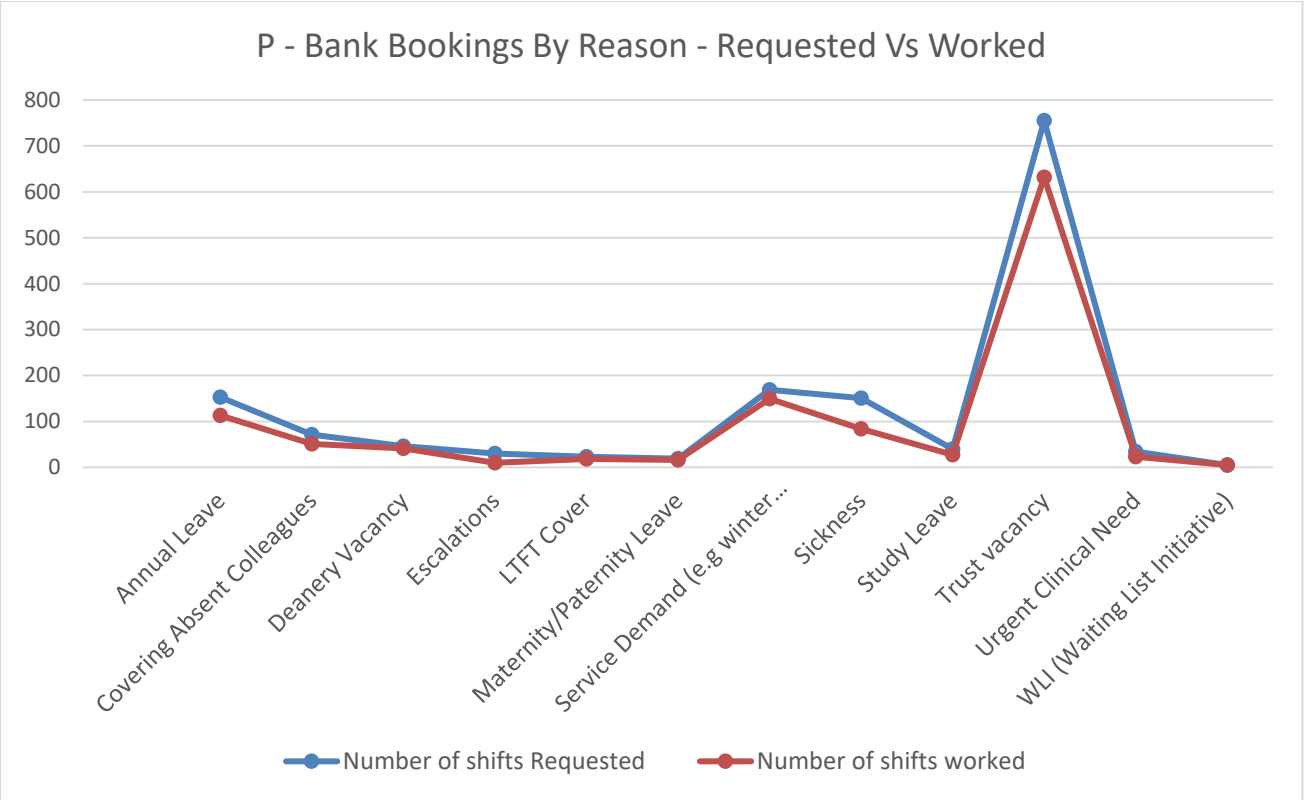
**Poole**



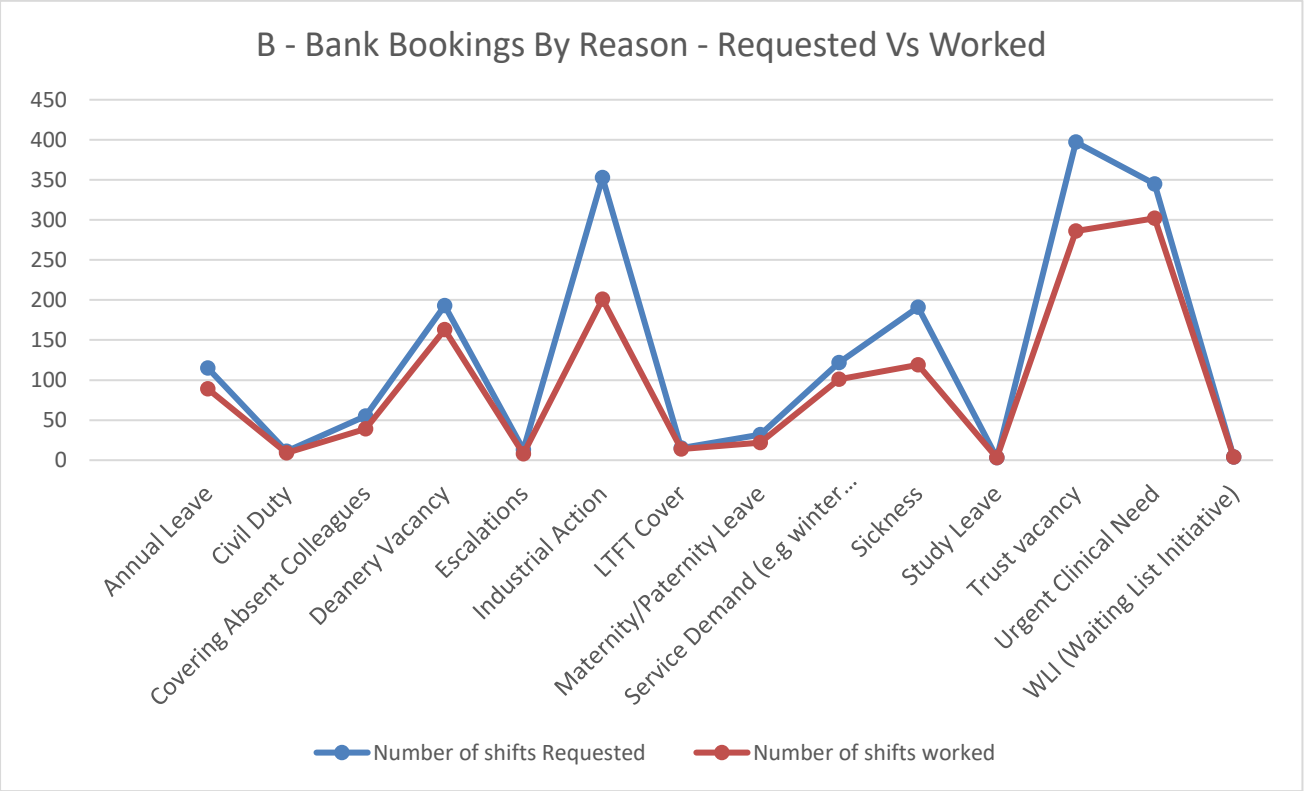

**Bournemouth**



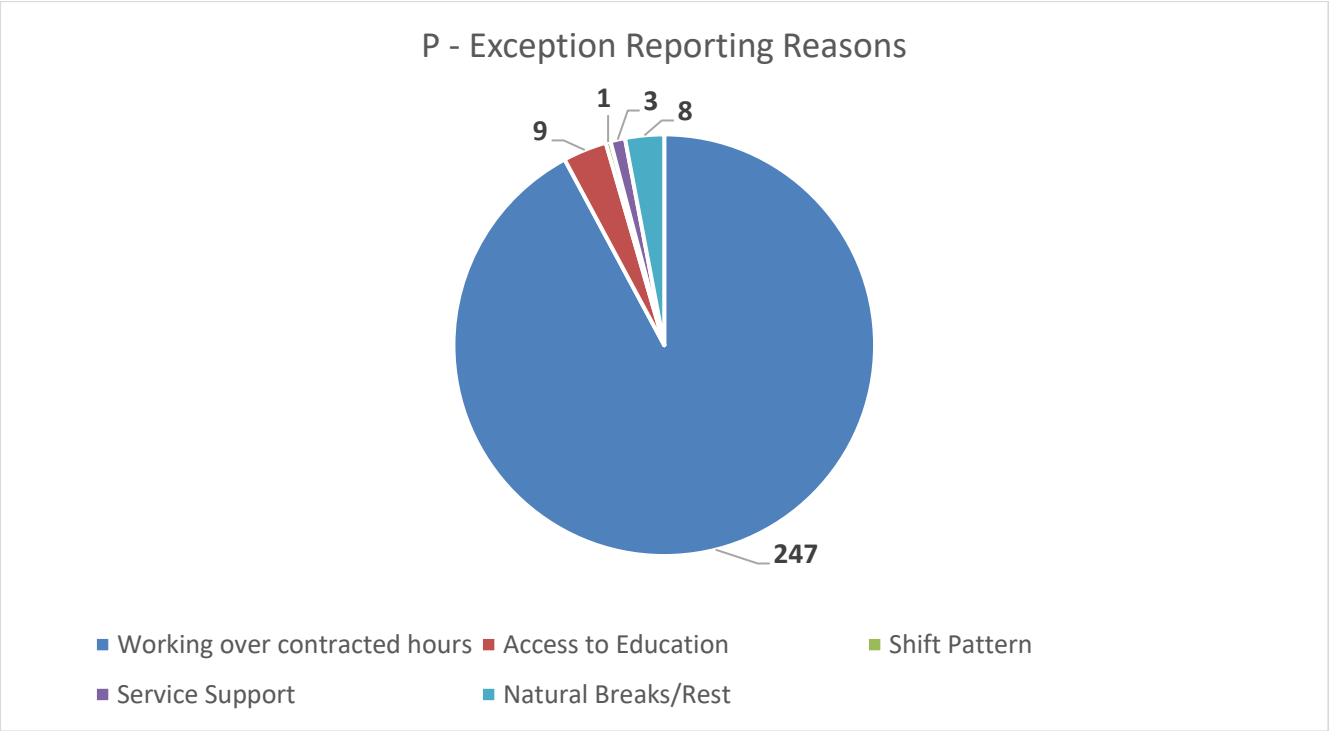

**Poole**



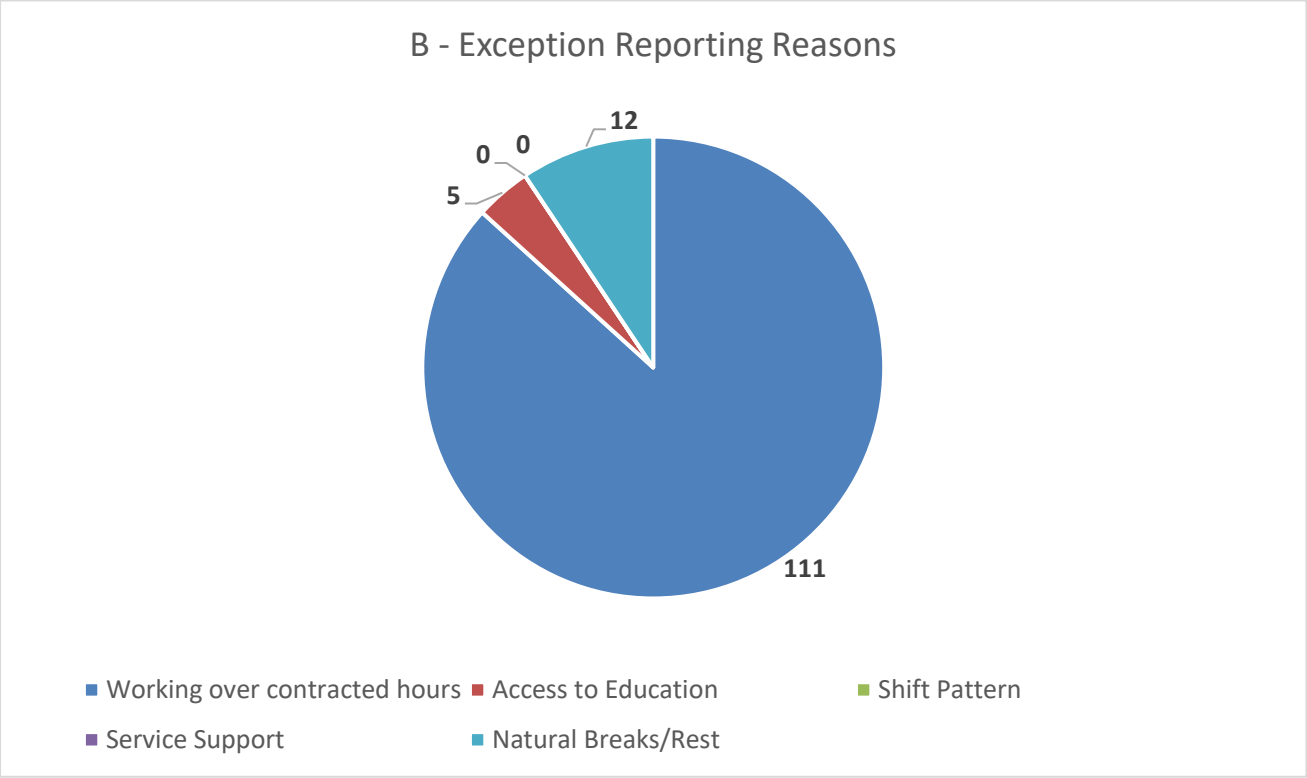

**Bournemouth**




**Poole**




**Bournemouth**



University Hospitals Dorset
NHS Foundation Trust

# BOARD OF DIRECTORS - PART 1 MEETING

## Meeting Date: 14 January 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 25 November 2025, the Committee received the following:<br>• Service Deep Dive: Older People's Services<br>• Integrated Performance Report<br>• Risk Register: risks rated 12-25 (Quality & Safety)<br>• Medical Device Replacement Programme<br>• Maternity and Neonatal Safety Champions Report<br>• Clinical Audit & Effectiveness Report<br>• Assurance/Alerts/Escalations from the Clinical Governance Group |
| **ALERT** | The Committee wishes to alert members of the Board that:<br>• For older peoples services there are challenges with pharmacy provision, radiology result acknowledgment and nursing homes transferring too many people into hospital towards end of life. The challenges of SDEC provision at Poole have been addressed along with expansion of Hospital @ Home.<br>• Whilst Infection Prevention Control (IPC) metrics are satisfactory in the report 2 MRSA cases have been identified.<br>• Venous thromboprophylaxis (VTE) reporting will start again in December.<br>• Sickness rates in maternity services remain high.<br>• Still birth rates remain a concern and a deep dive review has been completed. If after this is reviewed the Safety Champions lack assurance further work will be considered. |
| **ASSURE** | The Committee wishes to assure members of the Board that:<br>• The deep dive into Older Peoples Services showed the extensive work undertaken to try and meet both the growing demands that come with population growth of elderly people and the consequences of the UHD merger. The department shows a strong focus on care, quality of services and innovation whilst facing high demand<br>• Discussion on the Integrated Performance shows a strong focus on the twin challenges of NCTR and the 4- |

