University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS - PART 1 MEETING

Wednesday 5 November 2025
09:30 – 12:45

Boardrooms, Poole Hospital and

via Microsoft Teams

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

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 5 November 2025 in the Boardrooms at 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

9:30 on Wednesday 5 November 2025

Time	Item		Method	Purpose	Lead
9:30	**1**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
9:32	**2**	Declarations of Interest	**Verbal**		**Chair**
9:35	**3**	Patient Story	**Verbal**	**Discussion**	**CNO**
	4	**MINUTES**			
9:50	**4.1**	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 8 September 2025	**Paper**	**Approval**	**Chair**
9:52	**4.2**	Matters Arising - Action List	**Paper**	**Review**	**Chair**
	5	**TRUST CHAIR AND CHIEF EXECUTIVE UPDATES**			
9:55	**5.1**	Trust Chair's Update	**Verbal**	**Information**	**Chair**
10:05	**5.2**	Chief Executive Officer's Report • ICB minutes	**Paper**	**Information**	**CEO**
	6	**STRATEGY, RISK AND PERFORMANCE**			
10:15	**6.1**	Quality Committee – Chair's Report – September and October 2025: • Maternity and Neonatal Quality and Safety Report *(to be presented by Director of Midwifery)* • Annual End of Life Care Report • Mortality Report	**Paper** **Paper** **Paper** **Paper**	**Assurance** **Assurance** **Assurance** **Assurance**	**Committee Chair** **DoM** **CNO** **CMO**

10:35	**6.2**	Finance and Performance Committee – Chair's Report – September and October 2025: • Green Plan • Estate Master Plan 2025-35	**Paper** **Paper** **Paper**	**Assurance** **Approval** **Approval**	**Committee Chair** **CSTO** **CSTO**
10:50	**6.3**	People and Culture Committee – Chair's Report – October 2025: • Modern Slavery Statement	**Paper** **Paper**	**Assurance** **Approval**	**Committee Chair** **CPO**
11:00	**6.4**	Transforming Care Together – Chair's Report – October 2025	**Paper**	**Assurance**	**Committee Chair**
11:10	**6.5**	Audit Committee – Chair's Report – October 2025: • Standing Financial Instructions	**Paper** **Paper**	**Assurance** **Approval**	**Committee Chair** **CFO**
11:20	**6.6**	Board Assurance Framework	**Paper**	**Review**	**Execs**
11:30	**6.7**	Integrated Quality, Performance, Workforce, Finance and Informatics Report	**Paper**	**Assurance**	**Execs**
11:40	**6.8**	Trust Strategy	**Paper**	**Approval**	**CSTO**
11:45	**6.9**	Board capability self-assessment	**Paper**	**Assurance**	**CSTO**
11:50		**Break**			
	7	**PEOPLE AND CULTURE**			
11:55	**7.1**	Workforce Plan	**Paper**	**Review**	**CPO**
12:05	**7.2**	Freedom to Speak Up Guardian Report	**Paper**	**Assurance**	**FTSUG**
12:15	**7.3**	SeeMe First	**Presentation**	**Information**	**EDI Lead**
	8	**ITEMS FOR APPROVAL/INFORMATION**			
12:25	**8.1**	Risk Register: review of significant risks; new risks rated 15 and above	**Paper**	**Information**	**Execs**
12:35	**8.2**	Composition of Board of Directors: Amendment to Trust's Constitution	**Paper**	**Approval**	**Chair**
12:40	**8.3**	Board Meeting Schedule	**Paper**	**Approval**	**Chair**
12:42	**8.4**	Risk Oversight Committee Terms of Reference	**Paper**	**Approval**	**Chair/ CNO**
	9	Any Other Business	**Verbal**	**Discussion**	**Chair**
	10	Reflections on the Board Meeting	**Verbal**	**Discussion**	**Chair**
	11	Questions from the Council of Governors and Public arising from the agenda.			

		Governors and Members of the public are requested to submit questions relating to the agenda by no later than noon on 31 October 2025 to uhd.company.secretary-team@nhs.net			
	12	**Date and Time of Next Board of Directors Part 1 Meeting:** Board of Directors Part 1 Meeting on TBC			
	13	**Resolution Regarding Press, Public and Others:** To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend to the next part of the meeting be excluded due to the confidential nature of the business to be transacted.			
12:45	**14**	**Close**	**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

- Patient Story
- Trust Chair's Update
- Chief Executive Officer's Update
- Committee Chair's Key Issues & Assurance Report
- Integrated Performance Report
- Risk Register Report
- Maternity

Annual reports

- Maternity Incentive Scheme
- Private Patients Strategy

Quarterly Reports

- Quality Impact Assessment Overview Report
- Guardian of Safe Working Hours Report

AGENDA – PART 2 PRIVATE MEETING

13:00 on Wednesday 5 November 2025

Time	Item		Method	Purpose	Lead
13:00	**15**	Welcome, Introductions, Apologies & Quorum	**Verbal**		**Chair**
13:05	**16**	Declarations of Interest	**Verbal**		**Chair**
	17	**MINUTES AND ACTIONS**			
13:07	**17.1**	For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 1 October 2025	**Paper**	**Approval**	**Chair**
13:09	**17.2**	Matters Arising – Action List	**Paper**	**Review**	**Chair**
	18	**UPDATES**			
13:10	**18.1**	Chief Executive Officer's Update • CQC maternity inspection • Our Dorset Provider Collaborative Minutes	**Verbal** **Verbal** **Paper**	**Information** **Information** **Information**	**CEO** **CEO** **CEO**
13:30	**18.2**	Feedback/Escalations from Committee Chairs (not already covered in Part 1)	**Verbal**	**Information**	**Committee Chairs**
	19	**FINANCE**			
13:40	**19.1**	Finance Update	**Paper**	**Assurance**	**CFO**
	20	**QUALITY**			
13:55	**20.1**	Patient Safety Event Report	**Paper**	**Assurance**	**CMO**
	21	**GOVERNANCE**			
14:00	**21.1**	Organising for success – corporate project	**Presentation**	**Approval**	**CMO**
	22	**ITEMS FOR APPROVAL/INFORMATION**			
14:10	**22.1**	Trust Community Diagnostic Centre Scanners	**Paper**	**Approval**	**CFO/ CSTO**
14:15	**22.2**	Strategic Estates Masterplan Update	**Paper**	**Approval**	**CSTO**
14:20	**22.3**	HealthSet Preferred Supplier-Commercial Evaluation Report	**Paper**	**Approval**	**CDO**

14:25	**23**	Any Other Business	**Verbal**		**Chair**
14:28	**24**	Reflections on the Board Meeting	**Verbal**		**Chair**
		Date and Time of Next Standing Board of Directors Part 2 Meeting: Board of Directors Part 2 Meeting on Wednesday 3 December 2025 at 9:30.			
14:30	**25**	**Close**	**Verbal**		**Chair**

This meeting is being recorded for minutes of the meeting to be produced.

Materials in the reading room:

Items for Next Standing Board Part 2 Agenda

Standing Reports

- Trust Chair's Update
- Chief Executive's Update
- Escalations from Committee Chairs (not already covered in Part 1)
- Feedback from Service Visits
- Finance Report
- Patient Safety Event Report
- Recommendation Reports

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 – Associate Director of Corporate Governance

Other abbreviations

CDEL – Capital Delegated Expenditure Limit
CIP – Cost Improvement Programme
ED – Emergency Department
HSMR – Hospital Standardised Mortality Ratio
ICB – Integrated Care Board
ICS – Integrated Care System
IPR – Integrated Performance Report
ITU – Intensive Therapy Unit
MSG – Mortality Surveillance Group
NHSE/I – NHS England/Improvement
#NOF – Fractured neck of femur
NRTR – No reason to reside
OPEL – Operational Pressures Escalation Levels
RTT – Referral to Treatment
SDEC – Same Day Emergency Care
SHMI – Summary Hospital-Level Mortality Indicator
SMR – Standardised Mortality Ratio
SWAST – South West Ambulance Service NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS PART 1

Minutes of the Part 1 meeting of the Board of Directors held on Monday 8 September 2025 at 9:30 in Boardroom 1, Poole Hospital and via Microsoft Teams.

Present:	Judy Gillow	Trust Chair *(Chair)*
	Beverley Bryant	Chief Digital Officer
	Siobhan Harrington	Chief Executive Officer
	Sarah Herbert	Chief Nursing Officer
	Tracie Langley	Non-Executive Director
	John Lelliott	Non-Executive Director
	Femi Macaulay	Non-Executive Director
	Michael Marsh	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
	Cliff Shearman	Non-Executive Director
	Claire Whitaker	Non-Executive Director
	Melanie Whitfield	Chief People Officer
	Peter Wilson	Chief Medical Officer
In attendance:	Colin Blebta	Public Governor
	Robert Bufton	Public Governor
	Andrew Doe	Associate Non-Executive Director
	Jamie Donald	Director of Communications
	Eiri Jones	Non-Executive Director, Dorset County Hospital
	Simon Hall	Good Governance Institute
	Andrew McLeod	Public Governor
	Carrie Stone	Public Governor
	Lorraine Tonge	Director of Midwifery
	Michele Whitehurst	Public Governor
	Klaudia Zwolinska	Corporate Governance Manager
	XX member of the public in attendance	

BoD 225/25	**Welcome, Introductions, Apologies & Quorum** Judy Gillow welcomed Michael Marsh, who will be joining the Trust as a new Non-Executive Director, succeeding Cliff Shearman, whose term concludes at the end of this month. Judy Gillow, on behalf of the Trust and the Board, expressed sincere gratitude for Cliff Shearman's exemplary service and significant contributions. His dedication and support have been deeply appreciated and will be greatly missed. Siobhan Harrington introduced and welcomed Simon Hall from the Good Governance Institute, advising that he would be working with the Trust on a 12-week project aimed at evaluating and enhancing current governance arrangements. His attendance was in an observing capacity.

	Judy Gillow welcomed Melanie Whitfield, Chief People Officer, to her first Board Meeting. She also thanked both the Executives Directors and Non-Executive Directors for their support over the holiday period. Apologies had been received from: • Helena McKeown, Non-Executive Director The meeting was declared quorate.
BoD 226/25	**Declarations of Interest** No existing interests in the matters to be considered were declared. In addition, no further interests were declared.
BoD 227/25	**Patient Story:** Sarah Herbert introduced Rochelle, who attended with her baby Avery, to share her personal experience of maternity care within the Trust. Rochelle had given birth to two children, Otis at St Mary's and Avery at the new BEACH Building**,** offering a valuable comparison of services over time. Rochelle spoke candidly about the challenges of her first pregnancy, including severe hyperemesis gravidarum, and her induction at St Mary's. While the care was positive overall, she noted limitations such as the lack of access to a water birth and how the birth experience affected her recovery. Her second experience at the BEACH Building was described as significantly improved. She praised the modern, private environment and the continuity of care, particularly having the same midwife throughout her journey. She highlighted the convenience of Badger Notes, which allowed her to access her maternity records digitally, and appreciated the prompt referral to physiotherapy for pelvic pain. She described how she felt safe and relaxed and this in turn enabled her to have a very special experience. Having a midwife who knew her enabled her to deliver in the way she wanted and helped her feel in control, to the point that she was able to get home for her son finishing nursery post-delivery. When asked about how we could be even better, Rochelle raised important points about equity of access, noting that private antenatal classes had helped her make informed decisions, but not all families could afford them. She suggested the Trust explore more inclusive options. She emphasised the role of partners in maternity care, sharing how her husband Kyle was actively involved and supported by staff, which helped him advocate for her when needed. The Board thanked Rochelle and Avery for sharing their story. Judy Gillow formally recorded appreciation and confirmed that the insights would help shape future service improvements. The Board NOTED the Patient Story.
BoD 228/25	**For Accuracy and to Agree: Minutes of the Board of Directors Meeting held on 18 June 2025 and 2 July 2025** The minutes of the Part 1 meeting of the Board of Directors held on 18 June 2025 and 2 July 2025 were APPROVED as an accurate record.
BoD 229/25	**Matters Arising – Action List** Dorset Shared Service Governance Arrangements – to be reviewed at the next Board of Directors meeting.
BoD 230/25	**Trust Chair's Update** Judy Gillow presented the Trust Chairs Update.

	The Board was reminded of the upcoming Annual Members Meeting on 18 September at Poole Hospital, followed by an Understanding Health Talk led by Dr Tom Bartlett on transforming care for older people. The topic was noted as timely considering winter planning discussions. It was formally noted that Rob Whiteman, former Trust Chair, had been appointed Chair of the ICB Cluster covering Dorset, Somerset, B&NES, Swindon, and Wiltshire. The Board extended its best wishes and acknowledged the potential for continued collaboration. The Board NOTED the Trust Chair's Update.
BoD 231/25	**Chief Executive Officer's Report (including ICB minutes)** Siobhan Harrington presented the Chief Executive's Report. She acknowledged the recent period of industrial action by the BMA and thanked staff for managing the disruption effectively. A visit from South West Regional Director Sue Doheny had taken place at Royal Bournemouth Hospital, where she met with teams and praised the Trust's energy and frontline commitment. National updates were shared, including changes to commissioning and the anticipated publication of the NHS 10-Year Plan, to which she had contributed via a national working group on neighbourhood health. The evolving Integrated Care Board (ICB) leadership structure was noted, with full implementation expected by the end of October. The Board was updated on the development of our NHS shared services company in Dorset. Engagement with staff continued, including direct conversations with staff across the services affected across the Trust. A formal dispute process with Unison was underway, and no final decision had been made. The Trust was expected to place mid-table in the upcoming national performance league tables. The Winter Plan was scheduled for discussion, with the flu vaccination campaign beginning in October. A delay to the COAST Building was reported, impacting timelines for the Emergency and Planned Care Hospital. Siobhan Harrington reflected positively on the Cultural Celebration held in July, praising staff, particularly from the global majority, for promoting the days with joy and pride. The events were well attended and celebrated the strength of our diverse workforce. Judy Gillow echoed this, thanking Femi Macaulay for his support and encouraging greater Board participation in future events. Sharath Ranjan commended the strength of support for the Chief Executive and praised Sarah Herbert's leadership, thanking the Executive Team for their continued efforts. The Board NOTED: • The Chief Executive Officer's Report • ICB minutes
BoD 232/25	**Quality Committee – Chair's Report – March and April 2025** Cliff Shearman presented the Quality Committee – Chair's Report for March and April 2025. Referencing the report, the Board discussed the concerns regarding neurodiversity services; Siobhan Harrington confirmed that the issue had been escalated to Commissioners and that work was underway to redesign the pathway across Dorset. Peter Wilson acknowledged the organisational risk and confirmed that the service remained on the Risk Register. The Board agreed to receive a formal update at the next meeting.

	ACTION: To receive a formal neurodiversity services update at the next Board of Directors meeting. **Mark Mould** The Board noted the importance of learning from the maternity service's move into the BEACH Building, particularly around staff orientation, operational disruption, and increased workload. Richard Renaut was asked to reflect on these learnings in relation to other service transitions and upcoming reconfigurations. <u>Maternity and Neonatal Quality and Safety Report – Q1</u> Lorraine Tongue presented the Q1 Maternity and Neonatal Quality and Safety Report, referencing positive feedback from the Patient Story. Improvements were noted in serious incidents, complaints response times, and overall patient experience following the move to the BEACH Building. A slight rise in stillbirths had prompted a thematic review which would be reported back to safety champions in November. Ongoing estates issues were being addressed with support from Sarah Herbert. The service had seen increased demand, including referrals from surrounding areas, requiring adjustments to patient flow and workforce. Recruitment of neonatal consultants was progressing, with seven appointments made. The maternity incentive scheme and culture improvement plan remained active. Sarah Herbert thanked the Maternity and Estates teams and noted the evolving understanding of operational needs in the BEACH Building. The caesarean section rate was currently above 50%, impacting bed capacity and prompting work on theatre utilisation and a potential 24-hour service model. Siobhan Harrington queried the drop in PROMPT training compliance. Lorraine Tonge confirmed this was due to medical staff changeover, with recovery expected by November. Siobhan Harrington also suggested future reports highlight achievements and innovation, including Patient First and EUNIX developments. Sarah Herbert noted that formal confirmation of exit from the maternity support programme from the National team was received in August and thanked Lorraine Tonge and the team for all they had done to achieve this. <u>Annual Infection Prevention and Control Report and Statement</u> Sarah Herbert presented the Annual Infection Prevention and Control Report, highlighting concerns around hand hygiene compliance. The Trust remained an outlier in some infection rates, with hand hygiene identified as a key contributing factor in reviewed cases. A Trust-wide campaign and action plan had been launched, supported by visible leadership and local accountability. Claire Whitaker and Judy Gillow emphasised the importance of leadership in modelling good practice. Cliff Shearman noted the need for a cultural shift to embed infection control as a core professional standard. Femi Macaulay raised the importance of inclusive training and cultural awareness. Sarah Herbert confirmed IPC training was part of induction and ongoing education and committed to reviewing facilities to support religious practices. Richard Renaut stated that 100% compliance would be expected next year. **ACTION:** To review the provision of religious washing facilities in male toilets. **Sarah Herbert** Peter Wilson noted that hand hygiene concerns extended to the Trust's dress code policy, which was under review. Progress had been slow but was ongoing.

	Siobhan Harrington queried follow-up on the IPC action plan. Sarah Herbert confirmed oversight was maintained through quarterly IPC governance meetings to ensure continued monitoring and accountability. *Michael Marsh joined the meeting.* <u>Annual Safeguarding Report and Statement</u> Pippa Knight presented the Annual Safeguarding Report, noting a stable year despite significant organisational change. Referrals for adults, children, and DOLs applications had increased, while Section 42 referrals had decreased, reflecting improved collaboration. A deep dive audit was underway to review duplication in children's referrals. The Trust had led the development of a Memorandum of Understanding to support patients remaining in hospital for care, which had gained interest from NHS England. The appointment of a Specialist LD Nurse had positively impacted care, including the introduction of LD champions and improved use of patient passports. Training compliance had improved, particularly in the Emergency Department, following tailored Level 3 safeguarding sessions. Challenges remained in child safeguarding training due to its complex delivery model. Efforts were ongoing to improve uptake and reporting accuracy. The Board commended the safeguarding team for their professionalism, leadership, and impact. The Board acknowledged the team's contribution and the importance of maintaining high standards in safeguarding practice. <u>Mixed Sex Accommodation Declaration</u> Sarah Herbert presented the Mixed Sex Accommodation Declaration, noting a recent High Court ruling on gender identification. The Trust was awaiting formal guidance from NHS England but continued to respect patients stated gender identity, with side room accommodation preferred where possible. A clarifying statement had been added to the policy, and further actions would be taken to ensure respectful care. Richard Renaut added that 130 additional single rooms would be available next year, improving single sex accommodation options. <u>Mortality Report</u> Peter Wilson presented the Mortality Report, noting significant progress in mortality metrics, including an increase in Learning from Deaths compliance from 25% to 77%. The Board recognised this as evidence of the impact of applying a standardised, patient-first governance approach. Work continued to align processes across directorates, supported by the governance project. The First Leader Report would be presented at the next Quality Committee. The Board acknowledged the positive trajectory while noting that further analysis was needed to ensure no critical elements were overlooked. Peter Wilson also updated on efforts to triangulate governance and operational processes, including improved collaboration between key groups and the Medical Examiner service. A timeline for governance alignment had been set for the next 3–4 months, with support from the Good Governance Institute. Subcommittees and Board members would be engaged to help drive progress. <u>Annual Health and Safety Report</u> Jo Simms presented the Annual Health and Safety Report, highlighting extensive work to support staff wellbeing during transformation. Over 490 DSE reviews and 250 transition assessments were completed. Training

	compliance reached 95%, and the Trust continued to deliver the IOSH Managing Safely course in-house, with strong uptake and positive feedback. The Control of Contractors campaign improved safety awareness and reporting. John Lelliott raised queries on Legionella and Environment Agency compliance, which were noted for follow-up. The Board acknowledged good practice and noted areas for improvement, particularly around infection prevention and control. The Board NOTED: • The Quality Committee – Chair's Report – March and April 2025 • The Maternity and Neonatal Quality and Safety Report Q1 • Mortality Report • Annual Health and Safety Report The Board APPROVED: • The Annual Safeguarding Report and Statement • Annual Infection Prevention and Control Report and Statement • Mixed Sex Accommodation Declaration
BoD 233/25	**Finance and Performance Committee – Chair's Report – July 2025 and August 2025** Tracie Langley presented the Chair's Report for the Finance and Performance Committee (FPC) covering July and August. The Trust remained broadly aligned with its financial plan, with a temporary variance due to property revaluation. Recurrent savings targets have not yet been fully achieved, with several savings backloaded. The Committee discussed the role of the Integrated Care System (ICS) in tracking savings, particularly in relation to estates, and emphasised the importance of demonstrating clear value. <u>Winter Plan: Board Assurance Statement</u> Mark Mould presented the Winter Plan 2025/26 and Board Assurance Statement. The plan had been developed through established governance processes and aligned with system priorities and key organisational risks. It was approved for submission by 30 September. The plan focused on workforce support, local risks, capacity planning, impactful interventions, and oversight. A £1.5 million allocation from ERF resources was confirmed, with reduced elective activity expected due to delays in Phase 3 separation. If not fully required, unused funds would be returned for broader use. Pete Papworth supported the plan and funding approach, noting the need for national support to mitigate operational impacts. Michael Marsh raised concerns about bed deficits and industrial action, which would be addressed in the updated plan. The Board noted ongoing efforts to improve productivity, transfer of care, and alternative pathways to close the capacity gap. **ACTION:** To update Winter Plan 2025/26 to explicitly reference current arrangements for managing industrial action. **Mark Mould** Siobhan Harrington noted the additional costs associated with industrial action. Pete Papworth confirmed that while some direct costs were tracked, wider operational disruption remained unfunded and was impacting the Trust's £70 million efficiency programme. Cliff Shearman queried whether the proposed £283,000 allocation would meaningfully improve workforce capacity and patient flow. Mark Mould responded that the funding would accelerate existing plans, including

	extending Same Day Emergency Care (SDEC) services to seven days a week and longer hours, with recruitment underway to support a November launch. John Lelliott asked about progress in reducing Non-criteria to Reside patients. Mark Mould confirmed improvements were expected through enhanced transfer of care processes across 50 wards. Peter Wilson supported the approach, emphasising the need for long-term planning and collaboration with local partners. Claire Whitaker queried the flu vaccination target. Sarah Herbert explained the 5% figure aligned with national benchmarks and outlined measures to improve uptake, including peer vaccinators, drop-in sessions, and targeted inpatient vaccinations. <u>Premises Assurance Model (PAM)</u> Richard Renaut presented the Premises Assurance Model for Board approval and requested delegated authority to proceed with submission by the end of September. He outlined the self-assessment process led by service leaders, evaluating assurance levels across estates and facilities. The Trust had voluntarily participated in a national pilot to support a more objective approach. The model categorised services by assurance level and would inform future prioritisation, including capital backlog and alignment with other assurance processes. The Finance and Performance Committee had previously reviewed the model. The Board noted the update, approved the submission, and supported delegated authority. Claire Whitaker raised the importance of monitoring business continuity, particularly in cleaning. Richard Renaut confirmed robust plans were in place and under continuous improvement. Mark Mould added that preparations were underway for an ICB assurance meeting and that recent reviews confirmed compliance, with a focus on increasing local ownership and understanding over the next year. John Elliott emphasised the need for active testing of plans. Mark Mould confirmed regular real-world testing was occurring monthly, providing assurance but warranted review due to frequency. Further detail would be brought to the Board within eight weeks. Siobhan Harrington acknowledged mixed PAM ratings, noting progress over three years and benefits of the shared services model in enhancing scrutiny. She encouraged increased visibility and engagement with estates and facilities teams. Richard Renaut confirmed alignment efforts across Dorset. Judy Gillow queried governance arrangements; John Lelliott confirmed oversight had transitioned to the Finance and Performance Committee, with actions and alerts to be included in the Board Assurance Report. The Board NOTED: • The Finance and Performance Committee – Chair's Report – July and August 2025 • Premises Assurance Model The Board APPROVED: The Winter Plan 2025/26 and the Board Assurance Statement
BoD 234/25	**People and Culture Committee – Chair's Report – April 2025** Sharath Ranjan presented the April 2025 Chair's Report. He raised ongoing concerns regarding low staff appraisal compliance and questioned the organisational impact and support for line managers. He emphasised accountability and recommended continued monitoring as part of cultural development. He also noted limited benchmarking in the Guardian of Safe Working Hours Report due to lack of national data, which constrained assurance. The maternity move to the BEACH Building had generated both enthusiasm and concern, with increased stress reported; reassurance was

	provided through staff support plans. He concluded by highlighting the importance of sustained cultural focus and engagement. <u>Maternity Staffing Report</u> Sarah Herbert reported that the national maternity staffing tool was outdated and based on historic data. Although triangulated, it did not fully reflect current service needs. Additional staffing requirements had been identified, and further work was needed to align midwifery staffing with service demand and safety standards. <u>Guardian of Safe Working Hours</u> Peter Wilson presented the report, noting benchmarking challenges but confirmed the organisation was broadly in line with peers. Triangulation with GMC and NETS surveys revealed consistent concerns from junior doctors, primarily around supervision rather than working hours. All incidents had been reviewed with no direct patient safety concerns. Rotational gaps varied by specialty, and improvements to data presentation were underway. The Board welcomed the approach and acknowledged the importance of continued development. Michael Marsh reflected on variation in junior doctor reporting, suggesting cultural factors influenced perceptions. He noted higher positive reporting in surgical specialties linked to career development. Peter Wilson agreed, identifying supervision quality as a key safety issue. He confirmed findings were being triangulated and shared with care groups via the Deputy Director of Medical Education for oversight and follow-up. The Board NOTED: • The People and Culture Committee – Chair's Report – April 2025 • The Guardian of Safe Working Hours Report; and • The Maternity Staffing Report
BoD 235/25	**Transforming Care Together – Chair's Report – August 2025** Judy Gillow presented the August 2025 Chair's Report, highlighting the priority alert related to Phase 3 service moves. <u>Phase 3 Service Reconfiguration</u> Richard Renaut outlined the Phase 3 plans, confirming Trust Management Group approval for the separation of planned and emergency care, with the move scheduled for July 2026. The timeline reflected clinical advice to ensure safe implementation through planning, training, and simulation. The transition would occur over two weeks to minimise disruption. Bed mitigation planning was ongoing, supported by the Future Care programme. Capital spend was being reprofiled in line with original plans, with national engagement to manage costs. Siobhan Harrington acknowledged disappointment over the delay, noting the impact on morale. However, the revised date was now supported clinically and by contractors, allowing for improved planning and assurance. John Lelliott queried contractor issues; Richard Renaut confirmed resolution and commitment to delivery, supported by contractual penalties and incentives. Judy Gillow confirmed that the Steering Group would continue to monitor progress and escalate any delays to the Board. The Board NOTED: • The Transforming Care Together – Chair's Report – August 2025. • The Phase 3 Service Moves
BoD 236/25	**Charitable Funds Committee – Chair's Report – August 2025** Femi Macaulay presented the Charitable Funds Committee Chair's Report August 2025 adding that he had recently taken over as Chair of the Charitable

	Funds Committee and wanted to take the opportunity to formally thank Claire Whitaker for her leadership and contribution while chairing the committee previously. Siobhan Harrington informed the Board of the upcoming Walk the Wards event taking place on Saturday at Upton Park, describing it as a positive and well-regarded occasion. Board members were encouraged to attend if available. The Board NOTED the Charitable Funds Committee – Chair's Report – August 2025.
BoD 237/25	**Audit Committee – Chair's Report – July 2025** Tracie Langley presented the Audit Committee – Chair's Report – July 2025 which was NOTED by the Board.
BoD 238/25	**Integrated Quality, Performance, Workforce, Finance and Informatics Report** Mark Mould presented the Integrated Performance Report, confirming prior committee review. Operational performance remained challenged, with 71% of patients seen within four hours, showing no improvement despite the move to the new ED. However, improvements were noted outside ED, including reduced length of stay, lower bed occupancy (90%), and higher discharge rates. A co-designed improvement plan using the Patient First methodology was in development with external support. Elective activity remained strong, with a reduction of 5,500 patients on waiting lists. Diagnostic performance was high, with 97.5% of patients seen within six weeks, placing the Trust among top national performers. Sarah Herbert reported improved complaints response times, reduced from 55 to 38 days, nearing the 35-day target. Progress was attributed to the Patient First methodology, with response times now tracked as a driver metric. Pete Papworth confirmed the Trust remained broadly on plan year-to-date. However, the unmitigated forecast showed a potential £25.4m deficit due to challenges in meeting the 8% efficiency target. Identified savings totalled £58m (6.7%), with a risk-adjusted forecast of £47m (5.4%) and recurrent savings of £27.4m (3.1%). Including full-year effects, recurrent delivery stood at 4.3%, exceeding the national requirement of 2%. Key mitigations included £3m internal savings, £7m through ICS commissioning, and further savings via Dorset shared services. The financial position remained volatile, with plans in place to close the gap. Melanie Whitfield reported ongoing work to improve whole-time equivalent modelling and organisational design. Vacancy rates were consistent with regional benchmarks, with further analysis underway. Absence rates stood at 4.7%, with implications for agency use. She raised concern over appraisal compliance, stressing the need for meaningful engagement. Judy Gillow requested further assurance on workforce plans at the next Board meeting. **ACTION:** To provide further Workforce Plan assurance at the next Board of Directors meeting. **Melanie Whitfield** Beverley Bryant reported continued progress on the Electronic Health Record (EHR) programme. The procurement process launched in early July 2025 and is scheduled to complete by end October, with contract signature expected in early 2026. Kemi Adenubi, appointed Programme Director in August, had made a strong start, bringing clarity and momentum. In relation to digital transformation, attention had been given to the continued use of paper, particularly in

	outpatient services. The Outpatient Transformation Programme was exploring transition to digital systems, supported by emerging governance structures. Michael Marsh highlighted the value of digital communication in healthcare, sharing a personal example where digital correspondence improved care coordination. He emphasised the benefits of digital reminders replacing traditional methods. The Board NOTED the Integrated Quality, Performance, Workforce, Finance and Informatics Report.
BoD 239/25	**Risk Register** Sarah Herbert presented the Risk Register. Judy Gillow queried the establishment of the Risk Review Group, Sarah Herbert confirmed the first meeting was scheduled later in the month, with agreed Terms of Reference and a circulated agenda. The group would review risks by care group on a rolling basis to ensure thoroughness and feasibility. Risk owners would attend to provide assurance on progress and support needs. Feedback from the first meeting would be shared at the next Board session. It was reported that risk documentation and action detail had improved, with a notable increase in de-escalated and closed risks. Monthly SDR meetings were supporting this progress, with teams focused on quality risk management. Siobhan Harrington recommended adding dates to progress updates for clarity and raised concerns about the EPR risk. Judy Gillow agreed, suggesting some target ratings were unrealistic and should be reviewed. She emphasised the need to link actions to gaps in control and proposed a broader discussion on risk appetite and tolerance. The Board noted that the October Board Development Session would be externally supported and welcomed feedback from the newly established Risk Oversight Group. The Board NOTED the Risk Register.
BoD 240/25	**Board Governance Cycle** Judy Gillow informed the Board that the governance cycle may require review as part of the Organising for Success project. Any proposed changes would be brought back to the Board. In the meantime, the current cycle remained unchanged. The Board APPROVED the Board Governance Cycle.
BoD 241/25	**Committees Terms of Reference** The Board APPROVED the Committees Terms of Reference.
BoD 242/25	**Membership of Board Committees** Judy Gillow presented the Membership of Board Committees. Melanie Whitfield enquired about the possibility of joining the FPC instead of the Quality Committee. Given the current workforce challenges, she noted that her expertise would be better suited to the FPC. Judy Gillow welcomed Melanie's comments and agreed to consider the request, with feedback to be provided at the next meeting. The Board APPROVED the Membership of Board Committees.
BoD 243/25	**Any Other Business** The Board expressed its thanks to John Lelliott for agreeing to extend his involvement by one month, subject to all necessary approvals. Members acknowledged and appreciated his continued support, particularly during a period of significant focus on investment, buildings, and sustainability.

BoD 244/25	**Reflections on the Board Meeting** Judy Gillow reflected on the meeting, noting ongoing work to refine Board agendas for greater focus and alignment with the Patient First approach, to be explored further at the upcoming Board Development Session. She highlighted the quality of discussion and thanked members for their thoughtful and respectful contributions. She emphasised the importance of maintaining a culture of curiosity, scrutiny, and confident decision-making as the Board navigates increasingly complex challenges.
BoD 244525	**Questions from the Council of Governors and Public arising from the agenda** Sue Comrie queried the timeline for the transition to zones and updated signage at RBH. Richard Renaut confirmed a contractor had been appointed, with external signage expected within a month. Internal signage and zoning were planned with a dual-running period, aiming for full implementation between December and January, pending assurance. Volunteers continued to support wayfinding and had developed a help sheet to assist patients and visitors. Outdated signage was noted as a concern. Gareth Drinkwater (Unison) raised a question regarding the indicative Dorset Shared Services ballot on industrial action, with 98% voting in favour. Siobhan Harrington confirmed the Trust was in dispute with Unison, and a meeting with Non-Executive Directors had taken place. A joint response had been issued, and the Trust remained committed to staff engagement. If resolution could not be reached, the matter may proceed to ACAS for mediation.
BoD 246/25	**Resolution Regarding Press, Public and Others** 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 to the next part of the meeting be excluded due to the nature of the business to be transacted. There being no further business, the meeting was closed.
	The date and time of the next Standing Board of Directors Part 1 Meeting was announced as Wednesday 5 November 2025 at 9:30 in Boardroom 1, Poole Hospital and via Microsoft Teams.

Board Part 1 Action List - November 2025						
Meeting Date	**Minute No.**	**Matter Arising / Action**	**Lead**	**Due Date**	**Progress**	**Status**
08/09/2025	BoD 232/25	**Neurodiversity services update:** To receive a formal neurodiversity services update at the next Board of Directors meeting.	**Mark Mould**	Nov-25	Increasing number of patients waiting across the system for Neurodiversity services. •Business case for investment approved in Oct 25. •**Proposal** - DHC to lead delivery of proof-of-concept pilot of Neurodiversity Exploration and Strengths Tool – Dorset (NEST-D). DHC will design, build, clinically validate, and scale a digital profiling tool and platform that supports early identification and continuous monitoring of neurodevelopmental differences in children (0–18). **Aim to deliver:** •Earlier identification of need / Improved access to person-centred support •Reduced reliance on diagnostic assessments to gain support / A trustworthy digital profiling tool that **complements**—not replaces—clinical judgement. Aware that with the volume of referrals in the system and the planning guidance ask 25/26 further work required **Note: We await part 2 of the National ADHD taskforce outcome**	Complete
08/09/2025	BoD 232/25	**Washing facilities:** To review the provision of religious washing facilities in male toilets.	**Sarah Herbert**	Nov-25	**Nov-25:** A verbal update will be provided at the meeting.	In Progress
08/09/2025	BoD 233/25	**Winter plan:** To update Winter Plan 2025/26 to explicitly reference current arrangements for managing industrial action.	**Mark Mould**	Nov-25	Resident Doctors industrial Action planned for 14th-19th November. Operationally to revisit the Industrial action risk as part of the risk register and added to the winter plan under the risk section. Note an Industrial action risk, is wrapped around Business Continuity planning and principles including reorganising workforce and service priorities to maintain core activity, focusing on high-risk services to maintain safety. This is worked through central planning with key stakeholders as it arises.	Complete
08/09/2025	BoD 238/25	**Workforce Plan:** To provide further Workforce Plan assurance at the next Board of Directors meeting	**Melanie Whitfield**	Nov-25	**Nov-25:** Workforce plan, incudimg required further assurance, will be discussed under agenda item 7.1.	Complete

NOVEMBER 2025 TRUST BOARD
CHIEF EXECUTIVE UPDATE

1 INTRODUCTION

As we approach the winter period, the importance of coming together as one UHD team has never been greater. Whether it's supporting one another, protecting ourselves and our patients through flu vaccinations, or improving patient care pathways, your continued efforts are making a real and lasting impact. Thank you to everyone involved in preparing our hospitals for the challenges ahead and for supporting their colleagues.

Across the NHS, change is accelerating. The recent announcement of **NHS Online**, a virtual hospital launching in 2027, represents a major step forward in connecting patients to clinicians nationwide.

Locally, we have paused our joint proposal with Dorset HealthCare and Dorset County Hospital to establish an NHS-owned company for shared services. This follows updated national guidance from NHS England, which places greater emphasis on union engagement and the protection of NHS employment terms. We are now working closely with colleagues and union representatives to consider the best way forward.

In times of change, listening becomes even more vital. It remains a core value at UHD, and I encourage everyone to check in with colleagues and truly listen. It's how we learn, grow, and strengthen our culture of openness and support.

2 NATIONAL UPDATES

2.1 Medium Term Planning Framework (2026/27–2028/29)

The newly published NHS Medium Term Planning Framework sets out a strategic direction for the next three financial years, with a strong emphasis on restoring core service performance, improving productivity, and embedding financial sustainability. For UHD, this will mean aligning our operational plans with national priorities, particularly around reducing elective backlogs, enhancing urgent and emergency care pathways, and accelerating digital transformation. The framework's focus on prevention and neighbourhood health supports our integrated care ambitions across Dorset, while the emphasis on workforce engagement and leadership development aligns with our People Strategy. UHD will need to ensure robust planning and delivery mechanisms are in place to meet these expectations while maintaining quality and safety. Medium term planning framework - delivering change together 2026/27 to 2028/29

2.2 Performance Oversight and Accountability

In September, NHS England introduced a new quarterly performance league table for all NHS trusts. This system ranks providers across five domains: urgent care, elective services, diagnostics, cancer, and financial performance. Trusts placed in the top segment (Segment 1) may benefit from increased autonomy and investment, while those in lower segments will receive targeted support. Currently UHD is 67 of 134 Trusts and in segment 3. We will of course endeavour to continually improve our position.
https://www.england.nhs.uk/publication/nhs-oversight-framework-nhs-trust-performance-league-tables-process-and-results/

2.3 Strategic Priorities for 2025/26

Jim Mackey, Chief Executive of NHS England, issued a letter in September outlining the priorities for the remainder of the financial year. These include:

- Accelerating elective recovery and reducing long waits.
- Improving urgent and emergency care performance.
- Delivering financial sustainability through productivity gains.
- Supporting local leadership and system-level innovation.

The requirements are being reviewed locally.

https://www.england.nhs.uk/publication/building-on-our-progress-in-the-second-half-of-2025-26/

2.4 Martha's Rule Rollout

Martha's Rule is a major patient safety initiative in hospitals encouraging patients, families and carers to speak to the care team if they notice changes in someone's condition.

Martha's Rule is being expanded to every acute hospital in England, the NHS has announced, as new data shows hundreds of patients have benefited from potentially life-saving changes to their care thanks to the scheme. UHD has been involved in the scheme since its roll out in 2024.

Between September 2024 and June 2025, there were 4,906 calls made to Martha's Rule helplines to escalate concerns about care – leading to 241 potentially life-saving interventions being triggered. The positive results from the first year have led the NHS to expand its use to an additional 67 sites – meaning all 210 acute inpatient sites in England will offer the service.

Full evaluation of the programme is ongoing and will help inform proposals to expand to other settings. https://www.england.nhs.uk/2025/09/marthas-rule-rolled-out-to-all-acute-hospitals/

2.5 Actions to improve care for women, babies and families: next steps

Following the Secretary of State for Health and Social Care's announcement of a rapid independent investigation into maternity and neonatal services, an independent taskforce, and immediate actions to improve care for all women, babies and families.

The next steps have now been outlined in a letter published on 16 October to support Trusts to continue to go further and faster to improve maternity and neonatal care:

1. Perinatal Equity and Anti-Discrimination Programme
2. Perinatal Event Notification service
3. Maternity and Neonatal Performance Dashboard
4. Maternity and Neonatal Improvement Support Team

Our midwifery team are working through the detail of the programmes.

https://www.england.nhs.uk/publication/letter-actions-to-improve-care-for-women-babies-and-families-next-steps/

2.6 Request for action on racism including antisemitism

A letter from NHS England's Chief Executive and Chief Workforce Officer, to ICBs and NHS Trusts on 16 October, seeks support across the NHS to tackle hatred in all its forms. In line with this, NHS England is formally and actively adopting the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism IHRA-non-legally-binding-working-definition-of-antisemitism- NHS England strongly encourages all NHS organisations to adopt this definition and to note the associated commitments to free speech in order to reinforce a collective stance against antisemitism, and to redouble efforts to create workplaces where staff and patients feel safe and welcome.

https://www.england.nhs.uk/long-read/request-for-action-on-racism-including-antisemitism/

2.7 Research Matters: enabling and sustaining a research-positive culture for nurses, midwives and health-professionals.

NHS England on 20 October 2025 published a guide with suggests actions executive chief nurses can take to help their organisation become a research-positive healthcare organisation with research sustainably embedded in everyday practice and professional decision-making. These actions help build foundations in the 5 areas executive chief nurses from a range of NHS providers said they needed guidance on:

- understanding the research landscape
- fostering a research inclusive environment
- leading and sustaining a culture that values research
- embedding research practice in careers and workforce planning
- cultivating partnerships and collaborations

https://www.england.nhs.uk/publication/research-matters-enabling-and-sustaining-a-research-positive-culture-for-nurses-midwives-and-allied-health-professionals/

3 DORSET UPDATES

3.1 ICB Reorganisation

Rob Whiteman, has been appointed as Chair and Jonathan Higman has been appointed as Chief Executive Officer of the new Integrated Care Board (ICB) cluster across NHS Bath, and North East Somerset, Swindon and Wiltshire (BSW) ICB, NHS Dorset ICB and NHS Somerset ICB. Rob was previously Chair of Dorset ICB and Jonathan was CEO for Somerset ICB previously. We wish them both well in their new roles.

Shared Services

Following recent national guidance issued by NHS, we have paused our plans to establish a wholly owned subsidiary company. The revised position reflects a shift in national policy, which now requires any proposals involving staff transfers to demonstrate clear support from local trade unions and to fully protect NHS terms and conditions. A formal national consultation process is also being launched to shape future guidance. In light of this, the Trust has entered a new phase of engagement. ACAS is now facilitating structured liaison between the Trust and Unison to build trust and strengthen industrial relations.

Clinical Strategy

Dorset ICS has commissioned a strategic partner to help shape and deliver its emerging clinical strategy. This collaboration is focused on embedding innovation across the system, with an emphasis on sustainable adoption of proven solutions that align with local priorities. All providers are involved in this work which will run over the next 12 weeks.

Our Dorset Provider Collaborative

At the end of September, a full Board to Board to Board to Board informal development session was held between all three organisations and the GP Alliance. The October ODPC Board meeting reviewed progress across the six key programmes.

4 UNIVERSITY HOSPITALS DORSET

4.1 Performance Headlines

September saw pressure within our Urgent and Emergency Care (UEC) pathways, primarily driven by system-wide patient discharge challenges ('No Criteria to Reside'). At UHD the average NcTR patients exceed 200. We are managing these pressures with system partners, and are seeing an adverse impact on Emergency Department waits and bed occupancy. It is a testament to our focused efforts that our ambulance handover performance remains strong, providing a stable foundation as we enter the winter period.

Continuous improvement in planned care pathways has been evidenced, with RTT 18-week performance being maintained and both total RTT waits and time to first appointment reducing. The percentage of patients on the waiting list greater than 52 weeks also moved closer to the 1% target.

We continue to deliver an increase in elective activity compared to the baseline year of 19/20 as planned; in September this was 118.5% year to date.

Two of the three national cancer waiting time standards (Faster diagnosis and 31day diagnosis to treatment standards) were met. Our focus is on improving the 62d time to treatment performance, and we have an improvement plan in place to support this.

Finally, there is now sustained improvement in diagnostics (DM01) performance being demonstrated, driven by improvements in Echocardiology and Neurophysiology in month, with performance reaching 1.4% (target 5%), maintaining the Trust in the position of best performer in the South West.Finance

Whilst the Trust remains on plan financially at the end of September, this reflects a deficit of £9.2 million which must be recovered by the end of March. As such, the second half of the year will be very challenging and requires a significant reduction in the expenditure run rate.

A detailed plan is in place including an acceleration of identified efficiency schemes currently expected to deliver in 2026-27, together with a further tightening of workforce controls. However, a residual risk of £14.7 million remains, reflecting the financial impact of the previously planned Wholly Owned Subsidiary, and we are working closely with system partners and NHS England to agree how this could be covered.

Capital expenditure remains below plan, and actions are in train to mitigate the forecast under spends against the agreed profiling of national programme funding.

4.2 Digital

The HealthSet Electronic Health Record Programme for Dorset and Somerset has concluded the formal evaluation of the supplier responses, and a preferred supplier recommendation has

been submitted to the Boards for approval. This important milestone allows us to build full costs and benefits into the Full Business Case which we expect to start its approvals journey in late November / early December. Once all the approvals have been achieved, we will move into the implementation phase. Planning is already underway to involve clinical and operational staff across all our Dorset and Somerset teams in the implementation, and we will set up a Patient Panel to support the design of the patient-facing elements of the solution. The programme signifies a major transformation of our ways of working, improving how our care givers gather information and communicate with each other and their patients. Full preparations to switch over in March 2028 will be crucial and we are excited to be able to start this preparation work once the approvals have been secured.

4.3 Transformation

Significant progress continues to be made across our transformation programme. We continue to prepare for the opening of the planned and emergency hospitals in July 2026.

A new play area has been installed within the Children's Emergency Department, enhancing the patient and family experience and supporting a more therapeutic environment for young patients. This was thanks to our fantastic BEACH fundraising. Donors and children were at the official opening on 21st October.

At Poole the build of our new CDC Endoscopy hub continues. At the end of October, a further 17 modules were craned into position, completing the full building outline. This represents a major milestone in the project's delivery timeline as we work towards the planned opening in spring 2026. Once operational, the facility will enable us to diagnose and treat more patients, enhance the quality of care, and contribute to a substantial reduction in waiting times.

We continue to hold a range of public engagement events for our transformation, dates are available on our website. https://www.uhd.nhs.uk/news/public-engagement-events

4.4 OUR PEOPLE

Staff Survey

The 2025 National Staff Survey has been live for 6 weeks and our completion rate is currently 38.4% (compared to 44.6% this time last year). UHD remains 12% above the national mean response rate for all organisations using IQVIA, our main provider. We continue with our enhanced promotion campaign and communication engagement activities referencing the NHS People Promise. demonstrating our people services seven elements of the NHS People Promise.

Flu Vaccination

As of this week, 22.53% of our staff have received their flu vaccination. While this represents a positive start, we recognise there is more to do to ensure wider protection across our workforce as we head into the winter months. We are encouraging all colleagues to take up the offer of a free flu jab—not only to protect themselves, but also to help safeguard patients and each other. We understand that staff are balancing many pressures, and we are working to make access to the vaccine as easy and convenient as possible.

Staff Network Events

We were celebrating Black History with our colleagues from African and Caribbean backgrounds throughout the month of October, which gives everyone the opportunity to share, celebrate and understand the impact of black heritage and culture.

These celebrations included Black History in Dorset talks which included staff lived experience conversations and songs of celebration, with events both at Bournemouth and Poole sites.

Other events included World Menopause Day and National Pronoun Day on 15th October. Looking ahead to Quarter 3, we are planning activities in for Disability History Month and Transgender Day of Visibility in November and on 3rd December we will be holding Purple Light Up Day, celebrating the International Day of Persons with Disabilities.

Job Evaluation – National Profiles, Nursing and Midwifery

To note a significant additional programme of work, regarding the fair and consistent application of the NHS job evaluation scheme in support of the 2023 Agenda for Change (AfC) pay deal, revised national job matching profiles for nursing and midwifery staff were published in June 2025, along with guidance for employer action. Nursing and Midwifery and Human Resources colleagues are committed to working in partnership with trade unions to assess the local position in relation to job descriptions and job evaluation outcomes, along with agreeing a local action plan to ensure that staff are paid in line with the new profiles, for the work they deliver.

