BOURNEMOUTH UNIVERSITY

2026 BU-NHS Conference

Moving Forwards Together

Fusion Building, Talbot Campus
16th April 2026

NHS

Programme C
SHARE

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Key Note 3:

From Audit to Impact – Reimagining Clinical Audit for the Next Decade

Victoria Patel

National Quality Improvement & Clinical Audit Network (N-QI-CAN) – Chair,

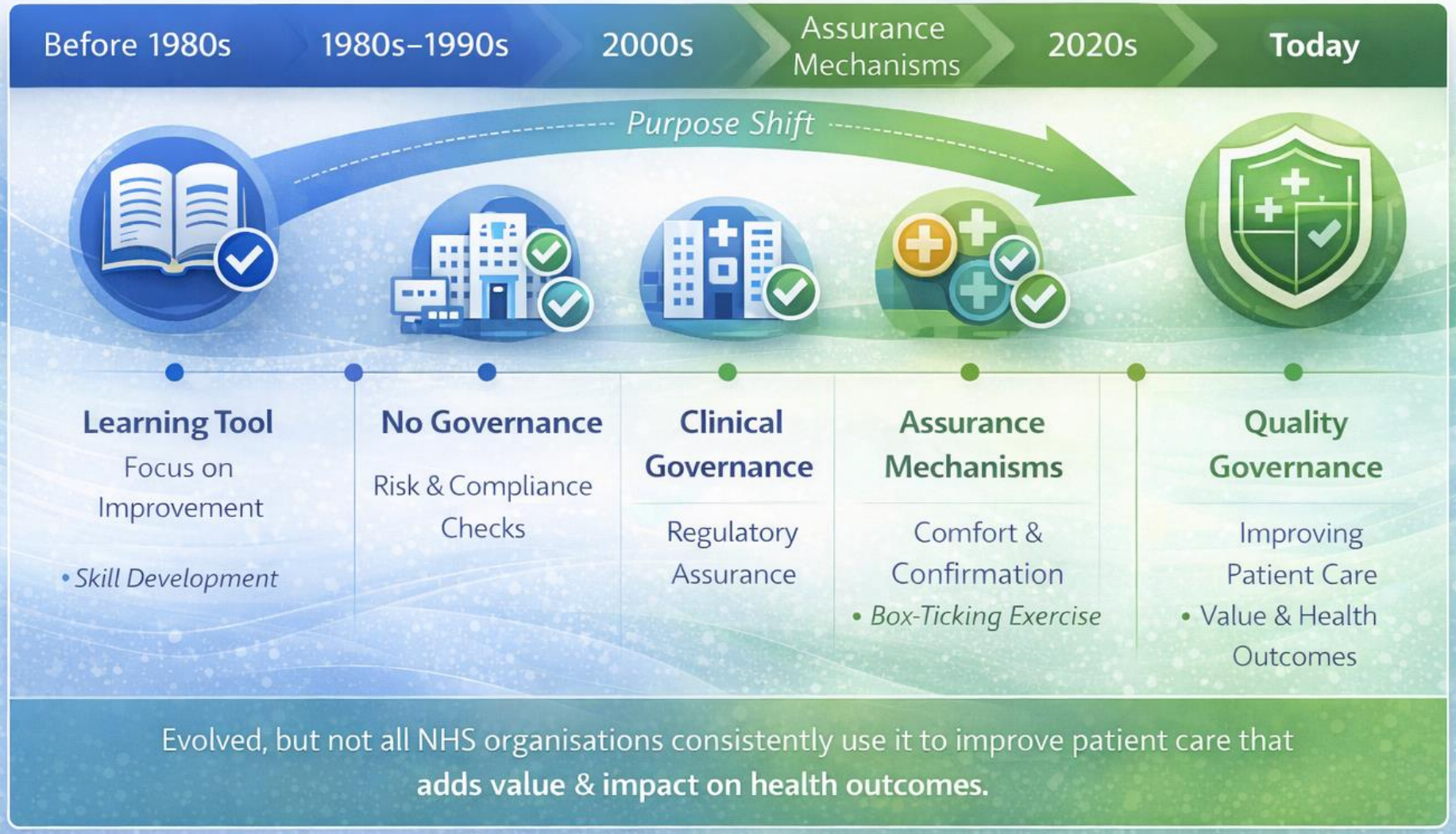
Clinical Effectiveness Manager, The Rotherham Foundation Trust

From **Audit** to **Impact**

Re-imagining Clinical Audit for the Next Decade

The Evolution of NHS Governance

From **Learning Tool** → Clinical Governance → Quality Governance



Evolved, but not all NHS organisations consistently use it to improve patient care that **adds value & impact on health outcomes.**

Clinical Audit as a Quality Improvement Tool

Box-Ticking Compliance vs. Full Potential Impact

Previously: Limited Impact

- Basic Checklist Compliance
- Minimal Real Improvement

✔ Box-Ticking Compliance

Applying Full Potential Clinical Audit

Now: Real Insights & Better Outcomes

- Data-Driven Analysis
- Continuous Improvement

✚ Using Clinical Audit as a QI Tool

ADDS VALUE	Applying Full Potential Clinical Audit	CREATES IMPACT
✔ Enhanced Care Quality	✔ Increased Efficiency	✔ Better Outcomes
✔ Box-Ticking Compliance		✔ Reduced Risks
		✚ Using Clinical Audit as a QI Tool

The NHS 10-Year Health Plan

What You Need to Know

Why it matters

- Sets the long-term direction of travel for the NHS this decade
- Focuses on sustainability, outcomes and population health
- Shifts emphasis from activity to impact

Three Core Shifts →

Hospital → Community & Home

Care closer to home, integrated pathways

Analogue → Digital

Smarter use of data & technology

Sickness → Prevention

Earlier intervention & healthier lifestyles

What this means for organisations–

Focus on Outcomes

Quality over volume

Collaboration

Working across systems

Collaboration

Working across systems

Learning & Leadership

Driving improvement

Why this links to today

Clinical Audit

Key tool for driving change

The Question:

How do we use audit to drive impact across the system?

Shifting from *Care Delivery* to Population Health *Thinking*

Understand Your Population

- ✓ Identify Risks & Needs
- ✓ Agree Shared Priorities

Embed Prevention in Care

- ✓ Falls & Lifestyle Interventions
- ✓ Implement NICE Guidance

Integrate Beyond Hospital Walls

- ✓ Partner with Primary, Community & Social Care
- ✓ Coordinate Patient Pathways

Why It Matters

- ✓ Prevent Deterioration, Not Crisis
- ✓ Wider Population Strategy

Next Steps

Segmentation & Risk Stratification

Standardise Prevention Efforts

Develop Clinical Leaders

Use Data for Insight

- ✓ Focus on Outcomes & Equity
- ✓ Tackle Health Inequalities

The Big Picture

From Treating Illness → Sustaining Wellbeing → From Silos → System Impact → From Short-Term Goals

The Future of Clinical Audit in in **Outcome-based** Neighbourhood Health Systems

Clinical audit will evolve into a system-wide, data-driven engine for improving population health, equity, and patient experience.

From Assurance to Accountability

- ✓ Validate Outcomes
- ✓ Contract Performance
- ✓ Detect Variation

System-Wide Approach

- ✓ Cross-Sector Pathways
- ✓ Joint Accountability

Data Quality Focus

- ✓ Trusted & Complete Data
- ✓ Standardised Outcomes

Outcome-Based Neighbourhood Health System

Real-Time Monitoring

- ✓ Live Dashboards
- ✓ Instant Alerts

Population Health & Equity

- ✓ Social Determinants
- ✓ Equity Metrics

Audit as a Driver of Improvement

New Skills & Partnerships

- ✓ Advanced Analytics
- ✓ Collaborative Working

What Changes When Neighbourhood Health Systems Use Outcome-Based Contracts?

Outcome Verification Focus

From *"Did you follow the guideline?"*

To *"Did patients get better, safer, more equitable care?"*

Integrated Audit Approach

Combining Data Across Providers & Shared Pathways

Real-Time Monitoring

Frequent Reporting & Dashboards

Emphasis on Data Quality

Risk Adjustment & Comparable Metrics

Real-Time Monitoring

Frequent Reporting & Dashboards

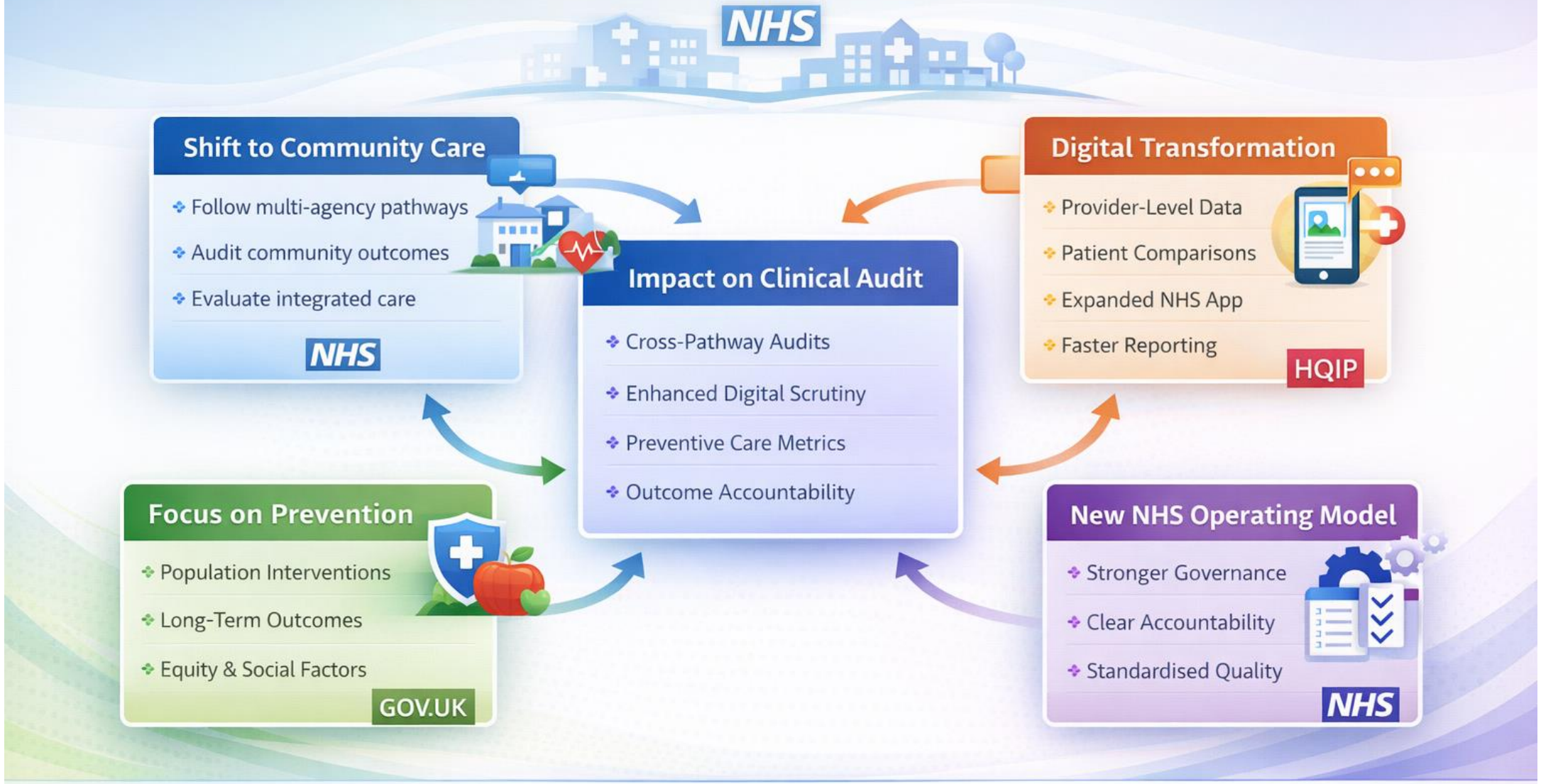
Population & Equity Focus

Addressing Health Inequalities

Collaboration with Commissioners

Working Closely with **Integrated Care Boards** & **Local** Authorities

What Else in the 10-Year Health Plan
Will Impact Clinical Audit?