| | |
|---|---|
| | hour target with clarity of actions required. Approaches have been made to both NHSE Regional Team and GIRFT for support on the 4-hour target though it remains a real concern. There is a drive on IPC measures including 'bare below the elbows and hand hygiene'.<br>• The Medical Devices Replacement Programme reported progress on the 6 pillars to address previously raised concerns. There are only 4/30 actions outstanding. The committee endorsed proposed changes to the pillars of work to address the governance for reporting.<br>• The Maternity and Neonatal Safety Champions' Report shows sustained improvement on 3rd and 4th degree tears and complaints responses.<br>• The Clinical Effectiveness and Audit Report demonstrate good attendance from all care groups and participation in both national and local audits. |
| **ADVISE** | The Committee wishes to advise the Board that:<br>• For older peoples services the future challenges include - 'super-stranded patients' NCTR, mortality in hospital (death within 2 days of admission) and conveyance of patients inappropriately.<br>• There has been improvement in the less than 30-day old neonatal readmission that is probably a result of a changed approach to clinical pathway. |
| **Review of Risks** | Access to a second obstetric theatre and care in non-clinical areas are both being addressed. |
| **Celebrating Outstanding** | Leadership with medicine for older peoples services. |

University Hospitals Dorset
NHS Foundation Trust

# BOARD OF DIRECTORS - PART 1 MEETING

## Meeting Date: 14 January 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 16 December 2025, the Committee received the following:<br>• Integrated Performance Report<br>• Risk Register: risks rated 12-25 (Quality & Safety)<br>• Maternity Incentive Scheme Submission<br>• Safeguarding Report<br>• Quality Impact Assessment Report<br>• Falls report<br>• Complaints & Patients Experience Report<br>• Assurance/Alerts/Escalations from the Clinical Governance Group |
| **ALERT** | The Committee wishes to alert members of the Board that:<br>• In relation to operational performance No Criteria to Reside (NCTR) and the 4-hour standard continue to be a challenge with lack of improvement that will be having a negative effect on quality. Despite all actions to improve 4-hour performance there has been a steady decline with it now sitting at 67.4%.<br>• The committee was not assured by the Clinical Governance Report as there are two Red rated outstanding actions relating to the CQC surgery review in January 2025. These relate to 1. Timely availability of emergency equipment and 2. audits. The Quality Committee requested assurance to be provided to the Board that these two issues have been adequately addressed.<br>• Two risks were discussed that whilst being addressed are of note, firstly – access to a 2nd obstetric theatre where simulations have taken place and mitigations made and will need to be under constant review until fully addressed, secondly – timely access to some Systemic Anticancer Therapies (SACT) where the services struggle to keep up with a combination of demand and introduction of new therapies nationally. |
| **ASSURE** | The Committee wishes to assure members of the Board that: |

| | |
|---|---|
| | • Despite some of the operational concerns the committee was assured in relation to the Integrated Performance Report.<br>• The Safeguarding Quarterly Report shows some challenges with Level 3 children's safeguarding training (surgery, operations). A targeted approach with more bespoke training is being taken. A separate challenge exists in relation to resident doctors that the CMO is addressing.<br>• Quality and Equity Impact Assessments have robust processes and appear effective in assessing cost improvement and productivity schemes.<br>• The annual Falls Report was reviewed and whilst recognising UHD has a high number of 'at risk' patients there is robust training on falls prevention and oversight of falls with a Steering Group.<br>• The quarter 2 patient experience report shows largely positive data from Friends and Family Test (FFT); complaints have been largely steady with consistent themes though there has been a recent increase in numbers.<br>• The Risk Register was reviewed and shows clear progress and recent actions on several risks. |
| **ADVISE** | The Committee wishes to advise the Board that:<br>• Reporting for Veno-thromboembolic prophylaxis (VTE) is up and running again though early data suggest performance needs to be improved, the CMO is working with the relevant team to address.<br>• There was a long discussion on workforce related issues, and particularly the data relating to occupational health referrals, recognising availability of a happy healthy workforce is key to delivering high quality care and outcomes.<br>• The 2 recent multi-resistant staphylococcal aureus case (MRSA)are under review and early learning is being acted upon, detailed findings will be reported and reviewed when available.<br>• The maternity incentive scheme was reviewed, and evidence was provided that all 10 actions are fully assured. The independent audit completed by BDO consistently supports the evidence.<br>• An increase in Section 42 safeguarding notifications will have occurred due to process changes at BCP, these have been challenged by the safeguarding team and should not be an issue.<br>• Increased medical input to the Falls Steering Group would be beneficial. |
| **Review of Risks** | Risk register reviewed and comments covered in Alert and Assure sections. |
| **Celebrating Outstanding** | Maternity Incentive Scheme Submission. |