Partnership Working

Continuing in the theme of partnership working we will continue to work in close partnership with our trade union colleagues as we progress our future collaborative initiatives, including the South Counties Pathology Network and the development of shared Procurement services, which UHD will host. This approach will ensure that staff engagement, transparency and collective input remain central to the successful delivery of these programmes.

Immigration Policy Changes

Last month I referenced the significant changes to UK immigration rules. These changes include an immigration skills charge increase of 32% to £1,320 per person per year for applications from 16 December 2025; increased English language requirements for new applications from 8 January 2026 and graduate visa reform which reduces the length of sponsorship for graduate visas from 2 year to 18 months from January 2027 (PhD graduate visa will remain at 3 years). Some of these changes will have an impact on the NHS, including the recruitment and ongoing employment of individuals who require Home Office documentation to live and work in the UK. UHD is working closely with managers and staff in the most impacted areas, such as Biomedical Sciences, to advise of available options and more detailed information regarding its impact will be noted through the People Committee. The Citizens Advice Immigration team will give on-site update sessions, support and advice to managers and staff during November and this will be publicised widely across UHD.

Education

And finally, one of a number of system collaborations, we have proudly hosted our first Pan-Dorset simulation event, bringing together 120 participants. The live all age meal support simulation, created by the Mental Health Training Group, was a great success and sets the stage for many more Pan-Dorset simulation events in the future.

Medical Director – Integrated Care

Mufeed Ni'Man has joined us at the beginning of October 2025. This role is to further develop the integration between primary and secondary care, and to support us on interface issues and how we consider care traditionally in the hospital setting redesigned to be in the community of in people's homes.

5 INTEGRATED CARE BOARD 10 JULY 2025

I attended the NHS Dorset ICB Board Meeting on 11 September 2025. The minutes of the meeting held on 10 July 2025 were ratified at this meeting. I attach a copy of the minutes of the meeting at appendix one.

Minutes of the meeting of the Part 1 Public ICB (ICB) Board of NHS Dorset
Friday 10 July 2025 at 10.15am
In the Phoebe Room, BCP Council Offices, Civic Centre, Bourne Avenue, Bournemouth, BH2 6DY and via MS Team

Members Present:		
	Kay Taylor (KT)	ICB Non-Executive Member and Deputy Chair (meeting Chair)
	Rhiannon Beaumont-Wood (RBW)	ICB Non-Executive Member
	Dawn Dawson (DD)	Deputy Chief Executive Officer, DCHFT/Dorset Healthcare (nominated deputy)
	Graham Farrant (GF)	Chief Executive, BCP Council and ICB Local Authority Partner member
	Leesa Harwood (LH)	ICB Non-Executive Member
	Alison Henly (AH)	ICB Interim Chief Finance Officer
	Nick Ireland (NI)	Leader Dorset Council and ICB Local Authority Partner Member
	Paul Johnson (PJ)	ICB Chief Medical Officer
	Pam O'Shea (POS)	Interim ICB Chief Nursing Officer
	Forbes Watson (FW) (virtual) (part)	GP Alliance Chair, Primary Care Partner Member
	Adrian White (AW)	ICB Non-Executive Member
	Rob Whiteman (RW) (virtual)	ICB Chair
	Dan Worsley (DW)	ICB Non-Executive Member
Invited Participants Present:		
	Louise Bate (LBa)	Manager, Dorset Healthwatch
	Paula Bennetts (PB)	Programme Director, Dorset VCSA
	Rob Carroll (RC)	Director of Public Health, BCP Council
	Sam Crowe (SC)	Interim Chief Executive, Dorset Council
	David Freeman (DF) (virtual) (part)	ICB Deputy Chief Executive Officer
	Dawn Harvey (DH)	ICB Chief People Officer
	Rachel Partridge (RPa)	Interim Director of Public Health Dorset Council
	Andrew Rosser (AR)	Chief Finance Officer, SWASFT
	Dean Spencer (DSp)	ICB Chief Operating Officer
In attendance:		
	Liz Beardsall (LB)	ICB Head of Corporate Governance
	Jane Ellis (JE)	ICB Chief of Staff
	Rachel Filmer (RF) (for item ICBB25/95) (in person)	Service User Voice Lead
	Hannah Leonard (HL) (for item ICBB25/95) (in person)	ICB Deputy Director of Maternity and Perinatal Services
	Steph Lower (SL) (minutes)	ICB Deputy Head of Corporate Governance
	Rachel Pearce (RPe) (virtual)	Managing Director (System Commissioning Development), NHS England South West
	Fran Pingarelli (FP) (virtual) (for item ICBB25/101)	ICB Senior OD Consultant
	Sapna Vohra (SV) (for item ICBB25/101) (virtual)	ICB EDI Business Partner
Public:		
	Two members of the public were present. The meeting was also available via livestream.	

Apologies:		
	Matthew Bryant (MB)	Joint Chief Executive Dorset County Hospital and Dorset HealthCare NHS Foundation Trusts and ICB Board NHS Provider Trust Partner Member
	Millie Earle (ME)	ICP Joint Chair (Leader of BCP Council)
	Charlotte Green (CG)	Chair of the Governance Board, Dorset VCSA
	Siobhan Harrington (SH)	Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Karl Hoods (KH)	ICB Non-Executive Member
	Patricia Miller (PM)	ICB Chief Executive
	Keith Phalp (KP)	Pro Vice Chancellor for Education and Quality, Bournemouth University
	Ben Sharland (BS)	Primary Care participant

ICBB25/091 Welcome, apologies and quorum

The meeting was chaired by the ICB Deputy Chair by prior arrangement, as the ICB Chair was not able to be in attendance in person.

The Deputy Chair declared the meeting open and quorate. There were apologies from Matthew Bryant, Millie Earle, Charlotte Green, Siobhan Harrington, Karl Hoods, Patricia Miller, Keith Phalp and Ben Sharland.

This was the last meeting for both Leesa Harwood and Keith Phalp. On behalf of the Board, the Deputy Chair thanked both for their commitment and contributions not only to the Board but to the wider system.

ICBB25/092 Conflicts of Interest

Kay Taylor declared an interest in agenda item 7 Governance Arrangements in relation to Section A – Senior Non-Executive Member approval. It was agreed that the ICB Chair would chair this section of the report, and the individual would not take part in the decision-making but would remain in the room.

ICBB25/093 Minutes of the Part One meeting held on 9 May 2025

The minutes of the Part One meeting held on 9 May 2025 were agreed as a true and accurate record.

Resolved: the minutes of the meeting held on 9 May 2025 were approved.

ICBB25/094 Action Log from the Part 1 meeting held on 9 May 2025

The action log was considered, and approval was given for the removal of completed items.

Resolved: the action log was received, updates noted, and approval was given for the removal of completed actions.

<u>Standing Items</u>

ICBB25/095 Maternity Board Story

The ICB Deputy Director of Nursing and Perinatal Services introduced the Maternity Board Story.

Key points included:-

- The national focus on safety and quality of care in maternity services
- The birth rate in Dorset was falling but the acuity of cases was rising
- Maternity services in Dorset provided substantial support for mental health with around one in three women experiencing mental health problems during pregnancy
- The importance of continuity of care was emphasised with evidence showing significantly improved outcomes
- A tailored approach was being implemented for women with greater needs

The Board welcomed the powerful story which highlighted a mum's experience of maternity services in Dorset, the special bond formed with her midwife during her pregnancies and the positive impact and importance that clear communication and continuity of care had on her experience which had led to better outcomes.

F Watson joined the meeting.

The Board discussed the challenges faced including the impact of national investigations, negative media and staff shortages, all of which had impacted staff morale and retention. Safe staffing remained a priority and support in place for staff included professional midwifery advocates, clinical supervision and immediate debrief plans for incidents. The importance of education and training support was emphasised.

The role of the ambulance service in maternity emergencies was discussed including the community simulations to enhance confidence and competence in handling such situations and shared protocols to ensure a co-ordinated and effective response to maternity emergencies based on the lessons learned from national investigations.

The Board noted the important role of the Maternity and Neonatal Voices Partnership in gathering service user feedback and influencing service development. Walk arounds were also undertaken by relevant trust executives to listen to the voices of staff and service users.

D Freeman joined the meeting.

Thanks were given for the insightful session and acknowledgement of the strong leadership and collaboration in maternity services.

Resolved: the Board noted the Maternity Board Story.

H Leonard/R Filmer left the meeting

ICBB25/096 Chair's Update

The ICB Chair provided an update on the current national context including the comprehensive spending review, the 10 Year Health Plan and the ICB organisational change.

He highlighted the challenges and opportunities presented by the 10 year plan, the need for strategic commissioning and the importance of working together as a team.

A resident doctors strike was planned for late July and local planning work was underway to mitigate the impact.

Resolved: the Board noted the Chair's update.

ICBB25/097 Chief Executive Officer's Report

The ICB Deputy Chief Executive Officer introduced the previously circulated CEO's report.

Key points included:

- The recently published 10 Year Health Plan which emphasised the three major shifts from moving care from hospitals to community settings, transforming analogue systems to digital and shifting the focus from sickness to prevention. The Plan confirmed the expectations in terms of the scale and pace of change required which aligned with what the Dorset system had committed to.
- Under paragraph 2.1 of the report, the increase of £29m in relation to the departmental budget for a three year period 2025/27 to 2028/29 should read 'an increase of £29bn'.
- In relation to the new NHS Oversight Framework published in June, there was a new segment 5 which was a stronger direction from the regional and national team in terms of focus. Publication of Dorset's initial segmentation under the new Framework was expected during July 2025.
- The national Urgent and Emergency Care (UEC) Plan was published in June with a focus on seven priorities that would have the biggest impact on UEC improvements this coming winter. The Dorset system was already drawing on this to develop its winter plan which would be stress tested in Quarter 2 to ensure risk mitigation plans were developed ahead of the start of winter.
- Attention was drawn to the good developments from partner organisations as set out in the report.

Work was underway to look at the detail of the 10 Year Health Plan in terms of what it would mean for the Dorset system and wider ICB cluster arrangements. This would then be taken into a Board session.

Access to the internal #FYI Sharepoint site for ICB Board non-executive members would be checked to ensure they were able to access internal updates.

Action: DH

It was expected that the new ICB cluster would focus on driving the work forward from a strategic perspective to deliver the ambitions of the Plan but there was a need to ensure that the work being undertaken in Dorset continued, to address the challenges.

Recognising the scale of the cluster work, it was suggested a milestone be created to check that the above intent was working as intended.

One of the challenges of the organisational change was the risk of having insufficient capacity/resourcing to both develop and deliver the Plan. Mitigations were being built.

Proactive work was being undertaken in terms of financial and operational scenario planning as the organisation moved forward into the new cluster arrangements.

The Board noted the publication of the English Devolution and Community Empowerment Bill which would deliver on the government's commitment to widen and deepen devolution across England, reforming local government as the foundation for devolution and giving communities stronger tools to shape their local areas. Both the Bill and the 10 Year Health Plan sought to improve public services and address specific challenges however their primary focuses and implementation strategies differed so there was a need for joint collaboration to ensure the right functions were preserved in the Dorset system.

Resolved: the Board noted the Chief Executive Officer's Report.

ICBB25/098 Board Assurance Framework

The ICB Deputy Chief Executive Officer introduced the previously circulated Board Assurance Framework (BAF).

The importance of maintaining the current framework whilst focusing on the key priority areas and continuous improvement during the national organisational change was emphasised. It was noted the cluster arrangements would create a new Board Assurance Framework.

The difference between the BAF and Strategic Risk Register was reiterated.

There was a request for an action for the next meeting to look at whether the ICB remained in tolerance on the ability to transform given both the financial pressures and the forthcoming clustering changes.

Action: DF

Resolved: the Board approved the Board Assurance Framework.

ICBB25/099 Integrated Performance - Committee Escalation Reports

Key areas of focus, progress and challenges from the previously circulated committee escalation reports were presented from the June meetings. Highlights included:-

Strategic Objectives Committee:

- Welcomed the inclusion of innovation partners at the meetings which had provided helpful insight into the work being undertaken.

Prevention, Equity and Outcomes Committee:

- Received the Health Inequalities Draft Annual Report with recognition of the areas of strength/improvement and the areas that needed further focus.

People, Engagement and Culture Committee:

- Approved the update on the Dorset ICS Widening Participation Plan 2025-2028.
- Completed the whole time equivalent deep dive which provided assurance in terms of being proactive and doing things differently this year.
- Approved two new risks relating to the sufficiency of human resources leadership and capacity for transition and maintaining sufficient operational capacity during the transition.

Quality, Experience and Safety Committee:

- Received a number of annual reports. It was helpful to see the work undertaken over the year with good progress being made in many areas.

Risk and Audit Committee:

- Received a number of annual updates including the Emergency Preparedness, Resilience and Response and Freedom to Speak Up annual updates.
- Noted the successful completion of the independent audit review of the ICB's performance against the Mental Health Standard for 2023/24.

Productivity and Performance Committee:

- Focused on the financial management and welcomed the new 'flash' reporting including an iterative dashboard that would ensure the system landed where it needed financially at year end.
- Approved the Children and Young People Mental Health Business Case. The opportunity to invest in these services was welcomed. Thanks were given to the relevant team for the responsive work on the business case.

The Board noted the GP patient survey had been published and in almost all indices Dorset was better than the national average and had improved on the previous year. The Board thanked general practice colleagues for their hard work. A more detailed consideration of the survey would be brought to the next committee cycle in terms of the ongoing variation that needed to be addressed.

Resolved: the Board noted the Committee Escalation Reports.

Items for Decision

ICBB25/100 Governance Arrangements

The ICB Deputy Chair declared an interest in section A of the report – Senior Non-Executive Member approval. It was agreed that the ICB Chair would chair this section of the report, and the individual would not take part in the decision-making but would remain in the room.

The ICB Chair introduced the Governance Arrangements report and updated on the proposed revised committee structure, emphasising the need for a streamlined approach to governance which would assist in aligning the future cluster governance, along with the importance of involving partners in the committees.

There was an additional proposed change to retain a more streamlined inward looking People Committee to focus on the internal people risks in relation to the capacity and capability to manage the transition.

The Chair was keen for there to be an improved sense of system throughout the committee structure and as such, would be inviting provider trusts Non-Executive Director representation on the three main committees and the Risk and Audit Committee.

If approved, the next steps would be to formalise the terms of reference and membership incorporating any comments raised.

Consideration would be given as to where Widening Participation would best sit within the revised structure.

Action: RW/LB

There was a statutory responsibility for engagement and there was a need to ensure this continued.

Oversight of the non-financial elements of the operational plan i.e. the performance of services would be undertaken at the ICB Board meeting, but recognising any finance issues that had performance implications, would be considered for discussion at the Finance and Planning Committee.

Following a query regarding whether there would be sufficient time to consider both quality and commissioning items under the revised Quality and Commissioning Committee, the

Board noted there would be flexibility in the approach to the Committee as the commissioning element evolved.

The revised committee structure would continue whilst the cluster governance arrangements were developed.

S Vohra joined the meeting
F Watson left the meeting.

The Head of Corporate Governance outlined the four governance items as set out in sections A-D of the report.

The ICB Chair took the chair for this section and the Board undertook the following:

- Approved the appointment of Kay Taylor into the Senior Non-Executive Member role.
- Approved the updated Scheme of Reservation and Delegation revision relating to specialised commissioning.
- Ratified the decision to approve the Joint Transition Committee Terms of Reference.
- Noted the updated Functions and Decisions Map.

Resolved: the Board approved all the recommendations set out in the Governance Arrangements report and the additional proposal for the inclusion of a streamlined People Committee as set out above.

Items for Noting/Assurance/Discussion

ICBB25/101 Equality Delivery System (EDS) deep dive

The ICB Chief People Officer introduced the Equality Delivery System deep dive.

The report highlighted the progress and challenges in addressing workforce inequity. The Dorset system had made meaningful progress in improving workforce equality, diversity and inclusion however persistent disparities remained.

Data trends showed that improvements in workforce experience and outcomes were not yet consistently felt by all staff and highlighted a critical gap between well-intentioned actions and lived experience.

A set of system-wide recommendations were proposed as enablers to reinforce the need for deeper cultural embedding and greater accountability.

Concern was raised regarding the reference to systemic bias in relation to recruitment processes. The report set out the focused work on creating the right processes to support better decision-making but there remained a need for a shift in thinking and investment in training.

Recognising the organisational transition and impact on the workforce, it was imperative that the EDS work remained at the forefront.

There was a need to ensure under-represented groups were encouraged to become involved in the networks to understand the perspective of those with lived experience which would better enable changes to be made.

There were a number of collaboratives being undertaken including staff story sharing, cross network working and alignment on common priorities, all of which would help build the momentum for systemic change.

The Board reiterated its support for a system wide approach to equality, diversity and inclusion. It acknowledged the inequalities highlighted by the deep dive, especially in relation to recruitment practices. The Board welcomed the recommended actions, including setting and tracking visible representation goals, and resourcing and formalising staff networks as strategic partners.

Thanks were given for the leadership and valuable work being undertaken.

F Pingarelli/S Vohra left the meeting

Resolved: the Board noted the Equality Delivery System deep dive.

ICBB25/102 Dorset 2025-26 Operational Plan and position to date

The ICB Interim Chief Finance Officer introduced the Dorset 2025-26 Operational Plan and position to date.

The progress in budget management, contract agreements and performance against targets was highlighted along with the importance of balancing financial sustainability with the delivery of high quality services.

A Dorset system workshop was planned for 22 July to consider what action was required individually or collectively to enable delivery of the financial position for this year.

The Board reminded itself of the importance of remaining citizen-focused.

Concern was raised regarding changes made to some services without being worked through with the local authorities before being enacted. This would be picked up in Part 2 of the meeting.

In relation to mental health services, there was a query regarding the report not covering a number of the data points that were in the operational planning metrics along with the accuracy of the data in relation to Children and Young People access which did not appear to be in line with published data. This would be picked up outside of the meeting.

Action: DS

Resolved: the Board noted the Dorset 2025-26 Operational Plan and position to date.

Items for Consent

ICBB25/103 There were no items for consent.

ICBB25/104 Questions from the Public

There were no questions from the public.

ICBB25/105 Any Other Business

There was no other business.

ICBB25/106 Key Messages and review of the Part 1 meeting

It was recognised the coming months would be challenging to balance the short-term goals with the long-term strategic planning during the period of organisational change. It was important during this time to continue to maintain focus on improving services for the population of Dorset.

ICBB25/107 Date and Time of Next Meeting

The next formal meeting of the ICB Board would be held on Thursday 11 September 2025 at 10.15am in committee room 1, County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ.

ICBB25/108 Exclusion of the Public

The Board resolved that representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity of which would be prejudicial to the public interest.

Signed by: K Taylor

Kay Talor, ICB Deputy Chair

Date: 11 September 2025

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 5 November 2025

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 23 September 2025, the Committee received the following: • Integrated Performance Report • Risk Register: risks rated 12-25 (Quality & Safety) • Quality and Safety Strategy • Maternity Safety Champions Report • Safeguarding Report • Patient Experience Report (including complaints) • Quality Impact Assessment Report • Annual Radiation Safety Report • National Cancer Patient Experience Survey • Assurance/Alerts/Escalations from the Clinical Governance Group At its meeting on 28 October 2025, the Committee received the following: • Integrated Performance Report • Board Assurance Framework and Breakthrough Objectives • Risk Register: risks rated 12-25 (Quality & Safety) • Electronic Results Acknowledgement Process • Maternity and Neonatal Quality and Safety Report Q2 • Maternity and Neonatal Quality and Safety Champions Report • Mortality Report • Annual End of Life Care Report and Care of the Dying Audit • 7 Day Services Board Assurance Framework • National Standards for Healthcare Food & Drink • Inpatients CQC Survey • Assurance/Alerts/Escalations from the Clinical Governance Group
ALERT	The Committee wishes to alert members of the Board that: • Work on Medical Devices Replacement continues and needs continued oversight to ensure safe and effective use by staff as well as clarity on finances to support along with overall governance

	• Work on the Risk Register has progressed with improved oversight and scrutiny by the Executive • Work has progressed on developing the Quality and Safety Strategy strengthening alignment to existing work and the Patient First approach • The National Cancer Patient Experience annual survey shows UHD services in a positive light with better than National average with exception of care review in primary care • Recent progress has been shown in relation to Infection Prevention and Control (IPC) metrics where previously UHD has been an outlier
ASSURE	The Committee wishes to assure members of the Board that: • Integrated performance was reviewed and consideration given to quality implications, 4-hour ED performance continues to be an area of concern, though plans are in place to improve • Maternity Safety Report was reviewed, and no new issues were highlighted. Work on supporting staff post the move into the Beach Building continues and remains a priority • Safeguarding report was reviewed and increased referrals noted in quarter 1 • Challenges remain in relation to Oliver McGowan part 2 training and options are being explored • There is a clear plan to address the issues identified with Electronic Results Acknowledgment. Further work is required and needs to be monitored closely • The Mortality Report was reviewed and whilst both SHMI and HMSR remain below expected the scrutiny continues to ensure potentially avoidable mortality • The Annual End of Life Care report was reviewed, and data is being used to drive improvement on 2 key areas • Progress continues to be made on 7 Day Service provision using the Assurance Framework; however Phase III of the reconfiguration is key to deliver improvement • The CQC Inpatient survey shows more consistency between the Poole and Bournemouth sites with improvements in most domains
ADVISE	The Committee wishes to advise the Board that: • The Annual Radiation Safety Report highlighted the new legislation (IMER 24) that has come into effect, UHD is almost compliant. New Standard Operating Procedures need to be put onto the Intranet. • The Chief Medical Officers team will link with primary care to share the National Cancer Patient Experience results • The Board should carefully review the plans to improve 4-hour ED performance

	• Further review of the National Standards for Healthcare Food and Drink is required as some key questions could not be addressed and were taken out of the committee
Review of Risks	Work on the risk register continues and no new risks were highlighted
Celebrating Outstanding	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 6.1.1

Subject:	Maternity and Neonatal quality and safety report Quarter 2, July - September 2025 data.
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 ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Assurance
Executive Summary:	This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety. The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) and Board of Directors of present and/or emerging safety concerns. The report follows the reporting requirement to Trust Boards to meet the Maternity incentive scheme in year 7. It triangulates intelligence from the maternity safety champions reports, maternity quadrumvirate and safety champions, safety champions listening and walkabout events in conjunction with IPR dashboard slides attached to give the board a summary of the key areas of focus for maternity. UHD have an overall continual improvement plan which has been developed to align all national and local improvement drivers into encompassing Ockendon 2022, the 3-year single delivery plan 2023, Saving Babies Lives Care Bundle v3, CQC inspection report received in 2023, CQC maternity patient survey, MSSP sustainability criteria and locally identified safety priorities, MIS year 7 maternity self-assessment, Score culture and staff survey improvements. The Trust will continue to report to the LMNS for assurance of progress and on continual improvement in the Mat Neo improvement plan

Areas which demonstrate continuous improvement

- There were no MNSI cases nor any babies having Hypoxic ischemic encephalopathy (HIE).
- Saving babies lives V3 (new version April 2025) assessment showed that 87% of all safety measures have been implemented
- Mandatory maternity training and overall compliance improvement are seen for all staff groups.
  Prompt compliance =96.83%
  Fetal monitoring compliance 99.66%
  SBLV3 - Midwives 91.91% MSW's 93.75%
  Neonatal life support overall >90%
- ATAIN was 4.3% this quarter was lower than Regional and National targets
- There is a significant increase in positive patient feedback received from MNVPS with an improved patient environment with privacy as the main theme and patients choosing to have their care from areas such as the new forest and Salisbury.
- Time to respond to complaints has much improved with the MNVP monitoring the quality of our responses.

Areas for continued focus

- This UHD Maternity and Neonatal Safety report identifies at the end of Q2 the UHD current rolling 12-month stillbirth rate of 3.76 per 1000 births. This rate has now stabilized with one stillbirth in September
  All cases in Q1 have been reviewed through the PMRT processes and learning disseminated.

  However, due to the increase in Q4 and Q1
  The cases are now undergoing a secondary review broadening the criteria for consideration.

  Findings will be shared with the Trust Board and safety champions in November.

Workforce

- The move to the BEACH building has been extremely positive for patient satisfaction overall. However, the safety champions have met staff members in quarters 1 and 2 who expressed challenges into settling into the new building. A robust action plan is in place and sponsored by Sarah
  Herbert CNO to support progress

	There are four main workstreams: 1. Building and estates defects or alterations required, 2. Patient flow throughout the service, 3. Workforce and new ways of working, 4. Communication with all staff groups. Support has been given by the patient's first team to have full team involvement. And progress is monitored by the care group. There has been good progress made in quarter 2 with the completion of estates works, and updates to staff given weekly and workforce reviews. The introduction of patient first huddles with has improved staff engagement in making changes and improvements in their wards Ongoing work continues with patient flow and staff engagement. Midwifery sickness has increased this quarter, with anxiety and stress being the main cause. The team is working with HR to provide support to staff members. “Thrive week" occurred in September, and midwives were encouraged to attend. The resources continue to be available online, and staff are signposted to use these collective help methods alongside other resources such as the professional midwifery advocate and the counselling service.
Background:	The purpose of the Maternity and Neonatal Safety Report is for the Board Level Safety Champion to share emerging guidance for maternity services, provide updates from reviews of published national and local inspection reports, include feedback from women and their families, support quality improvement and escalate locally identified safety issues in Maternity.
Key Recommendations:	To note reports and evidence in trust Board minutes.
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☐ Financial ☒ 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
Maternity quadrumvirate	17/10/2025	Noted and approved through Governance processes.
Safety champions meeting	17/10/2025	Noted and approved through Governance processes safety champions reports
Directorate meeting	14/10/2025	Noted and approved through Governance processes safety champion reports
Care Group Board	17/10/2025	Noted and approved through Governance processes safety champions reports
Quality Committee	28/10/2025	The meeting has not taken place at the time of submission of this 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	☐

MATERNITY AND NEONATAL SAFETY REPORT

QUARTER 2: JULY- SEPT 2025

Author: Lorraine Tonge

Director of Midwifery and Neonatal Services

REPORT OVERVIEW

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS), Board and the Board of Directors of present or emerging safety concerns within Maternity and Neonatal services. The information within the report reflects actions and progress in line with Ockenden 2022 and the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 7, published 2nd April 2025.

1.0 PERINATAL MORTALITY RATE

The following graphs demonstrate how University Hospitals Dorset (UHD) is performing against the national ambition to reduce stillbirth in the UK by 50%, and the local ambition for continual progression in reducing perinatal mortality within the Trust.

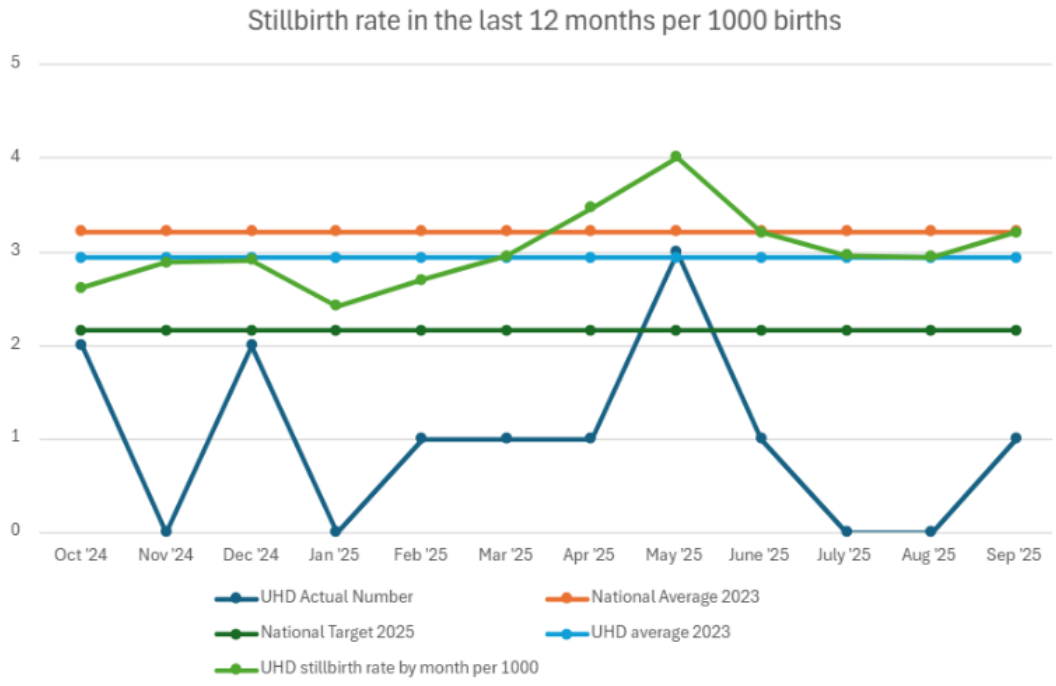


Table 1: UHD NHS Trust stillbirth rate per 1000 births over the last 12 months

Due to an increase identified by UHD of our perinatal mortality cases from December 2024 to June, a ‘Deeper dive’ has commenced, led by one of the Consultant Midwives at UHD to do a secondary review. This is to identify any potential themes and include ethnicity and areas of deprivation. Outcome of this review will be shared at safety champions meeting in November. From June the rate has now stabilised and one stillbirth in this quarter.

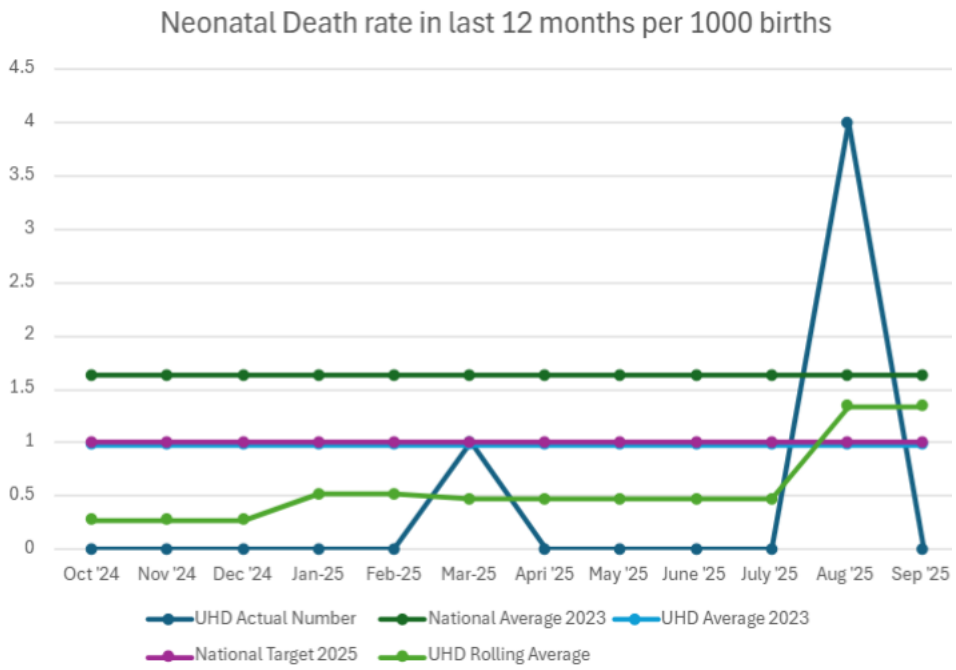


Table 3: UHD NHS Trust Neonatal Death rate per 1000 births over the last 12 months

Mothers and Babies: Reducing Risk through Audits and Confidential Enquires-UK (MBRRACE-UK) collects data on perinatal death defined as babies born without signs of life from 22 weeks' gestation to term and neonatal deaths at any gestation up to 28 days of age, excluding terminations of pregnancy.

Perinatal deaths are defined from birth after 22 weeks' gestation and include neonatal deaths, but stillbirths are defined from 24 weeks at diagnosis of death. The rate of stillbirth and perinatal death may therefore be different.

Trusts are provided with initial MBRRACE perinatal mortality rate per 1000 births; results are subsequently stabilised and adjusted to include deaths of babies who were born in providers but subsequently died elsewhere.

In Q2, there were four MBRRACE-UK reportable cases; one antenatal stillbirth (SB) and four neonatal deaths (two of which were counted as one case as was a twin pregnancy. No cases were eligible for referral to the Maternity and Newborn Safety Investigation program (MNSI). No cases required escalation through PSIRF.

Month	Late fetal loss	Stillbirth	Neonatal death
July 2025	0	0	0
August 2025	0	0	4 babies (twins are recorded as 1 case)
September 2025	0	1	0
TOTAL reported to MBRRACE meeting PMRT criteria	**0**	**1**	**3**

Table 4: UHD's cases reported to MBRRACE meeting PMRT criteria Q2 2025/26

There was no care issues identifed with the neonatal deaths . This was due to twins were 22 weeks gestation , concealed pregnancy and birth following a perimortem LSCS after a maternal cardiac arrest.

Ethnicity & Index of multiple deprivation (IMD)
(Quintile 1 being the most deprived and Quintile 5 being the least deprived).

Of the 4 PMRT reportable cases for Q2:

- 3x White British ethnicity- IMD quintiles 2&3
- 1x Indian ethnicity- IMD quintile 4

*All four mothers spoke English as their first language.

2.0 PERINATAL MORTALITY REVIEW TOOL (PMRT)
All perinatal deaths that occur within the Trust have been reported using the PMRT tool since 2018. PMRT reporting is a requirement of Safety Action 1 of the NHS-R Maternity Incentive Scheme (MIS) year 7.

All Q2 cases have been reported to MBRRACE via PMRT.

All families were informed of the PMRT process and review, and their feedback has, or will be sought.

Date of Delivery /Neonatal Death	Standard a) All eligible perinatal deaths from 1 December 2024 onwards are notified to MBRRACE-UK within seven working days	Standard b) For at least 95% of all deaths of babies who died in UHD from 1 December 2024, parents informed and perspectives of their care and any questions they have sought	Standard c) Following the death of babies:			Standard d) Quarterly reports should be discussed with the Trust Maternity Safety and Board level Safety Champions
			Standard c) 95% of reviews have been started within 2 months	Standard c) 75% of all reports completed and published within 6 months	Standard c) 50% to include and document the presence of an external member at MDT PMRT review panel	
05/12/24	Met	Met	01/01/25 Met	05/06/25 Met	Met	Met
08/12/24	Met	Met	01/01/25 Met	08/06/25 Met	Met	Met
17/02/25	Met	Met	16/03/25 Met	09/07/25 Met	Met	Met
03/03/25	Met	Met	12/04/25 Met	29/05/25 Met	Met	Met
03/04/25	Met	Met	15/04/25 Met	12/06/25 Met Awaiting clinical investigation results to re-open	Met	Met
04/05/25	Met	Met	13/05/25 Met	12/06/25 Met Awaiting clinical investigation results to re-open	Met	Met
07/05/25	Met	Met	29/05/25 Met	09/07/25 Met	Met	Met
20/05/25	Met	Met	28/05/25 Met	In progress Publish by 20/11/25	Met	Met
21/06/25	Met	Met	18/07/25 Met	In progress Publish by 21/12/25	Met	Met
26/06/25	Met	Met	29/06/25 Met	In progress Publish by 26/12/25	Met	Met
28/06/25	Met	Met	29/07/25 Met	In progress Publish by 28/12/25	Met	Met

01/08/25	Met	Met	14/08/25 Met	In progress Publish by 01/02/26	In progress Awaiting external Trust	Met
28/08/25	Met	Met	12/09/25 Met	In progress Publish by 28/02/26	In progress First review TBC	Met
30/08/25	Met	Met	03/09/25 Met	In progress Publish by 02/03/26	In progress First review TBC	Met
27/09/25	Met	To be sought	02/10/25 Met	In progress Publish by 27/03/26	In progress First review TBC	Met

PMRT eligible cases, MIS/CNST period Year 7 (01/12/2024 to 30/11/2025)

Cases not eligible for PMRT review, MIS/CNST period Year 7 (01/12/24 to 30/11/25)
x23 Medical Terminations
x14 Losses <22 weeks' gestation

UHD Maternity Services continue to experience a significant delay in receiving postmortem and placental histology investigation reports (>6 months). Where necessitated, PMRT Reports are closed (supported by the MBRRACE-UK team), pending receipt of the clinical investigation reports to confirm the cause of death, in order not to breach the Standards timeframe.

Duty of Candour completed for all cases, feedback from families of their care with follow up postnatal appointment with consultant to discuss outcome of reviews.

2.1 LEARNING FROM PMRT REVIEWS IN Q2

2.1.1 Summary of PMRT cases reviewed in Q2.

Two PMRT meetings were held in Q2 between UHD and Dorset County Hospital (DCH). No meeting took place in August. A total of six cases were reviewed, four first reviews (pending on postmortem and placental histology investigation reports) and two second reviews.

It has been agreed locally that any case where care factors were thought to have contributed to the outcome (C or D grading), will be escalated through the Trusts Risk and Governance processes for consideration of further escalation and investigation as

part of the Patient Safety Incident Response Framework (PSIRF). Cases meeting MNSI criteria are referred for a separate investigation, alongside the PMRT.

PMRT Meeting	UHD Cases Reviewed
09/07/25	**1: Antenatal Stillbirth diagnosed and delivered 33+5 weeks.** **Case: February 2025 (second review). See table above** • Confirmed grading of care: B and C (Discussed in Q1 report- not for further incident investigation) • Cause of death: Uteroplacental insufficiency, acute chorioamnionitis with delayed villous maturation and maternal vascular Mal perfusion • Family feedback considered when grading • Not for PSIRF • Case closed **2: Antenatal Stillbirth diagnosed and delivered 38+4 weeks.** **Case: May 2025 (first review).** • Initial grading of care: A and B • Cause of death: To be confirmed upon receipt of clinical investigations • Case ongoing **3: Antenatal Stillbirth, diagnosed 27+4 weeks, delivered 28+2 weeks.** **Case: June 2025 (first review)** • Initial grading of care: A and A • Cause of death: to be confirmed upon receipt of clinical investigations and second PMRT review • Case ongoing **4: Late Fetal Loss, diagnosed 22+4 weeks, delivered 23+0 weeks.** **Case: June 2025 (first review)** • Initial grading of care: A and A

	• Cause of death: to be confirmed upon receipt of clinical investigations and second PMRT review • Case ongoing
17/09/25	**5: Late fetal loss, diagnosed 21+4 weeks, delivered 22+0 weeks.** **Case: June 2025 (first review).** • Initial grading of care: A and A • Cause of death: to be confirmed upon receipt of clinical investigations and second PMRT review • Case ongoing **6: Late fetal loss, diagnosed 22+4, delivered 23+0 weeks.** **Case: June 2025 (second review)** • Confirmed grading of care: A and A • Cause of death: Placental insufficiency • Case to be closed

Table PMRT cases reviewed in Q2

Grading of care of the mother and baby up to the point of birth of the baby: **A** - The review group concluded that there were no issues with care identified up the point that the baby was born **B** - The review group identified care issues which they considered would have made no difference to the outcome for the baby **C** - The review group identified care issues which they considered may have made a difference to the outcome for the baby **D** - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby
Grading of care of the mother following the death of her baby: **A** - The review group concluded that there were no issues with care identified for the mother following the death of her baby

B - The review group identified care issues which they considered would have made no difference to the outcome for the mother **C** - The review group identified care issues which they considered may have made a difference to the outcome for the mother **D** - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother
In the case of a neonatal death, the above aspects are graded in addition to: Grading of care of the baby from birth up to the death of the baby: **A** - The review group concluded that there were no issues with care identified from birth up the point that the baby died **B** - The review group identified care issues which they considered would have made no difference to the outcome for the baby **C** - The review group identified care issues which they considered may have made a difference to the outcome for the baby **D** - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby

Table PMRT grading of care

2.1.2 Saving babies lives V3.2

The Saving Babies Lives Care Bundle (SBL) version 3.2 provides evidence-based best practice to achieve the national ambition to halve the rate of perinatal mortality by 2025 by driving innovation and quality improvement in key areas in maternity care. As part of the three-year delivery plan, providers are responsible for fully implementing all interventions for all 6 elements of SBL. All PMRT reviews are triangulated against SBL and improvements identified.

PMRT and Saving Babies Lives V3.2 [4]	Q2
Element 2: Fetal growth – risk assessment, surveillance, and management • 2c: Percentage of perinatal mortality cases annually where the identification and management of fetal growth restriction (FGR) was a relevant issue.	0 out of 4 0%
Element 3: Raising awareness of reduced fetal movements	0 out of 4

• 3c: Percentage of stillbirths which had issues associated with RFM management	
	0%
Element 4: Effective fetal monitoring in labour	0 out of 4
• 4d: The percentage of intrapartum stillbirths and early neonatal deaths, and cases of severe brain injury where failures of intrapartum monitoring are identified as a contributory factor	0%
Element 5: Reducing preterm births and optimizing perinatal care	0 out of 4
• 5k: Percentage of perinatal mortality cases annually where the prevention, prediction, preparation, or perinatal optimization of preterm birth was a relevant issue.	0 %

Table SBLs V3.2

There are no outcome indicators specific to PMRT for SBL Elements 1 or 6: Reducing Smoking in Pregnancy or Management of Pre-existing Diabetes in Pregnancy.

These elements are recognised and any issues in care provided are escalated to the Trust SBL leads.

2.1.3 Learning and Actions from PMRT Cases

From April 1st, 2021, all actions generated by the PMRT review process and any additional reviews such as MNSI or PSII, are added to the LERN/Datix system for completion and monitoring.

Learning/actions from PMRT reviews in Q2:

- To explore the possible process of ensuring patients receive a copy/oversight of sensitive types of letters that are sent to the GP.
- Joint work (UHD & DCH) to be undertaken with regards to dissemination of clear and robust patient communication regarding the reasons for not using home dopplers.
- Feedback to the teams, the importance of documenting staff arrival times in emergency response scenarios.

3.0 MATERNITY AND NEWBORN SAFETY INVESTIGATIONS (FORMERLY THE HEALTHCARE SAFETY INVESTIGATION BRANCH) AND MATERNITY AND NEONATAL PATIENT SAFETY INCIDENCES.

3.1 BACKGROUND

In September 2023, the Healthcare Safety Investigation Branch (HSIB) were formerly rebranded in line with their transformation to become hosted by the Care Quality Commission (CQC) as the Maternity and Neonatal Safety Investigations (MNSI) team

MNSI undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), based on Each Baby Counts and MBRRACE-UK

In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- Maternal deaths
- Intrapartum stillbirth
- Early neonatal death
- Potential severe brain injury

3.2 INVESTIGATION PROGRESS UPDATE

There were no new incidents which met MNSI criteria in Q2.
There were no ongoing MNSI investigations in Q2.

3.3 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) INVESTIGATIONS

There were 2 incidents escalated for a potential additional learning response through Care Group Insight group in Quarter 2.

1. 3.1L Major Obstetric Haemorrhage (MOH) following a forceps delivery in a labour room and transfer to theatre for perineal repair and management of MOH. Personal reflections were identified as the learning response following Risk MDT and through WCCSS Rapid Review meeting. These have been completed and SMART actions assigned.

2. Neonatal death (NND) < 5hrs of birth at home following a concealed pregnancy.Estimated gestation of 33-35 weeks pregnant. Case to be reviewed through PMRT process. SWAST are performing an incident review of their care.

There were no ongoing incident investigations (MNSI, AARs,PSIIs) or final reports at the close of Q2

3.4 LITIGATION

Summary of Litigation Claims in Maternity

1. **CURRENT POSITION**

- 31 open claims (includes one claim linked to Radiology)
- 5 open ENS matters
- 4 open inquest files (2 Maternity and 2 Neonatal)
- 0 open Healthcare Regulatory Matters

2. **ACTIVITY**

The following is a summary of activity in quarter 2:

- 2 new claims received
- 1 claim settled
- 1 claim closed in July but reopened later in the quarter
- 0 new ENS matters reported
- 0 ENS matters settled
- 0 ENS matter closed
- 1 Inquest investigation opened
- 2 Inquest files recategorized to Mat Neo
- 1 Healthcare Law Matters received

The value of open claims is just over £171m.

NEW CLAIMS RECEIVED

Description	Cause	NHSR Injury
Alleged failures in post-partum care. In particular alleged failures in drainage of fluid collection, failure to escalate care, inappropriate discharge and failure to plan appropriate surgical management.	Fail/Delay treatment, Fail/delay referring to hospital, Inappropriate discharge	Additional/unnecessary operation(s), Psychiatric/Psychological damage, Scarring, Unnecessary pain

NHSR notified the Trust that they had opened a claim file in anticipation of receipt of a Letter of Claim and advised the Trust to open a claim accordingly. The claim is linked to an ENS matter currently being investigated with the mother making a claim in her own right. Further details are not known at this stage.

Settled Claims in Q2:

There was 1 claim that settled in Q2. This was an incident from 2021 that had been thoroughly reviewed through PMRT, as a Serious Incident and through MNSI (formerly

HSIB). Recommendations had been converted to SMART actions following final reports. All actions have been completed.

A summary of Q2 maternity claims and early notification scheme has been shared with UHD's Quality Committee and with LMNS.

Description	Damages
Failure to identify and monitor a prolonged latent phase of labour, and failure to seek obstetric review, leading to intrauterine death.	£130,000.00

Table Litigation Claim resolved with damages being agreed in Q2

Reviews of litigation claims are triangulated against Incident Investigations
Learning identified:

- Latent phase policy updated and implemented
- Clarification of analgesia pathway in the latent phase of labour
- Training and education regarding antenatal CTGs
- Risk assessment training and audit

CLAIMS CLOSED

A claim file linked to an inquest was closed as a Letter of Claim had not been received following the inquest. However, the file was reopened later in the quarter when a Letter of Claim was received.

EARLY NOTIFICATION SCHEME MATTERS

Summary of ENS matters is shown below:

- 1 matter opened in 2017 has proceeded to a claim and will be settled in due course.
- 1 matter responded to previously has now become a formal claim, expert reports have been obtained, and liability has been denied.
- 1 matter previously sent an outcome letter remain open as their solicitors have indicated they are still investigating a potential claim.
- 2 matters are under an ENS investigation and awaiting a conference with experts.

NEW INQUEST

A new inquest file was opened in relation to a Neonatal death following a court order for the withdrawal of treatment. The baby had been delivered in ED at 32+5 weeks by perimortem caesarean section. Whilst an inquest has not formally been opened, a coronial investigation is in progress, and the Trust is assisting the coroner with her inquiry.

3.5 CORONER REGULATION 28 MADE DIRECTLY TO TRUST

Not applicable

4.0 OCKENDEN UPDATE

4.1 OCKENDEN FINAL REPORT UPDATE – Q2 July to September

The Trust is not required to submit evidence of compliance with the 15 Immediate and Essential Actions outlined within the Ockenden report of 2022. Monitoring of compliance and improvement towards compliance is monitored via the maternity improvement plan which is monitored though Directorate Governance, Maternity and Neonatal safety champions via the safety champions report presentation every month.

UHD have a continuous improvement plan which has been developed to align all national and local improvement drivers into encompassing Ockenden 2022, the 3-year single delivery plan 2023, Saving Babies Lives Care Bundle v3, CQC inspection report received in 2023, CQC maternity patient survey, the NHSE MSSP sustainability plan and locally identified safety priorities, MIS year 7, maternity self-assessment, Score culture and staff survey improvements.