A Structural Redesign of the NHS

GOV.UK | HQIP

What This Means for Clinical Audit

The **10-Year Plan** accelerates a transformation already underway.

System Change	Impact on Clinical Audit
Hospital → Community	Audit whole pathways, multi-agency care
Analogue → Digital	Real-time audit, public dashboards
Sickness → Prevention	Population health & equity metrics
New Operating Model	Integration with QI & performance
Transparency	More public, comparable audit data
Workforce Reform	New analytical & system skills
Financial Reform	Faster cycles, advanced methods

Clinical audit becomes more strategic, more visible, more system-wide, and more outcome-focused than ever before.

Future Skills Framework for Clinical Audit (2026–2036)

A capability model for audit teams working in outcome-based neighborhood health systems

System & Pathway Intelligence

- Pathway Analysis
- Integrated Care

Advanced Data & Analytics

- Real-Time Insights
- Equity Analysis

Digital & Automation Literacy

- Digital Tools
- AI & Automation

Quality Improvement Science

- QI Methods
- Implementation

Population Health & Equity

- Health Inequalities
- Prevention Focus

Contract & Value-Based Care

- Outcome Metrics
- Payment Models

Ethics & Data Governance

- Data Integrity
- Ethical Standards
- Community Links
- VCSE Partners

Building Future-Ready Audit Teams

Audit that Reduces Avoidable Hospital Use

What this looks like

— **Clinical audit** is used system-wide to:

Identify Avoidable Admissions

Admission Criteria Review

Target Early Intervention

Escalation Pathways

Evaluate Community Services

Virtual Wards Audit

Why This Matters for the 10-Year Health Plan

Shifting care from hospital to community improves sustainability & patient outcomes

Declining Admissions

Community Success

Sustained Change

Auditing for Prevention:
Shifting from Sickness to Health

System capability means audit is used to **prevent deterioration,** not just **review harm**.

What This Looks Like

Early Risk Identification

Falls, Frailty, Cardiovascular Risk

Preventative Interventions

Consistent Prevention Measures

Learning Impact

Tracking Reduction in Repeat Harm

Evidence of Impact
Prove Prevention Works

Why It Matters for the 10-Year Health Plan

Prevention is a Core Pillar of the NHS

Harm Reduction Outcomes

Fewer Adverse Events

Evidence of Impact

Embed in Every Contact

Progress Over Time

National Audit Tools

Audits Driving Improvement

gov.uk kingsfund.org.uk

From Analogue Audits to Digital, Data-Enabled Insight

What This Looks Like

Integrated Datasets
Across Providers

Trends & Predictions

Proactive Intervention

Audit is No Longer:

Collect Data → Submit Report → File Away

It Becomes:

Shared Data → Identify Risk → Act Early

Why This Matters for the 10-Year Health Plan

From Analogue to Digital, Intelligence-Led Care

What Evidence Looks Like

ICS Dashboards

Consistent Metrics

Informed Leadership

Audit that Enables Integration, Not Silos

What This Looks Like

Falls Care Audits

Across Hospital, Community & Care Homes

Long-Term Condition Audits

Primary, Secondary & Community Services

Why This Matters for the 10-Year Health Plan

Multi-Agency Discussions

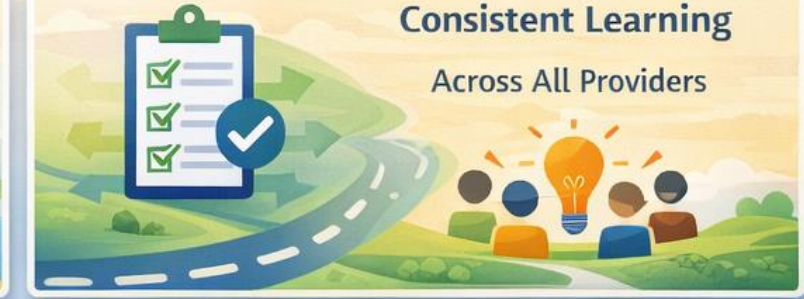
System Forums

Shared Action Plans

With System Ownership

Consistent Learning

Across All Providers



Audit Designed Around Pathways, Not Organisations

What This Looks Like

Admission → Discharge → Community Follow-Up

Acute Treatment → Virtual Ward → Primary Care → Hospital Care

Audit Questions Change:

Did we discharge appropriately?

Did we discharge appropriately?

Did the whole system support safe recovery at home?

Why This Matters for the 10-Year Health Plan

Multi-Provider Audits

Discharge, Info Transfer, Follow-Up

Joint Action Plans

Shared Steps Across Organisations

Reduced Variation

Consistent Care Across Places

A Shared System Purpose for Audit

Aligning Clinical Audit to ICS Priorities

Defining "Good" at System Level

Providers Measuring Success Together

- Population Health Needs
- Inequalities
- High-Impact Prevention
- Unwarranted Variation

Defining "Good" at System Level

Providers Measuring Success Together

- Shared Standards
- Common Metrics
- Joint Evaluation

Why This Matters for the 10-Year Health Plan

Towards Population-Based Improvement & Shared Accountability

A Learning Culture Across the System

What This Looks Like:

System Capability Means:

Variation is treated as a Signal, not Failure

Learning is Shared Between Providers

Improvement is Collaborative, Not Competitive

Improvement is Collaborative, Not Competitive

Why This Matters for the 10-Year Health Plan

Cross-System Learning Events **Shared** Improvement Stories

Building sustainable & psychologically safe systems that improve continuously

Repeat Issues Decrease Over Time

Staff Engaged in Audit & Improvement

From Audit *to* Impact:

A Call to Action for the NHS

The Challenge

- The NHS 10-Year Health Plan demands **Prevention, System Outcomes, Digital Insight** & Leadership Accountability
- Traditional, retrospective, **organisation-level audit** cannot deliver this on its own

Compliance → Impact

Organisations → Pathways & Systems

Retrospective Review → Early Insight

Delegated Task → Strategic Leadership

The Call to Action

- **Re-purpose** clinical audit
- Invest in **Future Skills**
- Enable **Earlier Action**
- Judge by **What Changed**

→ **System Improvement**

The Opportunity

Clinical audit becomes a strategic asset for **Safer Care**, **Better Outcomes**, **Sustainable Systems**

Any Questions?

University Hospitals Dorset
NHS Foundation Trust

Optimising the Young Stroke Screen

Improving Efficiency, Reducing Costs and Enhancing Patient Care

Dr Emma King, Foundation Year 2 Doctor
Dr Helena Dunn, Clinical Fellow ITU
Dr Michelle Dharmasiri, Consultant in Stroke Medicine

University Hospitals Dorset
NHS Foundation Trust

Young Stroke

<56 years of age, increasing prevalence

Requires further investigation, including essential bloods as part of a **Young Stroke Screen**

Quality Improvement Project PDSA

01

Review and update blood test panel
Knowledge questionnaire
Timing task
Cost analysis

02

Develop standardised information poster
Repeat questionnaire

Results

£145.19

Saved per patient

Improvement in doctor's knowledge (33-75%)

Reduced inefficiencies in ordering tests

Conclusions

01

Improved cost effectiveness
and patient care

02

Sustainable change has been produced

Can be expanded across departments

Quick Assessment of Stroke Symptoms Using Smartphones

Pavitra Holi[1] , Professor Venky Dubey[1], Clare Shearer[2], Dr Kamy Thavanesan[3]
[1] *Faculty of Media, Science and Technology, Bournemouth University, UK,*
[2] *Faculty of Health, Environment & Medical Sciences, Bournemouth University, UK*
[3] *University Hospitals, Dorset, UK,*

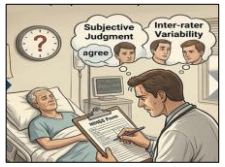
Limitations in Current Stroke Assessment

- Rapid and standardised neurological assessment is essential for the early recognition of strokes and determining their severity.
- The National Institutes of Health Stroke Scale (NIHSS) remains the gold standard for clinical assessment;
- However, this is traditionally conducted using paper-based questionnaires and relies on subjective judgment of clinicians

The Digital Objective:

- Develop a smartphone-based NIHSS application for structured data entry
- Integrate AI modules to enable objective assessment and track symptom progression

Comparison between Traditional methods and Digital app

Feature	Traditional Method(NIHSS)	Digital App
Assessment Method	 Subjective visual observation: Prone to inter-rater variability	 Objective AI module
Scoring Integrity	 Mathematical error	 Automated severity scoring
Operation environment	 Requires onsite neurology expertise	 Scalable -pre-hospital paramedics and tele stroke triage
Data Management	 Manual entry via Paper questionaries	 Standardised, remote, real time digital workflow
Time Efficiency	 Depends on specialist availability	 Immediate clinical decision supports/ Assists the non expertise

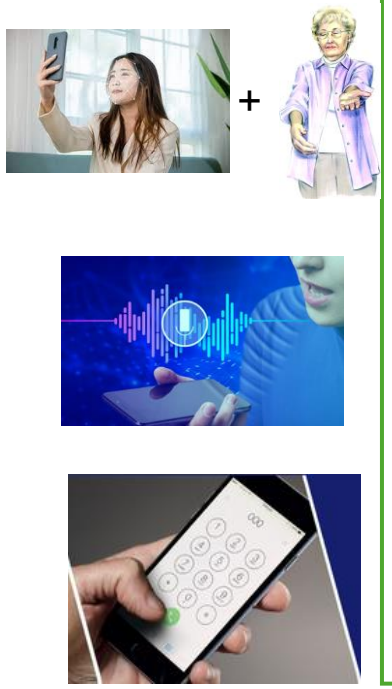
Digital Analysis of NIHSS and FAST Pipeline Map

Data Acquisition (Using Smartphone)

Digital Analysis Pipeline

Clinical Scoring And Integration

Diagnostic Output

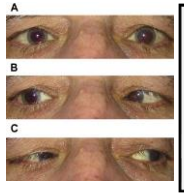


Camera
(Facial droop, Arm drift, Gaze analysis)

Microphone
(Speech analysis)