University Hospitals Dorset
NHS Foundation Trust

# BOARD OF DIRECTORS - PART 1 MEETING

## Meeting Date: 14 January 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 January 2026, the Committee received the following:<br>• Update on winter pressure<br>• Progress against Quality Priorities<br>• Electronic Results Acknowledgement Process<br>• Maternity and Neonatal Safety Champions Report<br>• Mortality Report<br>• National Standards for Healthcare Food & Drink<br>• Assurance/Alerts/Escalations from the Clinical Governance Group |
| **ALERT** | The Committee wishes to alert members of the Board that:<br>• Flu vaccination rates sit at 48.8% with an ambition to reach at least 50%, to date flu cases have been down compared to last year, lateral flow testing at the front door has aided management.<br>• High numbers of No Criteria to Reside (NCTR) continue to be a challenge and there is a need for ICB to support with commissioning action.<br>• Cost pressures may arise in relation to the IT support required in the Electronic Results Acknowledgement roll out. |
| **ASSURE** | The Committee wishes to assure members of the Board that:<br>• Winter pressures were discussed in detail and despite the demands of the difficult past few weeks the evidence suggests that services have coped better than previous years. It remains busy overall; elective activity has reduced long waits and eliminated > 65 week waits. Quality has largely been preserved with all the planning and operational management.<br>• Good progress is being made on the Trust's Quality Priorities, there is alignment with the Patient First Methodology and using data to drive improvement.<br>• Progress is being made on Electronic Results Acknowledgement with blood test reaching 90% in pilot areas. Work in Outpatient services requires some specific issues to be addressed on standing orders and bulk testing. |

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| | • The Maternity and Neonatal Safety Champions report provides positive assurance with improvement on several safety indicators. Some more detailed work is being undertaken in relation to post-partum haemorrhage (PPH). The review into still births provides assurance that appropriate care pathways and processes were used in all cases. There will be continued focus on still births.<br>• Mortality data continues to show a positive picture in relation to SHMI and HSMR. Work is being done to addressed coding issues as well as learning from deaths.<br>• Review of the National Standards for Healthcare Food and Drink is positive with clarity of areas that need improvement.<br>• The Clinical Governance Group appear to effectively identify issues and provide early insight for the Quality Committee. |
| **ADVISE** | The Committee wishes to advise the Board that:<br>• Work continues with the Region and ICB in relation to neurodevelopment services, it is hoped there will be an agreed commissioning plan in about 8 weeks. The Quality Committee will keep scrutiny on the issue due to the significant wait times.<br>• The period of Industrial Action prior to Christmas has been managed well and negative impacts limited with few cancellations of elective activity. No safety concerns resulted due to mitigations.<br>• Executives are focused on staff wellbeing and constantly doing 'temperature checks' to assess the status.<br>• Joint work should be commenced to look at benefit realisation coming from the Electronic Results Acknowledgement between the project group and the Chief People Officer's team.<br>• Sickness rates in maternity service remains higher than the wider trust and focused work continue to improve the position. |
| **Review of Risks** | We remain in the Winter period with the possibilities of surges of activity that will be challenging. |
| **Celebrating Outstanding** | Executive and hospital leadership teams' management of the winter activity to date. |

University Hospitals Dorset
NHS Foundation Trust

# BOARD OF DIRECTORS - PART 1 MEETING

## Meeting Date: 14 January 2026

| ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise | |
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| **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 24 November 2025, the Committee received reports on the following:<br>• 2025/26 Financial Performance Month 7<br>• Efficiency Improvement Programme<br>• New Hospitals Programme: Cashflow and Contract<br>• Operational Plan (draft)<br>• ICS Finance Update<br>• Operational Performance Month 7<br>• HealthSet Programme and EPR Stability<br>• HealthSet Programme Statement of Planned Benefits<br>• Our Dorset Digital Strategy<br>• Risk Register: review of significant risks; new risks rated 12 and above<br><br>In addition, the Committee approved the following contract awards:<br>• Cystoscopes – purchase and maintenance<br>• Blood collection devices contracts<br>• Rolling replacement of ECG devices<br>• Mammography equipment and maintenance<br><br>The Committee also recommend the Board approve the following:<br>• Lease of land to the Electricity Network Company Limited (RBH)<br>• Renewal of lease to Alliance Medical (PET/CT - PGH)<br>• Histology Modernisation |
| **ALERT** | 1. The Efficiency Improvement Programme is forecast to deliver £53m of the 2025/26 plan of £70m in 2025/6, with the majority of the shortfall due to delay of the planned wholly owned subsidiary. There is, however, a significant shortfall in recurrent EIP delivery forecast for 2025/26 impacting the underlying financial position which will lead to a very high EIP requirement in the 2026/27 Plan.<br>2. There remain two specific risks to delivery of the 2025/6 financial plan: (1) formal confirmation of cover for the |

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| | shortfall in EIP due to delay in the wholly owned subsidiary; and (2) the resolution of a £3m residual risk at the ICB level and any potential impacts on UHD.<br>3. The Trust has agreed a revised ED 4 hour performance trajectory which it met in October. The revised trajectory requires performance to rise progressively from 69% in October 2025 to 78% in March 2026 and the Trust is in the process of developing a plan to achieve this very significant improvement. The December F&P meeting will undertake a detailed review on this area. |
| **ASSURE** | 1. The Committee considered the latest full year forecast recognising that maintaining strong financial management controls will be essential and was assured by the detailed mitigation plan to recover the year to date deficit by year end with the exception of the two items noted in item (2) of the Alerts.<br>2. Good progress has been made in identifying the potential benefits that may be achieved by the HealthSet programme which will be an important aspect of the Full Business Case coming to the Board for approval in early 2026. |
| **ADVISE** | 1. The No Criteria to Reside position remained at c230 patients at the end of October. Actions have been agreed, including with system partners, and the impact of these actions against this trajectory will need to be monitored closely as the level is impacting several areas performance. Over the next 12 months it will be crucial to see sustained improvement as some aspects of the Transformation Programme are reliant on significantly lower levels of NCR being achieved and maintained.<br>2. The Committee reviewed the first draft of the 2026/27 Operating Plan following very recent release of the necessary guidance from NHSE. As expected, the draft suggests that a very high level of efficiencies will need to be delivered alongside a range of operational improvements requiring productivity improvements in addition to the efficiency improvements. Work is progressing to triangulate and firm up plans in order to assure the Committee and Board as the new (earlier, and multi-year) plan is developed. |
| **Review of Risks** | The Committee noted the risks rated 12 and above including new and retired risks |
| **Celebrating Outstanding** | 1. The Committee wish to thank the Digital team for the excellent Dorset Digital Strategy which the Committee endorsed |