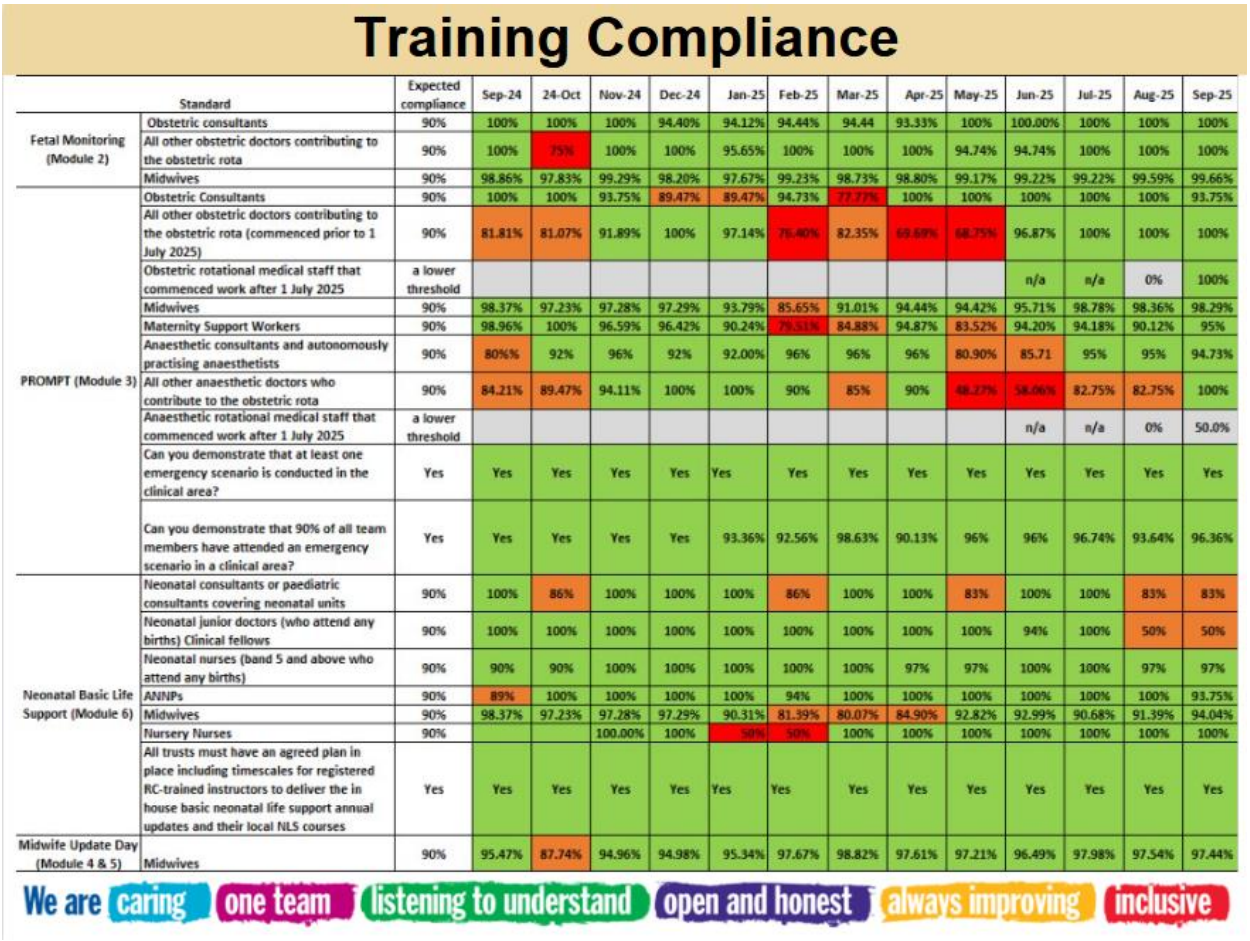
The Trust reports to the LMNS for assurance of progress on continual improvement.

5.0 TRAINING COMPLIANCE FOR ALL STAFF GROUPS IN MATERNITY RELATED TO THE CORE COMPETENCY FRAMEWORK AND WIDER JOB ESSENTIAL TRAINING

The report provides an update on the local training and development that is ongoing within the maternity and neonatal service, including a current position to year 7 of the Maternity (and Perinatal) Incentive Scheme (MIS), Safety Action 8. The Core Competency Framework version 2 sets out clear expectations for all Trusts, aiming to address known variation in training and competency assessment for midwifery staffing across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service.

Compliance with attendance and demonstrated competence for fetal monitoring, neonatal resuscitation and multi-disciplinary training (MDT) Emergency Skills Training (PROMPT) across all staffing groups is required to be above 90% to fulfil the requirements set out within the MIS. The service is also committed to working towards

‘stretch targets’ as outlined within the CCFv2 which is considered a measure of high functioning organisations



Training Compliance

Standard		Expected compliance	Sep-24	24-Oct	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Fetal Monitoring (Module 2)	Obstetric consultants	90%	100%	100%	100%	94.40%	94.12%	94.44%	94.44	93.33%	100%	100.00%	100%	100%	100%
	All other obstetric doctors contributing to the obstetric rota	90%	100%	75%	100%	100%	95.65%	100%	100%	100%	94.74%	94.74%	100%	100%	100%
	Midwives	90%	98.86%	97.83%	99.29%	98.20%	97.67%	99.23%	98.73%	98.80%	99.17%	99.22%	99.22%	99.59%	99.66%
PROMPT (Module 3)	Obstetric Consultants	90%	100%	100%	93.75%	89.47%	89.47%	94.73%	77.77%	100%	100%	100%	100%	100%	93.75%
	All other obstetric doctors contributing to the obstetric rota (commenced prior to 1 July 2025)	90%	81.81%	81.07%	91.89%	100%	97.14%	76.40%	82.35%	69.69%	68.75%	96.87%	100%	100%	100%
	Obstetric rotational medical staff that commenced work after 1 July 2025	a lower threshold										n/a	n/a	0%	100%
	Midwives	90%	98.37%	97.23%	97.28%	97.29%	93.79%	85.65%	91.01%	94.44%	94.42%	95.71%	98.78%	98.36%	98.29%
	Maternity Support Workers	90%	98.96%	100%	96.59%	96.42%	90.24%	79.51%	84.88%	94.87%	83.52%	94.20%	94.18%	90.12%	95%
	Anaesthetic consultants and autonomously practising anaesthetists	90%	80%%	92%	96%	92%	92.00%	96%	96%	96%	80.90%	85.71	95%	95%	94.73%
	All other anaesthetic doctors who contribute to the obstetric rota	90%	84.21%	89.47%	94.11%	100%	100%	90%	85%	90%	48.27%	58.06%	82.75%	82.75%	100%
	Anaesthetic rotational medical staff that commenced work after 1 July 2025	a lower threshold										n/a	n/a	0%	50.0%
	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	Yes	Yes	93.36%	92.56%	98.63%	90.13%	96%	96%	96.74%	93.64%	96.36%
Neonatal Basic Life Support (Module 6)	Neonatal consultants or paediatric consultants covering neonatal units	90%	100%	86%	100%	100%	100%	86%	100%	100%	83%	100%	100%	83%	83%
	Neonatal junior doctors (who attend any births) Clinical fellows	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94%	100%	50%	50%
	Neonatal nurses (band 5 and above who attend any births)	90%	90%	90%	100%	100%	100%	100%	100%	97%	97%	100%	100%	97%	97%
	ANNPs	90%	89%	100%	100%	100%	100%	94%	100%	100%	100%	100%	100%	100%	93.75%
	Midwives	90%	98.37%	97.23%	97.28%	97.29%	90.31%	81.39%	80.07%	84.90%	92.82%	92.99%	90.68%	91.39%	94.04%
	Nursery Nurses	90%			100.00%	100%	50%	50%	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%	95.47%	87.74%	94.96%	94.98%	95.34%	97.67%	98.82%	97.61%	97.21%	96.49%	97.98%	97.54%	97.44%

Table 11: Maternity Training MIS year 7 standards for Fetal Monitoring, Prompt, Neonatal basic life support and Midwife update training compliance.

Compliance

In September Q2 the table above demonstrates that

Overall Prompt compliance =96.83%

Overall fetal monitoring compliance 99.66%

Overall SBLV3 - Midwives 91.91% MSW’s 93.75%

Neonatal life support overall >90%

Reasons for non-compliance:

The table above shows the sub sections as defined by MIS.

PROMPT:

All staff groups are scheduled to meet the full compliance requirements apart from

Anaesthetic rotational doctors commencing with the trust after the 1st of July rotations. It is best practice that they receive training as soon as possible however if this cannot be achieved by the 30th of November, then an action plan must be shared with the board for approval and monitored throughout the six-month period.

Action plan for Board approval:

	September (current)		October (predicted)		November (predicted)		December (predicted)		January (predicted)	
	Number	%	Number	%	Number	%	Number	%	Number	%
Anaesthetic consultants	18/19	93.75%	18/19	93.75%	18/19	93.75%	18/19	93.75%	18/19	93.75%
Any other anaesthetists contributing to the obstetric rota who started before 1st July 2025	21/21	100%	21/21	100%	20/21	95.23	20/21	95.23	21/21	100%
Any other anaesthetists contributing to the obstetric rota who started after 1st July 2025	4/8	50%	2/8 (some have certs that expire)	25%	5/8	62.5%	5/8	62.5%	8/8	100%

Neonatal basic life support

Currently there are two medical members of staff who have not received their training however this has been due to sickness and have been trained in October.

Which Report	153 WCCSS Care Group	Total
National Core Skills	**90.83%**	**90.83%**
Safeguarding Children	76.16%	**76.16%**
Resus	83.75%	**83.75%**
Infection Control	86.59%	**86.59%**
Information Governance	88.12%	**88.12%**
Moving & Handling	91.95%	**91.95%**
Oliver McGowan	93.10%	**93.10%**
Health Safety & Welfare	94.06%	**94.06%**
Fire Safety	94.83%	**94.83%**
Safeguarding Adults	95.69%	**95.69%**
Equality Diversity & Human Rights	95.79%	**95.79%**
Patient Safety	96.17%	**96.17%**
Prevent (WRAP)	96.31%	**96.31%**
Conflict Resolution	96.73%	**96.73%**
Trust Core Skills	**92.82%**	**92.82%**
Total	**91.54%**	**91.54%**

Table 12: Mat Neo - Trust core skills and National core skills overall >90% compliance.

Safeguarding level 3 is below the expected standard and will be a focus with all teams for improvement in quarter 3

6.0 BOARD LEVEL SAFETY CHAMPIONS

The Maternity and Neonatal Safety Champions are active in their role to listen to the staff voice in maternity and neonatal services. All staff are encouraged to interact with Safety Champions during walkabouts and listening events with the Chief Nursing Officer, Chief medical Officer, the Non- executive, and the Director for Midwifery and Neonatal services. The Perinatal quadrumvirate leadership team meet monthly with the safety champions (at the safety champions monthly meeting) to identify any support needed and escalate any concerns.

Some themes which were raised during walkabouts listening events and from the maternity quadrumvirate were:

The move to the BEACH building has been overall extremely positive for patient satisfaction however the safety champions have met staff members this quarter who expressed challenges in settling into the new building

Challenges range from:

- Working in a large footprint,
- Physical distance,
- New ways of working and team structure changes
- Concerns around staffing models
- Inability to take breaks in a timely way
- System errors and human errors with baby tagging system
- Sound of call bells, due to soundproof rooms
- Regulating climate control system
- Completion of finishing cosmetic works example, signage, showers, paintwork
- Managing minor build defects
- Patient flow throughout the unit.

Staff expressing feeling of low in morale and with less resilience at work.

Actions have been taken:

- Senior trust leadership support
- A weekly estates and transformation meeting to address all issues.
- Patient flow MDT working party to address concerns
- Midwifery workforce template reviewed
- Weekly feedback and communication to the teams “you said we did “
- Daily walkabouts on the unit by all maternity and neonatal leadership team listening to staff to understand their concerns and feedback actions taken.
- Continual method of QR reader, in place to receive staff feedback on issues.
- Monitoring of progress will be through Care Group and executive oversight.

Many actions were completed in this quarter with estates and workforce and staff fed back to safety champions more positively in September.

Launch of patient first improvements boards in all areas enabled staff to feel involved in changes in their place of work.

Themes, commonalities, and actions from this feedback is monitored via the Maternity and Neonatal Safety Champions meetings and is triangulated with further service insights through Maternity safety champions report to drive our continuous improvement work. Ongoing work to continue with patient flow and supporting staff.

7.0 NHS RESOLUTION MATERNITY INCENTIVE SCHEME UPDATE Q1 2025/26

The service was able to declare full compliance with all 10 Safety Actions MIs year 6 detailed in the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme in January 2025.

	Maternity incentive scheme -safety action detail	Submission Rag MIS year 5	Submission Rag MIS year 6
1	Are you using the National PMRT to review perinatal deaths to the required standard?		
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		
3	Can you demonstrate that you have transitional care services in place to minimize separation of mothers and their babies?		
4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?		
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?		
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?		
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users		
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?		
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?		
10	Have you reported 100% of qualifying cases to the Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?		

Table 13: Declaration for compliance with MIS Year 5 and MIS year 6

Standards remain continuous and we are currently progressing with MIS year 7.

Planned assessment with auditors an LMNS In November to support verification of the evidence provided to declare MIS compliance.

8.0 SAFETY ACTION 6 - MIS SAVING BABIES LIVES CARE BUNDLE V3

ICB: NHS Dorset

NHSE Region: NHSE South West

% of interventions fully implemented (LMNS Validated)

		Assessments								
		1	2	3	4	5	6	7	8	9
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
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
Element 1	Smoking in pregnancy	20%	100%	90%	90%	80%	100%	100%	100%	90%
Element 2	Fetal growth restriction	45%	70%	65%	75%	70%	95%	95%	90%	80%
Element 3	Reduced fetal movements	0%	50%	100%	100%	100%	50%	100%	100%	100%
Element 4	Fetal monitoring in labour	40%	40%	40%	60%	40%	80%	100%	100%	100%
Element 5	Preterm birth	52%	85%	67%	78%	81%	85%	85%	93%	88%
Element 6	Diabetes	50%	83%	83%	100%	83%	100%	100%	100%	83%
All elements	All elements	43%	79%	70%	80%	76%	90%	93%	94%	87%

Table 14: UHD Maternity position for implementation of Saving Babies Lives Care Bundle v3 – Q1 was assessed in Q2.

Saving Babies Lives Care Bundle Version 3 implementation was assessed externally by the LMNS using the national implementation tool on NHS Futures. UHD evidenced position in Q1 is reported in table is 87% complete.

Saving Babies' Lives version 3.2 (SBLv3.2) released in April 2025 and updated national implementation tool detailing minimum evidence requirements released 04/06/2025.

Due to updated version and additional standards this quarter overall achievement does reflect a change from quarter 4 - 94% complete to 87% complete. The team are working on all elements in quarter 2 and 3 to continue progress on this bundle.

Key areas to focus for improvements outlined in quarter 1 were:

Saving Babies' Lives (Version 3.2) Board Report

Dorset Local Maternity and Neonatal System

Trust	University Hospitals Dorset
Date of report	05/09/2025
Review period	Quarter 1, 2025/26
ICB accountable officer	Pam O'Shea (Interim ICB Chief Nursing Officer)
Trust accountable officer	Peter Wilson (Chief Medical Officer)
LMNS peer assessor name(s)	Vicky Garner (LMNS Lead Midwife)

Executive summary:

- This is the first quarterly review since the launch SBLv3.2, with its updated interventions and evidence requirements.
- Q2 2025/26 priorities to demonstrate sufficient progress with SBLv3.2 implementation:
  - Compliance with 90% target for uterine artery doppler assessment (intervention 2.7)
  - Evidence of job planning for preterm birth neonatal consultant
  - Establishing and evidencing improvement meetings for Element 5
  - Evidencing additional requirements in Element 6 to reflect SBLv3.2 changes

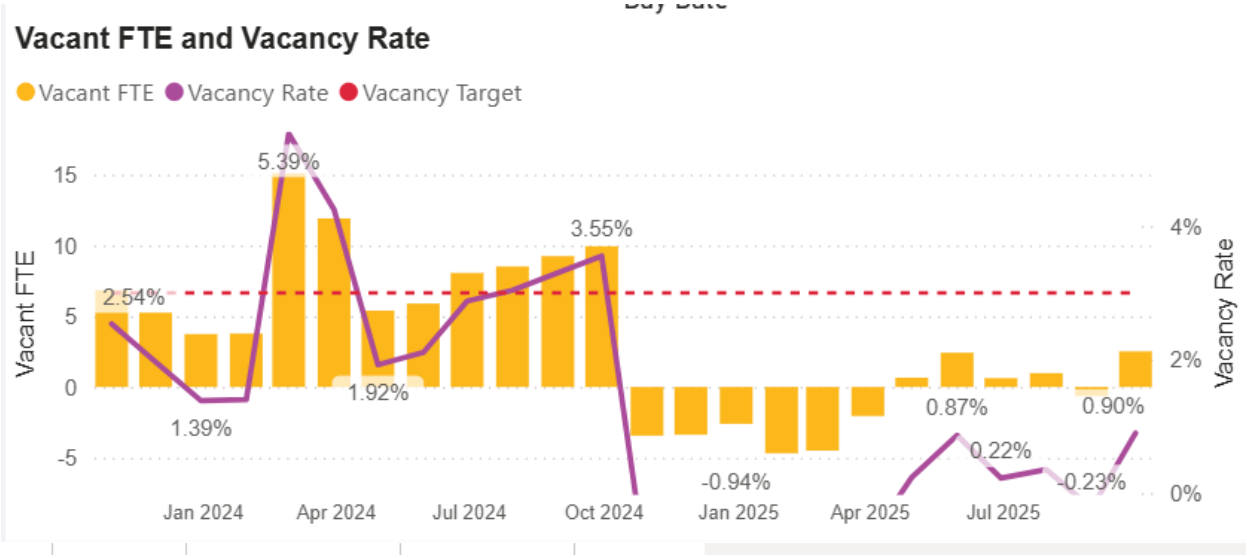
% of interventions fully implemented (LMNS Validated)	Q1	Q2	Q3	Q4
Element 1 Smoking in pregnancy:	90%			
Element 2 Fetal growth restriction:	80%			
Element 3 Reduced fetal movements:	100%			
Element 4 Fetal monitoring in labour:	100%			
Element 5 Preterm birth:	88%			
Element 6 Diabetes:	83%			
Total implementation (all elements):	87%			

Agreed Improvement Activity and Shared Learning

Element 1	• High uptake of National Smoke-free Pregnancy Incentive Scheme (NSPIS) has increased workload, impacting on CO verified non-smoker status at 4 weeks (intervention 1.6, process indicator 1e). High uptake of NSPIS is to be celebrated and with process now embedded, improvement with process indicator 1e is anticipated in Q2 2025/26.
Element 2	• Assurance needed that the rollout of pregnancy validated BP monitors has been completed, including evidence of ratified policy supporting practice (intervention 2.5). • Compliance with uterine artery doppler assessment (intervention 2.7) has not met 90% target since Q1 2024/25. Target to be met in Q2 2025/26 to demonstrate sufficient progress. • PMRT data provides reassurance of no associated harm with FGR management.
Element 3	• Next working day ultrasound compliance (intervention 3.2, process indicator 3b) sustained and to be celebrated.
Element 4	• 100% compliance with Element 4 sustained for third consecutive quarter. • Perinatal mortality review tool PMRT reporting shows no associated risks of harm with intrapartum fetal monitoring.
Element 5	• Increase in preterm birth rate in Q1 (8.6%), exceeding national target of 6% - recommendation to consider thematic review. • Following improvement of optimal cord clamping compliance (intervention 5.22), learning presented by UHD at Wessex preterm birth communities of practice. • PMRT reporting and incidence of brain injury shows no associated risks of harm in Q1. • A priority for Q2 is evidencing job planning for the preterm birth neonatal consultant, establishing improvement meetings and providing evidence of ongoing audit and quality improvement to meet the new requirements of SBLv3.2.
Element 6	• 100% compliance with new audit for type 1 diabetic patients being offered Hybrid Closed Loop System (intervention 6.2) to be celebrated. • Following changes to SBLv3.2, guideline updates and Trust Board confirmation that HCL specific roles are in place are required to achieve full compliance.

9.0 SAFE MATERNITY AND NEONATAL STAFFING

9.1 MIDWIFERY STAFFING



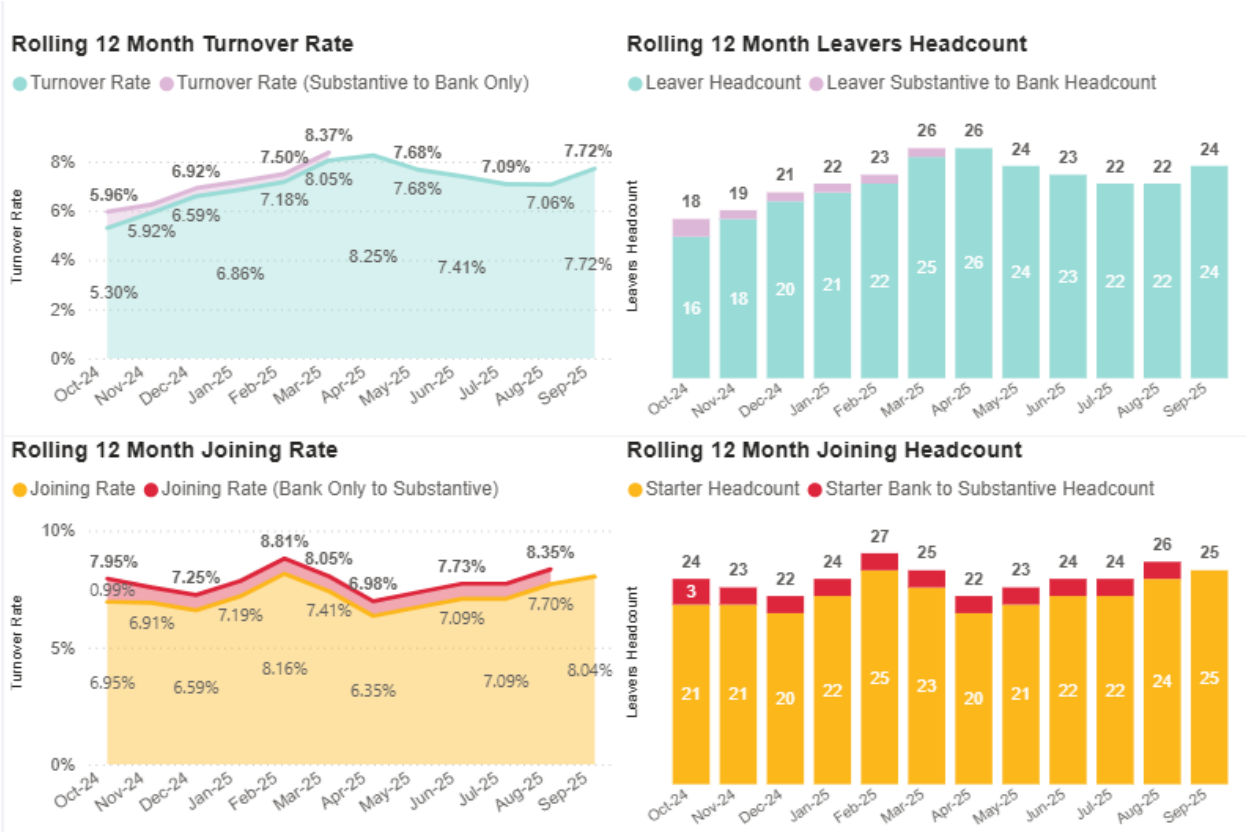


Table 15: Midwifery rolling vacancy and turnover rate -data source COSMOS 10th October 2025

From our data on cosmos, (and data is verified through workforce reviews), there has been significant sustained improvement in midwifery vacancy rate.

This positive position is reflective of a collective responses and actions taken to address the vacancy and preparation for our move in April 2025 and post move with fluctuation of staff turnover expected and to safely provide the additional set up training required.

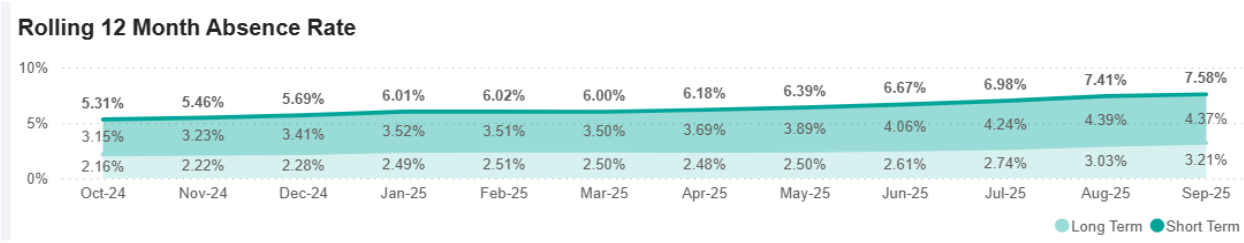
From exit interviews there was no common theme with staff leaving for retirement as the most common reason.

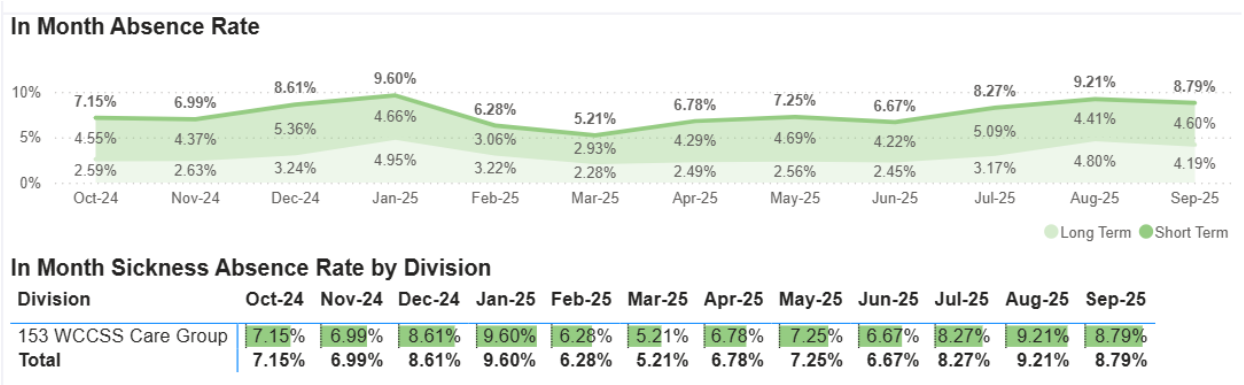
This quarter we reviewed our ability for employing our newly qualified midwives who are expected to qualify in September October.

This year there was limited posts available at UHD, which was reflective of the regional and national position for newly qualified midwives.

A paper was presented to address this issue, and which was evidenced by listening events with staff. Staff told us there was gaps in rotas due to sickness and maternity leave (On average 10WTE midwives are on maternity leave.) which causes significant pressures on the workforce. The paper was supported by the safety champions and executive team and 10 WTE are being employed for a one-year fix term to support them in their preceptorship and onward development.

UHD turnover remains stable below the national average of 8.4 and we continue to support midwives through flexible working or retire and return schemes to maintain experience in our workforce.





In Month Sickness Absence Rate by Division

Division	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
153 WCCSS Care Group	7.15%	6.99%	8.61%	9.60%	6.28%	5.21%	6.78%	7.25%	6.67%	8.27%	9.21%	8.79%
Total	**7.15%**	**6.99%**	**8.61%**	**9.60%**	**6.28%**	**5.21%**	**6.78%**	**7.25%**	**6.67%**	**8.27%**	**9.21%**	**8.79%**

Table 16: Midwifery absence rate - data source Cosmos portal 15th October 2025

Nationally midwifery absence rates are currently 5.3% (NHSE Digital, 2025), which is above the national target of 3% and trust target of 4%.

From the data we can see overall rise in the absence rolling rate in the last 6 months – with a consistent >6% absence rate.

This reflects the overall resilience of midwives currently and ongoing work continues in supporting staff on return to work by line managers meeting with staff, understanding their absence and sign posting to appropriate well-being services within the trust to offer overall health improvements.

In September there was THRIVE week and staff were encouraged to attend. This also continues as there are sessions that can be viewed online, and staff are offered this resource.

Anxiety stress and depression remain the overall top reported reason for sickness. Listening events are occurring frequently to enable staff to escalate work related issues that are creating stress. We have ensured that we have a PMA working Mon-Fri to support the emotional well-being of the team as issues arise.

Measure	Aim	July	August	September
Midwife to funded birth ratio BR plus	1:23.5	1:23.5	1:23.5	1:23.5
Midwife to actual birth ratio	1:23.5	1:23	1:22.5	1:22
Supernumerary labour coordinator at start of shift	100%	100%	100%	100%
1:1 care in labour provided	100%	100%	100%	100%

Table 17: Midwifery staffing safety measures

The birth ratio is within the expected however there has been an increase in complexity within pregnancy, birth and postpartum.

9.2 OBSTETRIC STAFFING

Measure	Aim	July	August	Sept
Consultant presence on labour ward (hours/week)	60 hrs. <4000 births	68	68	68
Twice daily MDT ward rounds	100%	100%	100%	100%
Anaesthetic staffing	>70%	100%	100%	100%

Table 18: Obstetric staffing safety measures

The recommended Consultant presence on the labour ward at UHD meets the criteria set for units with births less than 4000 as per RCOG guidance 2009 however in addition to this there is an expectation through the Ockenden immediate essential actions that consultants do twice daily ward rounds. To meet this standard the consultants are rostered 12 hours presence Monday to Friday and 5 hours Saturday and Sunday to complete twice daily ward rounds and 100% compliance was achieved in Q2

There are minor gaps in rotas for consultant presence on labour ward, however this is mitigated through the employment of locum consultants. Should there be a gap due to unexpected sickness there is a system in place for escalation, and the consultant team will step into the vacant position. An additional Obstetric consultant is currently in the process to be advertised. This will ensure the labour ward obstetric rota will be complete.

Compensatory rest is monitored through rosters and continued to be rostered in Quarter 2. Not currently fully compliant and clinical Director looking at long term solutions. Compliance not required in MIS year 7 however standard to work towards for all units.

Alongside these measures in year MIS year 7 additional standards have been set for continuous monitoring to ensure compliance of short term and long-term locums are meeting the required standard set by the RCOG. This a continuous standard measured and presented through maternity governance for full compliance.

Long term locums are supported throughout their employment from the obstetric team and meet the standards as per RCOG guidance on engagement of long-term locums with induction, regular feedback, and completion of a yearly appraisal.

Data bases are kept for short term and long-term locums and reviewed monthly by the Obstetric lead.

The Trust is compliant with monitoring of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'.
An initial audit was presented by Consultant Obstetrician in September Directorate quality and risk meeting. Discussion and learning shared with the team and the importance of safety reinforced.

A second audit within Mis 7 date criteria has been completed from March to May showing an improvement of 94% attendance and learning from nonattendance shared.

Obstetric Consultant job planning and service review has been completed. Obstetric staffing remains on this risk register. This is due minor gaps within the Consultant rotas and 4 WTE middle grade posts been vacant. Mitigation are in place and Consultant gaps are covered internally, and middle grade gaps are advertised as Locum.

With the service review there is the requirement for further appointments to address clinical need. Areas identified were the mental health service and increase in planned LSCS. Business cases will be presented at SSG in October for consideration.

Job planning has also strengthened leadership roles within the department so there is the addition of an obstetric lead and MDT training facilitator. This leadership strengthens maternity safety.

9.3 NEONATAL NURSING STAFFING

Neonatal Nursing

NHS England – Specialist Commissioning Service Specification for Neonatal Critical Care Review (NCCR, 2024) covers the provision of Neonatal Critical Care, including neonatal intensive care, high dependency care, special care and transitional care.

UHD provides Neonatal Care level 2 Local Neonatal Unit (LNU).

The British Association of Perinatal Medicine (BAPM) and NHS Toolkit for High Quality Neonatal Services provide a framework and calculation tool to determine neonatal nurse staffing depending on cot capacity, acuity and is endorsed by Department of Health (DH) to ensure safe and productive working.

As per MIS safety action 4, the Neonatal Matron with the Southwest ODN conducted a review in Q2 using the Safer Nursing Care Tool – Shelford Group (2013) using triangulated data sets, inclusive of an annual workforce review, acuity, recruitment, retention, skill mix and Qualification in Speciality (QIS). Compliance with BAPM standards for neonatal nursing is a detailed requirement of MIS safety action 4.

All BAPM standards are being met.

It was identified that the current compliance with (Qualified in Specialty) QIS Registered Nurse workforce is 66% in September (against standard requirement of 70%). It is expected that we will meet the standard in September with two staff expected to pass their course this year. We will continue to to follow our agreed action plan with the ODN.

There has been an action plan in place since 2024 to address the deficit due to new band 5's in post at that time. Two candidates started the course in November 2024 for completion in November 2025 with a request to train a further 7 colleagues over a period of two years (starting in November 2025) to maintain the standard within the context of turnover. The ODN is supported this action plan.

9.4 NEONATAL MEDICAL STAFFING

Measure	Aim	April	May	June
Tier 1 separate rota compliance 24/7 'At least one resident Tier 1 (ANNP or junior doctor ST1-3) practitioner dedicated the providing emergency care for the neonatal service 24/7.'	**100%**	100%	100%	100%
Tier 1 The Rota's should meet European working time directive (EWTD) complaint and have a minimum of 8 Whole time Equivalent (WTE) staff who do not cover general Paediatrics	**100%**	100%	100%	100%
Tier 2 Separate rota compliance 12h per day 'Resident Tier 2 (ANNP or junior doctor ST4-8) practitioner dedicated solely to the neonatal service 12 hours a day during the busiest times of the day'	**100%**	100%	100%	100%
	100%	100%	100%	100%

Tier 2 compliance: significant geographical separation between neonatal and paediatric units 'The Tier 2 (ANNP or junior doctor ST4-8) practitioner should be immediately available at all times to the neonatal unit and the labour ward. If the site of the paediatric unit makes this immediate response impossible separate Tier 2 rotas are required' Since the 1st of April there has been no call cover from Paediatric service as this remains in Poole site. Planned move in 2026. Interim arrangement is two ANNPs are rostered to meet safety standards.				
Tier 3 daytime compliance All consultants on-call for the unit have regular weekday commitments to the neonatal service only (ideally with a 'consultant of the week' system) and all consultants do a minimum of four 'consultant of the week' service weeks per year	**100%**	100%	100%	100%
A minimum of 7 WTE Consultants on the on-call Rota with expertise in neonatal care	**Compliant**	No	No	No

The neonatal medical workforce has been reviewed in alignment with the BAPM recommendations, and it was recognised that to achieve the standard, a 1:7 on call commitment from the neonatal Consultants was required. There are six neonatologists and therefore an additional consultant was required. With the support from the safety champions and the executive team, we are currently in the process of appointing the 7th Consultant. We will be interviewing in October with an appointment expected as several experienced candidates applied.

This additional post has also given the opportunity to review job plans and strengthen the leadership roles with the neonatal team.

10.0 INSIGHTS FROM SERVICE USERS AND MATERNITY VOICES PARTNERSHIP CO-PRODUCTION

10.1 COMPLAINTS/COMPLIMENTS/PATIENT ADVICE AND LIAISON SERVICE/CONTACTS

	July	August	September
Complaints	2	4	2

Table 20: Complaints Q2 25/26

Compliments are received through a variety of sources from the MNVP monthly survey, thank you cards and through friends and family monthly feedback and articles of thanks

in the echo. This feedback is given to the members of staff and their line manager to celebrate the good work within the team.

During Q2, 6 complaints were received a slight decrease from Quarter 1.

Themes from complaints identified which were communication, and understanding of clinical processes.

Triangulation of complaints with CQC maternity patient feedback 2024 showed us that the availability of staff and communication concerns were the main factors affecting service user experience.

Service users also said that they wanted more information in the antenatal period.

To address these themes,

Online classes have been updated and extended programme with good attendance and feedback received.

10.2 MATERNITY AND NEONATAL VOICES PARTNERSHIP (MNVP)

The Maternity and Neonatal Voices Partnership (MNVP) hold a key stakeholder membership in the LMNS and have been providing feedback into the meetings and direct feedback to the DoM from service user feedback.

The NHSE Maternity and Neonatal Programme have published the Maternity and Neonatal Voices Partnership Guidance in November 2023.

The priorities for the service are currently undergoing system-wide agreement within the Local maternity and Neonatal System (LMNS).

MNVP hours have been increased and agreed via the LMNS Programme Board to support the work plan across the Dorset wide system at DCH and UHD.

The additional MNVP's are supporting the delivery of the key priorities:

- Listen to Women & Families from all backgrounds & ethnicities.
- Support development of perinatal mental health services
- Improve digital systems and process for our families.
- Improvement in infant feeding.
- Working in collaboration to improve the complaints process and responses to service users.
- Improved involvement in governance and communication to support delivery of the 3-year Maternity and Neonatal delivery plan and transformation.

In March the **MNVP** and members of the public conducted the 15 steps on the new maternity unit in the Beach building. Positive feedback was given by the group, and the group was pleased to see that actions have been taken already in this new building

from previous feedback. Verbal feedback was given on the day by the MNVP, and immediate actions taken re signage to the unit as unclear at many entry points.

Further suggestions will be added to the overall 15 steps action plan to continue improvements in the next review planned for the 22nd of September.

In June and July, the MNVP's spent time on the wards to listen to patient feedback on the new environment and care experience. There was overwhelming positiveness from service users, particularly on the postnatal wards and NICU with patients expressing privacy and quite individual space to recover post birth as the most beneficial side of their care.
In September they spent time in the community hub in Christchurch on a NICU coffee morning, and a parent described how positive it was to be able to stay overnight and not to have to travel to be with their baby.

The MNVP's are also now quorate members in our Mat Neo governance structure and give valuable insight and patient perspective on all aspects.
Meetings they attend are:

- Safety champions meeting
- Mat Neo quality and safety meeting
- PMRT review meeting
- Patient safety meeting
- Mat Neo health and governance meeting (where guidelines are discussed).

The MNVP co-produced the maternity CQC patient feedback survey action plan with the Head of Midwifery and is monitored through governance structure. Ongoing progress is being made and awaiting release of the CQC 2025 survey.

11.0 PERINATAL CULTURE AND LEADERSHIP PROGRAMME

The Perinatal Culture and Leadership Programme (PCLP), funded by NHSE, aims to support perinatal Quadrumvirate (Quad) teams to create and craft positive safety cultures within perinatal services. The programme design was in direct response to nationally derived intelligence regarding the intrinsic relationship between a positive workplace culture and continuous quality improvement. It aligned with the response to the Immediate and Essential Actions in the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals and informs the Three-Year Delivery Plan for Maternity and Neonatal Services with the overarching aim is to support all perinatal teams in England to create and craft the conditions for a positive culture of openness, safety, and continuous improvement.

The Quad triangulate the feedback and staff insights, and the focus continued this quarter was on patient flow throughout our new unit.

Issues identified was slow postnatal discharge, causing delayed transfers from labour ward, resulting in induction of labour delays with poor staff job satisfaction. Inappropriate admissions through Triage causing further delays and overall pressure causing incivility.

A project plan has been developed with support from the patient first team to understand the root causes and implement immediate and long-term actions.

Other areas the quad have focus on are the overall increase in Caesarean sections rate and capacity within theatres. Planned all day lists have commenced for 2 out of 5 days and business plan progressing to find a long-term solution.

The preceptorship lead midwife presented to safety champions a data survey on psychological safety at work feedback from Band 5 midwives over a two-year period. The feedback themes were shared, and incivility was addressed with an immediate action plan. The action plan focused on training, in incivility, racism and unconscious bias. All staff addressing poor behaviours and launch of the behaviour charter. Check in points increased for band 5 midwives.

The data showed overall improvements in psychological safety however more work to be done with labour ward clinical leaders having additional focus sessions arranged in October.

12.0 AVOIDING ADMISSION INTO THE NEONATAL UNIT (ATAIN) & TRANSITIONAL CARE

12.1 THE NATIONAL AMBITION

In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. The national ambition for term admissions is below 6%, however Trusts should strive to be as low as possible.

This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on:

- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, teamwork, and improvement capability within maternity units

12.2 WHY IT IS IMPORTANT

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on

maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

12.3 ATAIN DATA

There has been a focused QI on ATAIN and ATAIN data in Q2 was below both the Reginal Target of ≤ 5% and National target of ≤6%.

In Q3 2024there were **42 term admissions** to NICU. This equates to **4.5% of all births.** This is lower than both the regional target of <5% and national target of <6%.

In Q4 2025 there were **56 term admissions** to NICU. This equates to **6.3% of all births** which is above the regional target of <5% and the national target of <6%.

In Q1 2025 there were **37 term admissions** to NICU. This equates to **4.1% of all births**. This is lower than both the regional target of <5% and national target of <6%.

In Q2 there were **44 term admissions** to NICU. This equates to **4.3% of all births** which is lower than the regional target of ≤ 5% and below the national target of ≤6%.

All cases have been reviewed with the multi-disciplinary team who fund 3 out of 44 cases as avoidable.

All 3 reason for admission to NICU were respiratory distress.

12.4 Themes identified were:

- CTG misclassification leading to missed opportunities for earlier intervention.
- Delays to induction of labour process.
- Respiratory and transition to ex-utero life is the primary reason for admission to NICU.
- A baby was admitted of a mother on multiple medications known to reduce respiratory drive. Although admission for respiratory support was needed, an ANNP could have been requested to attend the birth and provide respiratory support. This might have avoided ventilation of the baby

12.5 ATAIN QUALITY IMPROVEMENT

Drawing on insights from our quarterly themes identified from any term admissions to the neonatal unit we will be working on several QI initiatives.

QI initiatives commenced in 2024-25

Project 1: Improving the immediate thermoregulation and nutritional management of term babies to reduce admissions to NICU.
This work includes improvements to birth environmental temperatures, skin to skin practices, first feeds and staff training.

QI initiatives commenced in 2025-26
Project 2: The neonatal team are reviewing PEEP and CPAP practice and planning bedside CPAP for 1 hour for babies it may benefit.

The ATAIN process in UHD has been reviewed to align with the NHS England Toolkit.

Plans for 2025-26 include.
Continuation of the Warm Bundle work to maintain temperature and blood glucose of newborns.
Relaunch of Red Hat Initiative planned to enable staff to easily identify babies requiring additional monitoring post birth.
Informal 'Tea Trolley dash' information and teaching sessions.
Bringing back good practice and initiatives from similar sized maternity units regionally that we have visited.
We have updated the case review template to capture relevant details and to provide space to capture questions and learning.
ANNP attendance at elective caesarean birth is being considered due to admission rates for these babies.
Continued work with education of Fetal monitoring including uterine hyperstimulation.

To also reduce admissions of babies to Special care baby unit, during Q1, the Transitional Care service was facilitated 100% of the time with >50% of neonatal care provision within a Transitional Care Pathway (TCP), providing neonatal care at the mother's bedside.

13.0 Maternity Neonatal Risk Register:

There are 13 Live combined Risks across maternity and neonatal services during Q2: These are all closely monitored. Actions towards closing the gaps have been identified within the individual risk assessments on Datix, and continued mitigation of risk, will be monitored through Specialty and Divisional governance with Trust Management Executive, oversight to ensure appropriate actions are taken in accordance with the Trust Risk framework.

ID	Title	Risk level (current)	Rating (current)	Increse / decrease	Review by
2214	Replacement of neonatal ventilators	Moderate 8 - 12	12	⟺	30/09/2025
2098	Elective caesarean capacity	Moderate 8 - 12	10	⟺	30/09/2025
1202	Medical Staffing Women's Health	Moderate 8 - 12	8	⟺	11/08/2025
2183	High Risk Perinatal Mental Health Service	Low 4 - 6	6	⟺	29/08/2025
2100	Maternity Drug Assay in-house testing	Low 4 - 6	6	⟺	30/09/2025
2097	Viewpoint 6 obstetric ultrasonography package	Low 4 - 6	6	⟺	06/08/2025
2047	Translating Services in Maternity	Low 4 - 6	6	⟺	20/10/2025
2018	Ventilator on Portable Incubator	Low 4 - 6	6	⟺	31/10/2025
1523	24/7 service Labour Line	Low 4 - 6	6	⟺	20/10/2025
2005	Fetal Monitoring at UHD	Low 4 - 6	4	↓	28/10/2025
1995	Baby Abduction systems and processes	Low 4 - 6	4	⟺	30/09/2025
1648	Neonatal Consultant Rota	Very low 1-3	3	⟺	30/10/2025
2178	Possible Memory Leak in BadgerNet	Very Low 1-3	2	⟺	01/09/2025

⟺ Risk has remained the same.
↓ Risk has decreased.
↑ Risk has increased.

Table Maternity & Neonatal Risk Register

13.1 CLOSED RISKS IN Q2

During Q2 there were no closed Risks

13.2 REDUCED RISKS IN Q2

During Q2 there was 1 reduced Risk:
Risk 2005- ‘Fetal Monitoring at UHD’ was reduced from low ‘6’, to low’4’, due to a significant improvement in compliance for national and local standards.

13.3 NEW RISKS IN Q2

During Q2 there were:
2 new risks added to the Risk Register in the holding area:

Risk 2246- Inability to access a second obstetric theatre, High ‘15’. Mitigations- Protocol to risk assess and summon a second emergency obstetric team to theatres is in place.

- Risk 2247- Neonatal Workforce QIS training, Very Low ‘3’. Mitigations- Management and quality roles are all QIS trained and support when high acuity.

1 new ‘live’ risk for Radiology- linked to maternity:

- Risk 2229- Obstetric Ultrasound Scanning Service- High ‘15’ (Approved and live from 30th Sept 25). Mitigations-Substantive staff being offered bank shifts and Wait List Initiative (WLI) at weekends to increase capacity. Prioritisation of those areas measured for Maternity Incentive Scheme (MIS) audits.

14.0 RECOMMENDATION

The Board of Directors is asked to receive and discuss the content of the report. It also required to record in the Trust board minutes as requested to provide evidence for the maternity incentive scheme.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 6.1.2

Subject:	Annual End of Life Report
Prepared by:	Dr Amy Pharoh
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)	Quality and safety Patient Experience
Purpose of paper:	Assurance
Executive Summary:	UHD provides palliative and end of life care across the hospital sites, hospice inpatient and the community via specialist nurses and Hospice@Home. End of life care however at UHD is the responsibility of all, not just the specialist teams and at the end of 2024 the steering group undertook a piece of work to identify its objective. To establish a robust process for the regular review and thematic analysis of Medical Examiner (ME) feedback, complaints, and LERNs, ensuring accurate and timely reporting to identify trends, inform service improvements, and promote a culture of continuous learning and patient safety. This will directly feed through the End-of-Life Care Steering Group, to continue to shape improvements through the wider working groups.
Background:	On average 250 people die across UHD each month. The experience of patients and their families' end-of-life care at UHD is measured through a number of methods and are discussed as part of the agenda of the End of Life Steering Group. This information in conjunction with national audits and benchmarking is then used to inform work across the Trust to improve the experience of this patient group and their families through the identified workstreams.
Key Recommendations:	• To note the key workstreams that have been identified by the steering group by triangulating national and local data through numerous sources. Acknowledging the work that is being undertaken to deliver improvements in these areas.

	• To note the increased use that has been seen in Treatment Escalation Plans across the Trust and the need for ongoing audit to measure the quality of information in TEPS and to promote their use.
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**
Quality Committee	28/10/2025	The meeting has not taken place at time of the submission of this 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 ☐

Annual End of Life Report

Name of Subgroup:	End of Life Care Steering Group	**Dates of Last EOLCSG Meeting:**	September 2025
Chairperson:	Sarah Herbert	**Date of Quality Committee:**	October 2025

1.0 On average 250 people die across UHD each month. UHD provides palliative and end of life care across the hospital sites, hospice inpatient and the community via specialist nurses and Hospice@Home. End of life care at UHD is the responsibility of all not just the specialist teams and at the end of 2024 the steering group undertook a piece of work to identify its objective; To establish a robust process for the regular review and thematic analysis of Medical Examiner (ME) feedback, complaints, and LERNs, ensuring accurate and timely reporting to identify trends, inform service improvements, and promote a culture of continuous learning and patient safety. This will directly feed through the End-of-Life Care Steering Group, to continue to shape improvements through the wider working groups. This work is outlined in the paper below.

2.0 Patient Experience

The experience of patients and their families end of life care at UHD is measured through a number of methods and are discussed as part of the agenda of the End of Life Steering Group. This information in conjunction with national and local audits is then used to inform work across the Trust to improve the experience of this patient group and their families through the identified workstreams.

2.1 Post bereavement survey (UHD deaths excluding the hospices)

The survey ran from Dec 24 – April 25 (subsequently paused in lieu of NACEL). Prior to the pause 42 returns were received.

Results

- 90.5% felt that staff communicated with sensitivity and kindness.
- There was an increase in the number of patients being involved in decisions regarding their care and treatment although the percentage remains low – 52.4%
- 69% felt that the person died in the right place.
- Themes identified from comments included availability of side rooms and ward moves.