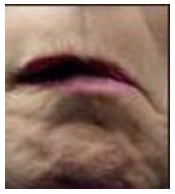
GPS/SMS/Call
(Triage information)

Facial Symmetry Analysis



Gaze Tracking

Arm Motor Drift Detection



Slurred Speech detection

FAST Scoring
(Triage Screening)

NIHSS Score
(11 neurological categories)

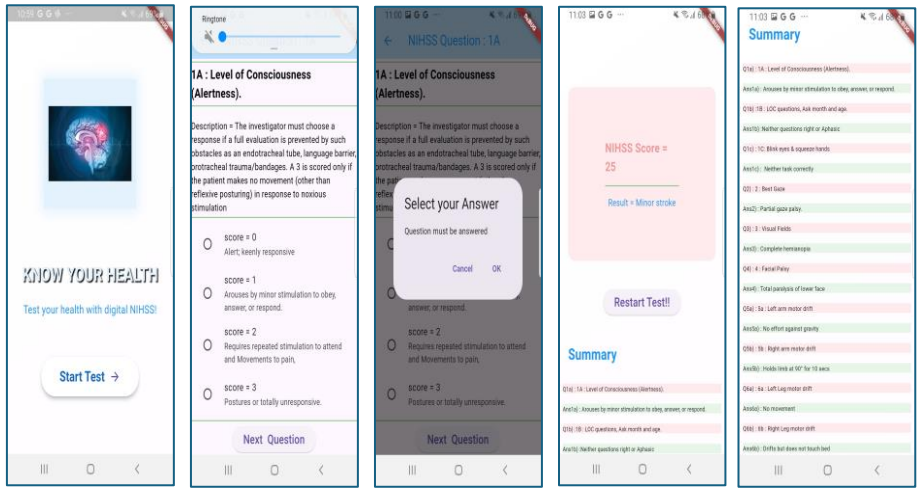
FAST triage recommendation

Automated NIHSS Score
(0-42) and severity classification

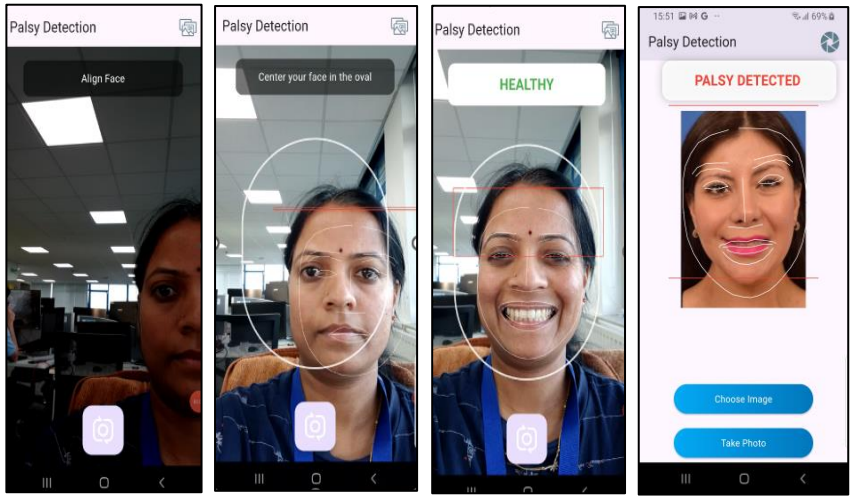
- Smartphones as edge devices → high accessibility
- Use of explainable AI (XAI) modules
- Integration of geometric comparison methods

Developed Smartphone App's Results

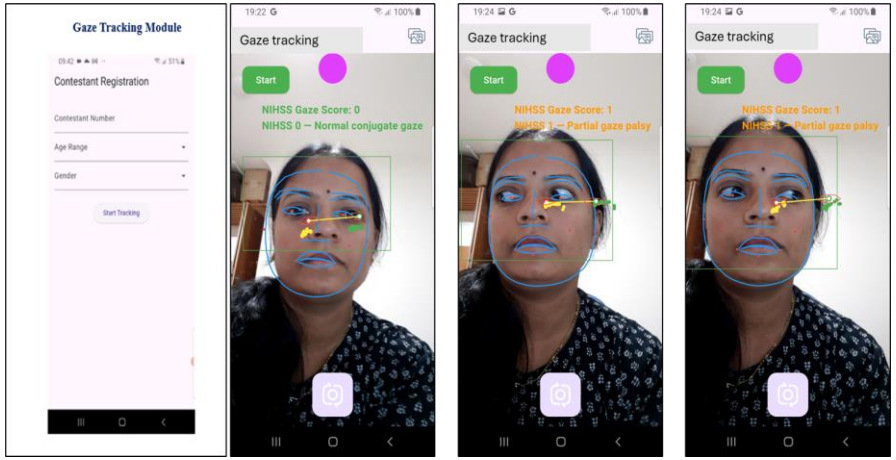
Digital NIHSS App design



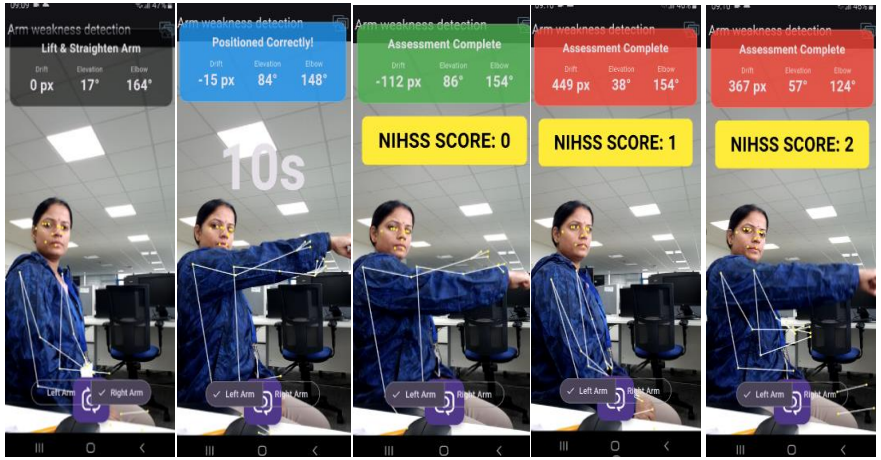
Facial Droop Detection Module



Gaze Tracking Module



Arm Drift Detection Module



Uses of Smartphone app

- Accelerating patient pathways
- **Speed:** Shorten door to needle time through instantaneous, automated scoring.
- **Scalability:** Empowers non specialist in emergency, pre-hospital, and resource –limited settings with objective diagnostic assistance.
- **Outcomes:** Early detection improves patient survival rates and functional recovery

SQuIRe

Stroke Quality Improvement for Rehabilitation

South West

University Hospitals Dorset NHS Foundation Trust

START ESD

Stroke Transitions and Rehabilitation Team

Early Supported Discharge

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

Consultant Therapist: **Dr Louise Johnson**

Project Lead and Physiotherapist: **Alahna Cullen**

Clinical Specialist Occupational Therapist: **Lucy Haynes**

We proposed that we could support more dependent patients in the community at an earlier stage of their rehab