University Hospitals Dorset
NHS Foundation Trust

# BOARD OF DIRECTORS - PART 1 MEETING

## Meeting Date: 14 January 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 15 December 2025, the Committee received reports on the following:<br>• 2025/26 Financial Performance Month 8<br>• Efficiency Improvement Programme<br>• New Hospitals Programme: Cashflow and Contract<br>• Draft Operational Plan submission<br>• Operational Performance Month 8<br>• Deep dive: Emergency Department<br>• HealthSet Programme and EPR Stability<br>• Risk Register: review of significant risks; new risks rated 12 and above<br>• Received an update on Private Patient arrangements<br><br>In addition, the Committee approved the following contract awards:<br>• High-Cost Equipment for Phase 3 Moves<br>• IT Hardware<br>• Staff Management System<br><br>The Committee also recommend the Board to approve the following:<br>• Contrast Media<br>• Public Procurement Thresholds update<br>• The Supply of Urology Equipment<br>• The Supply of Theatres Equipment (Head and Neck) |
| **ALERT** | 1. Emergency Department performance in November was 67.4%, 2.7% below the revised 2025/6 improvement trajectory. The revised trajectory requires significant ongoing improvement each month up to March 2026. The Committee received a detailed presentation of the analysis performed to understand the complex factors impacting this performance. The analysis had not yet progressed to a sufficiently clear action plan with timeframes to assure the Committee on the Trusts recovery to the revised trajectory and a further review has been scheduled for the 5 January 2026 meeting. |

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| | 2. 2026/7 operational planning requires the Trust to deliver a range of challenging operational and financial targets. The initial draft of the Plan was reviewed and the combined impact of the high level of non-recurrent Efficiency Improvement Programme delivery in 2025/6 and potential adjustments to income contracts make it clear 2026/7 will be very challenging, particularly in light of the major clinical and operational transformation that has been previously commissioned and is to be implemented in the year. Work over the next two months will also need to ensure the operational, financial and workforce dimensions of the plan are fully triangulated as aspects of the Plan become more firmly set. |
| **ASSURE** | 1. The Committee considered the latest full year financial forecast and continued to be assured that the Trust is likely to deliver the full year financial plan. Confidence that cover will be provided for the shortfall in EIP will be received for the delay in the wholly owned subsidiary programme as improved and this was the single largest risk identified in the previous forecast (the cover will be non-recurrent). The other mitigating actions are clearly identified and being actioned. The residual £3m risk at ICB and its impact on UHD remains at this stage. With the ongoing operational pressures (including industrial action) it is clear that delivery will continue to require maintenance and strengthening of financial controls. |
| **ADVISE** | 1. The No Criteria to Reside position has remained high. Actions have been agreed, including with partners, and it will be important to monitor both the actions and their impacts to ensure as many patients as possible receive care in the most appropriate setting for them. The improvement trajectory is also critical as an important element of the transformation plan in dependent on the significant reduction in No Criteria to Reside that is planned to be delivered. |
| **Review of Risks** | The Committee noted the risks rated 12. |
| **Celebrating Outstanding** | The Trust is continuing to deliver a complex range of major and often inter-related capital projects to tight cost and time constraints aligning to the broader transformation programme. The teams responsible are to be commended for the sustained strong performance. |

University Hospitals Dorset
NHS Foundation Trust

# BOARD OF DIRECTORS - PART 1 MEETING

## Meeting Date: 14 January 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 January 2026, the Committee received reports on the following:<br>• Efficiency Improvement Programme Deep Dive<br>• 4 Hour Organisational Standard deep dive follow up - Clarity of priority actions to improve delivery<br>• Sustainability programme<br>• Private Patients<br><br>In addition, the Committee approved the following contract awards:<br>• SWAST Lease for Parking and Accommodation<br>• Clinic Rooms for Spiro Feno Outpatient Clinics<br>• Ward Compliance Works to PGH & RBH<br><br>The Committee also recommend the Board approve the following:<br>• The Pathology South Six Network Full Business Case<br>• Purchase of a CT Scanner<br>• Purchase of Interventional Cardiology Consumables<br>• Purchase of Equipment for Endoscopy |
| **ALERT** | 1. The Committee received an update to its' December review of ED performance focussing on actions being taken to improve ED 4hr performance and building on the detailed analysis previously undertaken. The plan identifies key incremental improvement requirements that are anticipated each month to support moving the Trust's progress back towards the revised improvement trajectory. This remains an area of significant delivery risk. |
| **ASSURE** | 1. The Efficiency Improvement Programme deep dive provided assurance that the Trust has a robust Project Management Office and embedded processes to support identification, development and delivery of efficiencies. The Trust has good quality data to help identify productivity and improvement opportunities. Significant work remains to increase the level of identified savings required for 2026/7 and the Committee |