ACTION

- Treatment escalation plans (TEPS) is a key focus for one workstream of EoL improvement project. A rolling audit is underway measuring the quality of information in TEPS and to promote their use.
- Need for increased communication with patients and families about treatment decisions.

2.2 Bespoke Experience Measure

This has recently been developed for use in the Trust but is currently underused in the hospital (only 4 returns this year). Therefore, it is too early to be able to draw meaningful information from the returns.

ACTION

- A key team objective for the Hospital Palliative Care Team (HPCT) to actively ask patients about their experience of care in the hospital and to work with clinical teams to promote the use of this tool.

2.3 Medical examiner feedback

Analysis EDMES data from the last 6 months (March – August) showed from a total of 1292 deaths, there were 304 positive comments compared to 159 comments raising a concern. This data is reviewed through the steering group and themes identified. The most commonly arising concerns relate to the delivery of fundamental care.

ACTION

- The EOL group is linking with the work underway relating to Fundamentals of Care as part of the patient centred care corporate project.

2.4 Complaints

There were 20 complaints received that were related to end-of-life care between January and September 2025. 4 required formal response and action from HPCT.

Themes include – communication, access to palliative and end of life care, symptom control, discharge, poor care. This information is feeding into the current improvement workstreams for the EOL steering group.

3.0 National Audit of Care at the End of Life (NACEL)

Changes in the audit process now mean that NACEL is an ongoing audit and data is presented on a quarterly basis. However, the results of the audit cohort from 1st January 2024 – 31st December 2024, published in August 2025 identified the trust benchmarks well with national data (see appendix 1) but key areas from the report to note (positive or negative)

- The proportion of bereaved people that rated the overall care and support given to themselves and others by the hospital as excellent or good was 85.5% for RBCH compared to a national average of 71.7%
- The proportion of bereaved people that strongly agree or agree that they were communicated to by staff in a sensitive way was 95.8% for RBCH compared to a national average of 82.6%
- The proportion of people who died with ethnicity documented in their clinical records was 35.5% for Poole and 47.4% for RBCH compared to a national average of 86.4%

Improvements identified are made in line with results which often highlight an issue with documentation rather than with care. Work to capture ethnicity in documentation specifically needs to be an area of focus for the whole Trust. UHD has opted out of the bereavement survey section in favour of the UHD bereavement survey which yields richer information.

4.0 NCEPOD – End of Life Report 2024

Each year over 600,000 people die in the United Kingdom and many of these deaths occur in hospital, despite the majority of people saying they would prefer not to die there. This study was designed to identify opportunities to improve the provision of palliative care earlier in the disease trajectory and the impact of this on care at the end of life. It focused on hospital care provided in the last six-months of life as well as on the final admission. It adds to the data provided by the NACEL audit. The study population included patients aged 18 or over who died in hospital between 01.04.2022-30.09.2022 with one or more of the following conditions: dementia, heart failure, lung cancer and liver disease.

In response to the study a Trust action plan has been developed and shared with the end of life steering group. Key messages regarding advance planning, coordination of care and training have been shared with care groups.

5.0 Rapid Review of End-of-Life Care in East Dorset

A notes review took place of 112 patients who died in a week in February 2025.

Findings include that patients known to the palliative care team were more likely be at home, in a care home or hospice rather than in hospital when they died. Most of the patients dying in hospital had not met the palliative care team prior to their last days of life.

ACTION

- Improvement of Advanced Care Planning documentation at UHD with consideration of adding to WR sheets/admissions proformas/TEP. This has already been agreed as a focus of Phase 2 of the EoL improvement project.

6.0 Other audits and surveys currently being undertaken

- Annual eAAND (electronic Allow A Natural Death) audit: findings have led to the development of an updated form reducing the risk associated with previous processes and improving sharing of information.
- Consultant survey regarding attitudes to dying patients under their care – due November 2025
- Audit of NEWS calls outcomes and guidelines for TEP following a NEWS call

7.0 Learning from incidents

There were 42 recorded LERNS between Jan and Oct related to EoLC in the hospitals (this excludes the hospices,

pressure ulcers and falls).
The three most common themes were, Syringe driver incidents, Medicines and Communication
ACTION

- Syringe driver policy is under review which will include a significant change requiring 2 people to check all syringe drivers, not just those incorporating controlled drugs. Over the last 2 years compliance of syringe driver training has increased by 82%. These has been enabled by increased regular offer of training sessions and its incorporation as a clinical skill on the ESR record.
- Bespoke training delivered to ward areas or individuals where LERNS arise
- Themes from EoLC LERNS regarding communication shared with Fundamentals of Care group. The communication workstream being led by a palliative care consultant and due to launch in November.

8.0 Education

The end-of-life practice educator continues to deliver comprehensive education programmes. This essential post is funded until September 2025. alongside the HPCT who regularly deliver ward based clinical sessions to different clinical staff groups.

The HPCT led a Schwartz Round discussing culture a round death and dying.

Dying Matters week was marked on both sites with a program of events and displays.

9.0 Current focus and improvements:

- A trust wide end of life improvement plan was launched in late 2024
  Phase 1 workstreams: improving the recognition of dying and improving symptom control in those who are dying. A3's have been developed and the progress of each group is reported back via the EOL steering group.
- Following an educational drive, creation of new Treatment Escalation Plans was the highest ever measured in August 2025 – a total of 722. The next stage is improving the quality of the information they include.
- The new eAAND form was launched in October 2025 enabling better sharing of information within UHD and other appropriate partner organisations and a clearer process for cancellation of forms
- The UHD end of life care dashboard monitors activity and quality across UHD. This has been updated to track improvements identified in the strategic A3 as well as to inform improvements at directorate and care group level
- EPR Rapid discharge home to die pathway launched August 2024. Between 2 and 6 patients discharged home successfully on this pathway every month.
- Planning for a phased launch following a pilot of new symptom and comfort observation chart for patients on a Personalised Care Plan for the Last Days of Life (PCPLDL).

10 Summary

The End of Life agenda across the Trust remains a key priority and the realignmnet of the steering group has identified the main areas of focus in the coming year which it will be focusing on based on national and local data. Whilst the Trust benchmarks well Nationally around the care delivered at the end of life, learning from both NCEPOD and local review highlights more can be done and the group will drive improvements through the initially identified workstreams, improving the recognition of dying and improving symptom control in those who are dying. Improvements in these areas will be monitored through the steering group.

Appendix 1 National Audit of Care at the End of Life (NACEL) 2024 State of the Nations Report

Clinical Audit Ref No: 324-2526

Number of cases	Key Indicators	Poole 2024 Report	RBCH 2024 Report	National 2024 Report
Poole: 77 RBCH: 79	The number of deaths where it was expected that the person would die during the final admission as a proportion of the sample 'all deaths included in the audit	87.0%	89.9%	82.9%
Poole: 69 RBCH: 75	The proportion of people who died with documented evidence in their clinical records of communication about hydration with those important to the dying person, or a reason recorded why not	68.1%	52.0%	60.8%
Poole: 75 RBCH: 77	The proportion of people who died with documented evidence in their clinical records that anticipatory medication was prescribed for symptoms likely to occur in the last days of life	89.3%	92.2%	86.1%
Poole: 76 RBCH: 78	The proportion of people who died with documented evidence in their clinical records of an assessment of the emotional/psychological needs of the person, or a recorded reason why not	77.6%	74.4%	81.7%
Poole: 16 RBCH: 72	The proportion of bereaved people that rated the overall care and support given to themselves and others by the hospital as excellent or good	75.0%	87.5%	71.7%
Poole: N/A RBCH: N/A	The proportion of hospitals/sites with a face-to-face specialist palliative care service (doctor and/or nurse) available 8 hours a day, 7 days a week	No	Yes	62.7%
Poole: 16 RBCH: 71	The proportion of bereaved people that strongly agree or agree that they were communicated to by staff in a sensitive way	81.3%	95.8%	82.6%
Poole: 66 RBCH: 70	The proportion of people who died who had an individualised plan of care addressing their needs at the end of life, where it was recognised that the person may die during their final admission (Cat 1* deaths only)	90.9%	88.6%	82.9%
Poole: 76 RBCH: 78	The proportion of people who died with ethnicity documented in their clinical records	35.5%	47.4%	86.4%
Poole: 101 RBCH: 59	The proportion of staff respondents that strongly agree or agree that within the area they work there is a culture that prioritises compassion and support as fundamental in all interactions with dying patients and those important to them	89.1%	84.7%	87.7%

*Category 1: It was expected that the patient would die in the final admission. Life sustaining treatments may still be being offered in parallel to end of life care.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 6.1.3

Subject:	Mortality Report
Prepared by:	Jess Wiggins, Becky Jupp, Becky Protopsaltis, Grace Maughan
Presented by:	Dr Peter Wilson, Chief Medical Officer

Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☐ Patient Experience ☐ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Assurance
Executive Summary:	The UHD 12 month rolling HSMR has remained below the target of 100 since February 2025 and is currently 93.06 for the year to June 2025. The data from HED shows that UHD still has a SHMI score of 0.88 for the 12 months to April 2025, which is lower than the national average. Work to restructure MSG continues. Consistent reporting into MSG is improving month by month and standardisation of specialty morbidity and mortality meetings will ensure comprehensive reporting at Care Group level and information sharing from MSG back to specialties. This is still a work in progress, and this report reflects the on-going improvements to the group. MSG welcomes any feedback regarding the structure and content of this report.
Background:	The reporting structure for Mortality Surveillance Group (MSG) is changing to reflect Patient First methodology. There will be a period of transition, and this report will evolve to reflect this. The terms of reference for the group and the action tracker will also be adapted in line with the trust templates. To improve consistency of reporting into Mortality Surveillance Group from Care Groups, morbidity and mortality (M&M) evaluation will be standardised across the trust at specialty level to incorporate eLFD forms into

	the process and thus standardise output and action tracking for each group. HSMR In Month - Latest fully coded position is June 2025 at 101.2. This is above the national average of 100, after 8 months of consistently being below 100. Some monthly variation is expected but a continued upward trend would prompt further review. Data for July is expected next month. The new Learning from Deaths (eLFD) process has now been in place for six months. Compliance is monitored and reported monthly, with a target of achieving 100% completion. As of June 2025, compliance stands at 85%. Although this remains below the target, there has been steady month-on-month improvement. All Care Groups continue to engage proactively in supporting staff to address any barriers to completion. Each month, UHD receives Mortality Alerts from the Healthcare Evaluation Data (HED) system. These alerts are generated when mortality rates exceed expected thresholds. There have been no HSMR or SHMI alerts since July 2025. Previous alerts have involved small patient cohorts, allowing for effective case-by-case review. However, an alert affecting a larger patient group would require a more complex investigation process. To prepare for this, HED has provided training and a comprehensive escalation and review framework. Work is now underway, in collaboration with the Business Intelligence and Clinical Coding teams, to establish a clear protocol for investigating future alerts and determining when a thematic review may be warranted. **Rolling 12 Month HSMR (July 2024 to June 2025) is 93.06**. This has decreased further since February 2025 when the level dropped below the target of 100 for the first time since March 2022. **UHD is in the top 13 trusts which have a 'lower than expected' SHMI, out of the 119 Trusts** included in the reporting. The latest published data covers 12 months to April 2025 and is 0.88 (where the national average is 1). For all 10 of the SHMI diagnosis groups that are reported, UHD is either 'as expected' or 'lower than expected'.
Key Recommendations:	The Board is asked to note the report.
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**
Clinical Governance Group	25/09/2025	Information & Assurance
Quality Committee	28/10/2025	Assurance

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

Report To	**Quality Committee**
Date of Meeting	**28/10/2025**
Title of Report	**Mortality Surveillance Group Report**
Author	**Jess Wiggins, Becky Jupp, Becky Protopsaltis, Grace Maughan**

Key Discussion Points and Matters Arising to be Escalated from Meeting

ALERT: Alert to matters that require attention or action, e.g. non-compliance, safety, or a threat to the Trust's strategy

- The reporting structure for Mortality Surveillance Group (MSG) is changing to reflect Patient First methodology. There will be a period of transition, and this report will evolve to reflect this. The terms of reference for the group and the action tracker will also be adapted in line with the trust templates.

- To improve consistency of reporting into Mortality Surveillance Group from Care Groups, morbidity and mortality (M&M) evaluation will be standardised across the trust at specialty level to incorporate eLFD forms into the process and thus standardise output and action tracking for each group.

- HSMR In Month - Latest fully coded position is June 2025 at 101.2. This is above the national average of 100, after 8 months of consistently being below 100. Some monthly variation is expected but a continued upward trend would prompt further review. Data for July is expected next month.

ADVISE: Advise of areas of ongoing monitoring or development or where there is negative assurance

- The new Learning from Deaths (eLFD) process has now been in place for six months. Compliance is monitored and reported on a monthly basis, with a target of achieving 100% completion. As of June 2025, compliance stands at 85%. Although this remains below the target, there has been steady month-on-month improvement. All Care Groups continue to engage proactively in supporting staff to address any barriers to completion.

- Each month, UHD receives Mortality Alerts from the Healthcare Evaluation Data (HED) system. These alerts are generated when mortality rates exceed expected thresholds. There have been no HSMR or SHMI alerts since July 2025. Previous alerts have involved small patient cohorts, allowing for effective case-by-case review. However, an alert affecting a larger patient group would require a more complex investigation process. To prepare for this, HED has provided training and a comprehensive escalation and review framework. Work is now underway, in collaboration with the Business Intelligence and Clinical Coding teams, to establish a clear protocol for investigating future alerts and determining when a thematic review may be warranted.

ASSURE: Inform where positive assurance has been achieved

- **Rolling 12 Month HSMR (July 2024 to June 2025) is 93.06**. This has decreased further since February 2025 when the level dropped below the target of 100 for the first time since March 2022.

- **UHD is in the top 13 trusts which have a 'lower than expected' SHMI, out of the 119 Trusts** included in the reporting. The latest published data covers 12 months to April 2025 and is 0.88 (where the national average is 1). For all 10 of the SHMI diagnosis groups that are reported, UHD is either 'as expected' or 'lower than expected'.

Executive Summary

The UHD 12 month rolling HSMR has remained below the target of 100 since February 2025 and is currently 93.06 for the year to June 2025.
The data from HED shows that UHD still has a SHMI score of 0.88 for the 12 months to April 2025, which is lower than the national average.

Work to restructure MSG continues. Consistent reporting into MSG is improving month by month and standardisation of specialty morbidity and mortality meetings will ensure comprehensive reporting at Care Group level and information sharing from MSG back to specialties. This is still a work in progress, and this report reflects the on-going improvements to the group. MSG welcomes any feedback regarding the structure and content of this report.

Introduction

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

1. Analysis and discussion

1.1 Inpatient Deaths at UHD

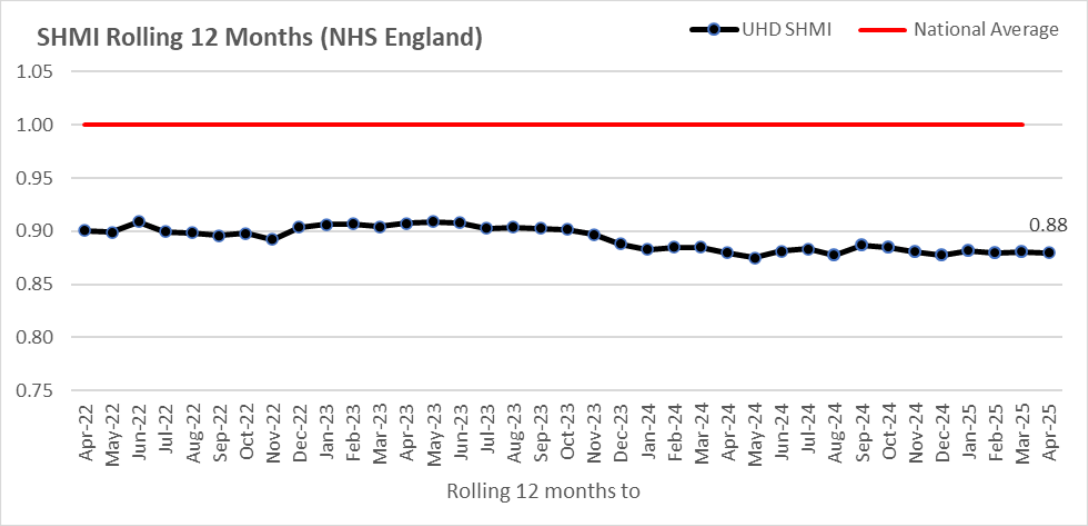
Quarter	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26
Q1	630	548	522	675	681	682	645
Q2	633	575	658	685	623	622	594
Q3	765	761	708	807	765	693	
Q4	689	989	715	749	693	741	
Total	2717	2873	2603	2916	2762	2738	

Data source is Camis.

Q1 of 2025-26 saw 645 inpatient deaths at UHD sites, compared to 682 in Q1 2024-25.

1.2 SHMI

SHMI (Summary of Hospital Level Mortality Indicator) is the ratio between the number of patients who die up to 30 days following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated here. Data is provided for rolling 12 months and always in arrears. Covid-19 related activity is included in if the discharge data is on or after 1st September 2021. Hospices are excluded. The national average is 1.
UHD's SHMI is in the 'lower than expected' range at 0.88 for the 12 months to April 2025.



Site level breakdown;

Site level breakdown

(official statistics in development)

Table notes

Site code	Site name	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
R0D02	Royal Bournemouth Hospital	49,335	1,895	2,290	0.8269	Lower than expected SHMI
R0D01	Poole Hospital	51,380	1,435	1,735	0.8282	Lower than expected SHMI

NHS England calculates SHMI values and bandings for 10 of the SHMI diagnosis groups. Below is for the latest rolling 12 month period to April 2025;

Diagnosis group description	Diagnosis group number	Provider spells	Observed deaths	Expected deaths	SHMI value	Banding description
Cancer of bronchus; lung	15	420	130	115	1.1056	As expected SHMI
Fluid and electrolyte disorders	37	810	60	55	1.1056	As expected SHMI
Secondary malignancies	30	810	145	130	1.0941	As expected SHMI
Septicaemia (except in labour), Shock	2	690	195	185	1.0430	As expected SHMI
Acute myocardial infarction	57	980	80	80	0.9946	As expected SHMI
Pneumonia (excluding TB/STD)	73	3,050	470	480	0.9792	As expected SHMI
Fracture of neck of femur (hip)	120	985	75	80	0.9615	As expected SHMI
Gastrointestinal hemorrhage	96	705	40	45	0.8638	As expected SHMI
Urinary tract infections	101	1,880	70	90	0.7631	As expected SHMI
Acute bronchitis	74	2,055	40	85	0.4571	Lower than expected SHMI

For the 12 months to April 2025, all diagnosis level values are either as expected or lower than expected.

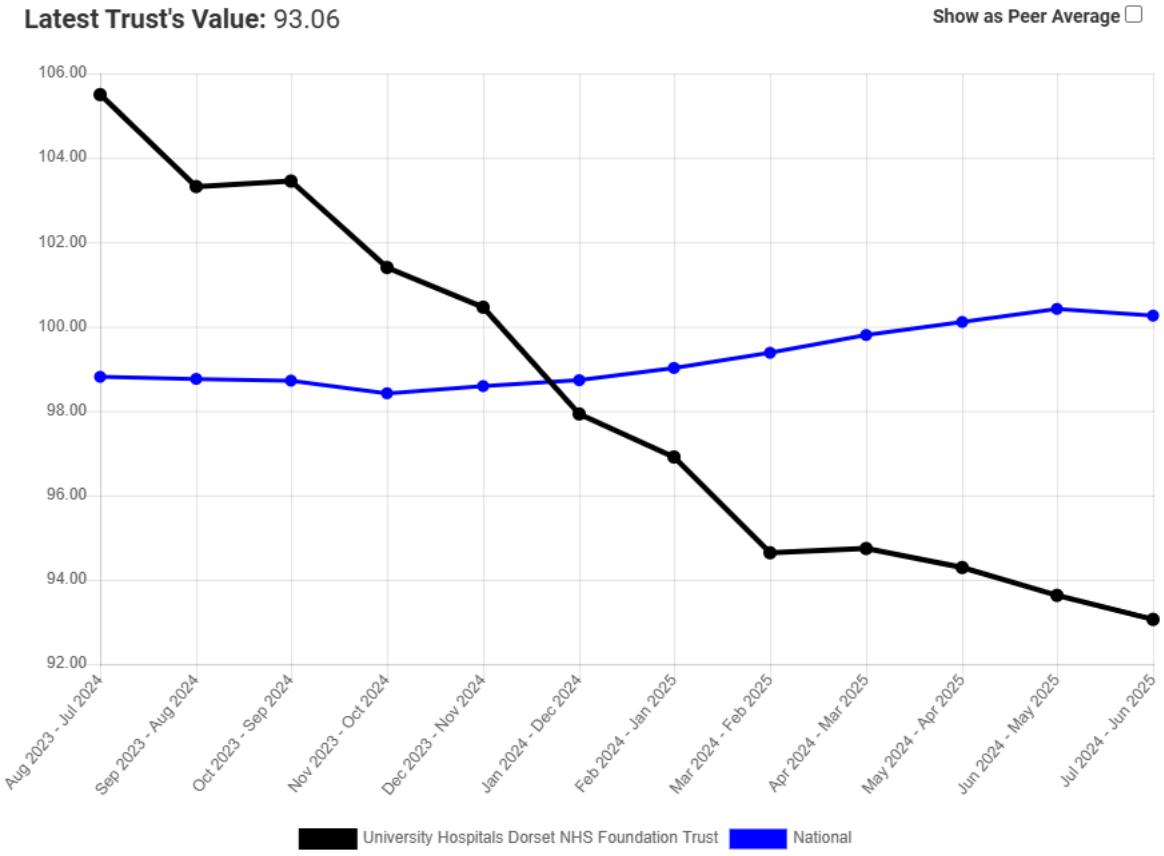
NHS England publish the latest statistics on a monthly basis. UHD is just in line with the lower control limit with a SHMI of ‘as expected’. UHD is in the top 13 trusts of the 119 trusts included.

1.3 HSMR

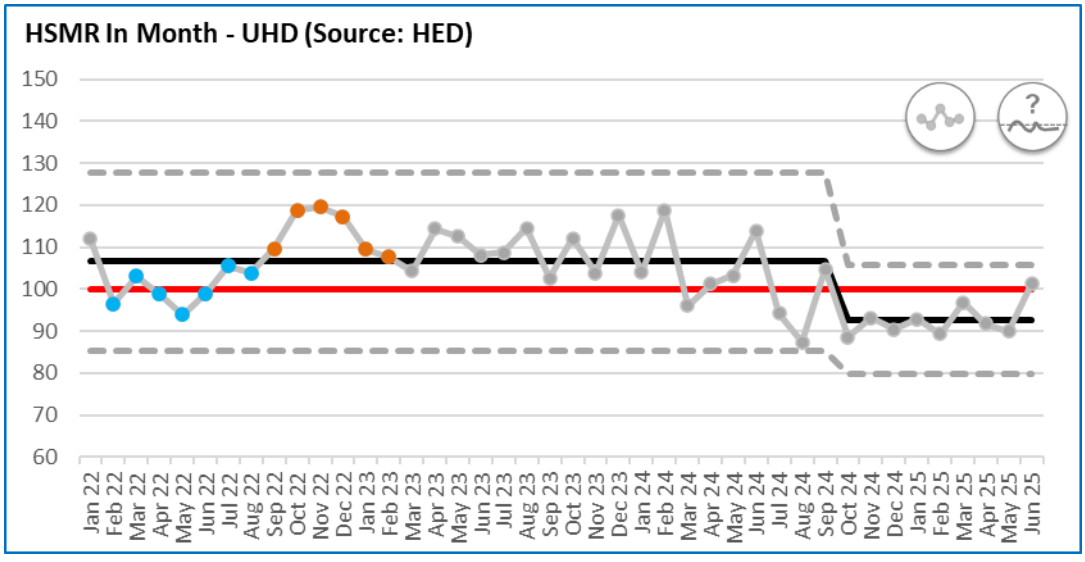
HSMR (Hospital Standardised Mortality Ratio) is the ratio of observed number of in-hospital inpatient deaths compared to the expected* number of in-hospital deaths. UHD report both

the in-month and rolling 12-month positions and data is usually a few months in arrears. Data is extracted from HED (Healthcare Evaluation Data) and excludes the latest month which is not yet fully coded. The national average is 100.

HSMR Rolling 12 Month: July 2024 to June 2025 is 93.06. The chart below displays UHD (black line) against the national picture (blue line).



HSMR In Month - Latest fully coded position is June 2025 at 101.2. This is above the national average of 100, after 8 months of consistently being below 100. Some monthly variation is expected but a continued upward trend would prompt further review.



2. Care Group Morbidity & Mortality Learning

There has been continued improvement in the quality and output of departmental Morbidity and Mortality (M&M) meetings, as reflected in the care group reports. To further enhance the process, the eLFD forms will be refined to provide greater clarity around identified learning and resulting actions. It is intended that these forms will be completed collaboratively during M&M meetings, allowing the outputs to be used directly as meeting reports for submission to the care groups. This approach aims to reduce administrative burden and improve overall eLFD compliance.

To strengthen feedback mechanisms, a monthly summary of key learning from the Mortality Surveillance Group (MSG) will be produced and shared as a standing agenda item at departmental M&M meetings, once these are fully standardised.

Ongoing challenges remain regarding the accurate identification of the responsible consultant to complete the eLFD form, which continues to affect compliance. The use of multiple IT systems and ward-tracking processes across the Trust can make it difficult to determine responsibility, particularly when patients transfer between specialties or locations. Additional complexities arise when patients are admitted directly to intensive care, bypassing ward areas. In such cases, it would be pragmatic for the ITU team to complete the eLFD form as part of their M&M process. The surgical and medical care groups are working collaboratively to agree a consistent approach for these scenarios.

3. Medical Examiner Service: Update to be provided in the next quarter.

4. LeDeR report summary:

During this quarter, there were sadly six deaths of adults with learning disabilities and no deaths of autistic patients at UHD. LeDeR notification referrals were completed for all cases to enable full LeDeR reviews. Of the six deaths, five were male and one female, occurring across the quarter as follows: three in April, one in May, and two in June.

Initial screening identified that, in some cases, a person’s learning disability had been cited as a reason for completing an Allow a Natural Death (AAND) form. In response, the Trust has introduced revised AAND forms that automatically flag any attempt to record a learning disability as justification for a DNACPR decision. Ongoing audit and monitoring will assess the impact of this change.

This quarter also marked the first Mortality Surveillance Group (MSG) report from the LeDeR group. It is anticipated that learning and actions arising from completed LeDeR reviews will be incorporated into future reports as the process becomes more embedded.

There remains some lack of clarity regarding roles and responsibilities within the new LeDeR process across UHD and NHS Dorset. A meeting has been scheduled to address these issues and to review compliance requirements.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 5 November 2025

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Finance and Performance Committee – Chair's Report
Presented by:	Sharath Ranjan, member of the Finance and Performance Committee
Agenda items discussed:	At its meeting held on 22 September 2025, the Committee received the following: • 2025/26 Financial Performance Month 5 including Board Assurance Framework and risks rated 12 and above • Efficiency Improvement Programme • Medium Term Capital Plan • New Hospitals Programme: Cashflow and Contract • Operational Performance including Board Assurance Framework and risks rated 12 and above • HealthSet Programme and EPR Stability • Sustainability: Climate Adaptation and Green Plan update • Housing Compliance • Car Parking Strategy • Estates Masterplan • Private Patients Strategy – Deep Dive and Exception Reporting • Risk Register: review of significant risks; new risks rated 12 and above
ALERT	There were no specific items to alert the board from this meeting. The meeting covered a broad range of strategic topics, including future planning and current financial performance. While the revenue and capital position shows cautious optimism, significant risks remained. Operational performance was strong, and sustainability continues to be a core focus
ASSURE	The Committee wishes to assure members of the Board that: • **Estates Masterplan** The committee noted the draft estates and the approach being taken. Feedback around highlighting patient voice and incorporating financial sustainability was acknowledged. The final plan will be brought back to the committee at a future date.

ADVISE	The Committee wishes to advise the Board that: • **Housing Compliance** The committee noted the proposed legislation changes through the Rental Reform Act and asked for assurance around the impact of the changes and plans to adapt to them. The committee also noted the low engagement compared to sector standards. • **Private Patients Strategy** The committee noted the current tendering process to identify a new joint venture partner. Considering the recent challenges related the formation of the wholly owned subsidiary, the committee stressed the need for an effective communications strategy to manage public and staff perceptions.
Review of Risks	The committee noted Risks rated 12 and above and discussed the impact of limited battery packs on theatre productivity in the event of a power failure. There were sufficient mitigations (11 additional packs have been purchased) currently in place with an acknowledgment of the significant future cost pressures for the UPS solutions.
Celebrating Outstanding	The Green Plan was discussed at this committee and praised as being an exemplar. Some outstanding work by Stuart Lane in developing this plan.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 5 November 2025

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Finance and Performance Committee – Chair's Report
Presented by:	Claire Whitaker, member of the Finance and Performance Committee.
Agenda items discussed:	At its meeting held on 20 October 2025, the Committee received the following: • 2025/26 Financial Performance Month 6 including Board Assurance Framework and risks rated 12 and above • Efficiency Improvement Programme • New Hospitals Programme: Cashflow and Contract • Operational Performance including Board Assurance Framework and risks rated 12 and above • HealthSet Programme and EPR Stability • Estates Compliance Report • New Hospitals Programme: Darwin Update • Sustainability – Green Plan • Risk Register: review of significant risks; new risks rated 12 and above In addition, the Committee received business cases and recommendation reports/briefings.
ALERT	There are no specific matters to alert the Board. The Committee discussed in detail the Trust and system wide financial position, including risks and mitigation. An update on the Trust's performance and New Hospital Programme were also received.
ASSURE	The Committee wishes to assure members of the Board that: • Financial Performance, EIP and forecast - The Committee received the month 6 financial report, detailing a £9.2 million deficit in line with the plan, efficiency delivery was ahead of target with ongoing risks and mitigation. • Green Plan - The Committee received the final Green Plan which sets out the climate adaptation as one of its goals. Members described the sustainability strategy as an exemplar. The Committee endorsed the Green Plan and recommended it to Board for approval. • HealthSet Programme and EPR Stability – The Committee received an update on the HealthSet programme and was assured that the essential systems review is going well.

ADVISE	The Committee wishes to advise the Board that: • Operational Performance – The Committee received the Integrated Performance Report in the new format.
Review of Risks	The Committee noted the risks rated 12 and above. The Committee was also informed about one new risk in relation to Parkinson's services. The mitigation has been considered and discussed by the Medical Care Group.
Celebrating Outstanding	The Committee would like to thank Richard Renaut and Stuart Lane for their outstanding work on the Green Plan.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 6.2.1

Subject:	Green Plan 2025
Prepared by:	Stuart Lane – Sustainability and Energy Manager
Presented by:	Richard Renaut – Chief Strategy & Transformation Officer

Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Decision/Approval
Executive Summary:	This paper presents the *Green Plan 2025 – Revised Edition*, setting out the Trust's updated Sustainable Development Strategy 2021–2026. The revised plan reflects national NHS priorities and includes progress made during 2025 across key areas such as travel, waste, and medicines. The *Green Plan 2025* strengthens UHD's ambition to deliver excellent healthcare for patients and communities while embedding sustainability at the heart of our operations. The update outlines progress against cornerstone targets including carbon reduction, clean air, staff engagement, sustainability goals, and adds a new one: climate adaptation.
Background:	The *Green Plan 2025 – Revised Edition* builds on the Trust's original strategy and reflects progress made to date across all key sustainability areas. It aligns with the NHS commitment to become a net zero health service and sets out UHD's approach to reducing carbon emissions, improving air quality, and strengthening climate adaptation. Further detail is provided in the full *Green Plan 2025* document.
Key Recommendations:	The Board is asked to **approve** the *Green Plan 2025 – Revised Edition* as the Trust's updated Sustainable Development Strategy.

	Next Steps: Implement the revised action plan across all sustainability workstreams. • Continue quarterly reporting through the Sustainability Steering Group and Finance & Performance Committee. • Provide annual progress updates to NHS England in line with Greener NHS reporting requirements.
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**
Finance & Performance Committee	20/10/2025	Endorsed and recommended to approve by the Board

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 ☐

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Green UHD Plan

2021-2026
Sustainable Development Strategy
2025 Revised Edition

Contents

Our Green UHD plan introduction

- Our Vision
- Our Mission
- Our Structure

Our Objectives

Our Cornerstone Targets

- **Target 01:** Carbon reduction
- **Target 02:** Staff Engagement
- **Target 03:** Clean air
- **Target 04:** Sustainability goals
- **Target 05:** Climate Adaptation

Our key Areas for Action

- Carbon and GHGs
- Social value
- Workforce and leadership
- Digital transformation
- Estates and facilities - utilities
- Supply chain procurement
- Sustainable models of care
- Travel and transportation
- Estates and facilities - waste
- Medicines
- Estates and facilities - capital projects
- Food and nutrition
- Climate adaptation
- Greenspace and biodiversity

Communicating and embedding the Strategy

Governance and reporting

What can you do to help

Annex: A, B

Our button links will allow you to navigate through the GUHD Plan quickly and easily.

Our Green UHD plan

Welcome to our Sustainable Development Strategy, which we call our Green UHD plan. As one of the largest organisations in our area, University Hospitals Dorset (UHD) has the ability and the duty to help build healthy lives, healthy communities and a healthy environment.

By having this sustainability and carbon reduction strategy at the heart of what we do, we can drive long-term success and real change. We have made significant progress in many areas, but we need to do much more. This Green UHD plan will guide the design and implementation of our future services at UHD as they are developed in line with the requirements of the Dorset Integrated Care System.

This Green Plan acts as our organisational strategy to ensure that we embed this ambition into every aspect of our activity, in tangible and measurable ways.

It is only by working together, using our Values of "Caring," "One Team" and "Always Improving" that we will succeed, we all have a role to play, so please do read our Green Plan and get involved.

Siobhan Harrington

Siobhan Harrington
Chief Executive Officer



Try using our progress bar you to navigate to important parts of the GUHD Plan quickly and easily.



Our Vision:

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

Advancing the Vision

The World Health Organisation (WHO) have stated that 'the climate crises is the single biggest health threat facing humanity'. The NHS recognises that our services must adapt to a changing climate and also ensure that our work respects and supports the natural world upon which we all depend.

That is why, at UHD, our stated mission is: "to provide excellent healthcare to our patients and wider community and be a great place to work, ***now and for future generations.***"

In 2021, UHD was one of the first NHS Trusts to publish a Green Plan aligning with the NHS dual 2040 and 2045 carbon targets. Since then, UHD has delivered an estates decarbonisation strategy setting out how we can reduce our building energy related carbon emissions. The Trust is now homing in on the technical and commercial solutions to deliver this strategy with strong indications that this will involve a geothermal heat network at the heart.

During 2025, the Trust has secured grant funding for fleet electric vehicle charging infrastructure. The Trust has been replacing fleet vehicles with zero carbon or ultra-low emission vehicles since 2023 and by 2027 all new vehicles will be electric. We continue to go further than legal or NHS requirements. For example, from 2023 we aligned the staff salary deduction car leasing scheme so that we are encouraging our staff to transition to electric and ultra-low emissions vehicles also.

Over the course of 2025, UHD also won over £3m in GB Energy grant funding for solar projects. By the start of 2026, the Trust Solar energy generation will reduce our carbon emissions by well over 400 tco2e per annum and save around £400k in electricity, allowing funds to go to front line services.

2025 has also seen the decommissioning of the Trust nitrous oxide manifolds as we implement more efficient delivery processes for this greenhouse gas. This follows earlier measure to eradicate the use of Desflurane, the most potent green-house gas used in anaesthetic procedures.

We continue to work closely in partnership with NHS Trusts in Dorset and have together successfully won funding for an NHS Ranger. Hosted by Dorset County Hospital, the ranger is working on a number of nature-based health and habitat projects on site and we plan to extend activity to University Hospitals Dorset by 2026.

Of course, we have been invested heavily in ensuring that our new buildings such as the Poole Theatre Block, the Dorset Pathology Hub and the Beach Building at the Royal Bournemouth Hospital site, all meet high standards of building design and energy efficiency.

We recognise that climate change is not just a possible future scenario, we are already experiencing the impacts as an organisation and must plan for more challenging climate scenarios. This is why we are working with NHS partners across Dorset and jointly investing in a comprehensive climate change risk assessment exercise and producing strategic action plan that will ensure the future resilience of our infrastructure and services. In recognition of the importance of this work, we have added Climate Adaptation as a cornerstone target in this revision of the Green Plan, replacing "Use of Resources". We continue to strive to be responsible with resources and have now secured the ambition of zero waste to landfill and 100% zero carbon energy.

Our 2025 revised edition Green Plan sets out ambitious targets which will continue to be turned into effective action by our dedicated team, ensuring UHD delivers against our mission ***now and for future generations.***



Stuart Lane

Sustainability and Carbon Manager UHD

Climate emergency *is a* health emergency



"Unabated it will disrupt care and affect patients and the public at every stage of our lives. With poor environmental health contributing to major diseases, including cardiac problems, asthma and cancer, our efforts must be accelerated."

Sir Simon Stevens, NHS Chief Executive
In office 1st April 2014 to 31st July 2021

Overview of Structure

Our Vision

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

Our Green Objectives

- Healthy Lives
- Healthy Community
- Healthy Environment

Cornerstone Targets

- **Net Core Carbon Footprint:** 80% target reduction by 2032 (in line with NHS Guidelines) Net Zero Carbon by 2040 **Carbon Footprint PLUS:** Net Zero Carbon by 2045
- Clean Air Hospital "Excellent" by 2026
- Comprehensive climate adaptation risk assessment and governance processes by 2027
- Sustainability Goal score - 100% by 2030
- Staff empowered and leading the changes

Areas of Activity

supported by the Corporate Approach

1. Carbon & GHGs
2. Social Value
3. Workforce & Leadership
4. Digital Transformation
5. Estates & Facilities
6. Supply Chain & Procurement
7. Sustainable Models of Care
8. Travel & Transportation
9. Medicines
10. Food & Nutrition
11. Climate Adaptation
12. Greenspace & Biodiversity

Sustainability actions, processes and projects tracked by NHS sustainability assessment tool and **UN Sustainable Development Goals.**

Our Objectives

Healthy Lives

Improving the health and wellbeing of our patients, our staff and our local community. This includes working with our partners to contribute towards better green healthcare approaches, pro-actively improving health and wellbeing of the local population, preventing ill health and health inequalities.

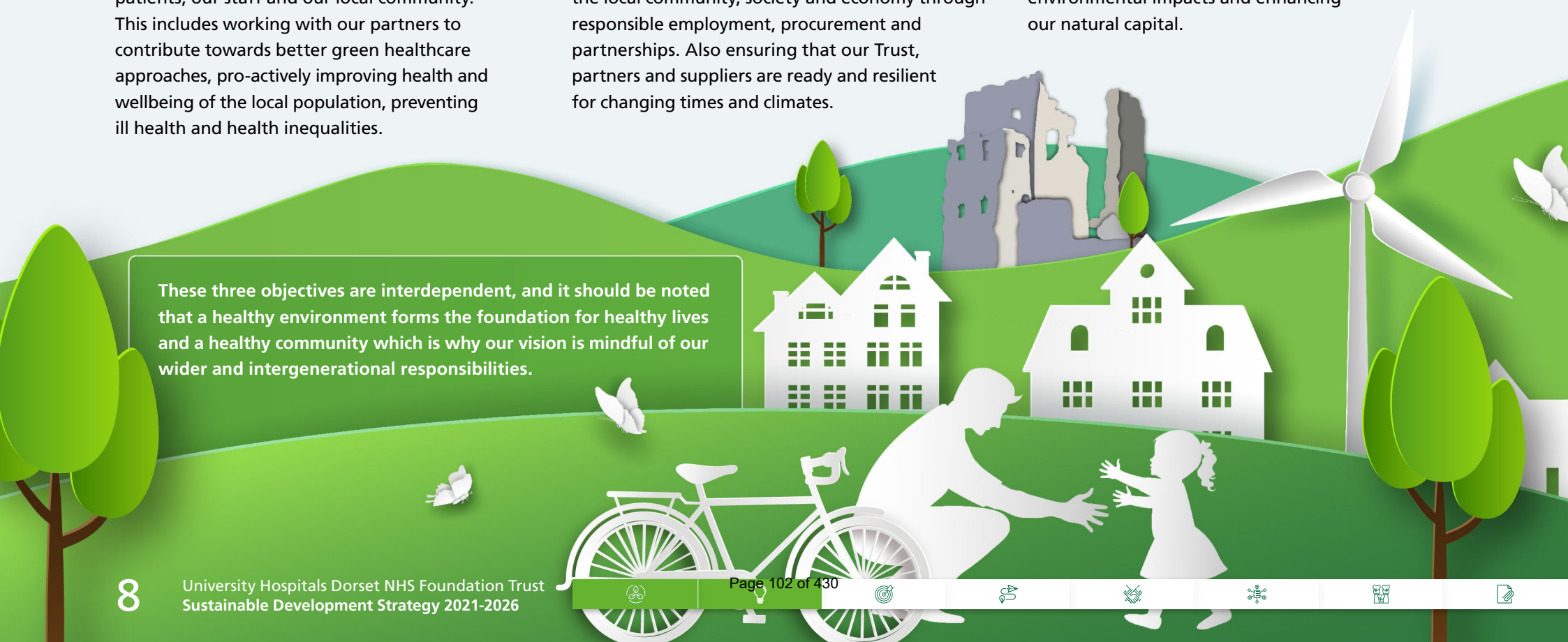
Healthy Community

Being a positive "Anchor Institution" by supporting the local community, society and economy through responsible employment, procurement and partnerships. Also ensuring that our Trust, partners and suppliers are ready and resilient for changing times and climates.

A Healthier Environment

Managing and reducing our negative environmental impacts and enhancing our natural capital.

These three objectives are interdependent, and it should be noted that a healthy environment forms the foundation for healthy lives and a healthy community which is why our vision is mindful of our wider and intergenerational responsibilities.



Our Objectives

In October 2020 the NHS adopted a plan to become the world's first net zero carbon National Health Service.

University Hospitals Dorset is one of the largest organisations in Dorset. Our hospital Trust has a significant economic, social and environmental impact. We spend over £600m per annum much of which goes directly or indirectly to local businesses, we employ over 9,000 local people.

As a result of our activity, we consume resources, generate substantial waste materials and are responsible for significant carbon emissions. In addition to these elements the travel and transport to deliver the materials we need and to move staff, patients and visitors impacts on local air quality.

In line with the NHS Long Term Plan and as an "anchor Institution" in Dorset we are committed to embedding sustainability across our own organisation and with partners, leading by example in our sector and improving the health and wellbeing of the communities we serve. We will collaborate with our healthcare partners and key stakeholders to ensure that our work is aligned to deliver a shared set of goals. Everyone has a part to play in delivering this plan and by working together, we will achieve more and deliver truly sustainable healthcare.



Cornerstone Targets

Net Core Carbon Footprint:
- 80% target reduction by 2032
- Net Zero Carbon by 2040

Carbon Footprint PLUS:
Net Zero Carbon by 2045

Clean Air Hospital Framework implemented by 2026

Sustainability Assessment score of 100% by 2030

Staff empowered and leading the changes

Climate Resilient:
- Comprehensive Climate Adaptation Risk Assessment by 2027
- Climate adaptation governance processes in place 2027



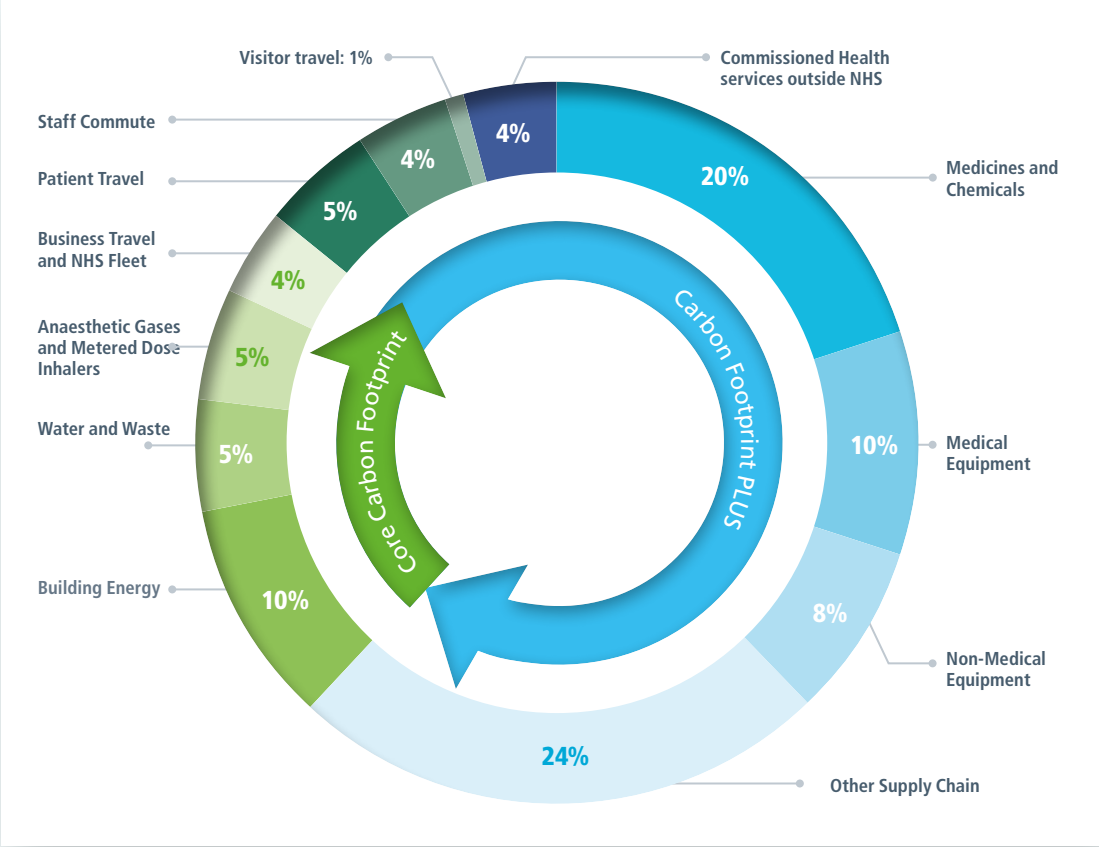
Target 1:
Carbon reduction

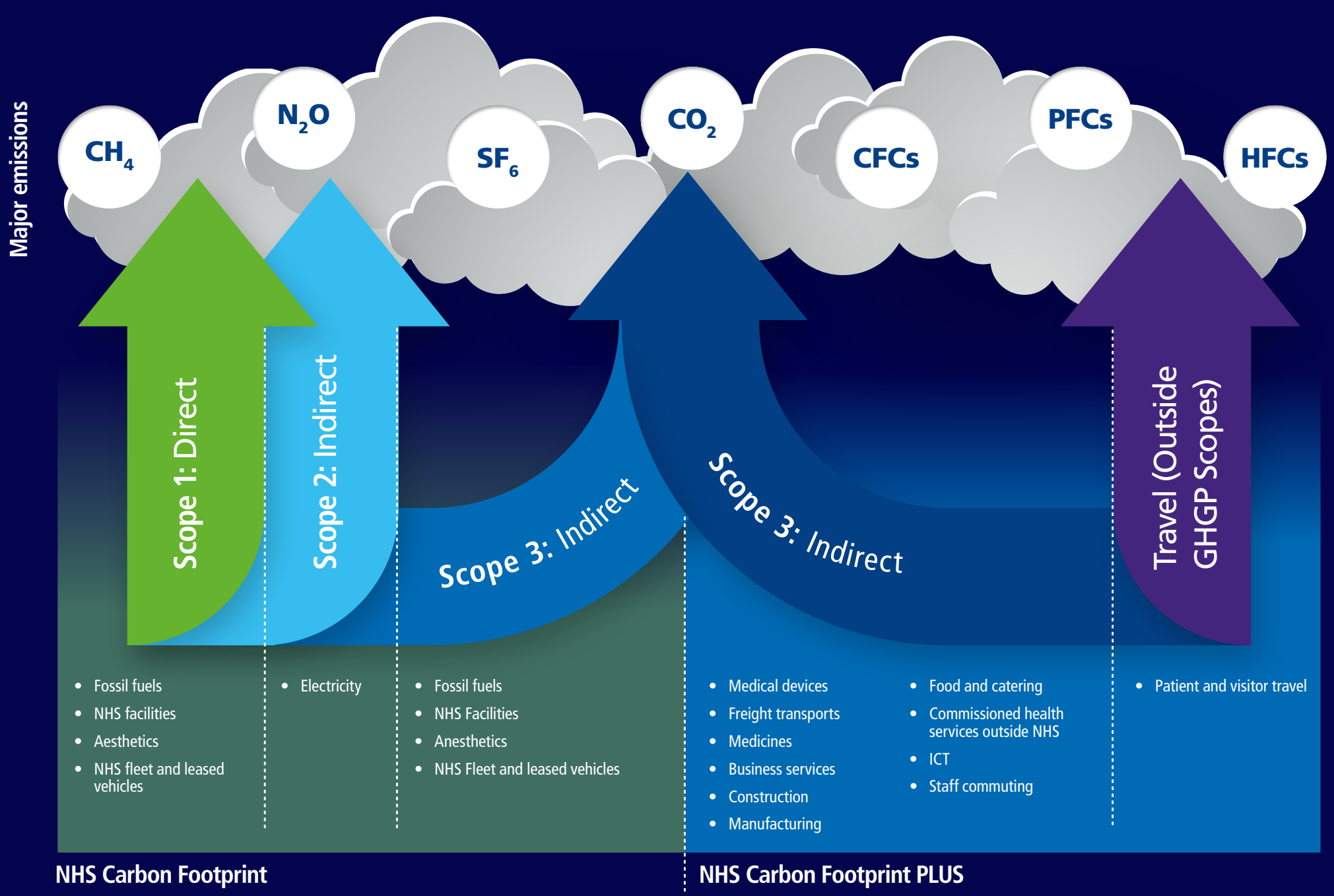
The diagram shows the elements that make up the NHS carbon emissions – the carbon "footprint". "NHS Core Carbon Footprint" (shown by the green arrow) includes carbon emissions that are directly produced through the use of building energy, water, waste processes, anaesthetics and inhalers and business travel. "The NHS Footprint PLUS" (shown by the blue arrow) includes the other emissions associated with products and services that we purchase."