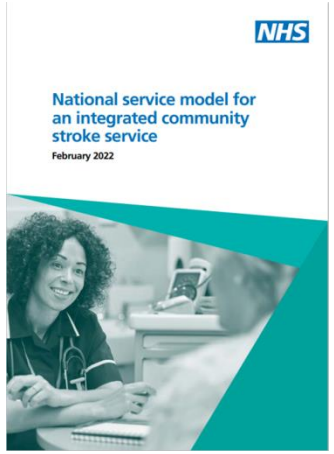
SQuIRE Funding applications opened 2023

Successful funding bid 2023/24

Project start: March 2024

Project Completed: May 2025

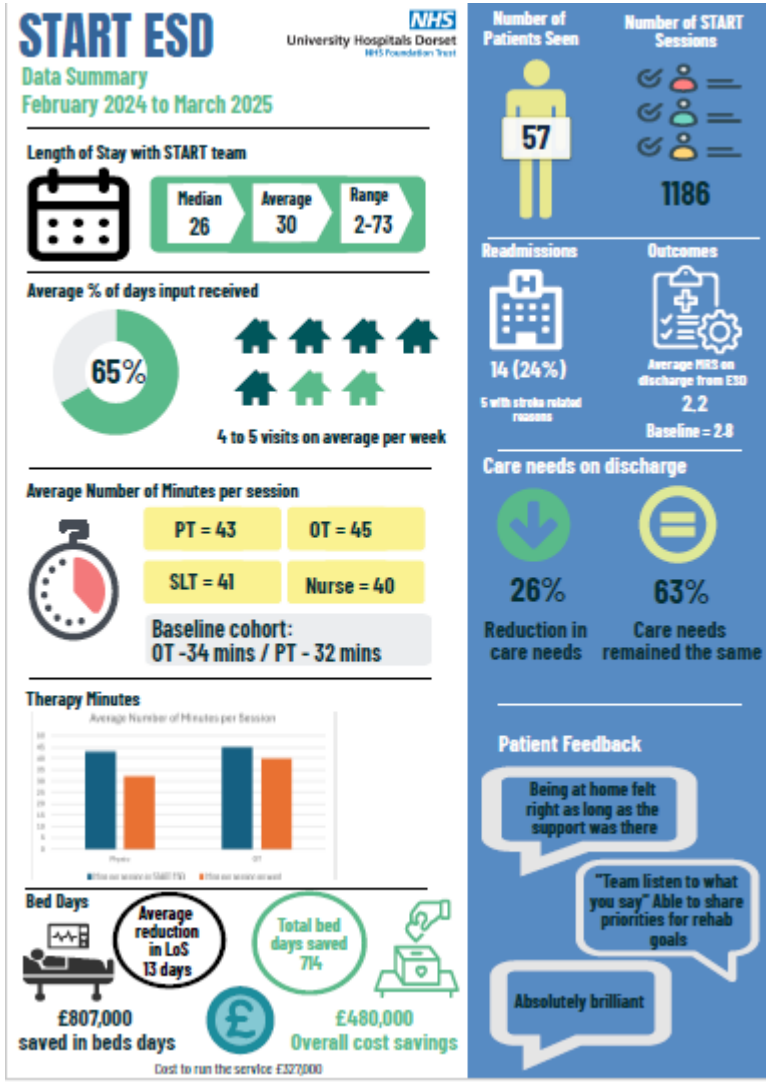
Business Case Agreed: August 2025



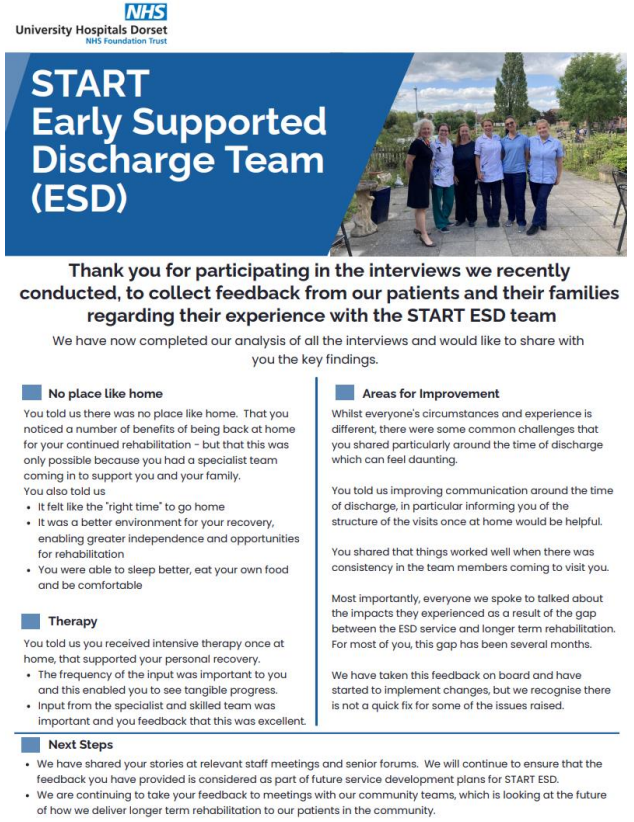
Hospital at Home

Virtual Wards

Results


START ESD
University Hospitals Dorset
Data Summary
February 2024 to March 2025
Length of Stay with START team
Median 26
Average 30
Range 2-73
Average % of days input received
65%
4 to 5 visits on average per week
Average Number of Minutes per session
PT = 43
OT = 45
SLT = 41
Nurse = 40
Baseline cohort:
OT -34 mins / PT - 32 mins
Therapy Minutes
Bed Days
Average reduction in LoS 13 days
Total bed days saved 714
£807,000
saved in beds days
£480,000
Overall cost savings
Cost to run the service £327,000
Number of Patients Seen
57
Number of START Sessions
1186
Readmissions
14 (24%)
5 with stroke related reasons
Outcomes
Average MRS on discharge from ESD
2.2
Baseline = 2.8
Care needs on discharge
26%
Reduction in care needs
63%
Care needs remained the same
Patient Feedback
Being at home felt right as long as the support was there
"Team listen to what you say" Able to share priorities for rehab goals
Absolutely brilliant

Most importantly, what do the people using the service think?



NHS
University Hospitals Dorset
NHS Foundation Trust

START Early Supported Discharge Team (ESD)

Thank you for participating in the interviews we recently conducted, to collect feedback from our patients and their families regarding their experience with the START ESD team

We have now completed our analysis of all the interviews and would like to share with you the key findings.

No place like home

You told us there was no place like home. That you noticed a number of benefits of being back at home for your continued rehabilitation - but that this was only possible because you had a specialist team coming in to support you and your family.
You also told us

- It felt like the "right time" to go home
- It was a better environment for your recovery, enabling greater independence and opportunities for rehabilitation
- You were able to sleep better, eat your own food and be comfortable

Therapy

You told us you received intensive therapy once at home, that supported your personal recovery.

- The frequency of the input was important to you and this enabled you to see tangible progress.
- Input from the specialist and skilled team was important and you feedback that this was excellent.

Areas for Improvement

Whilst everyone's circumstances and experience is different, there were some common challenges that you shared particularly around the time of discharge which can feel daunting.

You told us improving communication around the time of discharge, in particular informing you of the structure of the visits once at home would be helpful.

You shared that things worked well when there was consistency in the team members coming to visit you.

Most importantly, everyone we spoke to talked about the impacts they experienced as a result of the gap between the ESD service and longer term rehabilitation. For most of you, this gap has been several months.

We have taken this feedback on board and have started to implement changes, but we recognise there is not a quick fix for some of the issues raised.

Next Steps

- We have shared your stories at relevant staff meetings and senior forums. We will continue to ensure that the feedback you have provided is considered as part of future service development plans for START ESD.
- We are continuing to take your feedback to meetings with our community teams, which is looking at the future of how we deliver longer term rehabilitation to our patients in the community.

October 2026

- START ESD Re-Launched with substantial funding enabling patients the choice to continue their rehabilitation……

AT HOME

Any Questions?

University Hospitals Dorset
NHS Foundation Trust

Older persons Same Day Emergency Care Clinic Improves Outcomes for Older People

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

Moving Forward together 16th April 2026

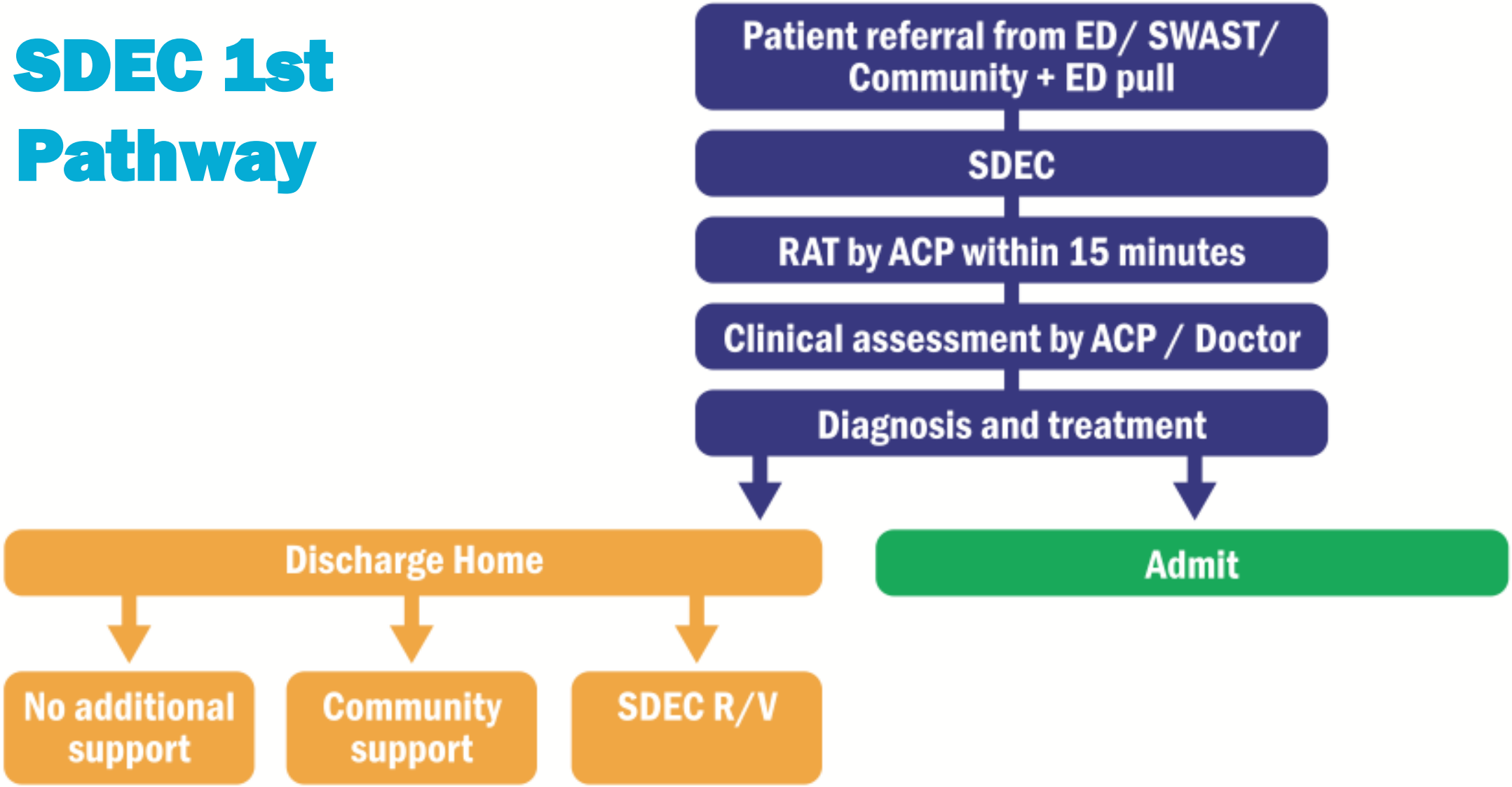
Kat Ebbrell
Advanced Clinical Practitioner

Dorset is home to

Bishops Caundle in Dorset is home to the oldest working post box in the UK

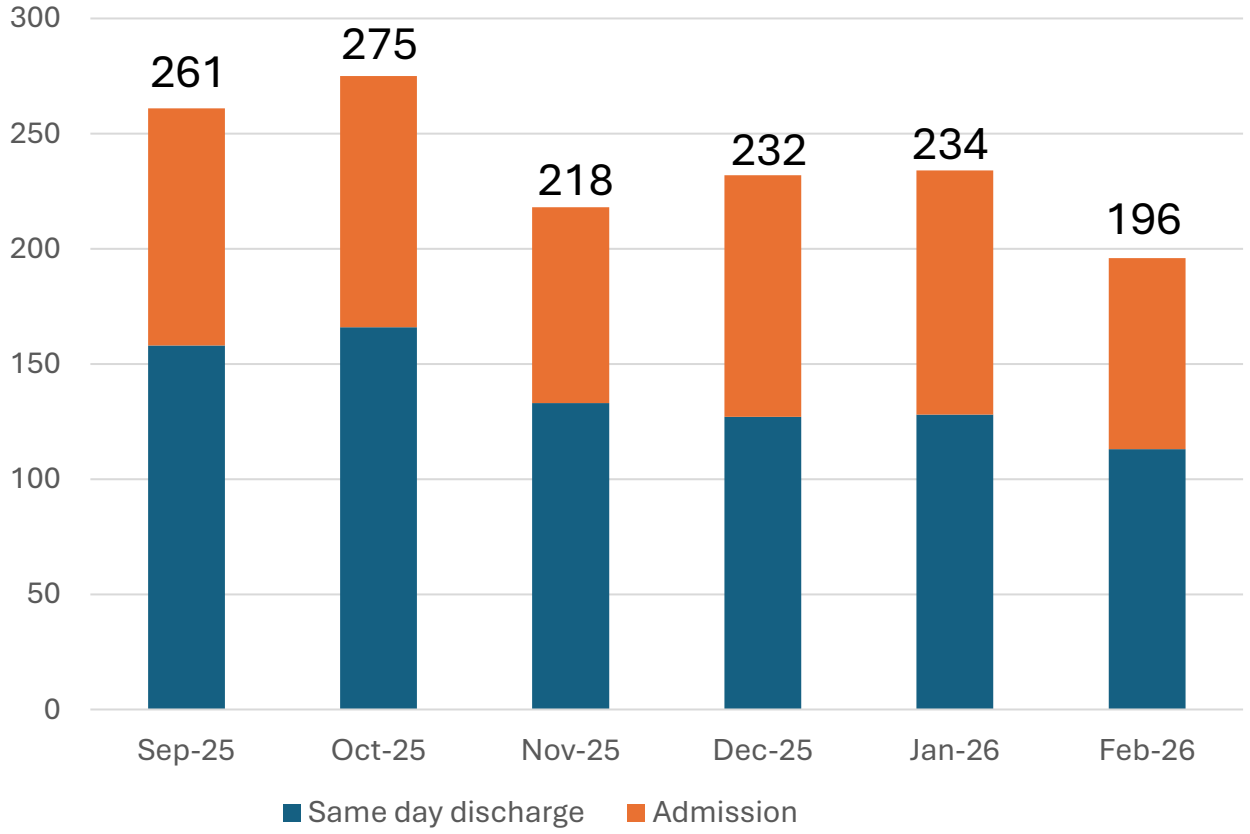
Dorset is also home to the oldest population in the UK with over 85% of the national average of over 85's.