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| | was updated on the next steps being undertaken to improve identification and confidence on delivery for 2026/7. |
| **ADVISE** | 1. Key current areas of focus for the Sustainability programme are adaption to climate change and heat decarbonisation, including the potential for a deep geothermal solution at the Bournemouth site. There is significant work ongoing to install solar panel arrays and LED lighting solutions by March.<br>2. Financial and Operational performance to November 2025 was reviewed at the 15 December F&PC meeting. The performance to December will be reviewed at the 2 February as part of the revised scheduling of Board & Sub-Committee meetings to better align with the overall Trust governance processes.<br>3. The scheduled review of the F&PC Terms of Reference was deferred to March to align with other Board Sub-Committees. |
| **Review of Risks** | Due to the changed timing of the monthly meetings the next review of risks will be at the F&PC on 2 February 2026 |
| **Celebrating Outstanding** | 1. The Trust has good data to support identification of opportunities for productivity and efficiency improvements including benchmarking. It was of particular note that this has already shared with care groups etc in the form of dashboards to support identification of projects to include in the Efficiency Improvement Programme. |

University Hospitals Dorset
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# BOARD OF DIRECTORS - PART 1 MEETING

## Meeting Date: 14 January 2026

| ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise | |
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| **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 5 January 2026, The Committee received the following:<br>• Staff Story – Chaplains<br>• Chief People Officer's Report –including system update, People Ready, Risk, and introducing revised People and Culture workplan for approval<br>• People & Culture Strategy Progress Report including initial Staff Survey results update<br>• Integrated Performance Report – People and Culture – now includes the Breakthrough Objective<br>• Nursing Establishment Review<br>• Guardian of Safe Working Hours<br>• Improving the Working Lives of Drs: Getting the basics right for resident Drs 10 point plan<br>• Pay Gap Reports (Ethnicity, Disability and Gender)<br>• Education update<br>• Workforce Operational Efficiency and Reduction Plan (WORP)<br>• HP policies for approval |
| **ALERT** | The Committee wishes to alert members of the Board that:<br><br>**Appraisals – Completion and Quality**<br><br>Across UHD, non-completion of values-based appraisals continues to be a concern (it is likely to have an impact on delivering organisational performance objectives, staff feeling valued and appreciated, staff engagement scores etc). There has been some improvement seen in Sep/Nov 2025 however the committee was not assured that we will achieve the 90% target March 2026. The committee also discussed the quality assurance mechanisms in place. The committee has asked for a report on appraisals along with an improvement plan for discussion at the next PCC meeting in March 2026.<br><br>**Nursing Establishment Review and Workforce Operational Efficiency and Reduction Plan (WOERP)** |

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| | The committee received a report of the nursing establishment review (to be presented at board). There is a request for an increase in establishment to maintain safe staffing levels. Majority of the increases are being funded from within care group budgets with a further £215000 investment recommended. Having also noted the alert from the WOERP report, the nursing establishment review recommendations will add further pressure on the objective of achieving the trust wide 260 WTE reductions by March 2026. |
| **ASSURE** | The Committee wishes to assure members of the Board that:<br><br>**Improving the Working Lives of Drs: Getting the basics right for resident Drs 10 point plan**<br><br>On the 29th of August 2025, NHS England published a 10-Point Plan to improve the working lives of resident doctors. The committee received a progress report including self-assessment results against the plan. An initial self-assessment within University Hospitals Dorset NHS Foundation Trust (UHD) indicated an overall compliance position of 69% against the plan. There is ongoing work to improve the compliance position and the committee will continue to receive AAA reports and provide assurance to the board in future. |
| **ADVISE** | The Committee wishes to advise the Board that:<br><br>**People and Culture Workplan (including ToR and Schedule of Business/People and Culture Group)**<br><br>A revised ToR and Schedule of Business were presented to the committee. In discussion, considering the scale of people related changes, risks and challenges the trust will face over the next year – the suggested 6 meetings (from 5) may need to increase to 9 in 2027. People and Culture Group will provide oversight and assurance to the People and Culture Committee. |
| **Review of Risks** | Risks were not presented/discussed at this meeting. The DCPO is undertaking a review of the current risks and its understanding and improve the reporting. This will be on the agenda for the next PCC meeting in March 2026. |
| **Celebrating Outstanding** | We heard from our Chaplain James Taylor about the recent celebrations of Christmas and Hanukkah at UHD. The Christingle service was well attended and a success. It was celebrated as a Christian festival that it is but done so in an inclusive and fun way. There was reference to what's happening in the Jewish community, both in terms of of Hanukkah, but also world events. UHD should continue supporting this and similar faith events across the year. |

University Hospitals Dorset
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# BOARD OF DIRECTORS - PART 1 MEETING