In line with the NHS commitment to become the world's first Net Zero Carbon National Health Service, UHD is committed to the following carbon targets:

Core Carbon Footprint:
- 80% target reduction by 2032
- Net Zero Carbon by 2040

Carbon Footprint PLUS:
Net Zero Carbon by 2045



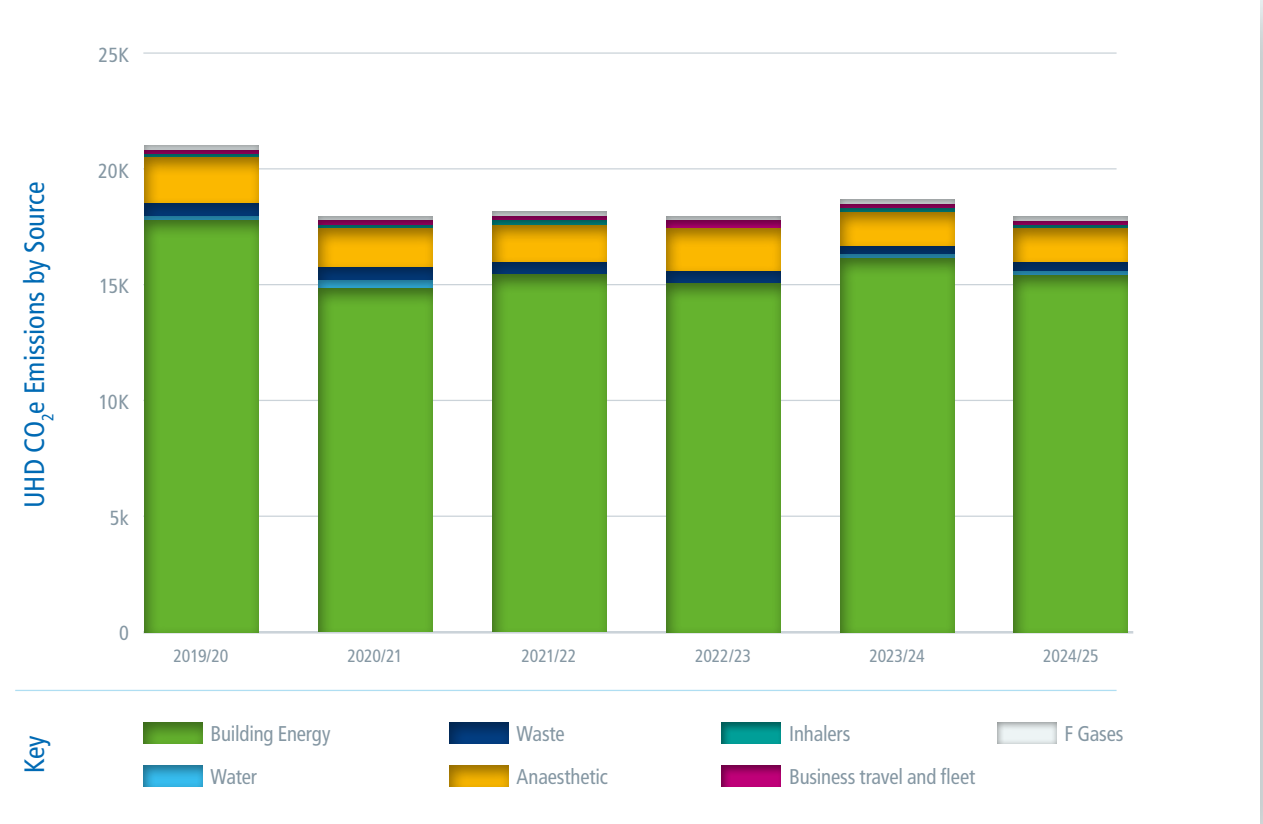

Major emissions
CH_4
N_2O
SF_6
CO_2
CFCs
PFCs
HFCs
Scope 1: Direct
Scope 2: Indirect
Scope 3: Indirect
Scope 3: Indirect
Travel (Outside GHGP Scopes)
Fossil fuels
NHS facilities
Aesthetics
NHS fleet and leased vehicles
Electricity
Fossil fuels
NHS Facilities
Anesthetics
NHS Fleet and leased vehicles
Medical devices
Freight transports
Medicines
Business services
Construction
Manufacturing
Food and catering
Commissioned health services outside NHS
ICT
Staff commuting
Patient and visitor travel
NHS Carbon Footprint
NHS Carbon Footprint PLUS

Progress so far:
Core Carbon Emissions

We strive to keep improving our understanding and assessment of trust carbon emissions.

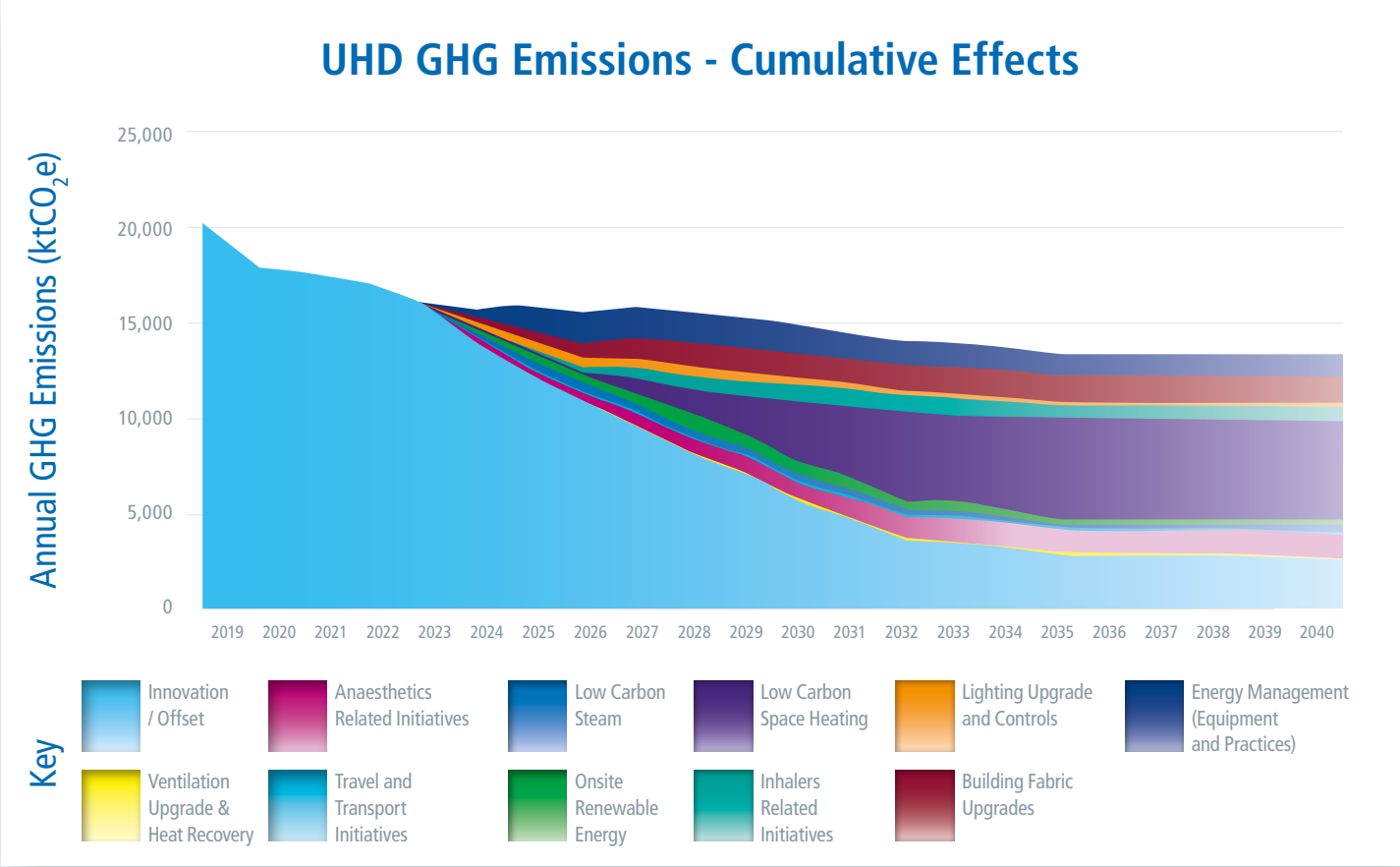
We have improved accuracy of data capture and prudently now include the carbon emissions relating to heated water supplied to the Royal Bournemouth Hospital. Revised calculations for 2019/20 add 4,200 tonnes to previously reported figures. This increase is now back-cast through to 2009/2010 - our baseline year providing a baseline of 30,500 tonnes CO_2e Core emissions.

Since 2019/20, the Trust has reduced core emissions to approximately 18,000 tCO2e. This represents a 41% reduction, about halfway towards our 80% target reduction by 2032. The next part of this journey will see a period of growth in emissions as our estate continues to grow, followed by a steep reduction in emissions as new heating systems come online.



The Challenge Ahead:
Core Carbon Emissions

The 'waterfall' diagram shows how the trust can decarbonise through various measures that have been identified within the trust decarbonisation strategy. The individual and cumulative impacts of these measures is laid out on a projected timeline.

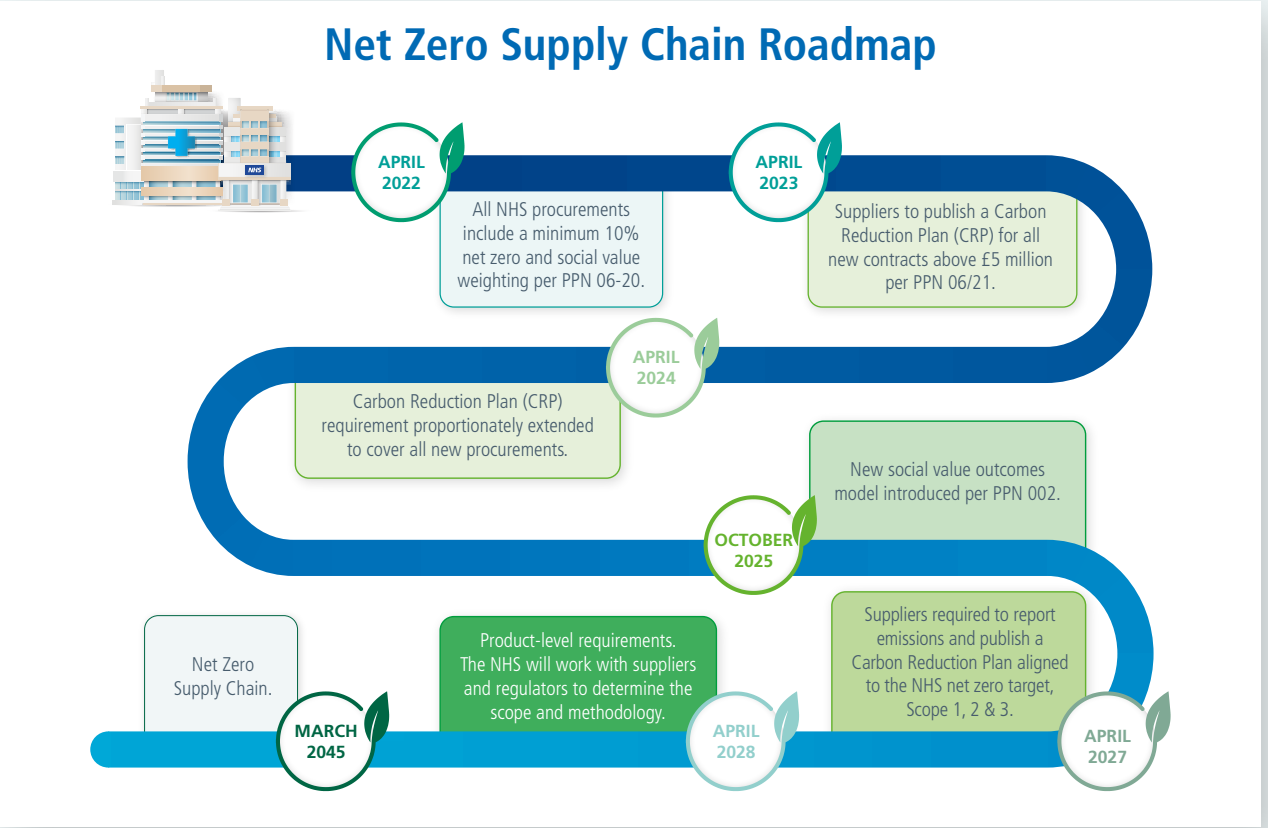


The Challenge Ahead:
Carbon Footprint Plus Emissions

Assessing and decarbonising NHS supply chain emissions is a complex undertaking The NHS is working step by step to both reduce emissions and the robustness of emission measurement and reporting.

During 2022/23, the central Greener NHS team carried out a nation-wide carbon footprinting assessment of NHS 2019/20 footprint plus emissions. This assessment provided disaggregated emissions down to trust level, providing UHD with the most comprehensive data to date for the trust footprint plus emissions.

UHD's Footprint Plus was 104,000 tonnes CO_2e for 2019/20. In collaboration with NHS-E and our suppliers, the trust must reduce this total by an average of 4200 tonnes each year to reach net zero by 2045.



Target 2:
Staff Engagement

Our ability to deliver on this ambitious Green Plan will be dependent upon the all parts of the organisation pulling together as one team. Whilst the sustainability steering group and committee will have co-ordination and assurance roles, it will be the actions of our thousands of staff members that will make the plan real. The role of our leaders in role modelling will be crucial.

The Trust will be supporting staff by setting expectations in staff inductions, including sustainability within all staff contracts and delivering Trust wide training. There will be additional support for specific roles such as our sustainability leaders and quality improvement team to enable them to help further embed sustainability as the business as usual approach for everything we do.

In addition the Trust will invest in sustainability programs to pull upon learning from outside of the organisation to inspire and offer new ways of working.

- **The Green Plan objectives are to be maintained as core Trust objectives and staff be will be appraised against these objectives.**
- **All staff have access to online sustainability training. 90% staff trained by 2027%.**
- **All sustainability leaders and QI staff to have undergone Sus QI training by 2026.**



Target 3:
Clean air



As a healthcare provider dealing with the ill-effects of air pollution, UHD has a duty to play its part in reducing levels of harmful pollutants such as nitrogen oxides (NOx), carbon monoxide (CO) and particulate matter (PM) in our atmosphere. A majority of the UK's greenhouse gas emissions is now caused by road transport.

As one of the largest employers and healthcare providers in the Bournemouth Christchurch and Poole area, emissions caused by staff and patient transport will account for a significant proportion of air pollution in the local vicinity.

UHD recognises that road transport is not the only contributor to air pollution across its sites. UHD's hospitals feature on-site incineration, generator exhaust, and some hazardous gases from clinical activity, all of which generate emissions to the atmosphere.

This green plan commits UHD to measuring the level of air pollutants in the atmosphere at The Royal Bournemouth Hospital, Christchurch Hospital and Poole Hospital sites on an annual basis and work with key strategic partners including Bournemouth University and BCP Council to achieve the mutual aims of reducing air pollution across the conurbation.

Clean Air Hospital Framework implemented by 2026.

Target 4:
Sustainability goals

The NHS has developed a sustainability assessment tool to track progress against approximately 300 sustainability measures which are mapped against the United Nation's 17 Sustainable Development Goals (2015-2030).

The Trust commits to making year on year improvements in score against the NHS Sustainability Assessment Tool and to achieve 100% rating by 2030.

The scope of work to achieve this target is extensive and will require considerable team efforts across our organisation in collaboration with partners and suppliers.



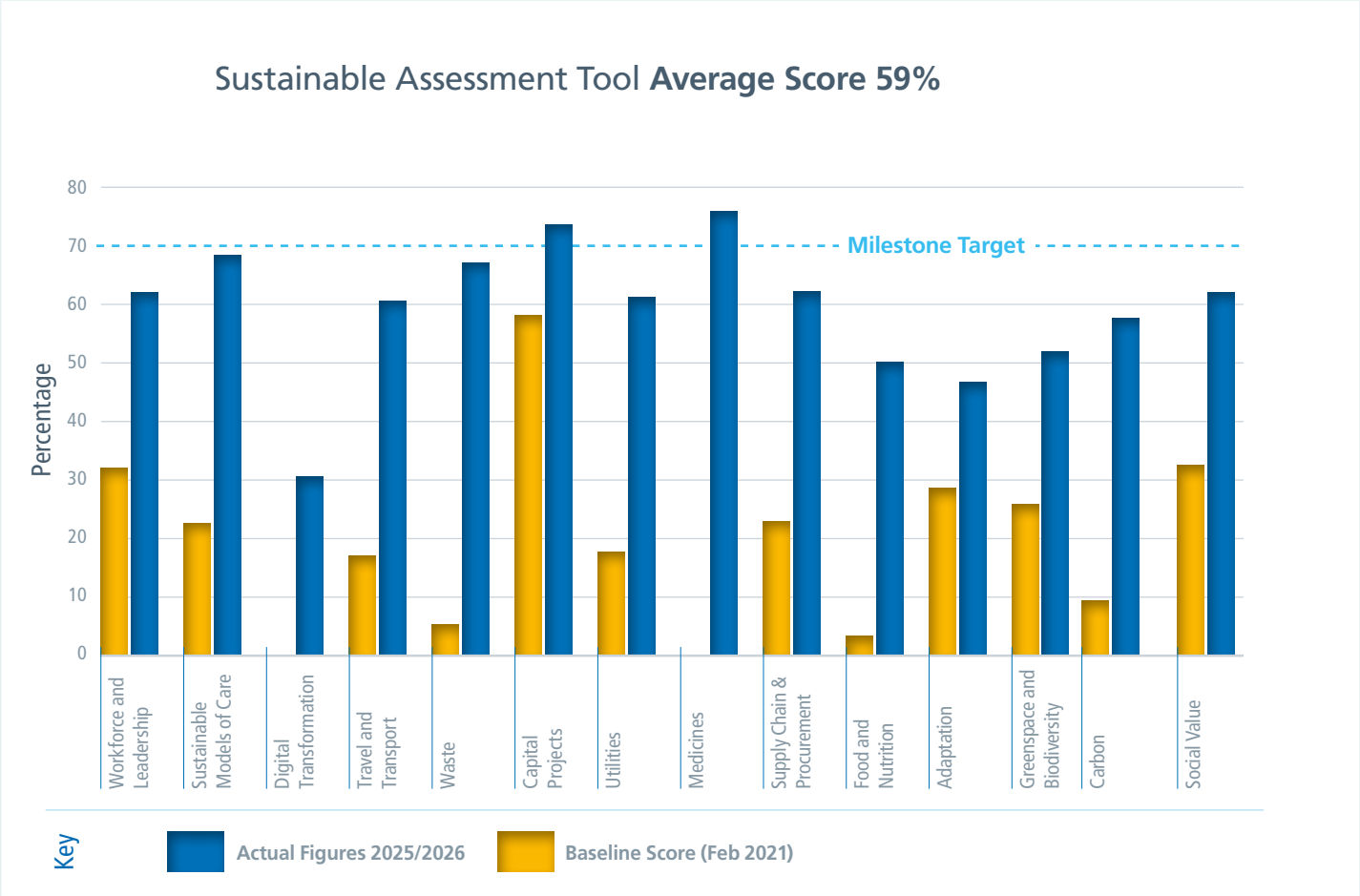
Sustainability Goals

We will measure our progress on sustainable development through the use of a revised version of the NHS Sustainability Assessment Tool - SDAT2.

Our baseline assessment for the trust was conducted in February 2021 and produced an average score of 20%*. As of 2025, across all activity streams, we have an average SDAT2 score of 59% and continue to push towards our 70% 2026 target and 100% 2030 target.

We have since added over 160 requirements and new distinct area of activity to the SDAT model and renamed it SDAT2. These changes required a new baseline.

As of 2025, across all activity streams, we have an average SDAT2 score of 59% and continue to push towards our 70% 2026 target and 100% 2030 target.



*baseline adjusted for transition from SDAT1 to SDAT2

Target 5 : Climate Adaptation

- Climate adaptation training for key stakeholders 2026–2027
- Climate adaptation workshops to gather risks 2026–2027
- Comprehensive climate adaptation risk assessment 2026–2027
- Climate adaptation governance processes in place 2026–2027
- Climate Adaptation Plan 2026–2027



Key Areas for Action:
Green Plan

Meeting our targets requires sustained effort across the organisation and with partners, over multiple years. To reflect this and to organise our activities, we have created 12 "Areas of Action". The Estates and Facilities action area has been further subdivided into Utilities, Waste and Capital Projects giving 14 sub Areas of Activity. Each of the 14 sub areas has an appointed sustainability lead that will report on progress to the Finance Performance Committee quarterly through the Sustainability Steering Group.

The Carbon and Social Value activity areas provide a way to collate and report on the cross threading activity mainly being actioned across other areas of activity. Progress is monitored using SMART targets captured within SDAT2. These will be reviewed and revised regularly.

The next part of the Green Plan dedicates a page to each area of activity and describes what we want to achieve, how we wish to achieve it and how we will measure this.

- Carbon and GHGs
- Social Value
- Workforce and Leadership
- Estates and Facilities - Utilities
- Digital Transformation
- Supply Chain and Procurement
- Sustainable Models of Care
- Estates and Facilities - Waste
- Travel and Transportation
- Medicines
- Estates and Facilities - Capital Projects
- Climate Adaptation
- Food and Nutrition
- Greenspace and Biodiversity

Carbon and Greenhouse Gases

What do we want to achieve?

- Measure our carbon emissions, identify hotspots and take targeted action to reduce emissions year-on-year in line with our Net Zero Carbon targets.
- **Core Carbon Footprint target** - Net Zero Carbon by 2040, 80% target from 2030 to 2032.
- **Carbon Footprint PLUS target** - Net Zero Carbon by 2045 and 80% reduction by 2040 against 1990 baseline.

How can we achieve it?

- Board level commitment to the Green Plan strategy with Trust wide contribution to the identified priority activities.
- Develop Carbon reduction plan with RIBA stage 3 including design and costings and deliverability to enable prioritisation decisions.
- Calculate and report core carbon emissions, targeting hotspots and horizon scanning opportunities.
- Develop methodologies to measure Scope 3 emissions and improve methodology for calculations of Carbon Footprint PLUS.
- Engage with staff, suppliers and partners such as BCP Council and BU to reduce our carbon footprint.
- Work with our Dorset system partners and contribute to the system- wide strategies consultations and initiatives for carbon measurement and reduction.

How will we measure it?

- Drivers of core carbon footprint to be monitored via embedded processes as per ERIC and the Trust annual report.
- Scope 3 emissions to be monitored via spend based analysis.
- Track metrics that help identify factors that influence carbon emissions e.g. CO_2 per patient CO_2 per m² Gross Internal Area
- Track the consumption of anaesthetic gases and refrigerant gases.
- Enhance carbon analysis with national tools and factors supported by third party consultancy where appropriate.
- Carbon reduction Plan.

l Social Value

What do we want to achieve?

- Positively contribute to BCP and the wider area in ways that go beyond the direct delivery of healthcare. UHD seeks to invest into out local community, having a broad impact on the wider factors that influence health and wellbeing.

How can we achieve it?

- Procuring goods and services in ways that support social benefit including local inclusive growth and reduced inequalities.
- Managing our land and buildings for social, environmental and economic benefit.
- Widening access for local people to quality work and training.
- Mitigating against and adapting to the impacts of climate change.
- Working with partners towards the commitments laid out under the Dorset Anchor Institutions Charter.
- Employ software systems to better capture and report on social value.

How will we measure it?

- Monitor the application of 10% or greater weighting for social value in tenders
- Track the number of apprentices, work placements and volunteers employed.
- Employ the Evergreen system to monitor social value relating to supplier contracts.

UHD's Workforce and Leadership

What do we want to achieve?

Ensure sustainability is embedded within organisational decision making:

- Deliver, monitor and report on sustainability progress.
- Senior staff, stakeholders and governors are engaged in, and accountable for, delivering our Green Plan.
- Strategies, policies, procedures, business cases and processes always have a meaningful sustainability impact assessment section.
- Staff are supported and empowered to improve sustainability at work and home.
- Staff engaged and enabled to adopt sustainable practices and to take ownership within their own areas of influence.
- Responsible anchor institution showing sustainability leadership and a positive impact for our communities.

How can we achieve it?

- Maintain an ambitious strategy – the UHD Green Plan underpinned with up to date activity plans with SMART targets and supporting policies as required.
- Report performance quarterly to the sustainability steering group and finance performance committee plus via the trust annual accounts.
- Support NHS Supply Chain and Regional Procurement initiatives to develop and deliver sustainable procurement.
- Play an active role as an Anchor Institution in Dorset, creating opportunities for local communities to become more sustainable.
- Incorporate the Green Plan into the Trust annual objectives.
- Expand participation in staff sustainability programmes and awards, main-streaming a sustainability mind-set and recognising good practise.

How will we measure it?

- NHS Sustainability Assessment Tool score in line with target of 70% by 2026.
- Number of policies and business cases including a sustainability impact assessment.
- Number of staff registered with EcoEarn staff sustainability platform.
- No of staff that have undertaken sustainability training including sustainability induction for new staff.
- Number of apprentices, work placements and volunteers employed.
- Clear, measurable targets in annual care group and corporate operating plans, and in senior leaders objectives.
- Carry out annual sustainability surveys to measure staff awareness levels.

Digital Transformation

What do we want to achieve?

- Digitally enabled care models that will improve efficiency and effectiveness of our operations.
- Digitally enabled care models that significantly reduce travel and journeys with care closer to home being delivered through remote consultations and monitoring
- Reduce the environmental impacts from IT related activity such as carbon emissions due to energy consumed by IT systems and services.

How can we achieve it?

- Embrace new and existing digital technologies to reduce the environmental impact of care eg cloud first, automation and AI.
- Apply 'What Good Looks Like' for low carbon digital care, across the system – Louisa Way – Chief Information Nursing Office (CINO).
- Apply a 5 year hardware refresh plan, updating to new efficient equipment.
- Support front-line digitisation of clinical records, clinical and operational workflow and communications, aided by digital messaging and electronic health and care record systems.
- Support working from home.
- Ensure IT service providers minimise their environmental impact using procurement levers and contract management KPIs.

How will we measure it?

- Carbon emissions from IT devices measured via dedicated software tools.
- Proportion of retired PC's and Laptops sent for resale & Recycling.
- Proportion of retired Hard disks and solid state drives recycled.
- Total number and proportion of virtual and remote consultations.
- Total number and proportion of staff homeworking.

Estate and Facilities - Utilities

What do we want to achieve?

Derive 100% of our energy from net zero carbon sources, embed energy and water efficient technologies and practices throughout our Estate and services and deliver year-on-year efficiencies in consumption:

- Accurately measure utilities and reduce consumption to make sure we're getting the best value for money and minimising environmental impact.
- Embed more efficient practices, new technologies and improve staff awareness to improve utility efficiency across everyday activities and as part of longer-term plans.
- Inform and educate staff, patients and visitors about how their actions affect energy and water consumption.
- Strategies, policies, procedures, business cases and processes always have a meaningful sustainability impact assessment section.

How can we achieve it?

- Improve metering, measurement and monitoring systems including updating BMS systems and adopting a Trust wide Energy Management System.
- Deliver a programme of targeted energy and water efficiency schemes to manage and drive down use.
- Work collaboratively with community partners to maximise the use of built assets and grounds including exploration of geothermal potential.
- Assess lifecycle costs of energy and water usage when purchasing new equipment and use this as a criteria in decision-making.
- Develop a Trust wide estates decarbonisation plan demonstrating timelines to achieve Net Zero Carbon and a business case for the required solutions to deliver the carbon savings.

How will we measure it?

- Annual ERIC return and model hospital metrics.
- Monitor monthly utility consumption and cost at a suitably granular level e.g. building, department, service or device.
- Percentage of energy from renewable sources.
- Amount of on-site renewable energy generation.
- Monitor energy saved through efficiency measures to ensure that performance is in line with the agreed plan.

Supply Chain and Procurement

What do we want to achieve?

- Meet national legal and regulatory requirements such as NHS Standard Contract and Net Zero Procurement Roadmap.
- Pro-actively support sustainable models such as the circular economy approach.
- Minimise unnecessary procurement and resource use.
- Re-use of materials and items where appropriate.
- A sustainable procurement culture and processes that shift consumption to sustainable products and services and considers broad criteria including materials, workforce, manufacturing processes, transport and social value.

How can we achieve it?

- Replace single use products with reusable alternatives where there is a viable, more sustainable option e.g. re-usable sharps bins.
- Promote a culture of reuse and refurbishment of items.
- Deliver / attend sustainability and social value training for procurement teams.
- Work with organisations innovating new sustainable approaches.
- Include sustainability criteria in procurement, tender evaluations, framework design and selection, and product selection, in line with PPN 06/20.
- Adopt the NHS plastics pledge.
- Work with NHS, partners and suppliers to better understand supply chain scope 3 emissions.
- Embed a Sustainable Quality Improvement approach.
- Develop scope 3 carbon foot-printing process.
- Assess the use of Evergreen system to support trust green plan objectives.

How will we measure it?

- Track the positive carbon and other environmental impacts from procurement initiatives e.g. introduction of reusable materials.
- Tracking departmental level requisitions of single use 'hotspot' materials.
- % of contracts awarded to suppliers with a carbon reduction plan (CRP).
- Reporting by exception any procurements awarded without min 10% social value weighting.

Sustainable Care Models

What do we want to achieve?

- Deliver the best quality of care while being mindful of its social, environmental and financial impact and take a whole systems approach to the way it is delivered.
- Improve the environmental sustainability of care pathways, and better integrate healthcare services to improve efficiency.
- Work with partners and stakeholders to identify and deliver solutions that reduce the number of hospital visits, such as the provision of treatment closer to or within home.

How can we achieve it?

- Identify carbon hotspots such as medical equipment and pharmaceuticals and ensure that action plans identify and mitigate environmental impacts.
- Reduce carbon emissions associated with areas of high impact by educating staff and encouraging lower impact alternatives.
- Work with partner organisations to support vulnerable patients upon discharge such as improving home energy efficiency.
- Pilot the redesign of selected care pathways to drive out any unnecessary stages or low value adding activities.
- Increase digital and other options for outpatient and other stages of care.
- Mainstream Sustainable Quality Improvement methodology through training.
- Facilitate virtual and telephone patients consultations in line with sustainable care pathways.

How will we measure it?

- Feedback relating to the care environment (e.g. temperature, light, services using PLACE surveys).
- The number of sustainable quality improvement projects.
- Model Hospital metrics such as weight activity units to monitor impacts from interventions at procedure, department, site and trust level.
- Reduction in onsite outpatient follow ups.
- Number or % of medical devices reduced or recycled.

Travel and Transportation

What do we want to achieve?

- Minimise the environmental and health impacts associated with the movement of goods and people through Trust activity.
- Increase use of sustainable and active modes of travel that deliver environmental and health benefits.
- Decarbonise the travel and transport relating to our operational activity.
- Prepare for and implement the opportunities from planned major service changes.

How can we achieve it?

- Facilitate active and sustainable travel options for staff, patients and visitors.
- Work with our strategic partners to reducing congestion and improving air quality.
- Better capture of travel related data through systems and surveys.
- Increase take-up of the Trust's cycle to work scheme, car sharing scheme and discounted bus fares.
- Consider travel options and impacts when planning changes to our services.
- Develop our electric vehicle fleet.
- Become a Clean Air Hospital.
- Become an accredited "Cycle Friendly employer".

How will we measure it?

- Staff and patient travel surveys to assist with travel data gathering for snapshots and trends.

Maintain a suite of key performance indicators, including:

- Reduction of single occupancy vehicle use by 2% per year and 10% by 2028
- Increase awareness of travel schemes by 10% from baseline and a minimum of 50% total awareness.
- Number of electric vehicles charging points per site.
- Air pollution monitors on each major site.
- Accurate recording of fleet mileage, fuel consumption and CO_2e emissions
- Accurate recording staff business travel mileage fuel consumption and CO_2e emissions.
- Ratio of cycle storage and changing facilities to staff number.

Estates and Facilities - Waste

What do we want to achieve?

- Meet legal responsibilities for waste.
- Optimise waste processes against the waste hierarchy.
- Widespread correct application of Trust sustainable waste policies and procedures.
- Apply best practise and seek to innovate to reduce waste and reduce the impacts from waste including carbon emissions.

How can we achieve it?

- Update the Trust Waste Management Strategy and Plan.
- Replace single use products with reusable alternatives where there is a viable, more sustainable option e.g. re-usable sharps bins.
- Promote a culture of reuse and refurbishment of items.
- Regularly audit waste and follow up on issues identified.
- Develop and implement e-learning modules for waste and sustainability.
- Work with organisations innovating new sustainable approaches.
- Drive out single use plastic waste where possible.
- Work with NHS, partners and suppliers to better understand and manage supply chain scope 3 emissions.

How will we measure it?

- Volume of waste for each stream.
- Monitor and manage proportion of waste being recycled.
- Monitor and manage proportion of clinical waste being segregated to meet NHS Waste Strategy 20:20:60 target by 2026/27.
- Quantity of packaging and single use plastics reduced or removed from services.
- Track the Carbon impact from waste and supply chain initiatives.

Sustainable Medicines

What do we want to achieve?

- Sustainability lens applied to medicines use in line with national best practice & contractual requirements.
- Reduce use of single use plastics in medicines distribution.
- Ensure medicines are specifically considered within the wider climate change adaption plan.
- Reduction of environmental impact of medicines prescribed by UHD NHS Trust (carbon footprint and ecotoxicology).

How can we achieve it?

- Appointment of Trust medicines sustainability lead.
- Annual action plan review for NHS Standard Contract, NHS-E updates and Dorset Green Plan.
- Replace use of single use plastic bags.
- Review Trust policy on medicines management during heat-waves & develop Trust policy on medicines most likely to aggravate heat-related illnesses.
- Support appropriate inclusion of non-pharmacological health interventions and medication cessation recommendations in Trust clinical guidelines.
- Inclusion of carbon-footprint and ecotoxicology risk assessments in formulary proposal form.
- Use Dorset Green Respiratory Care guidance to reduce the environmental impact of inhaler therapy.
- Cessation of Desflurane use by March 2024.
- Establish Nitrous Oxide waste minimisation programme and review of volatile anaesthetic gas emission reduction options.
- Educate staff/patients on sustainable medicines use and disposal.

How will we measure it?

This will be monitored through a suite of medicines specific sustainability dashboard of Key Performance Indicators, to include:

- Monthly consumption of all anaesthetic gases by type.
- Quantity of salbutamol pressurised metered dose inhalers issued (by brand / CO_2e profile)
- Nitrous oxide consumption per birth (home and within maternity unit).
- Monthly quantity of single use plastic bags purchased by pharmacy.

Estate and Facilities - Capital Projects

What do we want to achieve?

The trust has a major phase of building projects through to 2027 and we want to reduce the environmental impact of these building works during the design, refurbishment, construction, operation and decommissioning stages.

- Embed sustainability and efficiency using smart design and emerging technologies across our improvement works, including refurbishment and new build.
- Take a whole life cycle approach to projects by scrutinising sustainability in design, construction, commissioning, operation and decommissioning, helping to future-proof our organisation.

How can we achieve it?

- Include Sustainability Impact Assessments as a decision factor in all capital business cases.
- Develop sustainability guidelines for all capital projects, including major refurbishments, driving resource efficiency through the estates strategy and standard specification.
- Establish a process for the reuse of suitable furniture and equipment.
- Work with consultants and contractors to take a whole life costing approach to new building design and refurbishment to minimise in-use energy and water consumption.
- Give weighting to social value outcomes through procurement processes, including the support of local suppliers and SMEs.

How will we measure it?

- Energy and water consumption, both design and in-use performance (including soft landings).
- Achieve a rating of BREEAM “Very Good“ or higher for major capital projects that are underway and refurbishment projects.
- Achieve NHS Net Zero Carbon Building standard for future major estates projects.

Food and Nutrition

What do we want to achieve?

- Optimise the economic, social and environmental impacts that result from trust activities in relation to food and nutrition.
- Meet the sustainability and wider standards set out in the National Standards for Healthcare Food and Drink.

How can we achieve it?

- Use respected accreditation systems to evaluate triple bottom line performance.
- Reduce food waste using industry best practice methods.
- Maintain prohibition of single use plastic cutlery, plates and cups.
- Replace other single use plastics items with suitable more sustainable alternatives.
- Review and adapt menus for lower carbon options.

How will we measure it?

- Attain the Soil Association - Food for Life 'Silver' accreditation across UHD.
- Monitor against food waste reduction targets set using WRAP food waste reduction roadmap toolkit.
- Assess food and drink services against the GB food and catering services GBS standards – chapter 7 Going Green checklist.
- Report on procurement for catering to monitor single use plastics and high carbon ingredients.

Climate Change Adaptation

What do we want to achieve?

Ensure our whole organisation is prepared to deal with the effects of climate change, particularly extreme weather events such as heat waves and flooding, and continues to invest in adaptation and mitigation measures:

- Assess the impacts of climate change and adapt to mitigate the negative effects of past and future climate-altering actions.
- Reduce the impact on public health from climate change.
- Ensure our infrastructure, services, procurement, local communities and colleagues are prepared for the impacts of climate change.

How can we achieve it?

- Nominate an adaptation lead and incorporate adaptation into our sustainability governance structure, corporate risk register and reporting processes.
- Work with Dorset NHS partners to implement a comprehensive Climate Adaptation programme in line with the Climate Adaptation Framework for NHS organisations in England.
- Update our Trust climate change adaption risk assessment.
- Ensure that our emergency plans for extreme weather, consider support for vulnerable communities during any extreme weather events.

How will we measure it?

- BREEAM Building Standard or other sustainable buildings methodology scores.
- Monitor and report the progress of our Climate Change Adaptation Plan.
- The overall risk rating in our climate change risk assessment.
- Testing of emergency planning policies.

Greenspace and Biodiversity

What do we want to achieve?

- Maintain and improve our green spaces and biodiversity on-site.
- Help improve the physical and mental wellbeing of staff, patients and the wider community through access to green space, biodiversity and interactions with nature.
- Help to mitigate climate change and biodiversity loss through our biodiversity strategy.

How can we achieve it?

- Develop a biodiversity and greenspace strategy that encompass the challenges and opportunities across our Estate.
- Produce a biodiversity and greenspace action plan that details actions and those responsible for maintaining our green spaces.
- Leverage our successful grant funded Nature Ranger post to deliver Nature based Health and Habitat projects across our Estates and seek to expand the number of rangers.
- Ensure tight integration of biodiversity and greenspace plan with capital projects policy to underpin the approach for major new works and refurbishments.
- Repurpose unused areas with a focus on improving green space.
- Work with staff, local community organisations and strategic partners to enable increased access to green space and nature both on-site and traveling to and from site.

How will we measure it?

- NHS Sustainability Assessment Tool score for Greenspace and biodiversity section.
- Green Flag certification.
- Habitat and biodiversity site surveys.
- Progress against delivery of biodiversity and greenspace action plan.
- Assessment of staff and patient use of and interaction with greenspace via staff surveys.

Shout it from the cliff top:
Communicating our strategy



Communicating and embedding the Strategy

To help drive change across the whole organisation, we will take a considered, structured and engaging approach to disseminating the strategy and embedding our approach to sustainability.

A communication plan for the strategy will be developed that shows what we are doing both within and outside of the organisation, highlight key priorities and show excellence in sustainable development leading others to join us in making improvements. We will employ some key themes:

- **Collaboration:** leading on more joined-up-thinking as well as creating stronger links with the communities we serve.
- **Development:** showcasing sustainability initiatives for staff as well as opportunities to work outside the parameters of core roles.
- **Progress:** highlighting visible progress in delivering sustainability across the 10 areas of action.

Use of media

- Dedicated sustainability portal on both the UHD website and staff intranet.
- Regular articles in UHD staff bulletin and other corporate publications.
- Share positive progress on sustainability matters with our staff, our partners and the wider community.
- Promote progress against our Green Plan and wider sustainability matters across UHD's social media platforms and EcoEarn.

Engagement campaigns

- Embedding sustainability in decision making from individual actions to major projects e.g. EcoEarn, e-learning, induction, local champions.
- Reinforce engagement in the Green Plan through involvement in local and national sustainability campaigns and encourage staff to get involved e.g. NHS Sustainability Day.
- Make best use of corporate open days and community events.

Awards and rewards

- Apply for national sustainability awards.
- Run annual sustainability awards to recognise the most environmentally and socially sustainable team/department e.g. Sus QI Awards and EcoEarn.
- Recognise and celebrate progress against the targets in this plan.

Governance and reporting

Clear leadership is vital to ensure we successfully deliver the commitments in this strategy. Our sustainable development policy sets out governance arrangements.

As this strategy is broad and encompasses a wide range of work areas, there are other detailed documents that underpin our approach. Some of these have already been developed, such as the UHD Green Travel Plan, and some will be developed or revised in the future, such as a Greenspace and Biodiversity Strategy, Waste Management Plan, Climate Change Adaptation Plan, Estates Strategy, Estates Standard Specification and the sustainability section of the Care Group Operating Plans.

Clear reporting is required to monitor progress and ensure delivery is on track:

NHS Sustainable Assessment Tool: This will measure our qualitative progress on sustainability for the previous year, inform plans for the coming year, and will enable comparative performance against similar Trusts.

Clean Air Hospital framework: This will measure our qualitative progress on air quality for the previous year, inform plans for the coming year, and will enable comparative performance against similar Trusts.

Trust Annual Report Sustainability section: This reports progress against the Green Plan and provides highlights of the main activities delivered throughout the year.

ERIC (Estates Return Information Collection): A mandatory data collection for all NHS Trusts required by the Department of Health.

Progress reports: Internal progress reports are produced for the quarterly Finance and Performance Committee which feeds up from monthly Sustainability Steering Group meetings and sub group meetings for the 12 Activity Areas, each of which will track progress against their individual action plans and report on a suite of key performance indicators. The detailed action plan with SMART objectives will continue to be developed. A resource plan will be maintained demonstrating where staff time, finance and other resources are required together with savings and actions planned and achieved.

Related Internal Policies: Our Green Plan is to be supported by various related policies and guidance documents including the: Green Travel Plan, Waste Management Policy, Biodiversity and Greenspace Policy, Sustainable Procurement Policy, Climate Change and Adaptation Plan, Sustainable Construction Policy, Decarbonisation Strategy, Equality and Diversity Policy.

Join us on our journey

What can you do to help?

Visit the GreenUHD pages

Share your ideas in the GreenUHD online forum

Get advice and support email:
uhd.green@nhs.net

Join the Dorset NHS EcoEarn Community

You can contribute within your own role every day.
No matter what your role is at the Trust or as a partner there will be something for you!

GUHD

Annex A:

Live links to Drivers: Legislative, Economic, Technological, Political, Environmental, Social, NHS Long term plan, UN goals

Economics of Climate Change - Stern Review 2006	Government Buying Standards	Health Equity in England: Marmot Review 10 Years On	NHS Standard Contract 2022/23	EU Directive on Public Procurement	HPS Health Effects of Climate Change 2012
Health Co - benefits Evidence	National Adaptation Programme (2018-2023)	Defra Economics of Climate Resilience Report 2013	Principle 6 - NHS Constitution	HM Treasury Sustainability Reporting Framework 2020/2021	Civil Contingencies Act (2004)
Public Health Outcome Framework	Inter-governmental Panel on Climate Change AR5 2013/2014	Climate Change Risk Assessment 2017Defra Economics of Climate Resilience Report 2013	Health Sector Report on Adaptation 2015	Climate Change Act 2008	PHE Cycling and Walking for Individual and Population Health Benefits
WHO Europe - Social Determinants and the Health Divide	Taking Account of Social Value PPN 06/20	Delivering a 'Net Zero' Health Service	Health and Care Act 2022	NHS Marginal Abatement Cost Curves	Health 2020 WHO
MET UK Climate Projections (UKCP)	The Living Planet Report 2022	National Policy and Planning Framework	UN Emissions Gap Report 2022	Lancet Countdown Report 2022	

Click the box to explore each link

Annex B: What the UN Sustainable Development Goals mean to University Hospitals Dorset

Goals	Contributions
 **No Poverty** End Poverty in all its forms everywhere.	We helped to set-up Poole Africa Link in 2009 and continue to be actively involved with the charity. Our staff helped to train doctors, nurses and midwives in both Sudan and Uganda. The Trust also provides a range of retired equipment for the charity. The Trust helps to promote awareness about Healthy Homes Dorset – for free energy advice and home insulation. We will seek to embed this fuel poverty project within the hospital discharge processes to refer suitable patients for home energy efficiency measures. This should help with patient recovery, reduce re-admissions, and provides environmental benefits. The Trust has also helped to marry up the priority services register to the Healthy Homes Dorset scheme so that some of the most vulnerable in our community are given priority support if power is lost in their homes.
 **Zero Hunger** End hunger, achieve food security and improve nutrition and promote sustainable agriculture.	We take the nutritional value, environmental and ethical standards of the food we serve very seriously. During 2021 all of our hospitals are set to be certified Silver - Food for Life by the Soil Association. The Trust also only serves sustainably sourced fish and is accredited under Sustainable Fish Cities. The Trust's Nutrition and Dietetics team provide a wealth of healthy eating guidance to aid general understanding and to ensure that we best meet the nutritional needs of our patients.
 **Good Health and Well-being** Ensure healthy lives and promote well-being for all ages.	Maintaining and improving the health and wellbeing of colleagues is of paramount importance and central to our Trust values. Our Workplace Wellbeing Team coordinates numerous initiatives, including psychological support. We encourage staff to use active modes of travel to work and support them with initiatives such as free bike maintenance services.
 **Quality Education** Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.	As a University Hospital Trust we support innovation and education. Central to our vision is to be a great place to work and learning and development help the Trust underpin this. We provide professional support to apprentices and medical students as well as providing a range of clinical, leadership and management training. Our strong focus on staff development covers areas such as mentorships, apprenticeships, quality improvement projects and essential staff training.