SDEC 1st Pathway

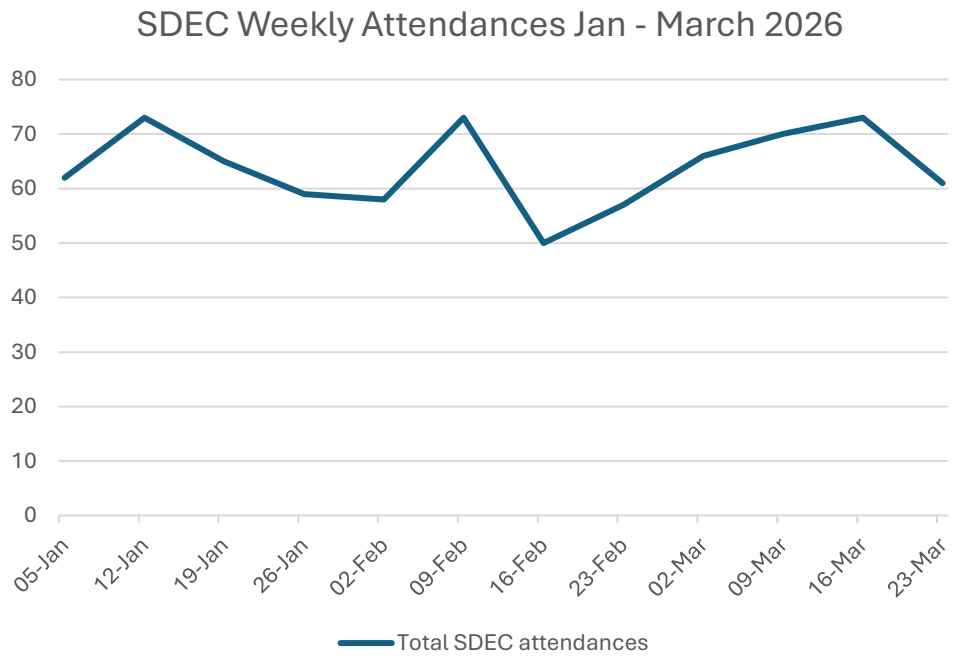


We are caring one team listening to understand open and honest always improving inclusive

Attendances: Admissions vs Discharges



SDEC Weekly attendances



Data taken from Cosmos

References

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- Cosmos.
- Frost et al. 2024. Most Hospital-Acquired Complications among Older Adults are associated with frailty: The South-Western Sydney Frailty and Hospital-Acquired Complications Study, The journal od Frailty and Aging. 13 (4) p522-528.
- Han et al, 2019. 'The impact of frailty on healthcare resource use: a longitudinal analysis using the Clinical Practice Research Datalink in England', Age and Ageing. Sep 1;48(5):665-671.
- Office for National statistics National population projections - Office for National Statistics [Accessed 26/3/26].

Driving Advice in ED

A clinical audit

METHOD

- Review of 80 patient's medical records presenting at Poole and Bournemouth Hospital Emergency Departments during June 2025, 20 from each of the following diagnostic groups: TIA, vertigo, epilepsy, and syncope selected at random.

- Medical record audited to see if relevant driving advice in accordance with DVLA guidelines is provided and documented. Target 100%.

- % of those in each diagnostic group with correct advice calculated.

Dr Motiur Chowdhury, Dr Abdelrahman Elkafoury, Dr Sreejeh Krishnan UHD

Seizures/ Epilepsy

25%

Any epileptic seizure: must stop driving immediately and *must notify DVLA*.

First unprovoked seizure (isolated): stop driving, typically 6 months seizure-free required before DVLA may consider reissue. If underlying cause increases risk, up to 12 months may be needed.

Epilepsy (multiple unprovoked seizures): stop driving 12 months seizure-free before relicensing considered.

Driving must not resume until DVLA confirms fitness.

Vertigo / Dizziness

0 %

DVLA treats episodes of vertigo/dizziness only when they are sudden, disabling or recurrent—meaning unpredictable attacks that could impair driving safety.

DVLA notification:

✓ Required if someone experiences sudden, disabling dizziness/vertigo.

✓ Patients must use DVLA form DIZ1 (cars) or DIZ1V (bus/lorry).

Fitness to drive:

No specific fixed stop period in the general GOV.UK page; DVLA assesses on individual basis, often requiring a symptom-free period (commonly 3 months) before reissue.

If only non-disabling or predictable symptoms (with good warning), doctors may advise notification but no fixed cessation is mandated.

Key clinical point: vertigo that is sudden and unpredictable must be declared and likely leads to licence restrictions until symptoms resolve.

Transient Ischaemic Attack

15%

Must stop driving immediately if TIA occurs.

Cessation period: ≥ 1 month from the event.

DVLA notification:

✓ Not required for a single TIA if fully recovered and no neurological deficits after 1 month.

✓ Required if after 1 month there is:

weakness in arms/legs

visual problems (field loss/double vision)

balance, memory, cognition issues

or if doctor thinks patient isn't safe to drive.

Recurrent TIA -> Treated similarly: stop driving ≥ 1 month after most recent episode. If multiple, report to DVLA.

Syncope

0 %

DVLA standards define syncope as transient loss of consciousness due to reduced brain perfusion. Guidance depends on:

whether syncope occurred while driving, presence/lack of reliable warning (prodrome), whether episodes are multiple or single.

Reflex syncope with reliable prodrome

Single episode (not while driving): may continue driving, no DVLA notify required (unless other issues).

Syncope while driving: must stop driving, typically resume after ~1 month, notify DVLA.

Multiple episodes: driving may resume after ~3 months; notify DVLA.

Reflex syncope without reliable prodrome

Single episode: must stop driving and must notify DVLA. If provoked + not while driving: may resume after ~3 months; notify DVLA.

Multiple episodes: must notify DVLA; may resume after 6 months (if no driving-time syncope).

Actions

- Findings shared at department’s Resident’s teaching session
- Reminder posters displayed in key areas in ED department
- Agyle notification
- Reaudit planned 2026

WET AGE-RELATED MACULAR DEGENERATION EMERGENCY SLOT AT EYE CASUALTY PILOT QUALITY IMPROVEMENT PROJECT

Dr. George Tsokolas[1], Mr. Harry Tossounis[2]

[1] Ophthalmology Specialty Doctor

[2] Consultant VR Surgeon

Eye Unit, Royal Bournemouth Hospital

BU-NHS Conference Moving forwards Together

16-04-2026

INTRODUCTION/BACKGROUND

- Wet age-related macular degeneration (AMD) is a condition that is one of the leading causes of blindness in UK
- Failure of prompt treatment results in irreversible visual loss affecting quality of life
- Anti-VEGF injections the cornerstone of treatment
- Pressures in the macula service due to COVID-19 pandemic restrictions
- Delayed follow-ups in MR clinic and subsequent delays in prompt anti-VEGF injection treatment
- Increased number or new referrals of new onset wet AMD patients
- Mismatch between capacity and demand
- Increased number of written and verbal complaints from patients to the Trust

WET AMD ED SLOT PROTOCOL

Tel Booking:

10:15 slot at EYE CASUALTY for urgent KNOWN WET AMD patient review/treatment

Pt comes in ED:

Tests and investigations performed by ED team prior to ED doctor review

Vision
IOP
Dilate Both eyes in all patients with IOP< 28 mmHg (if higher IOP ask ED doctor)
OCT Macula and Colour photos

Inform doctor in ED to review the scans/photos and the patient
Decision needs to be made if injection is needed
(If the ED doctor needs MR input, ED nurse with ED printout asks an MR senior doctor to review the info and decide)

If patient needs an injection
Patient is moved to the MR suite with appropriate paperwork
(MR Booking form and consent form to be filled by the MR doctors)

At the MR Suite:

- The MR doctor creates on Medisight a consultation entry stating at the **Plan section** (patient from ED AMD slot)
- Sets the number of injections to be done and arranges further management/F-up (Appropriate paperwork is filled and given to the MR Admissions team)
- Injection is performed at the end of the injection list (patient needs to be informed that there will be a wait before the injection)

RESULTS AND CONCLUSIONS

- Ongoing pilot introduced on 01/02/2023

- Data presented until 31/03/2026

(Just over 3 years)

- ***166 out 369 of patients (44.9%)***

of known or newly wet AMD patients with sudden deterioration ***were seen urgently at Eye Casualty and treated with an injection on the same day***

- ***Nearly 14 injection lists (12 patients each list) to be planned, funded and run were avoided***

- ***Cost saving but most importantly prompt patient treatment and satisfaction were achieved***

- Patient anxiety and staff pressure were efficiently managed with a structured timely response and certain protocol

Any Questions?

BOURNEMOUTH UNIVERSITY

2026 BU-NHS Conference

Moving Forwards Together

Fusion Building, Talbot Campus
16th April 2026

NHS

Afternoon Break

Health Innovation Wessex

Bournemouth University

Women's Health

A system-led, partnership approach to implementation

Part of the Health Innovation Network
Local change, national impact

PROGRAMME VISION:

To improve the health outcomes and experience for the women in Dorset with equal and timely access to existing services.

ORIGNAL AIM:

Bring together healthcare professionals and existing services to provide integrated women's health services, centred on meeting women's needs across the life course, where care is not limited to interventions for a single condition but instead is wrapped around the needs of an individual woman, which in some cases may be multiple needs. In addition, improving access to and experiences of care, improving health outcomes for women, and reducing health inequalities.

Dorset Women's Health Programme
6 Focus Areas

The public engagement which took place in Dorset, including previous work undertaken by Dorset Women CIC, resulted in the six priorities below being identified as most important to the women and girls of Dorset.

Dorset Women's Health online resource

- Website repository of information, education, awareness, self-help and service provision
- Programme branding and logo
- Education for professionals

Long-acting reversible contraception (LARC)

- Service improvement
- Provision in primary and secondary care where appropriate
- LARC for contraceptive and non-contraceptive reasons

Young women's mental and physical health

- Physical health including HPV vaccinations: education, engagement and uptake
- Mental health including perinatal mental health

Menopause

- Supporting women in the workplace, and enabling their colleagues to support them
- Supporting Dorset women to access symptom information and management, support groups and treatment where required – Online Resource
- Educating professionals on symptoms

Minority groups and mobile support

- PPI engagement to identify need and examine DiiS data
- Resource to visit rural areas and build on existing Dorset provision
- Taking a service to under-represented groups: information, education and provision

Pelvic floor disorders

- Current pathways including for immediate referral to pelvic health physio
- Campaigns and awareness for early help
- Innovation and use of mobile technology to manage symptoms

The programme has delivered **large-scale educational impact**, **expanded digital support**, **enhanced clinical pathways**, and **improved the visibility of women's health needs** across Dorset.