## Meeting Date: 14 January 2026

| ESCALATION and ASSURANCE REPORT – Alert, Advise, Assure | |
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| **Report from:** | Charitable Funds Committee – Chair's Report |
| **Presented by:** | Femi Macaulay, Chair of the Charitable Funds Committee |
| **Agenda items discussed:** | The Committee received the following:<br>• Investment Update<br>• Finance Report – Q2<br>• Fundraising Report – Q2<br>• Financial Forecast and Compliance with Reserves Policy<br>• Charity Recharges<br>• Surgical Care Group spend plan<br>• Charity Annual Report & Accounts<br>• Risk Register<br>In addition, the Committee received various proposals and business cases for approval and one business case for recommendation to Board to approve. |
| **ALERT** | There is nothing to alert the Board. |
| **ASSURE** | The Committee wishes to assure Board members that the charity is performing well and remains on plan. The fundraising report indicated that income at the end of quarter two stood at £2.9 million against a full-year target of £3.6 million, driven primarily by legacy receipts and successful appeal activity. |
| **ADVISE** | The Charitable Funds Committee wishes to advise the Board that:<br>• it has recommended the purchase of two $CO_2$ lasers for ENT and head and neck surgery at an approximate cost of £307,000.<br>• based on the number of business cases received, a strategic approach to funding of the practice educator roles across the organisation needs to be considered. This has been referred to the to the Chief People Officer and Charity Director to take it further.<br>The audited annual report and accounts were presented alongside the external auditor's governance report. No material issues or audit recommendations were identified, and an unqualified opinion was confirmed. The Committee endorsed the accounts and the letter of representation for submission to the Board and commended the quality of the annual report. |
| **Review of Risks** | Review of the charity risk register did not show any major risks. |
| **Celebrating Outstanding** | The Committee would like to thank the Charity team and Finance team to prepare very comprehensive Annual Report and Accounts. |

University Hospitals Dorset
NHS Foundation Trust

# BOARD OF DIRECTORS - PART 1 MEETING

## Meeting Date: 14 January 2026

| ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise | |
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| **Report from:** | Transforming Care Together Steering Group – Chair's Report |
| **Presented by:** | Judy Gillow, Chair of the Transforming Care Together Steering Group |
| **Agenda items discussed:** | At its meeting held on 15 December 2025, the Group received the following:<br>• Service Ready Update<br>• Build Ready Update<br>• People Ready Update<br>• TCT Digital Update<br>• Phase 3 Move Planning |
| **ALERT** | The Committee wishes to alert that:<br>• Workforce plans are still behind target, although progress is being made to improve the position. Focused work and monitoring continue. |
| **ASSURE** | The Group wishes to assure that:<br>• Baby tagging. System more stable and being monitored regularly. Further checks and training underway. To agree a target date for resolution. |
| **ADVISE** | The Group wishes to advise that:<br>• All phase 2 moves complete. Phase 3 planning is underway and ongoing review of critical path actions.<br>• TCT program, IT informatics is on track.<br>• Phase 3 move plan reviewed. External review requested of plan, as the delivery of the plan is crucial to success. |
| **Review of Risks** | • Emergency Department demand and capacity – need to improve internal efficiency and SDEC diversion to achieve phase 3 required capacity.<br>• Timely progression of workforce plans to allow adequate implementation time following consultation. |
| **Celebrating Outstanding** | • Thank you to all staff who are working on the planning and delivery of phase 3 moves. |

| Part 1 | | 07 May 2025 | 18 June 2025 | 02 July 2025 | 08 September 2025 | 5 November 2025 |
|---|---|---|---|---|---|---|
| Members Present | Beverley Bryant | | | | | |
| | Judy Gillow | | | | | |
| | Siobhan Harrington | | | | | |
| | Sarah Herbert | | | | | |
| | Tracie Langley | | | | | |
| | John Lelliott | A | | | | |
| | Femi Macauley | | | A | | |
| | Alastair Matthews | | | | | |
| | Michael Marsh | | | | | |
| | Helena McKeown | | | | A | |
| | Mark Mould | | | | | |
| | Pete Papworth | | | | | |
| | Sharath Ranjan | | | | | |
| | Richard Renaut | | | | | |
| | Cliff Shearman | | | | | |
| | Claire Whitaker | | | | | |
| | Peter Wilson | | | | | A |
| In Attendance (excl Governors, members of public and non-Standing Invitees) | David Broadley | | | | | |
| | Terri Clark | | | | | |
| | Andrew Doe | | A | | | |
| | Jamie Donald | | | | | |
| | Yasmin Dossabhoy | | | | | |
| | Paul Froggatt | | | | | |
| | Alison Honour | | | | | |
| | Eiri Jones | | | | | |
| | Phillipa Knight | | | | | |
| | Deborah Lane | | | | | |
| | Irene Mardon | | | | | |
| | Helen Martin | | | | | |
| | Deborah Matthews | | | | | |
| | Richard Moreman | | | | | |
| | Truda Scriven | | | | | |
| | Joanne Sims | | | | | |
| | Lorraine Tonge | | | | | |
| | Tara Vachell | | | | | |
| | Klaudia Zwolinska | | | | | |
| Was the meeting quorate? | | Y | Y | Y | Y | Y |

**Key**

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| | Not in Attendance |
| A | Apologies |
| D | Delegate Sent |