Annex B: What the UN Sustainable Development Goals mean to University Hospitals Dorset

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Goals	Contributions
Gender Equality Achieve gender equality and empower all women and girls.	The Trust publishes reports each year to provide information on performance against its equality objectives, statutes and national standards. This includes a gender pay gap report, workforce equality reports and action plans. We have an equality, diversity and inclusion group (EDIG) who have approved a new 3 year diversity and inclusion strategy which was ratified by the Board in March 2021. A programme plan is in place to monitor the progress of five priorities that have been identified within the strategy by EDIG.
Clean Water and Sanitation Ensure availability and sustainable management of water and sanitation for all.	The Trust, in partnership with ADSM, supports the Water Aid scheme which has helped transform lives in rural Mozambique by bringing fresh water to over 49 thousand people. The Trust has a Water Safety Policy and Plan, managed by a Water Quality Group. Collectively, they manage and control the risk of water-borne pathogens within the Trust. Monitoring is in place for temperature and turnover of all tanks and hot water vessels. A programme is in place to replace oversized pipework and improve our usage.
Affordable and Clean Energy Ensure access to affordable, reliable sustainable energy for all.	The Trust has implemented a portfolio of sustainable energy projects. Royal Bournemouth Hospital generates approximately 22% of its energy requirements on-site through Solar PV installations and the heat generated as a by-product from clinical waste incineration. Poole Hospital generates approximately half of its electrical energy requirements with an on-site combined heat and power plant and is also set to install a large roof top solar PV array. Major lighting replacement projects have now installed LED lighting in large areas of the Trust. Our grid supplied energy is soon to become 100% REGO certified renewable.
Decent Work and Economic Growth Promote sustained, inclusive economic growth, full productive employment and decent work for all.	The Trust contributes to routes to employment and improved work opportunities by providing apprenticeships and work placements and will be expanding opportunities for students for Bournemouth University students in particular to compliment their studies with opportunities for project work, dissertations and placements with the Trust. The Trust is a Disability Confident employer and all employees wages meet or exceed the Living Wage. We support small and medium sized suppliers through our procurement processes.

Annex B: What the UN Sustainable Development Goals mean to University Hospitals Dorset

3/4

Goals	Contributions
 **Industry, Innovation and Infrastructure** Build resilient infrastructure, promote inclusive and sustainable industrialisation and foster innovation.	The Trust is embarking on several large capital projects. All new buildings will meet BREEAM Excellent and all major refurbishments will meet BREEAM Very Good. Innovation is supported at the Trust by our Transformation Team and their Quality Improvement programmes. Poole Hospital has installed a dispensing robot to eliminate patient medication errors. The trust has also opened a state of the art linear accelerator for radiotherapy in the Robert White Centre. Our care pathways are being transformed by digitalisation projects which is bringing benefits to our patients, our operations and reducing negative environmental impacts from our services.
 **Reduced Inequalities** Reduce inequality within and among countries.	The Trust has an Equality, Diversity and Human Rights Policy and is committed to developing and enhancing a diverse and inclusive culture. Equality, Diversity and Human Rights training is included in staff training. We are proud to have a diverse community and support active BAME, LBGT Q+ and Pro ability networks.
 **Sustainable Cities and Communities** Make cities and human settlements inclusive, safe, resilient and sustainable.	The Trust has a Board-approved Sustainable Development Strategy and we are developing a revised Sustainable Procurement Policy plus Sustainability Impact Assessment process for large projects.
 **Responsible Consumption and Production** Achieve gender equality and empower Promote peaceful and inclusive societies, access to justice and build effective, accountable and inclusive institutions.	The Trust has demonstrated strong governance with transparent reporting on organisational performance. We have a team of Freedom to Speak Up Guardians who provide confidential support for any concerns about patient or staff wellbeing.

Annex B: What the UN Sustainable Development Goals mean to University Hospitals Dorset

Goals	Contributions
 **Climate Action** Ensure sustainable consumption and production patterns.	We are working to embed sustainability within our supply chain by considering the sustainability of our suppliers and the products and services that we purchase including evaluations of carbon and whole life cycle costs where viable. We will seek to work in partnership with the wider NHS network and local partners to meet this challenge.
 **Life Below Water** Conserve and sustainably use the oceans, seas and marine resources for sustainable development.	The Trust recognises the risk to water courses from irresponsible handling of materials and works hard to embed tight controls to ensure that no pharmaceuticals or other unsuitable chemicals enter the waste water system. The Trust is committed to reducing unnecessary consumption of single use plastics.
 **Life on Land** Protect, restore and promote sustainable use of terrestrial ecosystems, reverse degradation and halt biodiversity loss.	The Trust is committed to improving biodiversity on our sites and ensuring that our staff, patients and visitors are able to receive valuable contributions to their health and wellbeing from contact with nature. We have protected and restored areas of greenspace and we commit to doing the work required to maintain a Green Flag status for our Bournemouth site.
 **Peace, Justice and Strong Institutions** Strengthen the means of implementation and revitalise the Global Partnership for Sustainable Development.	We are working in partnership with Our Dorset Integrated Care System, Bournemouth University, BCP Council, the Dorset LEP and other local healthcare providers. Our work with other anchor institutions is to ensure we are active corporate citizens in sustainable development.
 **Partnerships for the Goals** Take urgent action to combat climate change and its impacts.	Our climate change mitigation efforts have resulted in Trust carbon footprint reductions exceeding the NHS target of a 34% reduction over 1990 levels by 2020. We will now double down on efforts in order to meet the New NHS targets of Core Carbon Footprint – Net Zero by 2040 and Carbon Footprint PLUS by 2045. The Trust will capture climate change on the Trust risk register and track progress on adaptation measures through its Climate Change Adaptation Action Plan.

Green UHD Plan



NHS
University Hospitals Dorset
NHS Foundation Trust

2021-2026
Sustainable Development Strategy

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 6.2.2

Subject:	Estates Masterplan
Prepared by:	Richard Renaut – Chief Strategy & Transformation Officer
Presented by:	Richard Renaut – Chief Strategy & Transformation Officer

Strategic themes that this item supports/impacts:	Population & System	☐
	Our People	☒
	Patient Experience	☒
	Quality Outcomes & Safety	☒
	Sustainable Services	☒
BAF/Corporate Risk Register: (if applicable)	None	
Purpose of paper:	Decision/Approval	
Executive Summary:	The UHD Estates Masterplan brings together more than £500m of investment to transform the Trust's three hospital sites, aligning physical infrastructure with our long-term clinical vision. The programme supports delivery of the Major Emergency Hospital at **Royal Bournemouth**, the Major Planned Hospital at **Poole**, and continued development of **Christchurch** as a modern community hospital. Key priorities include: • **Royal Bournemouth Hospital:** Construction of the new BEACH building, Coast ward block, expanded emergency and critical care, and enabling works at Wessex Fields. • **Poole Hospital:** Development of new theatres, an endoscopy hub, refurbished wards, and supporting infrastructure improvements. • **Christchurch Hospital:** Expansion of community facilities including the proposed Macmillan Unit and future senior living village. The UHD Estates Masterplan 2025–28 sets out a once-in-a-generation programme of investment, aligned with the Trust's Clinical Strategy and the Dorset Clinical Services Review. Over £500m of capital investment from national, local and charitable sources will transform our estate to deliver	

	safe, modern and sustainable healthcare. The strategy provides for: • **Royal Bournemouth Hospital** – development of the Major Emergency Hospital, including the new BEACH building, the Coast ward block, expanded emergency and critical care, and a long-term vision for Wessex Fields. • **Poole Hospital** – creation of the Major Planned Hospital, including a new theatres block, endoscopy hub, ward refurbishments and backlog reduction, supported by potential new key worker housing. • **Christchurch Hospital** – continued development as a modern community hospital, with plans for a new Macmillan Unit and senior living village. The masterplan also incorporates: • **Green UHD** – decarbonisation, biodiversity, sustainable travel and climate resilience. • **Supporting infrastructure** – digital, infection prevention, energy, water, ventilation and oxygen. • **Backlog reduction** – phased programme to tackle c.£250m of maintenance risk. This plan provides the framework to deliver the Clinical Strategy, support staff recruitment and retention, and ensure UHD plays its role as an anchor institution for Dorset.
Background:	The Estates Masterplan builds on the Dorset Clinical Services Review, which set out plans for a Major Emergency Hospital at Royal Bournemouth and a Major Planned Hospital at Poole. Since then, lessons from the pandemic, the move to Integrated Care Boards and national priorities on prevention, digital care and sustainability have all shaped our approach. With significant national, local and charitable investment now secured, UHD has a rare opportunity to modernise its estate, reduce backlog risks and deliver better, greener facilities for patients and staff.
Key Recommendations:	• Proceed with delivery of the Estates Masterplan 2025–28 across all three sites. • Maintain focus on completing the Major Emergency Hospital at Royal Bournemouth and the Major Planned Hospital at Poole, with Christchurch continuing as a community hub. • Support the Green UHD agenda by embedding decarbonisation, sustainable travel and climate resilience in all projects. • Continue to reduce backlog maintenance and strengthen core infrastructure.

	• Use the Masterplan as the basis for future planning, investment and partnership working. The Board is asked to receive this update and endorse continued delivery of the Estates Masterplan 2025–28.
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**
Trust Management Group	16/09/2025	Approved
Finance & Performance Committee	22/09/2025	Plan endorsed with recommendation for Board approval

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

Estates Master and Development Control Plan

for

University Hospitals Dorset (UHD)

2025-28

(updated 2025)





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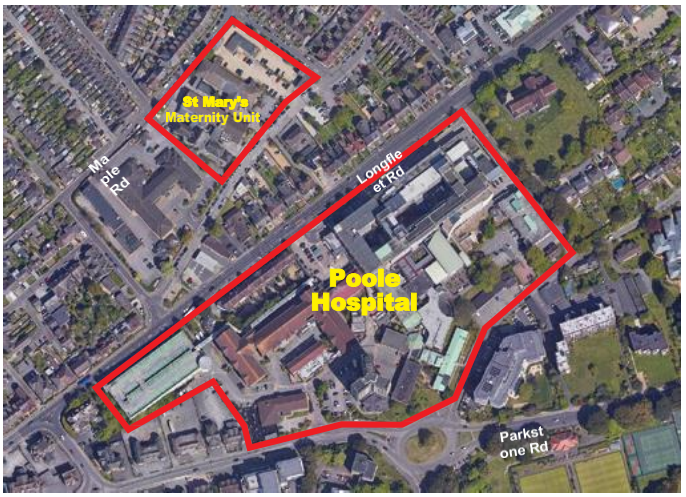
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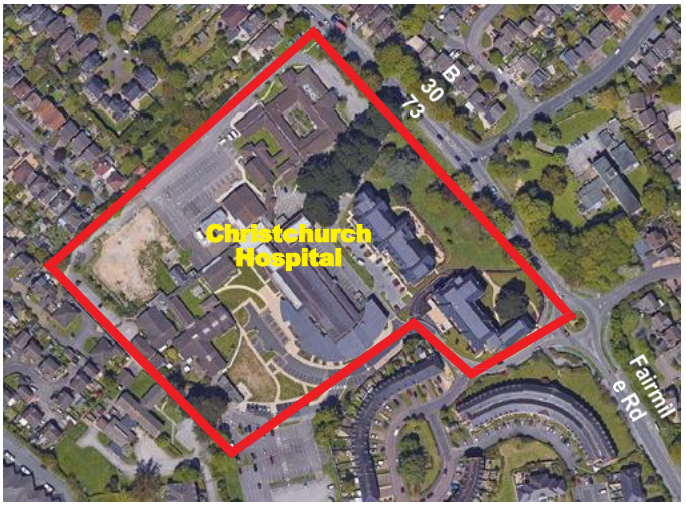


Poole Hospital

We are #TeamUHD



The Royal Bournemouth Hospital



Christchurch Hospital

1. Introduction

Serving our local population and improving health outcomes informs the work of the Dorset Integrated Care System (ICS). When hospital services are needed the rightful expectations are that these are high quality, safe, convenient, caring and accessible. This Estates Masterplan sets out how best to enable this to happen.

To achieve the best outcomes from the excellent teams working in Dorset's NHS, there was an extensive review of best practice, and widespread public and staff engagement. This generated Dorset Clinical Service Review (CSR) and was supported by the Secretary of State for Health in 2019. Our strategy since then has been to implement this.

The CSR provides the clinical blueprint to improve health outcomes and use the available skilled staff and partnerships to deliver the best care, within the resources available, for the public. This fits well with the 2025-2035 NHS Plan.

Key aspects of the CSR are:

- To shift to prevention at scale, and avoid ill health, as set out in the Dorset '5 year forward view'
- Integrated community and primary care, to provide local, joined up health and social care, built around GP services, now called Neighbourhood Health.
- Digital Healthcare, harnessing technology to support patients, streamline care and ensure the right information at the right time
- These are now the three key parts of the NHS 10 Year Plan (July 2025), and three shifts to prevention, neighbourhood and digital.
- Workforce development, to support and grow the health and social care staff, develop new roles and capabilities, and deliver the NHS People Promise.

Other key aspects in Dorset, funded partly by the New Hospitals Programme are:

- 'One Acute Network', joining up hospital services to meet the challenges, with Poole Hospital becoming the Major Planned Hospital and Royal Bournemouth Hospital becoming the Major Emergency Hospital
- Mental health Acute Care Pathways (ACP), which has seen investment in staffing and estates, improving these services.

Health needs and trends are regularly reviewed, including the growing and ageing population of Dorset, as well as health inequalities and access to care.

Since the CSR, clinical and wider strategies have been further developed. The following key changes are also important factors in the site masterplans:

- Value for money in the face of significant building cost inflation, energy costs, and high levels of backlog estates requiring billions of investments across the NHS.
- Infection Control, the Covid pandemic and wider resilience in the face of major changes and disruption to healthcare, some of which we cannot predict
- Better diagnostics and early detection including developing Community Diagnostic Hubs
- Last, but most importantly, climate change, with the need to recognise the climate emergency is also a health emergency. This demands a change to how we live, work and travel while adapting to more extreme weather, and the effect this has on health and service resilience.

As well as hospital services being important to the community, the NHS is part of the community. An “anchor institution” impacts the community as an employer, purchasing of goods and services, provision of education, research and wellbeing, and as a partner in many issues including transport.

The support of the public, in volunteering, donating to hospital charities and standing up for healthcare being free at the point of delivery, is never taken for granted. The NHS belongs to the public.

All these important trends inform the current clinical strategy of University Hospitals Dorset (UHD), which then informs the Estates Masterplan, as set out in this document. This then fits within the wider system estates, capital and clinical plans.

This masterplan provides the basis and will be updated, as both UHD and the NHS in Dorset provider collaborative update their strategies.



2. Starting with our Clinical Strategy for UHD

Within the context set out in the introduction, the clinical strategy for UHD has numerous key aspects which shape the Estates Strategy. These include:

a. Creation of the **Planned Hospital at Poole.** By volume and range of procedures, this is expected to be the largest planned care hospital in the UK. The construction of the new theatres, scanners and Endoscopy, extensive refurbishments, and reduction of backlog maintenance. This allows all year-round elective services, not affected by emergency pressures. This reduces the risk of cancellation, and supports modern, productive healthcare environments.

   In addition, Poole will retain many of its current services, including a 24/7 walk in urgent emergency care, outpatients, therapies, diagnostics and cancer treatments. These will all continue to be delivered from the Poole hospital site. Additional services will include specialist inpatient rehabilitation, for trauma patients and community hospital beds. A new endoscopy unit opens in 2026. Due to the high volume of elective care, especially for day surgery and inpatient treatments, Poole will remain a busy hospital, at the heart of Dorset's NHS, with the potential to be a regional centre for complex elective care.

b. The **Emergency Hospital at Royal Bournemouth** will bring together teams currently split across the conurbation, to provide better services, with greater resilience, allowing consultants and specialist staff to be available for more hours in the week. Providing quicker access to specialist teams and equipment, in fit-for- purpose facilities will improve care. This includes:

   - New Maternity and Children's inpatient facilities, co-located
   - New Emergency Department (ED) and an Urgent Treatment Centre. These are both in the BEACH building, which opened in 2025.
   - New Pathology Hub serving all of Dorset, in cutting edge facilities, opened 2024.
   - New and refurbished wards, with same day emergency care (SDEC) to provide prompt, expert care in a single day, avoiding the need to be admitted.

c. **Christchurch Hospital** has already undergone significant investment to create a vibrant community hospital, as well as co-location with GP and pharmacy services, care home and senior living. The ambition to fundraise and build a new Macmillan Specialist Palliative Care Unit and create a senior living village, remain the key aspects of a second phase, subject to approval and funding.

d. UHD provides **other services from locations**, including:

   - The Community Diagnostic Centre services Poole, providing flexible, high-volume clinics and diagnostics. This is based as an interim in St Mary's Hospital. Other CDC diagnostics in Boscombe and Weymouth allows easier access.
   - Sterile Services based at Alderney Hospital. Significant refurbishment over the next few years is underway in 25/26.
   - Yeomans House and Canford House as offices for corporate office-based staff, including patient appointment bookings
   - Linear accelerator for cancer treatments, based at Dorset County Hospital, providing greater access for patients in the West of Dorset.

e. **Wessex Fields**, adjacent to RBH, represents a significant opportunity. The location has significant potential for further key worker accommodation, allowing walking to work and affordable housing to attract and retain staff to Dorset. Working in partnership with BCP Council and other partners, including Bournemouth University, there may also be opportunities in research and education sectors. This opens the way for creating med-tech, "high value-adding jobs" co- located with the hospital campus, with its well-

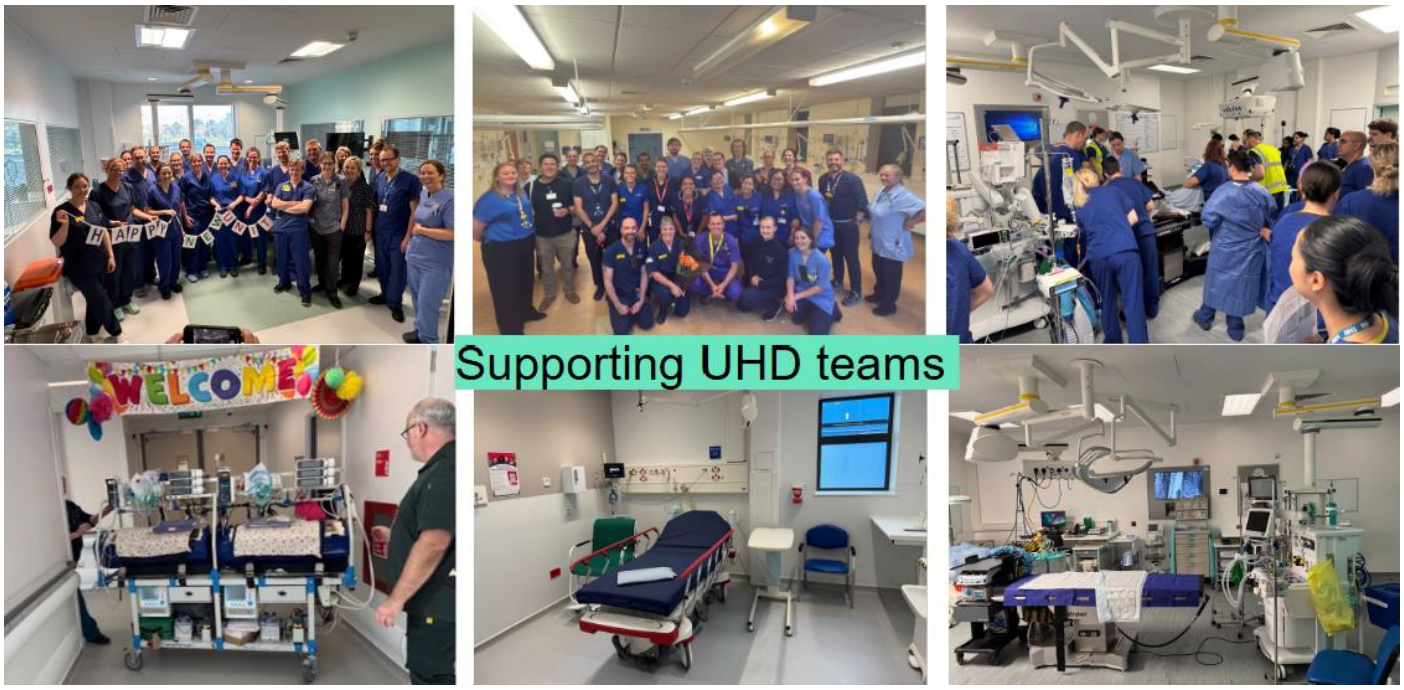
developed informatics, and whole system working. In the long-term developing a medical school would further add to the critical mass for use of this unique location.

The completion in 2025 of the A338 link road and cycle access to Bournemouth hospital was reduced congestion on Deansleigh Road and Castle Lane East. It is part of the wider green travel plan for promoting better bus, bike, carshare and work from home as alternatives to single occupant car journeys.

f. Neighbourhood and Digital Futures

The shift to neighbourhood health is very much welcomed, as the growing and ageing population will need this to succeed, otherwise the acute hospital sector will not cope. The extensive investment in hospital buildings in Dorset, after 30 years of minimal investment, is based upon not increasing the net number of beds or theatres, as growth will be in neighbourhood care. This is an ambition at the heart of the Clinical Strategy, supported across the Health System.

The digital future then goes further and looks to empower citizens with their own care, as well as improving care when needed. Dorset and Somerset are going to have a single Electronic Health Record by 2028, which should reduce the need for some hospital care to happen at all. Virtual wards and hospital appointments are already a reality, and this trend is expected to increase.



3. Estates Strategy: Exec Summary

The estates strategy is based upon a masterplan for the 3 main UHD sites, which aim to:

- Delivery the clinical strategy for better patient care as per Clinical Services Review (CSR) requirements and the NHS 10 Year Plan.
- Support the Green UHD plan, including carbon reduction, sustainable travel, climate adaptation and biodiversity
- Offer value for money and best use of resources, including reduced backlog maintenance.
- Meet all the planning requirements and conditions set by the Council and regulators.

The last set of significant clinical and estate changes in East Dorset were in the late 1980's with the creation of the Royal Bournemouth Hospital and the Philip Arnold Unit at Poole and a range of other changes completing in the early 1990s. Since then, Dorset has not had significant clinical service or estates changes, or the capital investment to make this possible.

This has changed as a result of the Clinical Services Review setting the blueprint, and allowing investment from sources:

- The £201m HM Treasury fully approved building works, mostly for Poole Theatres and the BEACH building
- £263m of the New Hospital Programme,
- A linked plan for mental health estate and Dorset County Hospital Emergency Department and Critical Care schemes.
- Targeted investments such as the new Pathology Hub and the new Poole Endoscopy building and Community Diagnostic Services.
- UHD's own funding plus charitable support.

Together this represents over half a billion-pound investment in the local NHS to create a once in a generation step change improvement.

Combined with developing our workforce, investment in technology and equipment and the wider CSR service improvements and working as an integrated care system, this represents not just catching up, but a nationally significant step up, setting new standards in healthcare.

Successful progress for both Poole and RBH has already been implemented, with move phases 0, 1 and 2 complete. Phase 3 is planned for summer 2026, which separates planned and emergency care. The final Phase 4 will be completed in 2027.

The next stage of significant changes by site are set out in more detail in the later sections of this strategy. In summary they are:

- Poole Planned Care Hospital: Significant internal refurbishments of wards, theatres and facilities, and removal of large amounts of backlog maintenance. This creates the planned

and community hospital hub. Surplus outlying land and buildings can then create additional key worker housing.

- RBH Emergency Care Hospital: A new build ward block, the Coast Building, and significant internal refurbishments, completes the major emergency hospital. A masterplan for Wessex Fields will be developed; until then use of the UHD land will be used to reduce congestion on site and disruption of services.

- Christchurch Community Hospital: Creation of the new Macmillan Unit, and then potential release of land to expand the affordable senior living facilities on site.

Our Green travel plan has already reduced traffic around the hospitals, and across the conurbation, whilst reducing air pollution and promoting healthier lifestyles. Significant further steps are planned and set out below. Supporting the masterplans are specific infrastructure plans, covering water, electricity, infection control, oxygen, ventilation, consequential improvements, and critical infrastructure requirements. These include a de-carbonisation strategy.

In developing a 5-year estates masterplan there is need for flexibility for the “unknown unknowns” - things that despite careful planning will still be required over the next 5 to 25 years. Therefore, reference is made to both firm plans and to potential opportunities, (the latter usually subject to funding and planning approval) and so some areas of each site are left for future master planning.



The Capital Estates team have been shortlisted for Public Sector Team of the Year at the 2025 Association for Project Management Awards.

4. Royal Bournemouth Hospital

RBH site prior to start of building works in 2021



RBH site 2025



New Wayfinding approach to RBH

With all the building changes on site, a complete overhaul of wayfinding and location names is underway at Royal Bournemouth Hospital.

This will make it easier to get to a zone (A,B,C) of the hospital. Then to find the actual department or ward in that zone.

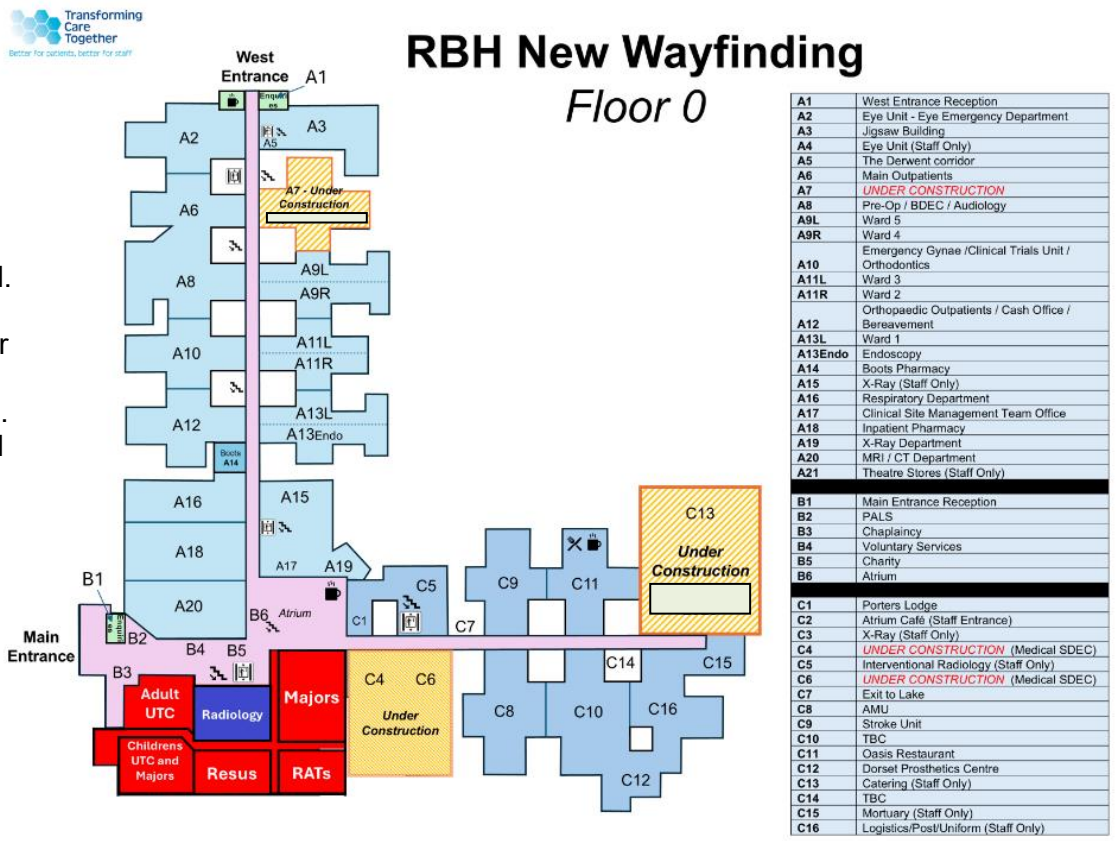
For those who know the site well, the adjustment will take a little longer, to forget the old. The transition will be phased.

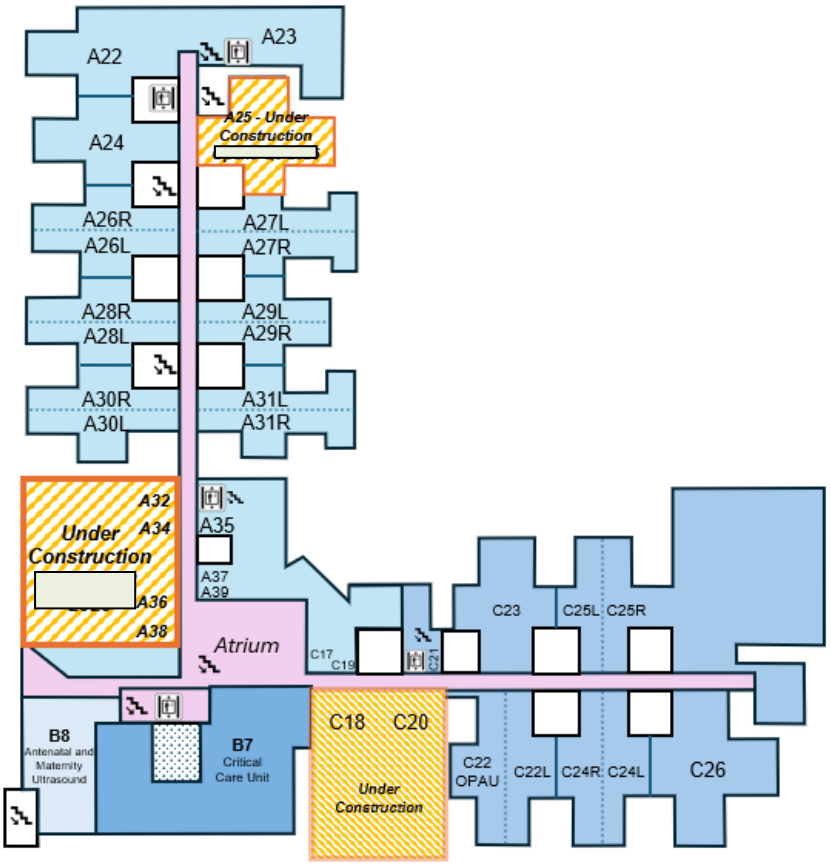
This evidence base from other hospitals and public buildings has been used, along with talking with patients, visitors and staff.

A second phase of the project is to have digital. These can be accessed in advance, or by QR codes when on site.

GPS will then allow you the best route to your destination, and back home.

UHD's charity has generously sponsored this project.





Introduction to the RBH site

RBH opened in the phases between 1989-91 as a greenfield build. Most of the RBH site directly provides patient care, based around the L-shaped main building. The wards are based on the nucleus designs in a cruciform shape, maximising light but providing some restrictions on layouts, which is a factor when areas are refurbished - a major part of the future plans for the site.

Other important clinical buildings on site include the Jigsaw Cancer & Women's Health building, the Derwent ward and theatres.

Ancillary buildings along the lake include the Education Centre, Dorset Heart Club Rehabilitation Centre and Tops Children's nursery.

There are over 200 residences, mostly made up of single rooms and shared living, for students and new staff relocating to the area.

The waste incinerator provides heat to the site and treats clinical waste.

Site access

Since opening, the RBH site has had a single access road, Deansleigh Road, from Castle Lane East. As further developments have been granted for offices, a hotel, law courts etc., so Deansleigh Road and the Castle Lane junction have got busier, putting pressure on the road infrastructure.

RBH staff and visitors have had periods where traffic and roadworks on Castle Lane and onto Christchurch have created grid lock and slowed ambulances. As such, a strict limit of permits for NHS staff parking now mean over half of UHD's staff arrive at work other than by car, despite the limited public transport and cycle routes, compared to other city regions.

High volume services have also moved off site to reduce traffic and provide better access. These include 100,000 blood tests per year, 60,000 sexual health clinical appointments and 40,000 outpatient physio attendances (4,000 trips per week less). In addition, a significant number of clinic appointments are now undertaken "virtually." Further information and future plans are discussed in the later section on transport.

Summary of recent developments at RBH

- In 2025, the new link road, Seacole Way, opened, providing access to the west of the site. This has significantly improved access and provides a valuable alternative if Deansleigh is blocked.
- The major new building at the front of the site, the BEACH building (standing for Births, Emergency department, Antenatal, Critical care and child Health). Next to this is the new Main Entrance, Patient and Visitor Centre (MEPV). Construction ran from 2021-2024.
- Dorset Pathology Hub, serving the whole county in a purpose-built facility on the corner of Wessex Fields, opened in 2024. The vision for the wider Wessex Fields is set out later.
- Improvements to cycle, bus and pedestrian access to the site, and new changing facilities.
- The moving of most public, visitor and staff parking to the rear of the site, to prioritise ease of access for sustainable travel and drop offs and disabled access to the front.

2023-2025 RBH Schemes

Estates projects completed since the start of the masterplan in 2023, for RBH include:

- One Dorset Pathology Hub
- Ward 7L
- Stroke Unit Refurbishment
- Wessex Fields Link Road – Seacole Way
- Bournemouth Thoracic Refurbishment
- Health Sciences University MRI
- Bournemouth Pharmacy Robot and Refurbishment
- IT Archive Refurbishment
- Waste Compound
- Bournemouth UTC
- Theatre Staff Rooms
- CT Turnkey Replacement
- BEACH Building
- Carpark alterations, including ANPR

New Hospitals Programme funding has also supported:

- Road Works
- Main Entrance for Patients and Visitors (MEPV – part of BEACH)
- Pneumatic Tube
- Contractor's Compound
- Interim Catering
- VIE Oxygen Upgrade
- Modular Building Enabling Works
- Stour Building
- Junior Doctor’s Mess (now part of BEACH)
- Mortuary Refurbishment
- Ward 7R
- Children's Theatre Recovery
- MRI Updates
- Ward 21

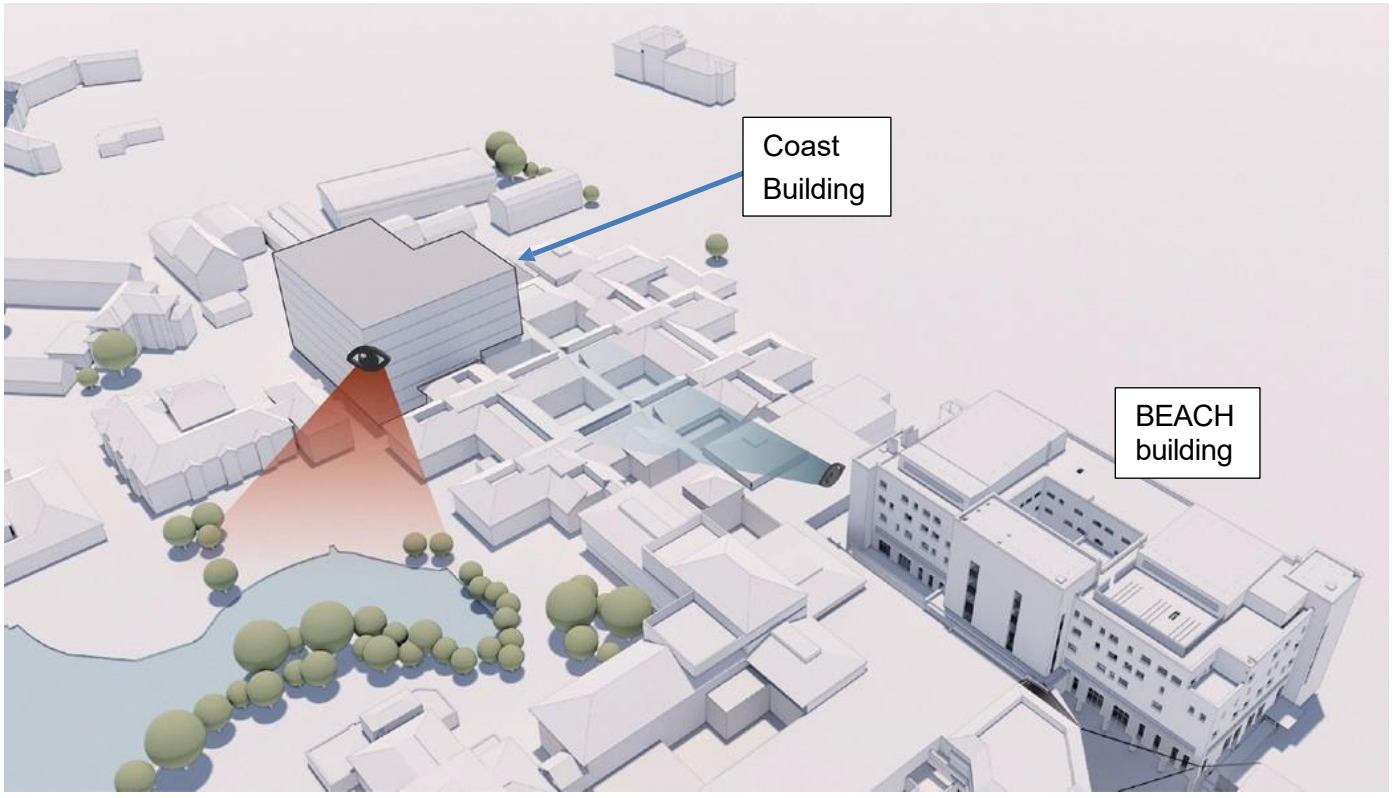
Developments coming soon to RBH

- Creation of the new Coast building, ready by 2026. This provides four wards and catering facilities.
- New Oncology ward.
- Surgical Admissions Unit (SAU), with Same Day Emergency Care (SDEC).
- Older People Assessment Unit and SDEC.
- Acute Medical Unit (AMU) and SDEC.
- Refurbishments to create Children's Outpatients and Neuro-rehab ward.

The **new NHS space standards,** required as part of the national funding for NHS buildings, has been updated. In particular, the higher ratio of single rooms, plus clinical support and associated space, has required a larger footprint for the same level of services than envisaged when the original planning application was submitted in 2019. Other areas requiring greater space include operating theatres and same day emergency care (SDEC) facilities. These larger spaces are as a result of several factors, including infection prevention, which the pandemic brought into sharp focus.

Single rooms will also enhance standards of privacy and dignity. The patient numbers, staff numbers and other planning assumptions remain the same, but the additional space required to house those services has increased significantly. This means whilst the amount of buildings in UHD is larger, the number of hospital beds and operating theatres at the end of the building works, will be similar.

The estate investment will mean more effective use of staff, by having teams on one site focused on emergency care, with fit for purpose layouts.



Future Aspirations for RBH Site

Once this phase of funded building schemes is completed, there remains aspirations within this site masterplan, to achieve even more for the population served, subject to funding. These include:

- an enlarged restaurant and catering facility (potentially charity funded)
- creation of a new ward, in the ex-pathology ground floor
- building a Multi-Storey Car Park (MSCP)
- a health building, and/or care home between the Derwent and nursery, overlooking the lake
- fabric upgrade to improve heat resilience so cooler in summer, less energy in winter
- development of Wessex Fields (see below)
- a staff well-being building, separate but near the main buildings
- more space for education and training, including expanding medical school places.

Wessex Fields is vacant land, next to the RBH site, totalling 15 acres. UHD has invested over £10m in providing electrical infrastructure for it and futureproofing the hospital. Combined with UHD's funding of the link road, this land now has the potential to be of significant benefit for Dorset.

Its temporary use is for contractor compounds and staff parking. Both these are essential to keep the hospital functional as it undergoes its transformation.

The masterplan for Wessex Fields is reliant on external funding, not yet secured. There is an exciting vision, combining housing for key workers, and senior living, with potential education, research and facilities to create a community atmosphere, including a village square.

The development also has energy transition in mind, with a district heat network, potentially using a geothermal heat source. This taps into Dorset's famous geology, to provide a constant, reliable, affordable and clean energy source. Thus, the whole development would be net zero carbon, and it allows the whole RBH site to achieve a 90% carbon reduction.

For further details see future UHD Future of Wessex Fields

Pathology

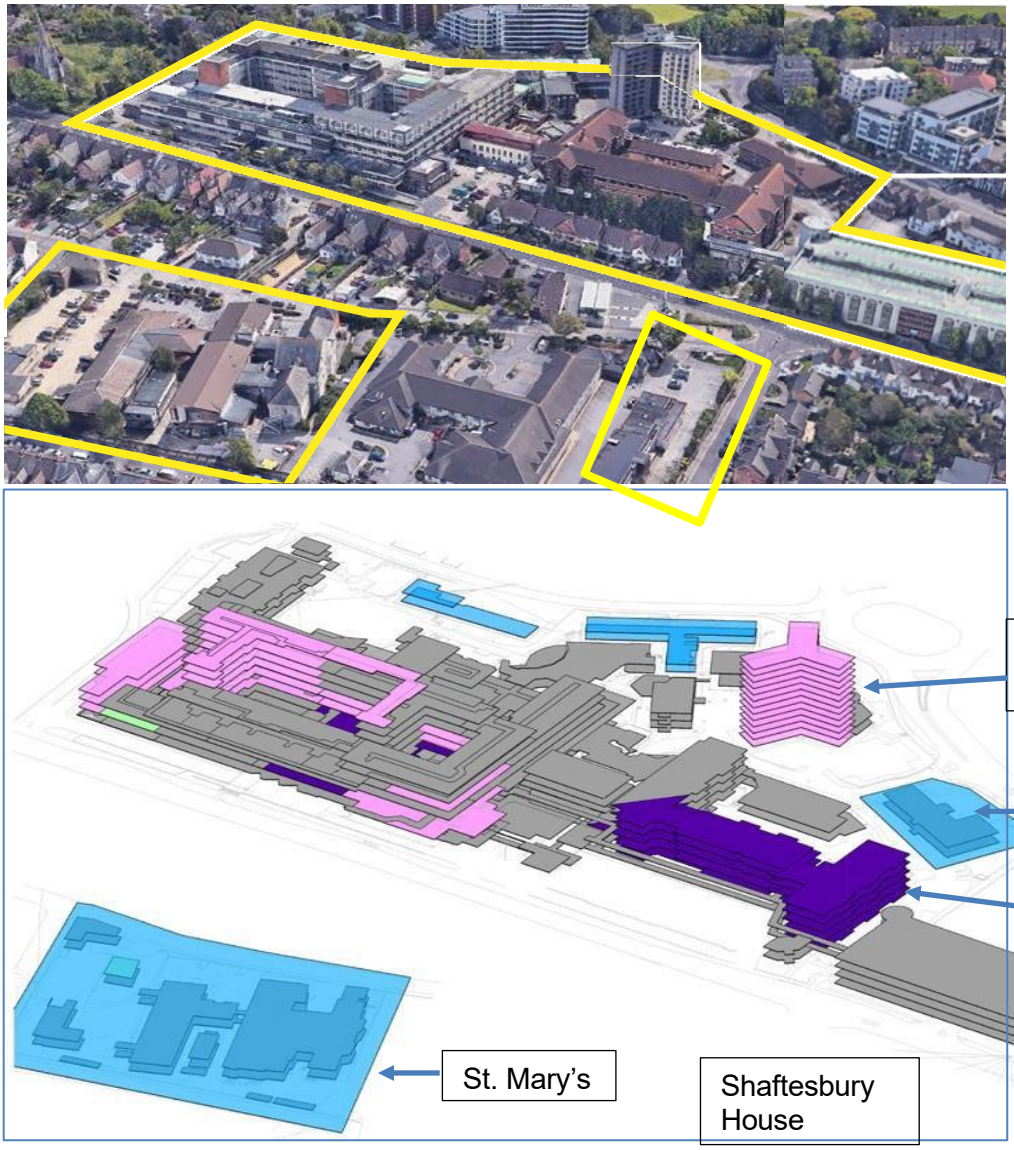




Dorset's Pathology Hub. A facility able to provide cutting edge diagnostic services to the entire region.

5. Poole Hospital

The Poole developments are underway with major investment and change to become the Major Planned Care hospital for Dorset. In addition, 24/7 walk in urgent care, outpatients, therapies, diagnostics, community services, cancer and radiotherapy, rehabilitation and many other services will continue to be delivered on site. Major estates investment and changes will continue until at least 2027/2028, including reducing the significant estates maintenance backlog.



There has been a hospital on this site since 1908, and the 'new' hospital was designed in the 1950s and opened in 1962. The major additions have been extensions to St Mary's Maternity Hospital and the building of the Philip Arnold Unit which opened in the early 1990s.

Poole Hospital comprises a high-rise building occupying about one quarter of the RBH site area. Many of the facilities do not meet modern healthcare standards especially for space for inpatient care. The new layouts address much of this. There are over 250 key worker residences, most in the 13 storey Parkstone House and the rest in houses nearby. A multi-storey car park provides patient and visitor parking, whilst most staff parking is at the nearby Poole Stadium. Being a town centre, bus and rail links are nearby.

Poole Works 2023-2025

Estates projects completed since the start of the masterplan in 2023 include:

- Poole Theatres build
- Philip Arnold Photovoltaic Array - Poole
- Outpatients Assessment Centre – Repurposing St Mary's
- Poole Pharmacy Robot – Poole
- Poole Library Refurbishment - Poole
- Boots Pharmacy Fit-out - Poole
- Brachytherapy Ventilation - Poole
- Lift Modernisation - Poole
- LED Light Replacement – all sites
- New Discharge Lounge – Poole and RBH
- Car park repairs and ANPR
- Fire and electrical system upgrades

First patient helps celebrate theatres opening

UHD staff and partners came together in July 2023 to see patient Julie Hills cut the ribbon to officially open the new Poole Hospital theatres. This was the first step in making Poole a planned care hospital.

The five-storey, purpose-built theatres are an extension to the existing hospital building. They incorporate a four-table open-plan 'barn' theatre, with each patient treated in a dedicated space with an ultra-clean air canopy over each station.







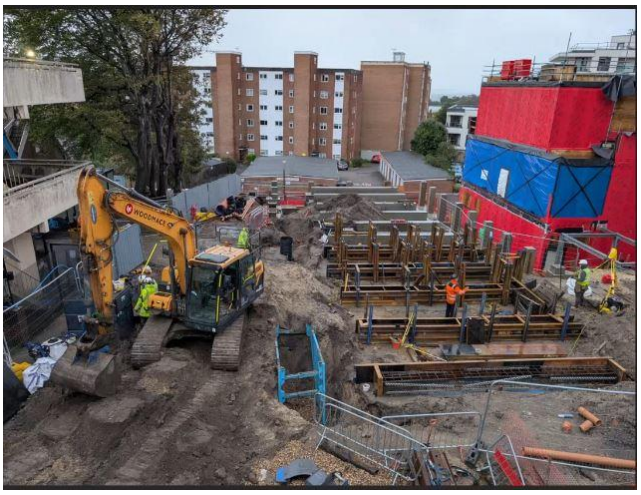
Whilst the number of patients treated at Poole will increase, their time in hospital will be shorter, as 85% of surgery is now day case. As such the physical space required will be smaller. This allows the existing space to be used for larger bed spaces and support areas, retrenchment of offices and ancillary services into the main building and spare space to be potentially offered to partners in health and social care.

Poole Site 2026-2028

Funded projects due for completion

- Refurbishment to create extensive theatres admissions and recovery areas
- New Enhanced Post Operative Care (EPOC) for patients otherwise needing Critical Care
- Two additional Operating Theatres
- Essential Service Laboratory
- Endoscopy Hub (see below)
- New CT/MRI at Shaftsbury House
- New Private Patients Unit
- SSD Refurbishment and Autoclave Replacement
- Poole ED Reconfiguration to create UTC
- De-steaming Site
- Continued work to reduce backlog repairs

A brand new, purpose designed and built endoscopy unit is part of investment to upgrade this service. This will allow an expanded number of rooms, allowing for modern and efficient diagnostics. This means earlier detection of cancer, and other diseases. This is part of the community diagnostics centre (CDC) hub, based at Poole, supporting easier access for all Dorset residents.