Key impacts

Improved access to women's health services

- **Two** new care pathways enabling more timely and better access to service closer to home.
- The creation of an online resource website supporting **thousands** of Dorset women with evidenced based self-help, education and support.
- The provision of **1,100 funded licences** for women to access the Squeezy app.

Significant increase in clinician knowledge & confidence

- **16** health care professionals (HCPs) attended pelvic floor training and have cascaded this training forwards.
- **11** HCPs attended racial discrimination training and **100% reported** to have good or excellent knowledge post training.
- In the first set of three menopause webinars, **218 HCPs** attended with **96%** of those attending reporting that they think it will reduce secondary care referrals.
- In total for all six webinars, **351 hours of training** has been provided to HCPs on menopause with those feeling extremely confident rising from 0% to **39%** post training.

Measurable influence on referrals & clinical behaviour

- **Reduced referrals** for bleeding during menopause due to national guidelines.
- More **efficient menopause service** has expediated query response.
- Increased reliance on Poole Menopause Clinic, multiple advice and guidance from the same GPs, seen as a **trusted specialist support.**

Key impacts

Strengthened community engagement and support

- Over **1600** responses to the digital women's surveys to hear the public voice.
- **21** groups connected to the work which amplified Dorset women's under-represented voices including women's lived experience stories.
- **28,868** views to the online health resource and **eight** podcasts providing support and increasing DWHP awareness.

Digital innovation driving reach and awareness

- The creation of an online resource website supporting **thousands** of Dorset women with evidenced based self-help, education and support.
- **5** digital apps uploaded to the Our Dorset ORCHA library.
- **226** downloads from **four** menopause apps.
- **170** registrants adopted Squeezy app licence due to targeted campaign.

Better understanding of women's experiences and barriers

- **Six** targeted schools supported human papillomavirus (HPV) vaccine campaign.
- **53** reviews from Dorset women supported changes to the online resource.
- The two digital surveys, lived experience stories and public engagement throughout has shaped this work and surfaced the experiences and barriers experienced by women.

Dorset Women's Health Hubs: Influencing Nationally

NHS Dorset and system partners including Health Innovation Wessex have been influencing colleagues nationally and showcasing the Dorset achievements and impacts.

Activities have included:

- Dorset celebration event on 24 April 2025 – attended by national NHSE and Getting It Right First Time (GIRFT) colleagues
- NHS Confed Expo presentation on 12 June 2025 – attended by national NHSE Women's Health team
- Presentations to NHSE, Department of Health and Social Care (DHSC) and National Institute for Health & Care Excellence (NICE) – between June 2025 and January 2026.

What is happening regionally and nationally?

National

- NHSE/DHSC Refresh of the National Women's Health Strategy – expected March 2026
- A Good Practice Guide to Implementing Neighbourhood Working in Women's Health Services
- Equity Framework
- NHSE and NICE focus on digital CBT for Menopause
- Cluster HIN programme on Women's Health – focus on innovation adoption

Regionally

- Regional Women's health workshops

Any Questions?

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NIHR | National Institute for Health and Care Research

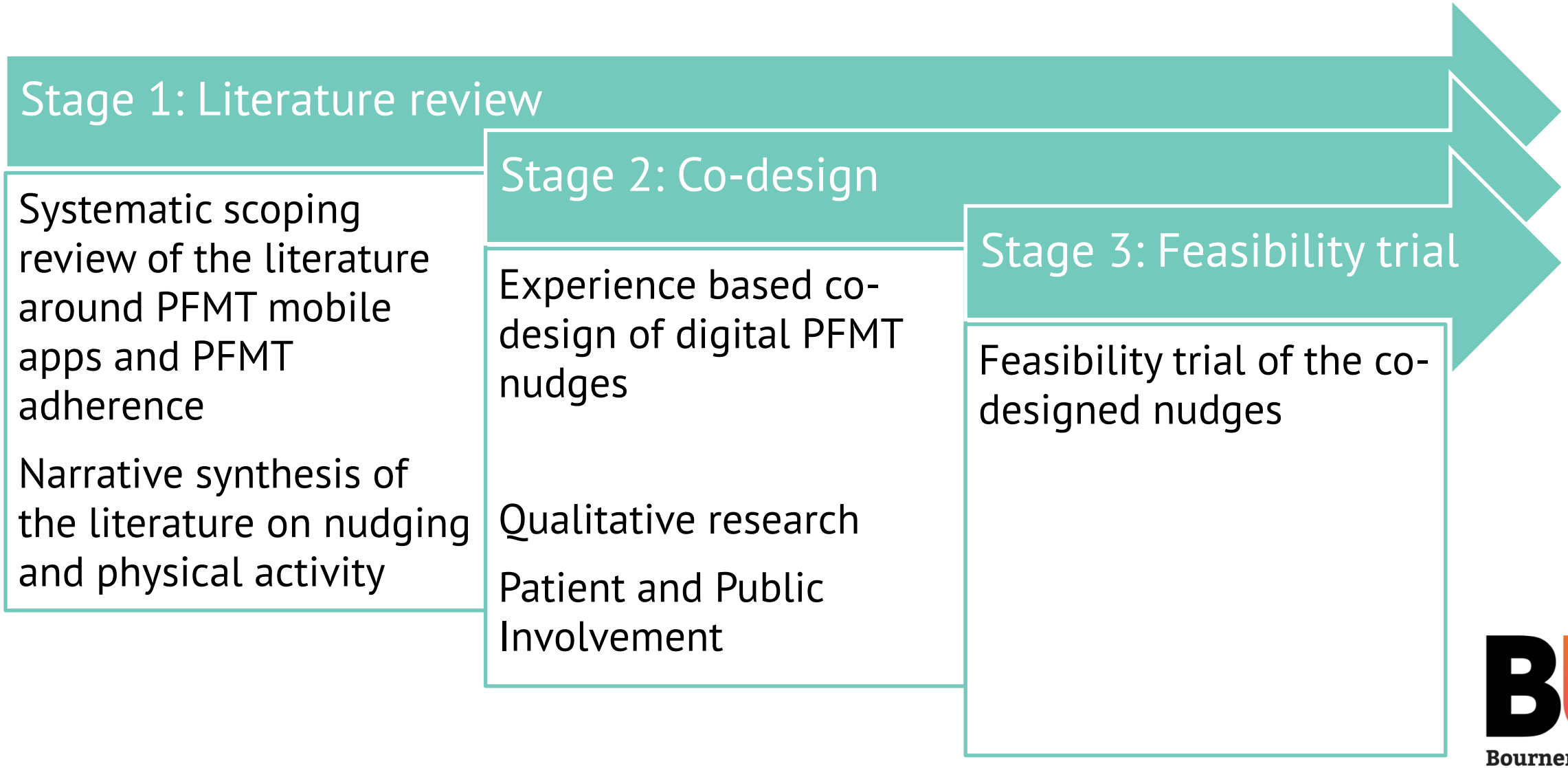
NHS University Hospitals Dorset NHS Foundation Trust

Nudging: A theoretical concept for a very practical approach to pelvic floor muscle training

By Sally Sheppard

Service Lead Pelvic Health Physiotherapy

Methods and research plan

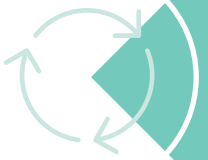


Bournemouth University

Conclusions and next steps

Digital pelvic floor nudges are an acceptable and scalable innovation that demonstrate promising influences on antenatal women's adherence to training

Asymptomatic antenatal women demonstrated higher levels of adherence to pelvic floor training compared to other populations



Opportunity is the core behaviour of the COM-BCW that requires targeting to influence antenatal women’s PFMT adherence

Humour can be used to gain-frame nudges to facilitate behaviour change around pelvic floor training

Bournemouth University

Preparing Teams and Systems for Large-Scale Healthcare Transformation Using Transformative Simulation

Rose Edwards
Olivia Cole
Kirsty Duncan

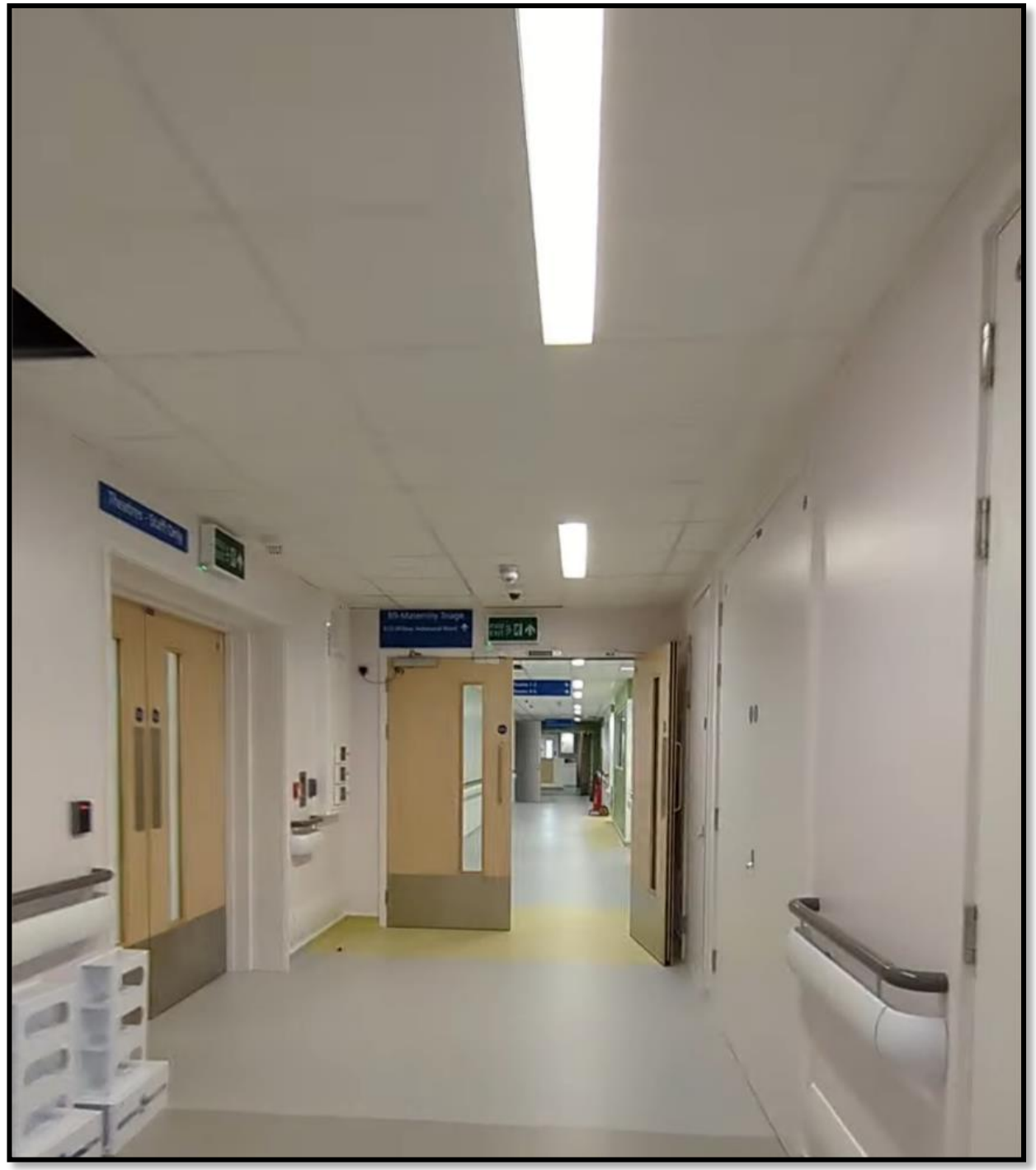
UHD SIMULATION

University Hospitals Dorset

UHD SIMULATION

University Hospitals Dorset


FIRE EXIT
6A


Maternity Triage

POWER

I was able to contribute during this session and my input was valued and respected