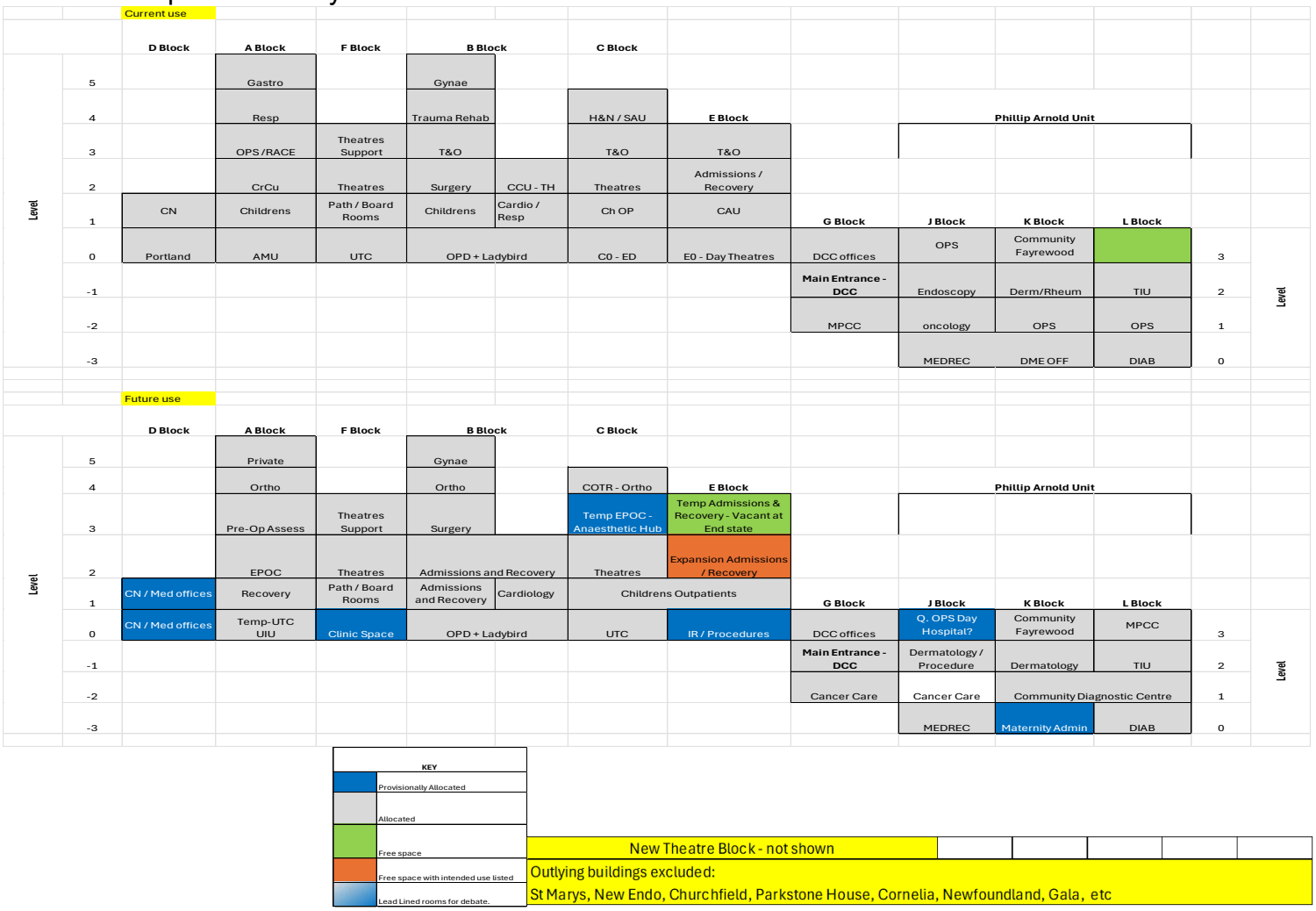




Construction and finished design of the new Endoscopy Unit at Poole

The complexity of the Poole site means the simplified schematics below is the best representation of the current and potential future allocations, noting this is still being developed as space use and clinical strategies develop.

Poole Hospital summary schematic of current and future use

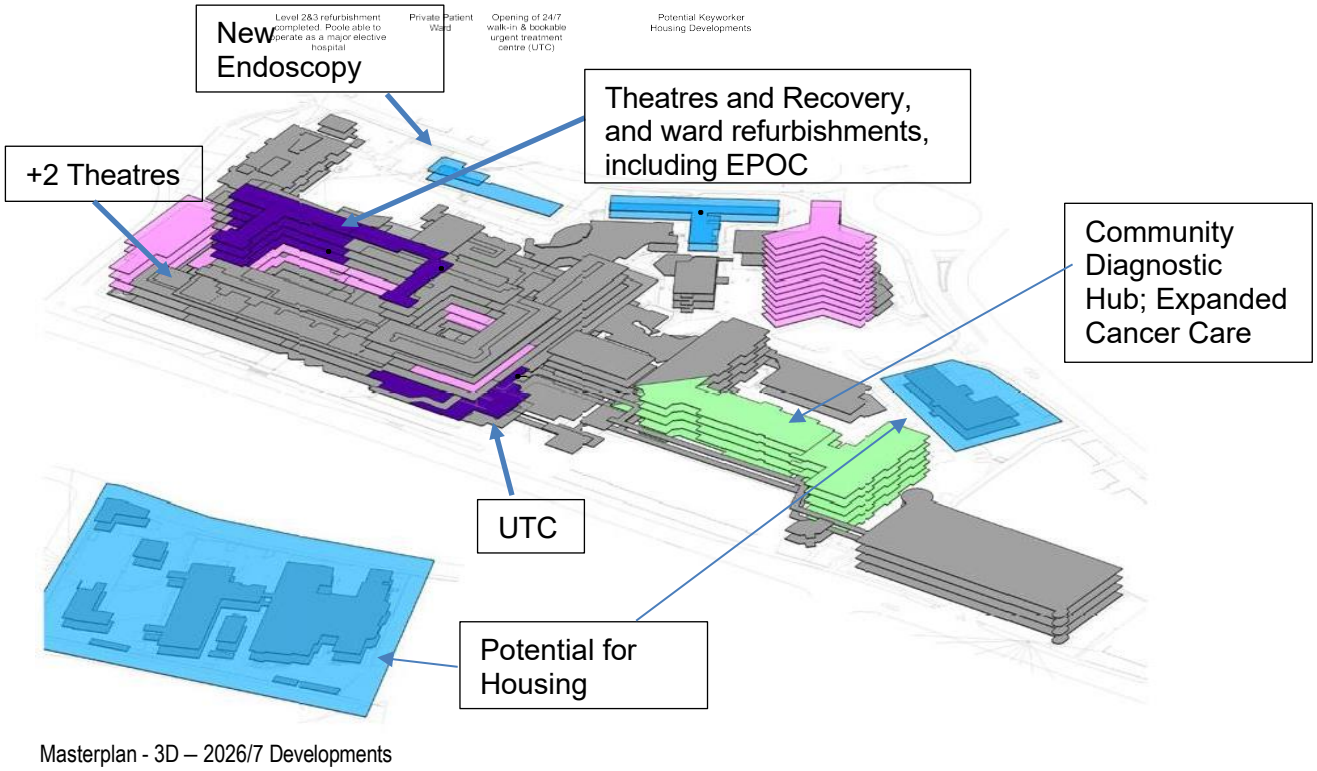


Our future aspirations for the Poole Site

Subject to funding, planning and approvals, there are numerous plans for further improvements at the site. This will build upon Poole's status as a planned and community-based hospital, serving Dorset and beyond.

- Urology Investigations Unit (UIU) to deliver more one stop, productive care
- A permanent Community Diagnostic Hub located in the planned care hospital
- Former day surgery area developed for procedures
- Cancer services clinic areas expanded (charity funded)
- A Maggie's Centre for supporting cancer patients (charity funded)
- More, and varied, key worker accommodation
- Building fabric improvements for energy saving, so cooler in summer and warmer in winter, included replaced windows, external materials and more solar panels
- Development of more clinic and office space for UHD, but also potentially partners, such as Primary Care
- Continued work to remove backlog maintenance
- Expanded and upgraded Radiology and Pharmacy aseptic facilities
- More space for education and training.

2027 Poole Planned and Community Care Hospital

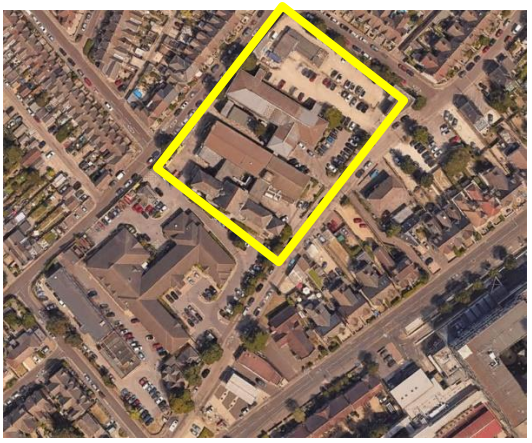


Masterplan - 3D – 2026/7 Developments

Key worker housing potential for Poole.

Rather than dispose of land that will become surplus, UHD would seek to create key worker accommodation. The location close to town and Poole Park with good transport links should make these attractive. This fits with the planning strategy for the local authority.





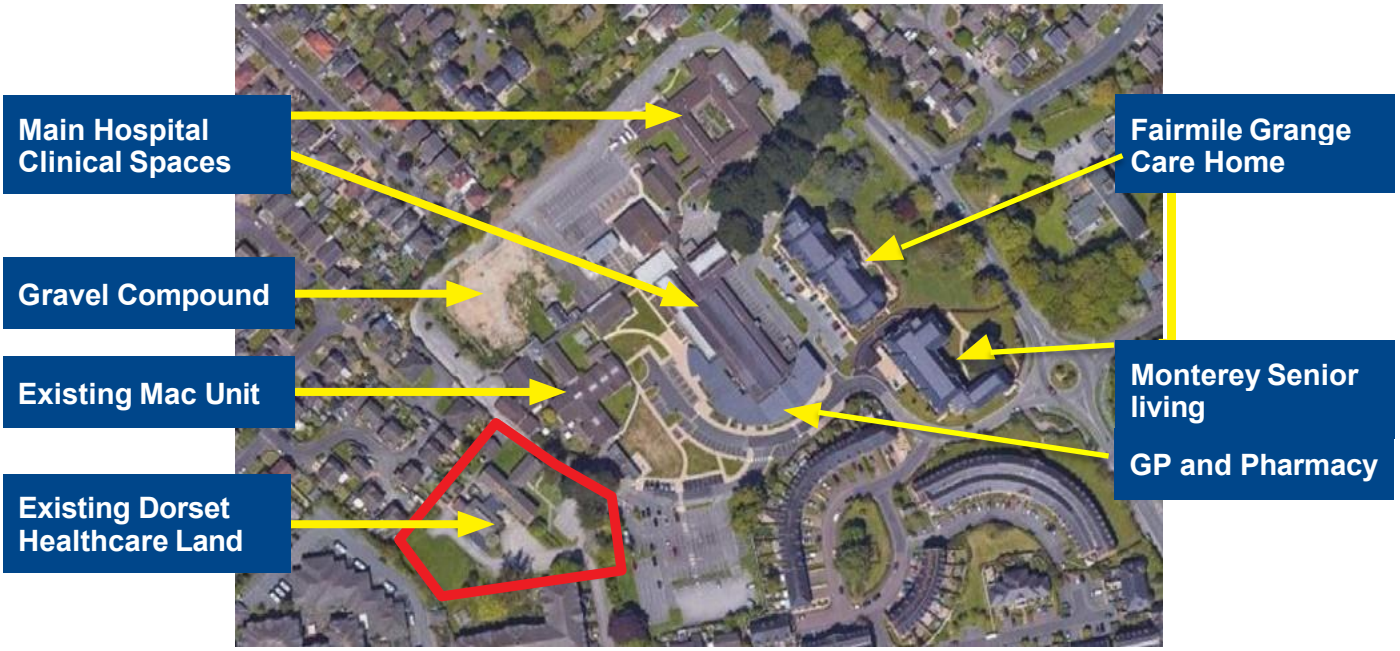
Dorset has a very high ratio of house prices to salaries. This makes it difficult to recruit and retain staff. Adding to the existing but limited on-site housing for staff and health students has significant benefits and contributes to local housing supply. The areas identified for key worker housing around the Poole site include St Mary's (photo on left). The Child Development Centre services offers another opportunity, once it has relocated to the new development at Royal Bournemouth Hospital, and to the Children's clinic space within the main building at Poole.

The CDC land and location allows a higher rise building. If this were of similar height to Parkstone House, then a significant number of modern, purpose-built homes could be built. These are indicative only and subject to further options appraisal work.

6. Christchurch Hospital and other Trust locations

Christchurch Hospital has already undergone significant changes in line with the masterplan agreed in 2013/14 and completed in 2017. This was Phase One. Since then, a major upgrade to the therapies services has enabled more care in better facilities. This has been supported by the Christchurch Hospital League of Friends.

Christchurch - site master plan at the end of phase one



Our Future Aspirations for Christchurch site

The Breast Screening service has a mobile unit regularly on site. With further support from the Christchurch League of Friends, a permanent, new facility could be built, providing easier access and better experience for patients.

Phase Two for the Christchurch site remains under review. The two key elements of specialist palliative care and senior living remain.

The Mac Unit already provides excellent care. Increasing 'hospice at home' services are meeting peoples' desire for their final days to be at home. When a hospice bed is needed, it needs to be in a modern, fit for purpose building. Work on the wider specialist Palliative Care Service across Dorset will inform the best way of achieving this.

Creating a **Senior Living Village** on land that may be spare will have the following benefits:

- Living in a community with greater support and social networks
- Better mental and physical health for independent living
- Lower demand on statutory services
- Typically, family-sized housing is freed up, aiding families in property searches
- Release of equity to support more economic freedom (ending "asset rich, cash poor" trap)
- Purpose built accommodation has lower maintenance, utilities, running costs and hassle of maintaining larger properties.

The Mac Unit new build is being funded via charitable donations, thanks to the MacMillan Caring Locally charity. Significant building cost inflation, seen across the UK, means there remains a significant gap between funds raised and the cost of the new building. A review of options will be undertaken on how to find a way forward.

Other UHD Locations

The Trust also has other sites:

- Yeomans House and Canford House as offsite offices
- Sterile Services Department at Alderney Hospital which is undergoing a planned programme of upgrading equipment and facilities
- Key worker housing on Longfleet Road, Poole plus the RBH site and one purpose- built off-site location in Pokesdown, Bournemouth called Abbotsbury House.
- Radiotherapy at Dorchester
- Scanners at Boscombe

In addition, some staff also work from home.

Other staff also work in community settings, and visit patients at their homes, including older peoples and stroke services, and maternity and children's care, plus specialist services.

7. Sustainable Transport

The Bournemouth, Christchurch, Poole (BCP) council area is one of the most congested in the UK with slow travel times. In line with the Green UHD plan promoting sustainable transport includes a multi-year, multi-million-pound investment including:

- Creating more and better shower and changing facilities including free towels
- Creating cycling lanes and more bike storage
- A strict parking permit policy for staff, limiting overall numbers and supporting individual travel plans and alternatives
- A shuttle bus route linking Poole and Royal Bournemouth Hospital is now in place
- Subsiding bus passes to make bus travel cheaper than car travel
- Staff benefits to reduce the cost of bikes, electric bikes and accessories and incentivise electric cars
- Supporting home working where this is practical
- Creation of the Wessex Field link road (including cycle lanes) at RBH, reducing congestion at the main entrance on Deansleigh Road
- Supporting car shares, with apps to make this as easy as possible.

Reducing the need to travel to hospital at all is also a better way to cut congestion and pollution. Actions include:

- Increased virtual clinics and digital outpatients by up to 30%.
- Work from home (WFH) for staff and partners and more online training courses.
- More key worker housing located so staff can walk to work.
- Shifting services into the community e.g. outpatient's physio, blood tests and diagnostics.

Travel patterns to the RBH site will also change. The mix of services will change, with more 24/7 services on site, such as enlarged ED, critical care, maternity, child health and more inpatient wards. This will be balanced by more 'office hours' work moving offsite; elective operating lists and rehabilitation wards moving to Poole; virtual clinics and one stop clinics reducing trips to site.

With the staff on site having a higher proportion of "long day shifts" (often 3 x 12-hour shifts per week, and spread over nights and weekends). So, whilst the net increase of 2,000 staff on site, there will be less staff journeys during peak hours of 8-9 and 4-5:30. Combined with the other measures listed above so the impact on traffic is designed to be neutral or beneficial to the conurbation and immediate Littledown area. Taken together this represents the biggest shift of any organisation in BCP towards reducing congestion, pollution and supporting the health benefits of walking and cycling.



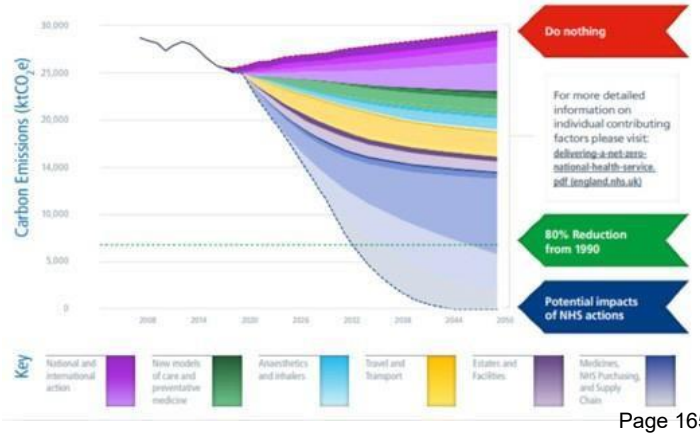
8. Green UHD

The NHS and UHD have committed to an 80% reduction in carbon by 2032 against the 1990 baseline. This entails a complete change in approach to how we operate. More detail is set out in the Green UHD plan. This also includes actions against the cornerstone targets.



Within the Estates Masterplan this includes the following key actions:

- 100% zero carbon electricity supply achieved, and extensive solar PV installations.
- Developing plans for geothermal district heat systems.
- Smart buildings, minimizing energy usage including use of ground and air source heat pumps
- BREEAM excellent for new building, and very good for refurbishments
- Use of modern methods of construction (MMC) to standardize design and reduce time, cost and wastage
- Designing in climate adaptation to reflect expected climate change over the 50-60-year life of these buildings to cope better with extreme temperatures and rainfall
- Enhancing the biodiversity of all sites, including plans around planting, and supporting insect and wildlife habitats.





9. Supporting Plans

This estates masterplan sits within the wider UHD and Dorset ICB plans, as well as those of the Local Authority, including their Local Plan. This strategy also takes into consideration national policies and recommendations, including the 10-year plan and Getting It Right First Time (GIRFT). As these are updated so will this strategy.

This plan will also inform specific plans within UHD, for infrastructure investment and maintenance. These include strategies for:

- Digital developments
- Patient experience
- Infection control and prevention
- Waste management
- Energy (electrical, gas and resilience)
- Decarbonisation
- Oxygen supplies
- Water supply and safety
- Fire prevention and control
- Ventilation
- Design quality assessment process

Others as required.

NHS 10 Year Plan

The NHS plan signifies three shifts, to a neighbourhood NHS, to digital and to prevention. The capital programme and Estates masterplan will continue to develop and support all three.

The neighbourhood approach is to site health services closer to the communities they serve. Poole and Christchurch hospitals are well placed with good access. RBH as the major emergency hospital will specialise in what it needs to do for the whole catchment of 750,000 residents plus visitors. Supporting community services is already underway with Community Diagnostic Services placed in areas of deprivation across Dorset to improve access. Working with colleagues in primary care and community to develop a community estate strategy will enable this part of the 10-year plan.

UHD is also a leading site for digitising outpatients, and bringing Dorset's services into a modern, patient-centred approach. This is an ambitious, multi-year redesign of a significant part of the NHS. This will reduce trips to hospital and give greater power to patients.

The current model of care, requiring patients to attend hospital on multiple occasions, will change, and instead, join up information, decision making, monitoring, diagnostics and health promotion, especially for long term conditions. The Estates Masterplan will continue to update to reflect these policy priorities.

Estates backlog reduction

Backlog works for maintaining buildings and systems is a growing national issue, estimated at over £10 billion for the NHS. UHD is in line with this national benchmark, having a current estimated backlog of over £200m to bring all estate to condition B. The largest part of this is, at £132m, is within the Poole estate, as this is older.

The significant infrastructure works at Poole will be phased for 2027-30 when the site has greater flexibility following the emergency/planned service moves. Until then works are focused on the most urgent critical infrastructure. A robust Quality Management system is in place, and national reporting is via the Premises Assurance Model (PAM) reporting. The five yearly six facet survey approach helps quantify and prioritise the backlog.

All values are £'000s, based on 2025 six facet survey:

	High	Significant	Medium	Low	TOTAL (Works Costs)	TOTAL (Project Costs)
RBH	0	13,127	30,943	3,522	47,592	79,320
Poole	131	30,150	43,290	5,918	79,489	132,482
Christchurch	0	2,056	766	164	2,986	4,977
Alderney	0	904	276	27	1,207	2,012
TOTAL	131	46,237	75,275	9,631	131,274	218,791

Each year a backlog reduction plan is agreed via the Capital Management Group. As well as making services safer and more reliable, backlog reduction also cuts costly maintenance and energy costs. Since UHD was formed in 2020 the stronger capital funding and planning has been able to target critical backlog.

This investment to reduce backlog has allowed focused risk-based projects to keep pace with the degradation of the overall estates condition. The critical backlog has remained relatively static as a consequence:

Backlog £m	Critical	Total	Investment
2021-22	41.5	67	3
2022-23	42.8	72.5	3.1
2023-24	25.9	52.4	6
2024-25	30.3	68.7	7.7

This investment has included over £4m in fire safety. Whilst much work remains it is important to note that the backlog strategies go beyond basic replacement of items and ensure the specifications of works future-proof the estates with enhanced technologies with focus on sustainability, digital solutions and decarbonisation & energy efficiency. Examples of such include modernisation of Building Management Systems, sitewide replacement of fluorescent lighting to LEDs, and modern electrical infrastructure which adds resilience to the networks and allows for future capacity as the Trust continues decarbonisation.

Whilst the major reconfiguration programmes have removed significant backlog through demolitions and refurbishments of ageing buildings, it should be noted that the increase in the built environment footprint will result in an increase in fabric and infrastructure costs that will also require maintaining. For this reason, the future investment in the estates backlog programme must be significant (circa £15-20m p/a) in order to reduce the risk of infrastructure failure affecting the operation of the hospital sites.

10. Public, patient, volunteer and staff involvement

In developing this strategy, it draws on significant public, patient and staff involvement, over many years. This includes over 12,500 hours of clinical staff time in ensuring the new and refurbished buildings are designed to provide the optimal care for patients.







Public Consultation and engagement across Dorset

Access for all

As designs are developed, they undergo design quality assessments (DQs). This considers disabilities to ensure buildings are accessible, and patient centred against many criteria. In addition, many further opportunities will be designed into the programme of works to ensure patient, visitors and staff wisdom and insights are incorporated.

Visual art and decoration can bring buildings to life. They also allow further opportunities for stakeholder input and can convey health messages.





Improved catering facilities, to improve patient experience of staying in hospital.

Volunteers

Volunteers are part of the team and make a large difference to the quality of patient experience. This includes welcoming and directing, companionship, helping at mealtimes, gardening and many other activities. If you would like to find out more about these fulfilling activities, then please visit Volunteering

Share your views

The NHS belongs to the people and so quite rightly those views should be asked for, and collated, to ensure this once-in-a-generation investment and change in services is reflected in these plans. To comment please email **communications@uhd.nhs.uk** quoting “UHD Estates Masterplan.”

To receive updates on these plans and the work of the UHD team please become a member of UHD Becoming a member (uhd.nhs.uk)

For more information including floor plans of the new estate and “walk through” videos please visit the website **www.uhd.nhs.uk** and search for “future care.”

We are #TeamUHD

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University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 5 November 2025

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	People and Culture Committee – Chair's Report
Presented by:	Sharath Ranjan, Chair of the People and Culture Committee
Agenda items discussed:	At its meeting on 8 October 2025, The Committee received the following: • Staff Story – Behavioural Charter • Board Assurance Framework: Breakthrough Objectives and Strategic Initiatives • People and Culture Strategy Progress Report • Integrated Performance Report – People and Culture • Chief People Officer's Report, including Culture Champions update • People Ready Assurance Report • WRES and WDES • Diverse Ethnicity Network update • Freedom to Speak Up Report, including FTSU Strategy 2026/29 • Patient First Update Report • Modern Slavery Statement • Assurance/Alerts and Escalations from Surgical Care Groups • Risk Register – Workforce and Organisational Development • Advanced practice policy and SOP • Assistance with Relocation Expenses Policy and Procedure
ALERT	The Committee wishes to alert members of the Board that: • **People and Culture Strategy, appraisals and health & well-being** The appraisal completion rates continue to remain low. In discussion, the committee has sought further assurance around the quality of these appraisals. A holistic approach is necessary to understand the interconnectedness of wellbeing, fatigue, appraisals and engagement.
ASSURE	The Committee wishes to assure members of the Board that:

	• **Freedom to Speak Up Report, including FTSU Strategy 2026/29 and Behaviour Charter implementation update** The committee noted the later FTSU report and the updated strategy and support its approval by the board. The committee also heard from Megan Howarth, our culture Champion, around the use of the behaviour charter to address unkind behaviours with clinical settings. Staff Networks and Culture champions will be playing a key part in sustaining the charter's impact.
ADVISE	The Committee wishes to advise the Board that: • **Workforce Operational Plans and Financial Controls** Bank usage continues to remain higher than expected with clear reductions in the use of agency. In discussion, the committee noted the impact on morale and perception of Admin and Clerical staff that there was a recruitment freeze. The controls are being tightened around temporary staffing with rigorous scrutiny still leading to approvals for recruitment. There are gaps in the communication of this approach which will be addressed by Irene and her team. • **WRES and WDES** The WRES and WDES reports had already been through the Board meeting. However, in discussion, the committee noted the disparities across several metrics especially for the global majority and sought the need for intersectional analysis of the data. The trust should continue to examine systemic biases which may be contributing to the disparities. Declaration rates for disabilities continues to remain low in comparison to data from staff survey.
Review of Risks	There were no People and Culture related risks rated 15 or above on the Risk Register. However, there were some risks on the Care Group which did not align with the Trust's register and an action has been set to review this.
Celebrating Outstanding	The Diverse Ethnicity Network provided an overview of the support they provide to their members and the value they add to UHD's vision of making this a great place to work. A recent change to Relocation Expenses Policy (removal of band restriction) demonstrated our commitment to inclusion driven by the removal of systemic barriers.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 6.3.1

Subject:	Modern Slavery and Human Trafficking Statement
Prepared by:	Deepa Pappu, EDI lead
Presented by:	Deb Matthews, Director of Organisational Development Deepa Pappu, EDI Lead, Organisational Development Team

Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☒ Patient Experience ☐ Quality Outcomes & Safety ☐ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	BAF 3 and BAF 8
Purpose of paper:	Decision/Approval
Executive Summary:	The attached statement is a statutory requirement and requires to be published on the trust internet. The Trust must comply with section 54 of the Modern Slavery Act 2015 as the following applies: • are a corporate body (wherever incorporated) or a partnership. • carry on a business, or part of a business, in the UK • supply goods or services; and have an annual turnover of £36m or more
Background:	A statement must contain the steps an organisation has taken to prevent modern slavery in its supply chains and own business. The statement must be approved and signed by a director, member or partner of the organisation. The statement must be published on the UHD website with a link in a prominent place on the homepage. Any incident of modern slavery should be dealt with appropriately and relevant remedies made available to potential victims.

	Modern Slavery is a term used to encapsulate both offences in the Modern Slavery Act: slavery, servitude and forced or compulsory labour; and human trafficking. The offences are set out in section 1 and section 2 of the Act.
Key Recommendations:	The People and Culture Committee are requested to approve the Modern Slavery and Human Trafficking Statement
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 & Culture Committee	01/09/2025	Approved
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

Modern Slavery and Human Trafficking Statement

This statement, made in accordance with section 54(1) of the Modern Slavery Act 2015, sets out the approach taken by University Hospitals Dorset NHS Foundation Trust (UHD) to understand all potential modern slavery risks related to its business, and the actions undertaken to mitigate any such risks during the financial year ending 31 March 2026.

What is Modern Slavery?

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

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

Trust's Compliance Requirements with the Modern Slavery Statement

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

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

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

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

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

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

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

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

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

Training of our staff:

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

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

This statement will be reviewed annually.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 5 November 2025

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
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 20 October 2025, the Committee received the following: • Service Ready Update • Build Ready Update • People Ready Update • TCT Digital Update • Phase 3 Comms and Engagement Strategy • Funding Approach: Medium Term Capital Plan
ALERT	The Committee wishes to alert members of the Board that: • Workforce plans are still behind target but good progress being made to improve position. Focused work and monitoring continue.
ASSURE	The Committee wishes to assure members of the Board that: • Baby tagging. System more stable and being monitored regularly. Further checks and training underway. To agree a target date for resolution.
ADVISE	The Committee wishes to advise the Board that: • All phase 2 moves complete. Phase 3 planning underway and ongoing review of critical path actions. • TCT program, IT informatics is on track. • Comms and engagement plan reviewed. Consideration requested for external review of plan, as so crucial to success.
Review of Risks	• ED demand and capacity – need to improve internal efficiency and SDEC diversion to achieve phase 3 capacity. • Timely progression of workforce plans to allow adequate implementation time following consultation.
Celebrating Outstanding	• Thank you to all staff who all went 'above and beyond' to ensure completion of phase 2 moves.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 5 November 2025

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Audit Committee – Chair's Report
Presented by:	Claire Whitaker, member of the Audit Committee
Agenda items discussed:	At its meeting held on 16 October 2025 the Committee received the following: • Internal Audit: Progress and Follow-Up Report • External Audit Progress Report • Counter Fraud Report • Emergency Preparedness, Resilience & Response Report • Board Assurance Framework • Risk Register • Clinical and Non-Clinical Policies Report • Health of the Ward Update • Risk tolerance - housing compliance • Research – governance arrangements • Clinical Audit – report from Quality Committee • Standing Financial Instructions Review • Review of Losses and Special Payments >£15k (for this period • Commercial Compliance Report • Freedom to Speak Up Report • Review of Effectiveness: ○ Internal Audit ○ External Audit ○ Counter Fraud • Risk Oversight Committee Terms of Reference
ALERT	The Committee wishes to alert members of the Board that: • A discussion of the broader strategic implications of Research is recommended.
ASSURE	The Committee wishes to assure members of the Board that: • Robust oversight of internal and external audit progress and follow-up reports is maintained. • Matters are in hand regarding Data Security and Protection Toolkit and the sourcing of one outstanding respiratory suit as set out under the Trust's Emergency Preparedness, Resilience and Response submission to NHSE.

ADVISE	The Committee wishes to advise the Board that: • Outstanding internal audit recommendations are being followed up. • New Risk Oversight Committee Terms of Reference (led by Sarah Herbert, CNO) were received and agreed. • A Procurement Steering Board is being established for the One Dorset Procurement Service. • Internal, external and capital audit contracts have been extended.
Review of Risks	• The Risk Register was subject to detailed review.
Celebrating Outstanding	• As this was John Lelliott's final meeting as chair, he was thanked for his significant contribution and support.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 6.5.1

Subject:	Standing Financial Instructions – Annual Review
Prepared by:	Pete Papworth, Chief Finance Officer
Presented by:	Pete Papworth, Chief Finance 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)	N/A
Purpose of paper:	Decision/Approval
Executive Summary:	The SFIs have been reviewed with only trivial, drafting corrections being made with tracked changes for ease of reference. Mainly, this adds specific reference to the UK Procurement Act alongside the Public Procurement Regulations. As part of the development of the One Dorset Procurement shared service; further amendments will be required to the Trusts Scheme of Delegation and SFIs to recognise the proposed new Procurement Steering Board. This steering board will need delegated authority from all three FT Boards to ensure timely decisions can be made recognizing the current differential internal approval levels within the current organisations. Proposed amendments will be brought to a future meeting for consideration and approval once developed.
Background:	The Trust Standing Financial Instructions were prepared and implemented immediately upon merger, in October 2021. They reflect the model NHS FT SFIs amended as appropriate for UHD. They have subsequently been reviewed and updated annually.
Key Recommendations:	The Board is asked to approve the Standing Financial Instructions.
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**
Audit Committee	16/10/2025	The Committee endorsed the report and recommended it to Board for approval.

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	☐

STANDING FINANCIAL INSTRUCTIONS

A) SUMMARY POINTS
•
•
ASSOCIATED DOCUMENTS
•
•

B) DOCUMENT DETAILS	
Author:	Pete Papworth
Job title:	Chief Finance Officer
Directorate:	Board of Directors
Version no:	4
Target audience:	All Trust staff
Approving committee / group:	Board of Directors
Chairperson:	Rob Whiteman
Review Date:	November 2024

C) CONSULTATION PROCESS			
Version No.	**Review Date**	**Author**	**Level of Consultation**
1	July 2020	Jill Hall	
2	October 2021	Pete Papworth	
3	October 2023	Pete Papworth	Audit Committee
4	June 2024	Pete Papworth	Update for New PPR Thresholds
5	October 2024	Pete Papworth	Audit Committee

D) VERSION CONTROL						
Date of Issue	**Version No.**	**Date of Review**	**Nature of Change**	**Approval Date**	**Approval Committee**	**Author**
October 2020	1	October 2021	Updated to reflect Public Procurement Regulations (previously OJEU).	November 2021	Board of Directors	Pete Papworth
October 2021	2	October 2022	Addition of new CEO approval limit and corresponding increase to FPC approval threshold; update to reflect Public Procurement Regulations thresholds.	November 2022	Board of Directors	Pete Papworth

October 2023	3	November 2024	Minor drafting corrections; review of approval limits in Annex 1 including introduction of higher approval limit for capital expenditure.	29 November 2023	Board of Directors	Pete Papworth
June 2024	3a	November 2024	Updated for new national PPR Thresholds	N/A	N/A	Pete Papworth
October 2024	4	November 2025	Annual Review	November 2024	Board of Directors	Pete Papworth
October 2025	5	November 2026	Annual Review Added references to UK Procurement Act	November 2025	Board of Directors	Pete Papworth

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1. Introduction

1.1. General

1.1.1. These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures to be adopted by the Trust. They apply to everyone working for the Trust and its constituent organisations.

1.1.2. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Delegation adopted by the Trust.

1.1.3. They do not provide detailed procedural advice. They should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Chief Finance Officer.

1.1.4. Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Finance Officer must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.1.5. Failure to comply with SFIs and/or Standing Orders is a disciplinary matter which could result in dismissal.

1.1.6. These SFIs shall have effect as if incorporated in the Standing Orders of the Trust.

1.1.7. This document should be reviewed by the Chief Finance Officer at least annually.

1.2. Terminology

1.2.1. Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these SFIs and the following words shall have the following meanings:

2006 Act	means the National Health Service Act 2006.
2012 Act	means the Health and Social Care Act 2012.
Accounting Officer	means the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.
UK PPR	United Kingdom Public Procurement Regulations.
UK PA	United Kingdom Procurement Act 2023
Auditor	means the person appointed to audit the accounts of the Trust who is called the auditor in the 2006 Act.
Board	means the Board of Directors of the Trust.

Budget	means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
Budget Holder	means the director or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.
Chief Executive or CEO	means the Chief Executive of the Trust.
Director	means a member of the Board of Directors (which expression, for the avoidance of doubt, shall not include an individual who attends meetings of the Board of Directors but who is not a member of the Board).
CFO	means the Chief Finance Officer of the Trust.
Chief Officers	means an executive director on the Board of Directors of the Trust (which expression, for the avoidance of doubt, shall not include an individual that holds the title of Director and attends meetings of the Board and/or executive directors but who is not a member of the Board).
Financial Year	means each successive period of twelve months beginning with 1 April.
Funds held on Trust	means those funds which the Trust holds on the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under section 218 of the 2006 Act, as amended. Such funds may or may not be charitable.
Governor	means a member of the Council of Governors.
Members' Meeting	means the Annual Members' Meeting or any Special Members' Meeting as referred to in the Trust's Constitution.
NHS Body	means NHS England, an NHS foundation trust, , an NHS trust, Integrated Care Board, a special health authority or a Local Health Board.
Non-Executive Director	means a non-executive director on the Board of Directors of the Trust (which expression, for the avoidance of doubt, shall not include an Associate Non-Executive Director who attends meetings of the Board of Directors but is not a member of the Board of Directors).

Scheme of Delegation or SD	means the Reservation of Powers and Scheme of Delegation as approved by the Board of Directors which sets out those powers reserved to the Board and those powers which it has delegated.
SFIs	means these Standing Financial Instructions.
Standing Orders or SO	means the Standing Orders of the Board of Directors.
Trust	means University Hospitals Dorset NHS Foundation Trust.

1.2.2. Wherever the title CEO, CFO, Director or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them in their absence.

1.2.3. Wherever the term **employee** is used and where the context permits, it shall be deemed to include agency staff and employees of third parties contracted to the Trust when acting on behalf of the Trust.

1.2.4. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice versa.

1.3. Responsibilities and Delegation

1.3.1. The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

(d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation.

1.3.2. The Board of Directors has resolved that certain powers and decisions may only be exercised by it in formal session. These are set out in the Scheme of Delegation.

1.3.3. The Board of Directors will delegate responsibility for the performance and its functions in accordance with the Scheme of Delegation document adopted by the Trust.

1.3.4. Within the SFIs, it is acknowledged that the CEO is ultimately accountable to the Board and, as Accounting Officer of the Trust has a statutory duty to ensure that the Board meets its obligation to perform its functions within the available financial resources. The CEO has overall executive responsibility for the Trust's activities and is accountable to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5. The CEO and CFO may delegate their detailed responsibilities but they remain

accountable for financial control.

1.3.6. It is a duty of the CEO to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these SFIs.

1.3.7. The CFO is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

1.3.8. Without prejudice to any other functions of directors and employees to the Trust, the duties of the CFO include:

(a) the provision of financial advice to the Trust and its directors and employees;

(b) the design, implementation and supervision of systems of financial control;

(c) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.9. All directors and employees, severally and collectively, are responsible for

(a) the security of Trust property;

(b) avoiding loss;

(c) ensuring economy, efficiency and value for money in the use of public resources;

(d) complying with the requirements of the Constitution, Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

1.3.10. Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the CEO to ensure that such persons are made aware – this would normally be done by adding reference to the SFIs to the tender document.

1.3.11. For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the CFO.

2. Audit

The Trust shall comply with the directions of NHS England with respect to the standards, procedures and techniques to be adopted in maintaining the Trust's financial records.

2.1. Audit Committee

2.1.1. In accordance with Standing Orders the Board shall formally establish an Audit Committee, with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) overseeing internal audit, external audit and counter fraud services and reviewing the reports produced;

(b) reviewing the effectiveness of internal control, risk management, corporate governance and financial systems and the assurance framework;

(c) monitoring compliance with SO and SFIs;

(d) reviewing the annual financial statements and making recommendations to the Board of Directors

(e) reviewing the Annual Report and Accounts and the Quality Account.

2.1.2. Where the Audit Committee consider that there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the chair of the Audit Committee should raise the matter at a meeting of the Board of Directors. Exceptionally, the matter may need to be referred to NHS England or to the CFO in the first instance.

2.1.3. It is the responsibility of the CFO to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

2.2. Fraud, Bribery and Corruption

2.2.1. in line with their responsibilities, the Chief Executive and CFO shall monitor and ensure compliance with guidance issued by NHS England or the NHS Counter Fraud Authority on counter fraud, bribery and corruption.

2.2.2. The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS counter fraud manual and NHS Counter Fraud Authority standards and guidance.

2.2.3. The Local Counter Fraud Specialist shall report to the Trust's CFO and shall work with staff in NHS Counter Fraud Authority.

2.2.4 The Local Counter Fraud Specialist and CFO will, at the beginning of each financial year, prepare a written work plan outlining the Local Counter Fraud Specialist's projected work for that financial year.

2.2.5. The Local Counter Fraud Specialist will provide a written report to the Audit Committee, at least annually, on counter fraud work within the Trust.

2.2.6. The CFO shall be responsible for the implementation of anti-bribery controls.

2.3. Chief Finance Officer (CFO)

2.3.1. The CFO is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an effective internal audit function;

(b) ensuring that the internal audit is effective and meets the NHS mandatory audit standards

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities;

(d) ensuring that an annual audit report is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:

(i) a clear statement on the effectiveness of internal control;

(ii) major internal financial control weaknesses discovered;

(iii) progress on the implementation of internal audit recommendations;

(iv) progress against plan over the previous year;

(v) strategic audit plan covering the coming three years;

(vi) a detailed plan for the coming year.

2.3.2. The CFO, the auditors (both external and internal) and the Local Counter Fraud Specialist are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case, they shall have a duty to safeguard that confidentiality);

(b) access at all reasonable times to any land, premises or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under an employee's control;

(d) explanations concerning any matter under investigation from any employee, agent or any employees of third parties contracted to the Trust when acting on behalf of the Trust

2.4. Role of Internal Audit

Internal Audit primarily provides an independent and objective opinion to the Chief Executive, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the Trust's objectives. Internal Audit will review, appraise, and report upon:

2.4.1.

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management information and data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;

(ii) waste, extravagance and inefficient administration;

(iii) poor value for money or other causes;

(iv) risk;

(e) report upon the adequacy of follow-up action on audit reports;

(f) carry out investigative/project work as agreed with and under a plan and the terms of reference laid down by the CFO and agreed by Audit Committee.

2.4.2. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the CFO must be notified immediately.

2.4.3. The Internal Auditor will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and CEO of the Trust.

2.4.4. The Internal Auditor shall be accountable to the CFO. The reporting system for internal audit shall be agreed between the CFO, the Audit Committee and the Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

2.4.5. The Internal Auditor is responsible for developing and maintaining an Internal Audit Strategy.

2.4.6. Internal Audit must be sufficiently independent of the activities which it audits to enable auditors to perform their duties in a manner, which facilitates impartial and effective professional judgements and recommendations. Internal Audit will have no Executive responsibilities.

2.4.7. The Internal Audit team must endeavor to fulfil the four main principles of the code of ethics for Internal Audit, integrity, objectivity, competency and confidentiality.

2.5. External Audit

2.5.1. The External Auditor is appointed, or removed, by the Council of Governors at a general meeting of the Council of Governors and paid for by the Trust. The Audit Committee must ensure a cost-efficient service.

2.5.2. The Audit Committee will receive and agree with External Auditors their annual plan.

3. Business Planning, Budgets, Budgetary Control and Monitoring

3.1. Finance and Performance Committee

3.1.1. The Board shall establish a Finance and Performance Committee with clearly defined terms of reference.

3.1.2. The role of the Finance and Performance Committee is to review, on behalf of the Board of Directors, the financial performance and controls reporting as necessary and to take decisions on such financial matters that may be delegated to the Committee for decision from time to time by the Board of Directors.

3.2. Preparation and Approval of Business Plans and Budgets

3.2.1. The CEO will compile and submit to the Board of Directors an annual plan, strategic and operational, which takes into account financial targets and forecast limits of available resources. As a minimum, this will meet the requirements laid down by NHS England. The annual operational plan will contain:

(a) a statement of the significant assumptions on which the plan is based

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

3.2.2. Prior to the start of the financial year the CFO will, on behalf of the CEO, prepare and submit budgets for approval by the Board of Directors. Such budgets will:

(a) be in accordance with the aims and objectives set out in the strategic plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds;

(e) identify potential risks.

3.2.3. The CFO shall monitor performance against budget and operational plan and report to the Committees and Board of Directors.

3.2.4. All budget holders must provide information as required by the CFO to enable budgets to be compiled.

3.2.5. The CFO has a responsibility to ensure that adequate training is delivered to budget holders to help them manage successfully.

3.3. Budgetary Delegation

3.3.1. The CEO and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

3.3.2. The CEO may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;

(b) the purpose of each budget heading;

(c) individual and group responsibilities;

(d) authorities to exercise virement;

(e) planned levels of service;

(f) provision of regular reports.

3.3.3. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the CFO, subject to any authorised use of virement.

3.3.4. Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the CFO.

3.3.5. Expenditure for which there is no provision in an approved budget and is not subject to funding under the delegated powers of virement, or approved procedures for new funding obtained during the year, may only be incurred if authorised by the CFO.

3.4. Budgetary Control and Reporting

3.4.1. The CFO will devise and maintain systems of budgetary control and financial reporting. These will include:

(a) financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) summary cash flow and forecast year-end position;

(iii) summary balance sheet

(iv) movements in working capital;

(v) capital project spend and projected out-turn against plan;

(vi) explanations of any material variances from plan;

(vii) details of any corrective action where necessary and the CEO's and/or CFO's view of whether such actions are sufficient to correct the situation;

(vi) such other information that Board may require.

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and workforce budgets;

(d) monitoring of management action to correct variances;

(e) arrangements for the authorisation of budget transfers.

3.4.2. Each budget holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is reported to the Finance and Performance Committee;

(b) the amount provided in the approved budget is not used in whole or in part

for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the CFO other than those provided for in the budgeted establishment as approved by the Board of Directors.

(d) the systems of budgetary control established by the CFO are complied with fully.

3.4.3. The CFO is responsible for ensuring cost improvements are identified and implemented and income generation initiatives in accordance with the requirements of the annual Business Plan and a balanced budget.

3.5. Capital Expenditure

3.5.1. The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Section 11). All items of capital expenditure must be referred to the CFO for inclusion in the capital planning and approval process.

3.5.2. The CFO is responsible for submitting to NHS England all capital programme information required by them in line with their requirements and timescales.

3.6. Monitoring Returns

3.6.1. The CFO is responsible for ensuring that:

(a) Financial performance measures have been defined and are monitored;

(b) Reasonable targets have been identified for these measures;

(c) A robust system is in place for managing performance against the targets;

(d) Reporting lines are in place to ensure overall performance is managed;

(e) Arrangements are in place to manage/respond to adverse performance.

3.6.2. The Chief Operating Officer is responsible for ensuring that the appropriate governance returns are submitted to the relevant monitoring organisation.

4. Annual Accounts and Reports

4.1. Accounts

4.1.1. The CFO on behalf of the Trust will:

(a) keep accounts, and in respect of each financial year must prepare annual accounts, in such form as NHS England may, with the approval of the Treasury, direct. This will be in accordance with paragraphs 24 and 25 of Schedule 7 of 2006 Act.

(b) ensure that, in preparing the annual accounts, the Trust complies with any directions given by NHS England with the approval of the Treasury as to:

(i) the methods and principles according to which the accounts are to be prepared; and

(ii) the information to be given in the accounts.

(c) ensure that a copy of the annual accounts and any report of the External Auditor on them, are laid before Parliament and that copies of these documents are sent to NHS England

4.2. Annual Report

4.2.1. The Trust will publish an Annual Report, in accordance with paragraph 26 of the 2006 Act. This will be presented to the Board of Directors for formal approval and then presented to a general meeting of the Council of Governors. The document will also be presented to the members of the Trust at a Members' Meeting. The document will comply with NHS England's Annual Reporting Manual.

5. Bank Accounts

5.1. General

5.1.1. The CFO is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account any guidance and directions issued by NHS England.

5.1.2. The Finance and Performance Committee shall approve the banking arrangements.

5.2. Bank Accounts

5.2.1. The CFO is responsible for:

(a) bank accounts;

(b) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

(c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) establishing separate bank accounts for the Trust's non-exchequer funds;

(e) ensuring donations are managed via accounts operated by the Trust's charitable body.

5.3. Banking Procedures

5.3.1. The CFO will prepare detailed instructions on the operation of bank accounts which must include:

(a) those authorised to sign cheques or other orders drawn on the Trust's accounts and the limitation on single signatory payments;

(b) the limit to be applied to any overdraft;

(c) the conditions under which each bank account is to be operated.