94%

agreed / strongly agreed

945 Responses

Power Influence

	A	B	C	D	E	F	G	H	I	J	K	L
1	PHASE 3 SIMULATION ISSUES RAISED LOG - THEATRES											
2	NUMBER	ISSUE	DATE OF ENTRY	ADDED BY	WHERE/HOW RAISED	CATEGORY	PATIENT SAFETY OR GO/NO GO ISSUE	ISSUE OWNER	PROGRESS UPDATE	ISSUE RESOLVED	ESCALATED TO	ADDITIONAL COMMENTS
3												
4												
5												

UHD SIMULATION

University Hospitals Dorset

Olivia Cole
Kirsty Duncan
Rose Edwards

MAPPING LEADERSHIP, TEAMWORK AND TRUST IN MATERNITY CARE: A STRUCTURED LITERATURE REVIEW TO INFORM DOCTORAL RESEARCH

AFFILIATIONS
Bournemouth University
AUTHORS
Kate Burgess

BACKGROUND

Leadership and teamwork are widely recognised as central to safe, high-quality and personalised maternity care. However, the literature remains theoretically fragmented and often insufficiently attentive to the relational and moral conditions in which intrapartum care is enacted. UK maternity inquiries have repeatedly identified cultures of fear, silence and hierarchy as contributory to harm. Within this context, teamwork cannot be understood only as technical coordination; it must also be understood in relation to trust, psychological safety and the professional courage required to advocate for women within complex organisational systems. This concern also underpins the wider doctoral project, which positions compassionate and relational leadership as key enablers of courageous, personalised care.

AIM

To critically examine how leadership, teamwork and trust are conceptualised within maternity care literature, and to identify how these factors shape midwives' courage and capacity to provide personalised care during labour.

REVIEW QUESTION

To critically examine how leadership, teamwork and trust are conceptualised within maternity care literature, and to identify how these factors shape midwives' courage and capacity to provide personalised care during labour.

RESULTS

A structured literature search was undertaken across CINAHL, MEDLINE, PsycINFO and Scopus. English-language literature from 2000 onwards was reviewed using a critical–interpretive approach to examine how leadership, trust, hierarchy and culture shape teamwork in maternity care.

KEY THEMES

Trust as the foundation of teamwork
Trust emerged as a core condition for effective teamwork, open communication and safe care. In maternity services, trusting relationships support collaboration, shared learning and mutual reliance.

Leadership is relational, authentic and distributed.
The literature favours relational, authentic and distributed leadership over hierarchical models. These approaches appear to strengthen trust, team cohesion and personalised care.

Psychological safety and speaking up
Psychological safety was central to staff feeling able to ask questions, raise concerns and challenge unsafe practice. Where it is present, midwives are better able to advocate for women and contribute to decision-making.

Hierarchy, silence and professional inhibition
Hierarchical cultures have been repeatedly linked to weaker communication, reduced openness, and constrained professional confidence. Such conditions can undermine both teamwork and courageous practice.

MAIN FINDINGS

Leadership and teamwork are widely recognised as central to safe, high-quality and personalised maternity care. However, the literature remains theoretically fragmented and often insufficiently attentive to the relational and moral conditions in which intrapartum care is enacted. UK maternity inquiries have repeatedly identified cultures of fear, silence and hierarchy as contributory to harm. Within this context, teamwork cannot be understood only as technical coordination; it must also be understood in relation to trust, psychological safety and the professional courage required to advocate for women within complex organisational systems. This concern also underpins the wider doctoral project, which positions compassionate and relational leadership as key enablers of courageous, personalised care.

CONCLUSION

This literature review provides a critical conceptual foundation for doctoral inquiry into how leadership and teamwork shape midwives' courage and capacity to provide personalised care during labour. It supports the development of an emergent model in which leadership, trust, psychological safety and courage are understood as mutually reinforcing conditions for safe, relational and personalised maternity care. The review therefore moves beyond narrow accounts of teamwork as technical coordination and instead highlights teamwork as relational, moral and organisationally mediated.

REFERENCES

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MAPPING LEADERSHIP, TEAMWORK AND TRUST IN MATERNITY CARE: A STRUCTURED LITERATURE REVIEW TO INFORM DOCTORAL RESEARCH

AFFILIATIONS
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AUTHORS
Kate Burgess

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Any Questions?

Having contraception and pregnancy discussion with young adults with diabetes aged 16-21 at University Hospitals Dorset (QIP/Audit)

Lead Author – Dr Cing Lian Kim

Affiliation – University Hospitals Dorset
Dr Helen Partridge, Linda Burles

Background and Aims

- Contraception and pregnancy discussions are **not commented on in paediatric NICE guidelines;** this is therefore possibly the first opportunity patients may have had.

- **Poor glycaemic control** in early pregnancy is associated with **increased risks** of miscarriage, congenital anomalies (including neural tube and cardiac defects) and complications during labour.

- **Effective pre-pregnancy planning** including optimising HbA1c in range alongside folic acid supplementation is vital for **achieving healthy pregnancy outcomes.**

Methods

- **Clinic letters documented** by consultants and specialist nurses for **67** female patients aged 16-21 attending YPDS between **January 2023 and April 2025** were reviewed. Using Dorset Care Record and **GP notes**, we also assessed whether each patient had an active contraception prescription.

Results

- Discussions were documented in **21 patients (32%) -** 16 patients had discussion by consultants and 5 patients by specialist nurses.

- **22 patients** were prescribed oral contraceptive pills **(OCP).** Notably among them , **8 patients were on OCP despite no documented discussion with YPDS service a**nd 4 patients were taking OCP for menstrual irregularities.

- **One patient who is pregnant** with history of **previous termination of pregnancy** due to **congenital abnormalities** and **one patient was documented miscarriage** with **no documented** evidence of prior contraception or pregnancy-planning discussion.

- **No patients indicated a desire to discuss** pregnancy or contraception on the pre-clinic proforma.

Conclusion

- Although the whole YPDS team recognises the importance of routine contraception and pregnancy discussion, documentation was present in **only 32% of cases.** It remains unclear whether discussions occurred but were not recorded or did not take place.

Next steps/ Impact

- **A new tick box question has been introduced on the clinic proforma** since end of April 2025 to document whether this particular discussion and documentation has been held.

- The reaudit from May to October 2025 found **18% increase** in documentation after using the clinical new proforma and **5 new patients on OCP** with **no new patients** with pregnancy or termination of pregnancy outcomes.

Interprofessional Identification of Cardiac Disease in the Perinatal Period

Rebecca McKee

BU Postgraduate Researcher I UHD Triage Midwife

Supervision Team: Dr Lindsay Welch (BU/UHD), Dr Pete Phillips (BU),
Dr Carol Clark (BU), Dr Victoria Pereira (UHD)

What are we trying to achieve?

What are the current recommendations and practice for an inclusive assessment of cardiac disease for women presenting to outpatient/ community settings, during the perinatal period?

What are the current recommendations for an assessment of cardiac disease in the perinatal period in?

How is cardiac disease inclusively assessed during the perinatal period?

To **explore** the lived experiences of women presenting with cardiac disease during the perinatal period.

To **co-produce** primary research.

How will we achieve this?

Phase 1

A systematic review will be used to identify recommendations for practice, map current literature and identify any gaps.

Phase 2

PPIE will be used to explore the lived experiences of women presenting with symptoms of cardiac disease during the perinatal period.

Phase 3

PPIE findings will be used to co-produce primary research.

Phase 2 estimated to start in May 2026 – Would you like to be involved?

Bournemouth University

Supporting women in early labour: an interdisciplinary digital approach

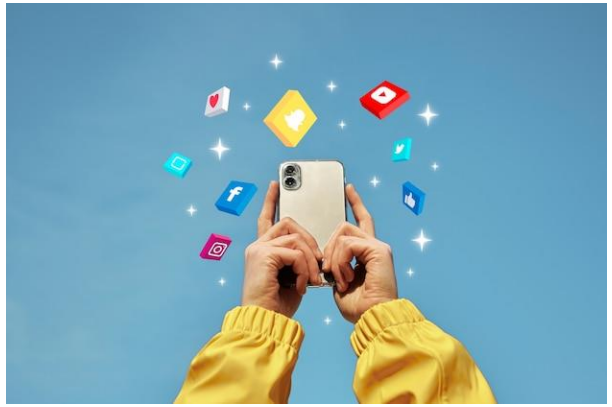
Dr Dominique Mylod

On behalf of the Early Labour App team

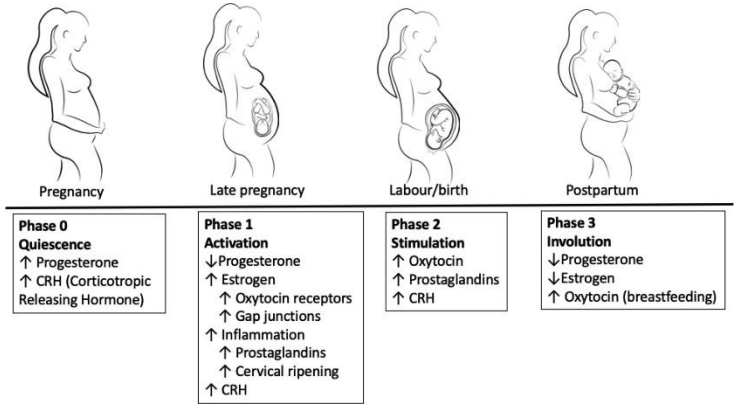
Early labour is challenging for women & midwives

Social - Place of birth

Power of family & friends



Impact of media – particularly social media



Biological influences

Why an interdisciplinary app?

- Drawing together 4 evidence-based strategies into 1 easily accessible location
- Gen Z birthing demographics are digitally literate
- UK midwifery staffing crisis & poor service user experience of latent phase
- Consistent, evidence-based advice & strategies
- Modest development & implementation costs

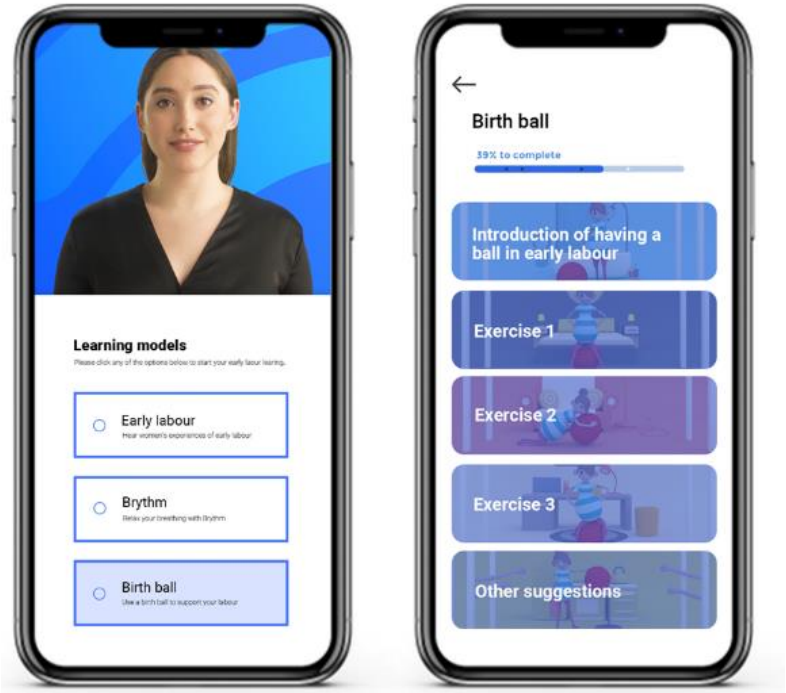
Let's Talk Early Labour (L-TEL)

(Edwards et al., 2023)

http://www.letstalkearlylabour.org/

- Underpinned by self-efficacy theory
- Web-based intervention
- Co-created with women
- Early labour advice
- Videoed experiences

Using the birth ball

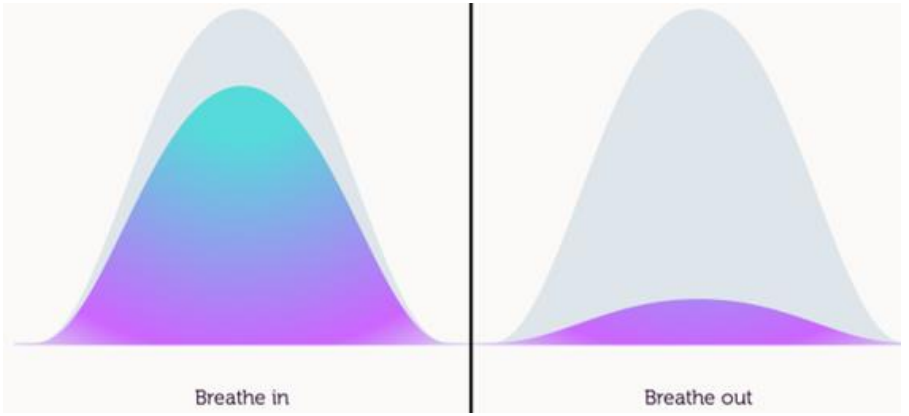


- ↑ acceptability & satisfaction
- ↑ admission in active labour
- ↓ chance of unplanned CS

(Mylod et al., 2024)

The BALL Trial

Slow and Deep Breathing (SDB)



(Felton et al., 2021)

- Promising intervention to reduce blood pressure in primary hypertension
- 6 breaths per minute
- Based on pranayama yoga techniques
- May overcome sympathetic adrenergic response & engage parasympathetic system

PPIE & Development

Liked	Suggestions
Content balance good – not too overwhelming	Controls on L-TEL videos to pause, retart, show duration
L-T s	
B	
D	
H	
Ea	
Information	tners
	Add a closing summary page

When can we start using it?

Questions?

The Team

Prof Carol Clark
Dr Rebecca Edwards
Dr Malika Felton
Prof Vanora Hundley
Dr Dominique Mylod
Ms Tracey Thomson
Prof Xiaosong Yang

and

UHD midwives
Staff & families at Boscombe Family Hub
Staff & families at Blackberry, Clovelly & Seashell Hubs Southampton
Anna Marsh & Komal Khuti-Dullaart (UCLH MVP Lead)

Thanks to our Research Assistants

Dr. Yaqing Cui & Dr. Kun Qian
Megan Chesters
Tom Lower
Carys Nash
Kaisei Numao-Wieczorek

Any Questions?

NHS
Dorset County Hospital
NHS Foundation Trust

Effectiveness of Biofeedback with Dilator Therapy for sexual function in Women with Primary Vaginismus: Randomized Controlled Trial Study

Farnaz Jokar et al
Senior Physiotherapist, BSc, MSc
International Urogyneacology Journal, 2025

Introduction

- Definition: vaginismus is a genito-pelvic pain/penetration disorder (GPPPD) caused by involuntary spasm of pelvic floor muscles (PFMs)
- Clinical challenge: significant impact on quality of life, psychological well-being, and marital satisfaction.
- Knowledge gaps: lack of comprehensive data on the synergy between EMG-biofeedback and traditional dilators, as part of physiotherapy intervention.
- Goal: to evaluate the impact of combining EMG-biofeedback with dilator therapy on female sexual function in women with primary vaginismus.
- Hypothesis: the combination therapy (active + passive) is more effective that dilator therapy alone (passive)

Methods

- Design: single-blind Randomized Controlled Trial (RCT)
- Ethical approval: IR.MUI.NUREMA.REC.1402.069, approved by Isfahan University of Medical Sciences' research ethics committee
- Sample size: 32 married women (aged 18-45) with primary vaginismus (Lamont grade 2-4)
- Setting: Pelvic Floor Physiotherapy Clinic, Isfahan University of Medical Sciences, Isfahan, Iran (February 2023-February 2024)
- Tool: Female Sexual Function Index (FSFI) Questionnaire (6 dimensions: Desire, Arousal, Lubrication, Orgasm, Satisfaction, Pain)

Consolidated Standards of Reporting Trials flowchart

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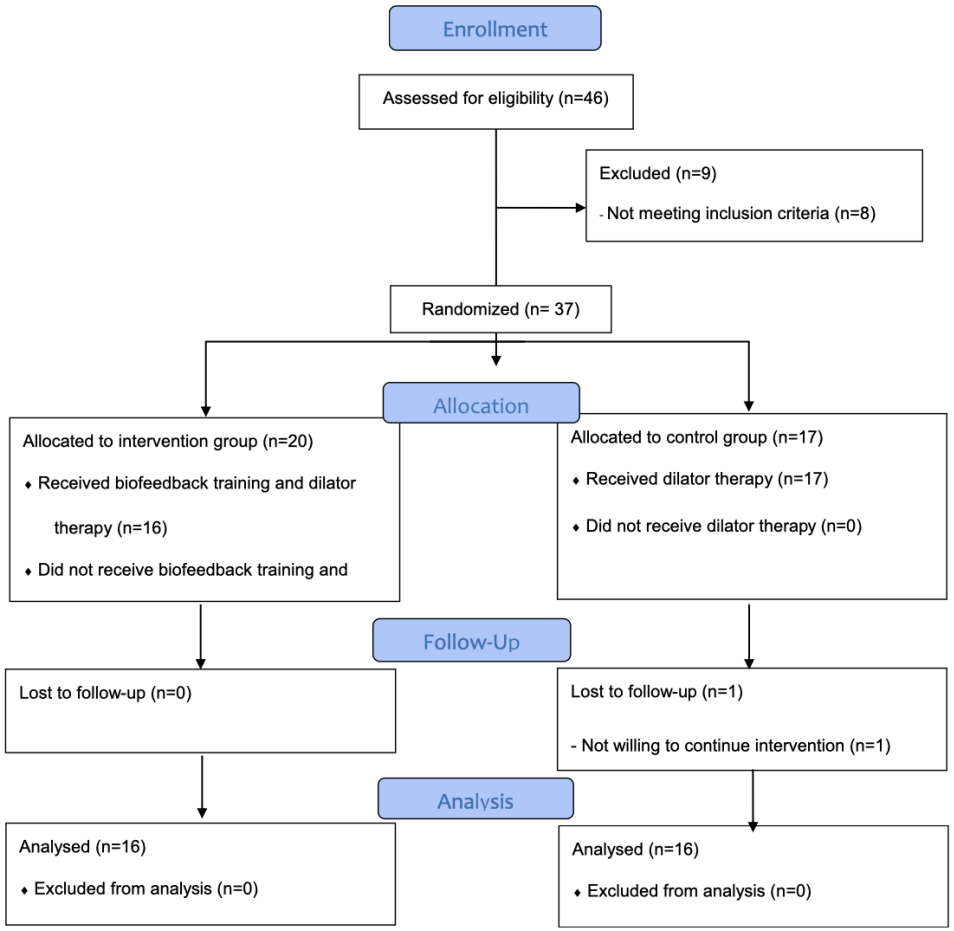
NHS Foundation Trust

Fig. 1 Consolidated Standards of Reporting Trials flowchart showing the randomization of 37 participants



Intervention Protocols

Control Group (n=16)	Experimental Group (n=16)
10 sessions of graded silicon dilators (1 cm to 5 cm-dimension) under physiotherapist supervision	Dilator therapy similar to control group + 15 mins of EMG-biofeedback (Glazer protocol) for neuromuscular reeducation Intra-vaginal probe introduced gradually

Frequency: twice weekly for 6 weeks, in clinic with supervision only

Statistical analysis

- FSFI comparison: independent t-test, analysis of variance, post hoc Bonferroni test for interaction effect for within and between group comparison
- SPSS software
- Measurements: before treatment, immediately after 10th session, 1 month follow-up

Results

Dorset County Hospital
NHS Foundation Trust

- Individual characteristics between 2 groups (Age, Height, Weight, Duration of marriage (years), vaginismus grade): no significant difference (P>0.001), comparable groups
- Overall Score: Significant improvement in both groups, but higher gains in the experimental (biofeedback) group (p <0.001)
- Key dimensions: the experimental group showed superior results in:
- Desire (p <0.001)
- Arousal (p <0.001)
- Satisfaction (p <0.001)
- Pain reduction (p <0.001)
- Lubrication: no significant difference between groups (p=0.182)

Discussion

- Why biofeedback was superior?

Neuromuscular control	Desensitization	Patient autonomy
biofeedback provides visual/auditory cues to help patients control involuntary spasm and become more aware of the PFMs	gradual exposure via dilators combined with active relaxation reduces fear-avoidance cycle	improved awareness of PFMs tone leads to better functional confidence

Conclusion

Dorset County Hospital
NHS Foundation Trust

- Summary: biofeedback with dilator therapy is a highly effective treatment for primary vaginismus
- Outcome: it targets more aspects of sexual function compared to physical spasm and the functional sexual outcome
- Clinical implications

Efficiency	Resource allocation	Patient-centered care
Combined therapy can lead to faster outcomes	EMG-biofeedback is a cost-effective tool for specialized PH physio clinics	Addressed both the physical spasm and the functional sexual outcome

Final thoughts and Q&A

Dorset County Hospital
NHS Foundation Trust

- future research: investigating long-term sustainability of results and the role of combined psychotherapy
- Acknowledgements: Isfahan University of Medical Sciences (funding of the study)
- Any questions?

You can find me: Farnaz.jokar@dchft.nhs.uk

Any Questions?

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16th April 2026

PRESENTATIONS