5.3.2. The CFO must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.3.3. All funds shall be held in accounts in the name of the Trust. No officer other than the CFO shall open any bank account in the name of the Trust.

5.4. Tendering and Review

5.4.1. The ~~Finance and Performance Committee~~ Chief Finance Officer will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

5.4.2. Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Finance and Performance Committee.

6. Income, Fees and Charges and Security of Cash and Cheques and other Negotiable Instruments

6.1. Income Systems

6.1.1. The CFO is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all income due.

6.1.2. The CFO is also responsible for the prompt banking of all monies received.

6.1.3. Any new business enterprise activities which fall within NHS England's definition of high risk investments (which includes significant capital expenditure, acquisitions, joint ventures, equity stakes, and major property transactions) must be reviewed by the Finance and Performance Committee and approved by the Board of Directors.

6.1.4. The Trust will carry on activities for the purpose of making additional income available in order to better carry on the Trust's principal purpose, subject to any restrictions in NHS England's authorisation and as stated in the Constitution.

6.2. Fees and Charges

6.2.1. The Trust shall follow NHS England's advice in establishing reference costs and Payment by Results tariffs in setting prices for NHS contracts.

6.2.2. The CFO is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health and Social Care or by statute. Independent professional advice will be taken as necessary;

6.2.3. The Trust's price tariff for private patient treatment will ensure that prices are at least equal to those charged to NHS Commissioners and ensures that public funds are not used to subsidise private patient activity.

6.2.3. All employees must inform the CFO promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, Trust sponsorship, tenancy agreements, private patient undertakings and other transactions.

6.3. Debt Recovery

6.3.1. The CFO is responsible for the appropriate recovery action on all outstanding debts.

6.3.2. Overpayments should be detected (or preferably prevented) and recovery initiated.

6.3.3. Income not received should be dealt with in accordance with losses and

compensations procedures.

6.3.4. The Audit Committee should receive reports of debts that are proposed for write-off

6.4. Security of Cash, Cheques and other negotiable instruments

6.4.1. The CFO shall be responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery or electronic records;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) prescribing systems and procedures for handling cash and cheques on behalf of the Trust.

6.4.2. Official money shall not, under any circumstances, be used for the encashment of private cheques.

6.4.3. All cheques, cash etc. shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the CFO.

6.4.4. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7. NHS Contracts for Provision of Services

7.1. Commissioning

7.1.1. The CFO is responsible for commissioning NHS service agreements for the provision of services to patients in accordance with the business plan, and for establishing the arrangements for out of area treatment. In carrying out these functions, the CFO should take into account the following:

(a) costing and pricing of services;

(b) payment terms and conditions;

(d) the contract negotiation process and timetable;

(c) amendments to NHS contracts and out of area arrangements.

7.2. Contract Pricing and Reporting

7.2.1. NHS contracts should be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. NHS contract prices should comply with the NHS Payment Scheme.

7.2.2. The CFO shall produce regular reports detailing actual and forecast NHS income with a detailed assessment of the impact of the variable elements.

8. Terms of Service

8.1. Remuneration and Terms of Service

8.1.1. In accordance with SO the Board of Directors shall establish an Appointments and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2. The Committee will:

(a) decide and keep under review the remuneration and terms of service for the CEO and other Chief Officers and other senior employees, including:

(i) all aspects of salary (including any performance-related elements/bonuses;

(ii) provisions for other benefits, including pensions and cars.

(iii) arrangements for termination of employment and other contractual terms

(b) determine the remuneration and terms of service of Chief Officers and other senior employees to ensure they are fairly rewarded for their individual contribution to the Trust, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;

(c) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

8.1.3. The Committee shall report in writing to the Board of Directors the reasons for its recommendations and report on its activities in the Trust's annual report.

8.1.4. The Board of Directors will review and if considered appropriate approve proposals presented by the CEO for setting of remuneration and conditions of service for those employees not covered by the Committee.

8.2. Funded Establishment

8.2.1. The workforce plans incorporated within the annual budget will form the funded establishment.

8.2.2. The funded establishment of any department may not be increased without the approval of the CFO.

8.3. Staff Appointments

8.3.1. No director or employee may engage, re-engage or re-grade employees, either of a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration that would exceed the approved staff budget unless authorised to do so by the CFO.

8.3.2. The Board of Directors will approve procedures presented by the CEO for the determination of commencing pay rates and conditions of service for employees.

8.4. Processing of Payroll

8.4.1. The CFO is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay;

(c) making payment on agreed dates;

(d) agreeing method of payment.

8.4.2. The CFO will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act 2018;

(g) methods of payment available to various categories of employee;

(h) procedures for payment by cheque or bank credit to employees;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

8.4.3. Appropriately nominated managers have delegated responsibility for:

(a) submitting time records and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the CFO's instructions and in the form prescribed by the CFO;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the CFO must be informed immediately.

8.4.4. Regardless of the arrangements for providing the payroll service, the CFO shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5. Contracts of Employment

8.5.1. The Board of Directors shall delegate responsibility to the Chief People Officer for:

(a) ensuring that all employees are issued with a contract of employment in a form approved by the Board of Directors and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

(c) ensuring that the Trust has process and procedures in place that ensure compliance with HM Treasury Guidance on Public Sector Exit Payments.

9. Non-Pay Expenditure

9.1. Delegation of Authority

9.1.1. The Board of Directors will approve the level of non-pay expenditure on an annual basis and the CFO will determine the level of delegation to Budget Managers.

9.1.2. The CFO will set out:

(a) the list of managers who are authorised to raise requisitions and/or place orders for the supply of goods and services;

(b) the maximum financial level for each requisition/order and the system for authorisation above that level.

9.1.3. The CFO shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2. Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

9.2.1. The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always seek to obtain the best value for money for the Trust. In so doing, the advice of the Trust's Commercial Services Department shall be sought. Where this advice is not acceptable to the requisitioner, the CFO (and/or the CEO) shall be consulted.

9.2.2. The CFO shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.2.3. The CFO will:

(a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) and/or formal tenders must be obtained; once approved, the thresholds (whole life costs) should be incorporated in these standing financial instructions and regularly reviewed, and refer to the schedule of levels depending on speciality/service/category of goods;

(b) prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for budget holders) on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) a list of Directors/employees, (including specimens of their signatures), authorised to certify requisitions, orders, goods receipts or invoices;

(ii) certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the timesheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the CFO of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

(f) ensure compliance with NHS England guidance on use of non-clinical agency and consultancy spend.

9.2.4. Prepayments are only permitted where appropriate circumstances apply. In such instances:

(a) prepayments are only permitted where the financial and/or commercial advantages outweigh the disadvantages and the intention is not to circumvent cash limits (e.g. cash flows must be discounted to NPV);

(b) the appropriate Director must provide a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is, at some time during the course of the prepayment agreement, unable to meet their commitments;

(c) the CFO will need to be satisfied with the proposed arrangements before contractual arrangements proceed;

(d) the budget holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or CEO if problems are encountered.

9.2.5. Official Purchase Orders must:

(a) be allocated a unique identifier;

(b) be in a form approved by the CFO;

(c) state the NHS Standard Terms and Conditions and/ or the Trust's terms and conditions as appropriate;

(d) be held securely, issued to and used only by those duly authorised by the CEO;

(e) ~~Digital electronic trading applies;~~

(f) be priced (firm or estimate).

9.2.6. Budget Managers must ensure that they comply fully with the guidance, policies and limits specified by the CFO and that:

(a) all contract and purchase orders (other than as permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the CFO in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with UK law on Public Procurement

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by NHS England;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits.

(e) no requisition or subsequent order is placed for any item or items for which there is no budget provision unless authorised by the CFO on behalf of the CEO;

(f) all goods, services, or works are ordered on an official order additional to any covering contract for the same apart from categories and circumstances as set out in the Trust Purchase Order Exemption Policy or purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the CFO and only in cases of emergency or urgent necessity. These must be confirmed within one working day by an official order which is clearly marked "Confirmation Order";

(h) orders are not split (disaggregated) or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on a trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of Directors/employees authorised to certify invoices are notified to the CFO;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the CFO;

(l) petty cash records are maintained in a form as determined by the CFO.

9.2.7. The Chief Strategy and Transformation Officer (CSTO) and CFO shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with NHS England guidance

The technical audit of these contracts shall be the responsibility of the relevant Director.

10. Tendering Procedure

The following procedures will apply for all goods and services, as set out in these SFIs, and as undertaken using a Trust approved e-tendering, evaluation & award system. By exception, (eg temporary lack of access to cloud based systems), the use of manual processes will be adopted as set out in Annex 3 – Manual Tendering procedures.

10.1. Scope of Activity:

10.1.1. This applies to all areas of Trust non-pay expenditure inclusive of Estates and Pharmacy purchases for:

(a) capital requirements;

(b) revenue purchases;

(c) supply of goods and services;

(d) works contracts;

(e) lease, hire and loan of equipment and goods.

10.1.2. It excludes categories of property rent, rates and utilities expenditure.

10.2. Invitation to Tender (ITT)

10.2.1. Invitations to tender will be undertaken utilising the Trust's approved e-tendering software package providing a secure and auditable process at all stages in the tender cycle through to award of contract. The supplier's response will be completed online and uploaded into a secure electronic mailbox until the opening time.

10.2.2. Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Sections 10.2.3 and 10.2.4 below.

10.2.3. Every tender for building and engineering works, except for maintenance work only where Estate code guidance should be followed, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or Department of the Environment (GC/Wks) standard forms of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the

General Conditions of Contract recommended by the Institution of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the CFO or Department of Health and Social Care.

10.2.4. Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must have given an electronic undertaking not to engage in collusive tendering or other restrictive practice.

10.2.5. Levels of expenditure (Annex 1)shows the levels at which either quotations or tenders are mandatory with the exception of compliant framework agreements where the conditions of the framework are fulfilled in the instance of single source selection and verified by Commercial Services as providing value for money (**VFM**) and appropriate competition. It also excludes works, utilities and 'Light Touch Regime' for services. The value is deemed as the estimated total life cycle cost (**TLC**) – noted that tenders will be sought at any value if deemed appropriate by Commercial Services to do so in order to provide VFM outcomes and rigour required.

(i) Exclusive of VAT;

(ii) Subject to specific product/market considerations as verified by applicable procurement officer.

10.3. Receipt, Safe Custody and Record of Formal Tenders

10.3.1. Tender documents will be securely stored in the electronic mailbox until the closing date and time. An audit log within the e-tendering system will record the data and time the offer documents are received.

10.4. Opening Formal Tenders

10.4.1. The details of the designated Trust Officers opening the documents will be recorded in the e-tender system audit trail together with the date and time of the document opening.

10.4.2. All actions by both procurement staff and suppliers are recorded within the system audit reports.

10.5. Admissibility and Acceptance of Formal Tenders

10.5.1. In considering which tender to accept, if any, the designated Officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

10.5.2. Tenders received after the due time and date may be considered only if the Chief Executive or the relevant Executive Director decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Executive or the relevant Executive Director shall decide whether such tenders are admissible and whether re-tendering is desirable. Re-tendering may be limited to those tenders reasonably in the field of consideration in the original competition. If the tender is accepted the late arrival of the tender should be reported to the Board of

Directors at its next meeting.

10.5.3. Technically late tenders (i.e. those dispatched in good time but delayed through no fault of the tenderer) may at the discretion of the Chief Executive be regarded as having arrived in due time.

10.5.4. Incomplete tenders (i.e. those from which information necessary for the adjudication of the tender is missing) and amended tenders (i.e. those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under Section 10.5.2.

10.5.5. Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing his offer.

10.5.6. Necessary discussions with a tenderer of the contents of his tender, in order to elucidate technical points etc., before the award of a contract, need not disqualify the tender.

10.5.7. Where only one tender/quotation is received the Chief Executive shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

10.5.8. In the event of a payment being made by the Trust, the Board of Directors will normally approve the best value for money unless satisfactory justification is provided to accept an alternative offer and the decision is recorded in their minutes and in the record referred to in 10.4 above. In the event of a payment to be received by the Trust, the Board of Directors will normally approve the highest tender unless satisfactory justification is provided to accept an alternative offer and the decision is recorded in their minutes and in the record referred to in 10.4 above.

10.5.9. All Tenders should be treated as confidential and should be retained for inspection.

10.6. Authority to buy protocol

10.6.1. Authorisation will be at the 'authority to buy' stage and will be via the purchase requisition authorisation or via the 'Request for Commercial Support' (**RCS**) document as appropriate. All medical devices and medical equipment must require authorisation to purchase, trial or loan via the medical devices governance process (MD1) prior to the commitment to purchase. This process ensures safety, quality and risk and full life cycle costings (FLC).

10.6.2. At the RCS stage, the relevant authorisation, according to value of expenditure, will be sought from the internal budget manager, countersigned by the appropriate Finance Business Partner.

10.6.3. The Scheme of Delegation will detail aggregated values above which contracts will require Finance Committee or Board of Directors approval prior to award of contract.

10.7. Procurement Reporting Protocol

10.7.1. Purchases and/ or contracts for which the award value is in accordance with the original authorised value and that the aggregated value is below that requiring subsequent approval in accordance with contract approval thresholds below will not require further authorisation to proceed to purchase.

10.7.2. If the value of expenditure is of a higher level than initially authorised then re-authorisation will be required in accordance with Standing Financial Instructions.

10.7.3. If an offer other than the best value offer is recommended then approval to recommend will be required via submission to the CFO. Contracts for the supply of goods and/or services (arising from competitive and compliant procurement) will be submitted for approval in accordance with Annex 1 prior to award of contract being made.

10.7.4. Following the above, contracts will be reported to the CFO, the Finance Committee and/or Board of Directors in accordance with values listed in above section (Contract Approval Thresholds) for final approval.

10.8. Waiver of Standing Financial Instructions

10.8.1. The above regulations may only be varied by the Chief Executive or the CFO as set out below and within the limits described in the Annex.

10.8.2. On receipt of a completed 'Standing Financial Instructions Waiver' (**SfiW**) form signed by the originating authorised officer and countersigned by a manager designated by the CFO.

10.8.3. A central Trust register of SfiW for tenders/ Quotations will be maintained by Procurement and reported to the CFO. The Audit Committee should also receive information on these.

10.8.4. Waiver of procurement procedures above UK PPR/ UK PA levels will require authorisation by the CEO or CFO on behalf of the Board of Directors.

10.9. UK PPR/ UK PA Regulations and Aggregation

10.9.1. UK PPR/ UK PA regulations as implemented and applicable in the UK under the laws of England and Wales will be applied to specified values, which are reviewed and published currently bi-annually. At these published levels for defined categories or types of product/service, prescribed processes apply.

10.9.2. UK PPR/ UK PA promulgated by the Department of Health and Social Care prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SFIs.

10.9.3. Formal Competitive Tendering - The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) and for disposals.

10.9.4. Formal quotation or tender, up to the prevailing UK PPR/ UK PA tender values, may be waived by either the Chief Executive or CFO on submission of a fully completed SfiW where:

(a) the timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for SfiW; or

(b) specialist expertise is required and is available from only one source; or

(c) the task is essential to complete the project and arises as a consequence of a recently completed assignment and engaging different consultants for the

new task would be inappropriate; or

(d) there is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

(e) provided for in the NHS Foundation Trust Annual Reporting Manual (ARM).

10.9.5. The limited application of the SfiW rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

10.9.6. Such SfiW must be numbered, entered onto a register and retained for inspection in the Commercial Services Department.

10.9.7. It should be noted that the financial limits imposed at the various authorisation levels include VAT and have to be aggregated in the event of a contract covering a given number of months or years, i.e. full life commitment.

10.10. IN-HOUSE SERVICES

10.10.1. In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or Nominated Officer(s) and specialist(s);

(b). In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support; and

(c) Evaluation group, comprising normally a specialist officer, a procurement specialist and a finance specialist.

10.10.3. All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.

10.10.4. The evaluation group shall make recommendations to the Board of Directors.

10.10.5. The Chief Executive shall nominate an officer to oversee and manage the contract.

11. External Borrowing and Investments

The CFO will be responsible for the management of the Trust's cash flow.

11.1. External Borrowing

11.1.1. The CFO will advise the Board of Directors concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, within the limits set by NHS England. The CFO is also responsible for reporting periodically to the Board of Directors concerning the originating debt and all loans and overdrafts and associated interest

11.1.2. Any application for a loan or overdraft will only be made by the CFO or by an employee so delegated by him/her. External loan applications (i.e. not NHS England loans/financing), require Finance and Performance Committee approval.

11.1.3. The CFO must prepare detailed procedural instructions concerning applications for loans and overdrafts.

11.1.4. All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short-term borrowing requirement in excess of one month must be authorised by the CFO.

11.1.5. All long-term borrowing must be consistent with the plans outlined in the current Business Plan.

11.2. Investments

11.2.1. Temporary cash surpluses must be held only in such public or private sector investments as authorised by the Finance and Performance Committee and subject to any guidance issued by NHS England.

11.2.2. The CFO is responsible for advising the Board of Directors on investment strategy and shall report periodically to the Board of Directors concerning the performance of investments held.

11.2.3. The CFO will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11.3. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

11.3.1. The CEO shall:

(a) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon Business Plans;

(b) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including depreciation and interest payable.

11.3.2. For every capital expenditure proposal the CEO shall ensure:

(a) that through the management of capital schemes policy a business case is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) appropriate project management and control arrangements.

(b) that the CFO has endorsed the cost and revenue assumptions made in the business case.

11.3.3. For capital schemes where the contracts stipulate stage payments, the CEO will issue procedures for their management

11.3.4. The CFO shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

11.3.5. The approval of a capital programme shall not constitute approval for expenditure on any scheme. The CFO shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

11.3.6. The CEO will issue a scheme of delegation for capital investment management and the Trust's Standing Orders.

11.3.7. The CFO shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.4. Asset Registers

11.4.1. The CEO is responsible for the maintenance of registers of assets, taking account of the advice of the CFO concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

11.4.2. The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Annual Reporting Manual issued by NHS England.

11.4.3. The Trust may not dispose of any protected assets without the approval of NHS England. This includes disposal of part of the property or granting an interest in it.

11.4.4. Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

11.4.5. Where capital assets are sold, scrapped, lost or otherwise disposed of, their

value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices.

11.4.6. The CFO shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

11.4.7. The value of equipment shall be indexed to current values in accordance with methods specified in the Annual Reporting Manual.

11.4.8. The value of each asset shall be depreciated using methods and rates as specified in the Annual Reporting Manual.

11.5. Security of Assets

11.5.1. The overall control of fixed assets is the responsibility of the CEO.

11.5.2. Asset control procedures (including protected property, non-protected assets, cash, cheques, negotiable instruments and donated assets) must be approved by the CFO. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques and negotiable instruments.

11.5.3. All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the CFO.

11.5.4. Whilst each employee has a responsibility for the security of property of the Trust, it is the responsibility of Directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

11.5.5. Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and employees in accordance with the procedure for reporting losses.

11.5.6. Where practical, assets should be marked as Trust property.

12. Stores and Receipt of Goods

12.1. General

12.1.1. Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to regular stock-take - perpetual and/or annual;

(c) valued at the lower of cost and net realisable value;

(d) be kept as secure as practically possible.

12.2. Control

12.2.1. Subject to the responsibility of the CFO for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the CEO. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/ keepers, subject to such delegation being entered in a record available to the CFO. The control of pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer; the control of fuel oil of a designated estates manager.

12.2.2. The responsibility for security arrangements and the custody of keys/electronic swipe access for all stores and locations shall be clearly defined in writing by the designated manager/pharmaceutical officer. Wherever practicable, stocks should be marked as property of the Trust.

12.2.3. The CFO shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.2.4. Stocktaking arrangements shall be agreed with the CFO and there shall be a physical check covering all items in store at least once a year.

12.2.5. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the CFO.

12.2.6. The designated manager/pharmaceutical officer shall be responsible for a system approved by the CFO for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the CFO any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13. Disposals and Condemnations, Losses and Special Payments

13.1. Disposals and Condemnations

13.1.1. The CFO must prepare detailed procedures for the disposal of assets including condemnations, scrap materials and items surplus to requirements and ensure that these are notified to managers. The Trust may not dispose of any protected property without the approval of the NHS England. These procedures shall comply with all appropriate Standing Orders and Standing Financial Instructions in addition to the requirements specified in the Trust's Policies and Procedures.

13.1.2. When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the CFO of the estimated market value of the item, taking account of professional advice where appropriate.

13.1.3. All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the CFO;

(b) recorded by the Condemning Officer in a form approved by the CFO which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose of the CFO.

13.1.4. The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the CFO who will take the appropriate action.

13.1.5. Any asset that is condemned or otherwise marked for disposal shall be removed from the asset register and departments responsible for maintenance of these assets must be informed. This is to ensure we do not pay for maintenance etc. of assets not in use.

13.2. Losses and Special Payments

13.2.1. The CFO must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The CFO must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

13.2.2. Any employee discovering or suspecting a loss of any kind must immediately inform their head of department, who must immediately inform the CEO and the CFO or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This officer will then appropriately inform the CFO and/or CEO. Where a criminal offence is suspected, the CFO must immediately inform the police if theft or arson is involved.

13.2.3. For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the CFO must immediately notify:

(a) the Board of Directors;

(b) the Local Counter Fraud Manager and

(c) the External Auditor.

13.2.4. Within limits agreed by the Board of Directors, the CFO shall approve the writing-off of losses.

13.2.5. The CFO shall be authorised to take any necessary steps to safeguard the Trust's interests in personal and company insolvencies.

13.2.6. For any loss, the CFO should consider whether any insurance claim can be made.

13.2.7. The CFO shall maintain a Losses and Special Payments Register in which write-off action is recorded. The Audit Committee should receive regular reports on losses and special payments.

14. Information Governance

14.1. Controls

14.1.1. The Director of Informatics, (who is also the Senior Information Risk Owner (SIRO)) has overall responsibility for accuracy and security of computerised data in the Trust supported by a network of Information Asset Owners who have this responsibility for their individual systems. The CFO has responsibility for Financial Systems.

14.1.2. The Director of Informatics/SIRO shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the General Data Protection Regulation and the Data Protection Act 2018;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the live computer environment is separated from development, testing and training environments wherever possible;

(d) ensure that an adequate management (audit) trail exists through the computerised system (including those obtained by external agency arrangements) and that such computer audit reviews as he/she may consider necessary are being carried out;

(e) prepare and maintain an Informatics Strategy for regular approval by the Board of Directors. He/she will also ensure that all purchases of hardware/software are in compliance with the Trust's Informatics Strategy.

14.2. System Development

14.2.1. The CFO shall satisfy himself/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.3. Data Security and Integrity

14.3.1. The Director of Informatics shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

14.3.2. Where another health organisation or any other agency provides a computer service for financial applications, the CFO shall periodically seek assurances that adequate controls are in operation.

14.3.3. Where computer systems have an impact on corporate financial systems the CFO shall satisfy themself that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Informatics Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) CFO staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

(e) appropriate disaster recovery and contingency arrangements are in place to ensure continuity in execution of the Trust's business.

14.4. Archives

14.4.1. The CEO shall be responsible for maintaining archives for all documents required to be retained under the storage retention and disposal of records policy.

14.4.2. The documents held in archives shall be capable of retrieval by authorised persons.

14.5. Destroyed Documents

14.5.1. Documents shall only be destroyed in accordance with the Health Records Policy.

15. Patients' Property

15.1. Responsibilities

15.1.1. The Trust has a responsibility to provide safe custody for money and other personal property (hereinafter referred to as **property**) handed in by patients or in the possession of confused or unconscious patients.

15.1.2. The CEO is responsible for ensuring:

(a) that patients or their carers, as appropriate, are informed before or at admission by:

(i) notices and information booklets;

(ii) hospital admission documentation and property records;

(iii) the oral advice of administration and nursing staff responsible for admissions.

(b) that the Trust will not accept responsibility or liability for patients' property brought into health service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

15.1.3. The CFO must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of patient's money in order to maximise the benefits to the patient.

15.1.4. Where Department of Health and Social Care instructions require the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the CFO.

15.1.5. In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of the property is £5,000 or less, forms of signed indemnity shall be obtained.

16. Charitable Funds

16.1. Introduction

16.1.1. Standing Orders identify the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust and define how those responsibilities are to be discharged. They explain that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition given to the dual accountabilities to the Charity Commission for charitable funds held on trust and to NHS England for all funds held on trust.

16.1.2. The reserved powers of the Board of Directors and the Scheme of Delegation make clear where any decision regarding the exercise of dispositive discretion are to be taken and by whom. Directors and officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

16.1.3. As management processes overlap most of the sections of these SFIs will apply to the management of funds held on trust. This section covers those instructions which are specific to the management of funds held on trust.

16.1.4. The overriding principle is that the integrity of each trust must be maintained, and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

16.2. Existing Charitable Funds

16.2.1. The CFO shall arrange for the administration of all charitable funds and ensure that a governing document exists. Detailed procedures covering the financial management of charitable funds must be produced for the guidance of Directors and employees.

16.2.2. The CFO shall periodically review the funds in existence and shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

16.2.3. The CFO may recommend an increase in the number of funds where this is consistent with the Trust's policy for ensuring the safe and appropriate management of restricted funds, e.g. designation for specific Wards or Departments.

16.3. New Charitable Funds

16.3.1. The CFO shall arrange for the creation of a new charitable trust where funds and/or other assets, received in accordance within the Trust's policies, cannot adequately be managed as part of existing charitable fund arrangements.

16.3.2. Governing documents for any new funds shall be presented to the Charitable Funds Committee by the CFO.

16.4. Sources of New Funds

16.4.1. In respect of **donations** the CFO shall:

(a) provide guidelines to Officers of this Trust as to how to proceed when offered funds. These will include:

(i) the identification of the donors' intentions;

(ii) where possible, the avoidance of new funds;

(iii) the avoidance of impossible, undesirable or administratively difficult objects;

(iv) sources of immediate further advice.

(b) provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into this Trust's charitable funds and that the donor's intentions have been noted and accepted.

16.4.2. In respect of **legacies and bequests**, the CFO shall:

(a) provide guidelines to officers of the Trust covering any approach regarding:

(i) the wording of wills;

(ii) the receipt of funds/other assets from executors.

(b) if necessary, obtain grant of representation, or make application for grant of letters of administration, where the Trust is the beneficiary

(c) be empowered, on behalf of the Trust, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty;

(d) be empowered, subject to appropriate legal advice, to enter into any agreement with the personal representative of the estate relating to the treatment of legacies and bequests.

16.4.3. In respect of **fund raising**, the CFO shall:

(a) be empowered to liaise with other organisations/persons raising funds for the Trust and provide them with an adequate discharge;

(b) be responsible, for alerting the Board of Directors to any irregularities regarding the use of the Trust's name or its registration number;

(c) no income will be raised from trading activities without the prior and express permission of the Charitable Funds Committee.

16.4.4. In respect of Charitable Funds **investment income**, the CFO shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

16.5. Investment Management

16.5.1. The CFO shall be responsible for all aspects of the management of the investment of charitable funds. The issues on which he shall be required to provide advice to the Charitable Funds Committee shall include:

(a) the formulation of investment policy within the legal powers of the Trust and to meet its requirements with regard to income generation and the enhancement of capital value;

(b) the appointment of advisers, brokers, and, where appropriate, fund managers and:

(i) the CFO shall agree, the terms of such appointments; and for which

(ii) written agreements shall be signed by the CEO.

(c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;

(d) the participation by the Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds;

(e) that the use of charitable assets shall be appropriately authorised in writing and charges raised within policy guidelines;

(f) the review of the performance of brokers and fund managers;

(g) the reporting of investment performance.

16.6. Use of funds

16.6.1. The exercise of the Trust's discretion to use funds shall be managed by the CFO in conjunction with the Charitable Funds Committee. In so doing they shall be aware of the following:

(a) the objects of various funds and the designated objectives;

(b) The availability of liquid funds within each charitable fund;

(c) the powers of delegation available to commit resource;

(d) the avoidance of the use of Trust funds to discharge charitable fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Trust shall be discharged by charitable funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Trust;

(f) the definitions of "charitable purposes" as set out by the Charity Commission.

16.7. Banking Services

16.7.1. The CFO shall advise the Charitable Funds Committee and, with its approval, shall ensure that appropriate banking services are available to the Trust as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each Trust where this is deemed necessary by the Charity Commission.

16.8. Asset Management

16.8.1. Assets in the ownership of or used by the Trust as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The CFO shall ensure:

(a) in conjunction with the Trust's legal adviser, that appropriate records of all assets owned by this Trust as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;

(b) that appropriate measures are taken to protect and/or to replace assets including decisions regarding insurance, inventory control, and the reporting of losses.

16.9. Reporting

16.9.1. The CFO shall ensure that regular reports are made to the Charitable Funds Committee on the receipt of funds, investments and the disposition of resources.

16.9.2. The CFO shall prepare annual accounts in the required manner which shall be submitted to the Board of Directors within agreed timescales.

16.9.3. The CFO shall prepare an annual trustees' report (separate reports for charitable and non-charitable Trusts) and the required returns to NHS England and to the Charity Commission for adoption by the Board of Directors.

16.10. Accounting and Audit

16.10.1. The CFO shall maintain all financial records to enable the production of reports as above and to the satisfaction of Internal and External Auditors.

16.10.2. The CFO shall ensure that the records, accounts and returns receive adequate scrutiny by Internal Audit during the year. He will liaise with External Audit and provide them with all necessary information.

16.10.3. The Board of Directors shall be advised by the CFO on the outcome of the Charitable Funds annual audit. The CEO shall submit the Management Letter to the Board of Directors.

16.11. Administration Costs

16.11.1. The CFO shall identify all costs directly incurred in the administration of funds held on Trust and, in agreement with the Board of Directors, shall charge such costs to the appropriate charitable funds.

16.12. Taxation and Excise Duty

16.12.1. The CFO shall ensure that the Trust's liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17. Risk Management and Insurance

17.1. Risk Management Programme

17.1.1. The CEO shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board of Directors.

17.1.2. The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including internal audit, clinical audit, health and safety review;

(f) arrangements to review the risk management programme.

17.1.3. The existence, integration and evaluation of the above elements will provide a basis to make a statement on internal control within the Annual Report and Accounts as required by the Annual Reporting Manual.

17.1.4. The CFO shall ensure that insurance arrangements exist in accordance with the risk management policy approved by the Board of Directors.

Annex 1 – Contract Approval Thresholds

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS
CONTRACT APPROVAL THRESHOLDS

Proposed contracts require formal approval before they can be entered into. The approval route is defined by the financial value of the proposed contract, as follows:

Contract Value *(See Note 1)*		**Authorising Officer/ Committee**
Revenue	**Capital**	
£0 to £200,000	£0 to £200,000	Deputy Chief Finance Officer
£200,001 to £400,000	£200,001 to £400,000	Chief Finance Officer
£400,001 to £600,000	£400,001 to £600,000	Chief Executive Officer
£600,001 to £1,200,000	£600,001 to £2,500,000	Finance and Performance Committee
Over £1,200,000	Over £2,500,000	Board of Directors

Note 1:
This is the total agreed contract value, or forecast contract value based on expected purchases over the full contract duration/ lifecycle; and is exclusive of VAT.

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS
TENDER THRESHOLDS

The following table shows the levels at which either quotations or tenders are mandatory:

Expenditure Value *(See Note 1)*	**Minimum Number** *(See Note 3)*	**Quotation or Tender**
£1 to £20,000	1	Quotation
£20,001 to £50,000	2	Quotation
£50,001 to UK PPR/ UK PA threshold *(See Note 2)*	3	Quotation
UK PPR/ UK PA threshold and over	4	Tender

Note 1:
This is the total expenditure value based on expected purchases over the full contract duration/ lifecycle; and is exclusive of VAT.

Note 2:
From 1 January 2024 the UK PPR/ UK PA threshold for supply and service contracts is £139,688 inclusive of VAT.
The threshold for works contracts is £5,372,609 inclusive of VAT. The threshold for contracts under the light touch regime is £663,540 inclusive of VAT.

Note 3:
The minimum number may be subject to specific product and/ or market considerations as verfiried by Commercial Services.

Note 4:
Compliant framework agreements are exempt from these minimum numbers where single source selection is permitted under the framework and this has been verified by Commercial Services as representing Value for Money.

Annex 2 – Levels of Expenditure

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

STANDING FINANCIAL INSTRUCTIONS
AUTHORISED NON-PAY EXPENDITURE LIMITS

Personal delegated limits must be agreed before an individual is authorised to commit or approve non pay expenditure. Personal authorisation limits will be confirmed in writing once approved and included within the Trust's Authorisation Database. Limits will be set based on the specific role profile of the individual and the needs of the service, however individual limits cannot exceed those noted below.

All Staff	
AfC Band 2	£0
AfC Band 3	£0
AfC Band 4	£0
AfC Band 5	£5,000
AfC Band 6	£5,000
AfC Band 7	£5,000
AfC Band 8a	£25,000
AfC Band 8b	£50,000
AfC Band 8c	£75,000
AfC Band 8d	£100,000
AfC Band 9	£250,000
Trust Board	
Chief Executive	Unlimited
Chief Finance Officer	Unlimited
Chief Medical Officer	£1,000,000
Chief Nursing Officer	£1,000,000
Chief Operating Officer	£1,000,000
Chief People Officer	£1,000,000
Chief Digital Officer	£1,000,000
Chief Strategy and Transformation Officer	£1,000,000
Finance	
Deputy Chief Finance Officer	£1,000,000
Pharmacy	
Chief Pharmacist	£250,000
Estates	
Associate Directorate of Estates and Capital development	£250,000

Annex 3 – Manual Tendering Procedures

The following manual intervention procedures apply in instances where the approved Trust electronic tendering, evaluation & award system is not/cannot be used.

18.1 Invitation to Tender

18.1.1. Invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:

(a) a plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender); or

(b) in an envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.

18.1.2. Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Sections 18.1.3 and 18.1.4 below.

18.1.3. Every tender for building and engineering works, except for maintenance work only where Estate code guidance should be followed, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or Department of the Environment (GC/Wks) standard forms of contract amended to comply with Concode.

When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the CFO or Department of Health and Social Care.

18.1.4. Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

18.2. Receipt, Safe Custody and Record of Formal Tenders

18.2.1. Formal competitive tenders shall be addressed to the Trust Secretary.

18.2.2. The date and time of receipt of each tender shall be written on the unopened tender envelope/package at the time of receipt.

18.2.3. The Company Secretary shall receive tenders on behalf of the Trust and be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with Section 18.3 (Opening Formal Tenders).

18.3 Opening Formal Tenders

18.3.1. As soon as practicable after the date and time stated as being the latest time

for the receipt of tenders, they shall be opened in the presence of two senior Officers designated by the Chief Executive and not from the originating department.

18.3.2. On the envelope for every tender received shall be written the date of opening and this shall be initialled by two of those present at the opening.

18.3.3.A permanent record shall be maintained to show for each set of competitive tender invitations despatched:

(a) The names of firms/individuals invited;

(b) The names of and the number of firms/individuals from which tenders have been received;

(c) Closing date and time;

(d) Date and time of opening.

18.3.4. The persons present at the opening shall sign the record.

18.3.5. The two Officers opening the tender shall each sign pages within the tender that show price information on one copy of the received tenders.

18.4 Admissibility and Acceptance of Formal Tenders

18.4.1. See section 10 of the SFI's as above.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 6.6

Subject:	Board Assurance Framework 2025 2026 – Q2
Prepared by:	Jo Sims, Associate Director for Quality Governance and Risk
Presented by:	Sarah Herbert, Chief Nursing Officer

Strategic themes that this item supports/impacts:	Population & System Our People Patient Experience Quality Outcomes & Safety Sustainable Services	☐ ☐ ☐ ☒ ☐
BAF/Corporate Risk Register: (if applicable)	All	
Purpose of paper:	Review and Discussion	
Executive Summary:	The UHD Board Assurance Framework for 2025 2026 has been redesigned. The new format provides greater depth and enhanced visibility of the controls, assurances in relation to the 5 strategic objectives of the Trust. The risk descriptions and details have been linked to relevant breakthrough objectives, corporate projects and corporate risks. Links have also been made to the Internal Audit Plan for 25/26. The Risk Management Strategy states that the Audit Committee will receive the full BAF quarterly and the Board of Directors will receive the full report 6 monthly. Board subcommittees will receive a quarterly report on current BAF risks linked to any relevant strategic objectives for the committee. In order to ensure that updates to the BAF are aligned with risk register reporting, leads are responsible for updating the BAF report at the end of each quarter. A central repository has been established to ensure document and version control is achieved. This report provides the position of the BAF at the end of Q2 (July-Sept 25).	
Background:	The Board Assurance Framework (BAF) – The BAF is a key mechanism to reinforce the strategic focus of the board and better manage risk. It is used to help the organisation capture, report and monitor key risks to the strategic objectives, implement corrective action and	

	report to Board on progress. It is designed to provide assurance that the organisation is delivering on its objectives and draw attention to areas of concern.	
Key Recommendations:	To note	
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	☒ ☐ ☐ ☐ ☒ ☐

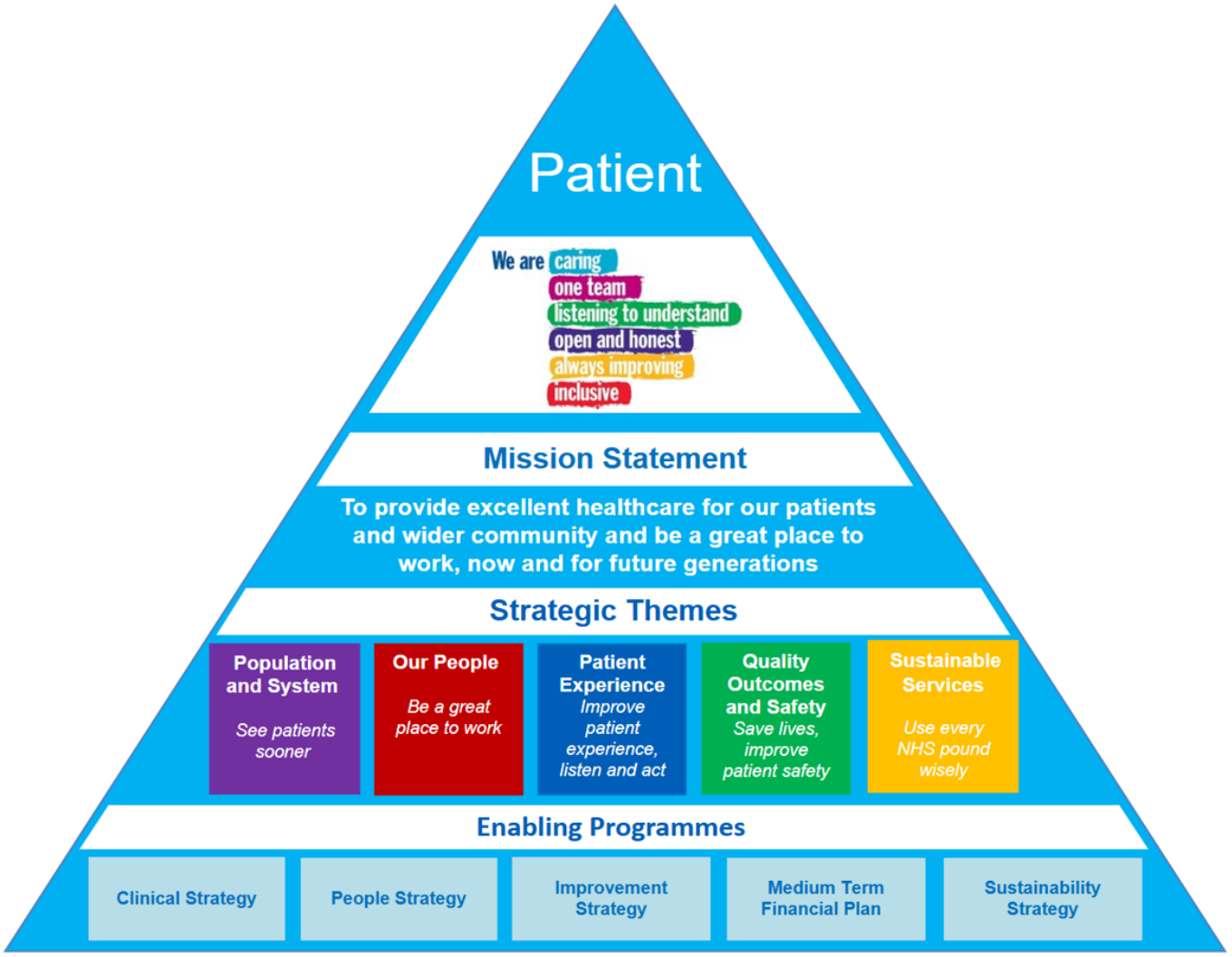
Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Audit Committee	4 June 25	New format supported
Board of Directors	2 July 25	Noted
Risk Oversight Committee	29 Sept 25	Noted updates needed, reminder to be sent to all Exec leads. Previous access for updates may have been affected by the move to nhs.net as all Teams links needed to be established.

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	☐ ☐ ☐ ☐

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Board Assurance Framework

Threats to the achievement of the Trusts strategic priorities and 2025/26 goals

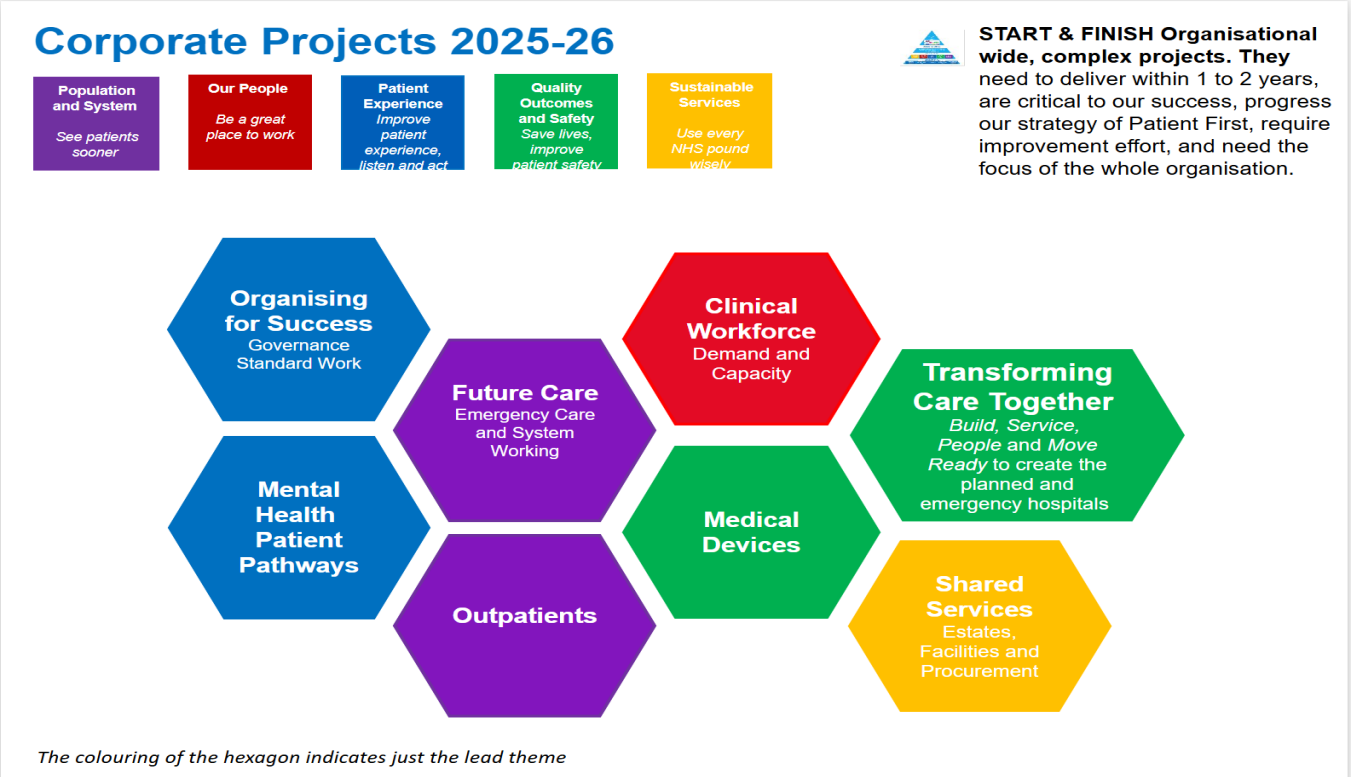

Patient
We are caring
one team
listening to understand
open and honest
always improving
inclusive
Mission Statement
To provide excellent healthcare for our patients and wider community and be a great place to work, now and for future generations
Strategic Themes
Population and System
See patients sooner
Our People
Be a great place to work
Patient Experience
Improve patient experience, listen and act
Quality Outcomes and Safety
Save lives, improve patient safety
Sustainable Services
Use every NHS pound wisely
Enabling Programmes
Clinical Strategy
People Strategy
Improvement Strategy
Medium Term Financial Plan
Sustainability Strategy

5 strategic themes

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

- **Population and System**
  - Future care – emergency care and system work
  - Outpatients
- **Our People**
  - Clinical Workforce – demand and capacity
- **Patient experience**
  - Organising for success
  - Mental Health patient pathways
- **Quality Outcome and Safety**
  - Medical Devices
  - Transforming care together
- **Sustainable services**
  - Shared services – Estates, Facilities and Procurement

Corporate Projects 2025/26



Annual Objectives 2025/26

Strategic Theme	Strapline	Vision *LONG TERM*	Strategic Goal *MEDIUM TERM: 3 - 5 YEARS*	Breakthrough Objective *SHORT TERM: 1 YEAR ** (* May be kept another year if not achieved)
POPULATION AND SYSTEM *Mark Mould*	"See patients sooner"	Consistently delivering timely, appropriate, accessible care as part of a wider integrated care system for our patients.	• Meeting the patient national constitutional standards for Planned and Emergency care, reducing inequalities in outcome and access and improving productivity and value	• To achieve 109% weighted value elective activity against the 2019/20 baseline, including specialist advice and guidance • No more than 66.1% of patients on incomplete RTT pathways should have been waiting more than 18 weeks (18 week RTT) for treatment • >78% of patients to be treated within 4 hours through the emergency care pathway
OUR PEOPLE *Irene Mardon*	"Be a great place to work"	To be a great place to work, attracting and retaining the best talent.	• Significantly improved staff experience, engagement and retention • NHS Staff Survey results in top 20% of comparator Trusts	To deliver improvements in the NHS Staff Survey Results for: • "I would recommend my organisation as a place to work" > 65% • Staff Engagement Score > 7.1 / 10
PATIENT EXPERIENCE *Sarah Herbert*	"Improve patient experience listen and act"	All patients at UHD receive quality care which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change.	• Rated as Outstanding by CQC as Caring • Over 80% of our employees see patient care as a top priority for UHD • In the top 20% of NHS Acute Hospital Trusts on the 'overall experience' section in all CQC national surveys	• 100% of complaints to be closed within 35 days, with associated action plan • Increase the number of Early Resolution of complaints by 20% • Reduce the number of complaints received per 100 contacts for clinical services by 10% from baseline
QUALITY OUTCOMES AND SAFETY *Peter Wilson*	"Save lives, improve patient safety"	To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios – HSMR) and patient safety (Patient Safety Incidents - PSIs).	• In the top 20% of trusts in country for Hospitalised Standard Mortality Ratios (HSMR) • Rated as Outstanding by CQC for Safety • Decrease severe/moderate harm Patient Safety Incidents (as a ratio of all incidents) by 30% • Over 80% of employees believe the Trust promotes a safety culture	• To statistically reduce our rate of Falls per 1,000 bed days • To ensure the % of patients given timely VTE prophylaxis is 95% or higher • To statistically reduce the rate of pressure ulcers (hospital acquired) per 1,000 bed days • Doctors to achieve 100% compliance in eMortality reviews
SUSTAINABLE SERVICES *Pete Papworth*	"Use every NHS pound wisely"	To maximise value for money enabling further investment and sustainability in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.	• Return to recurrent financial surplus from 2026/27 • Rated as Outstanding by the CQC for our Use of Resources • Achieve our Green UHD goals of sustainability for people and planet, and 80% carbon reduction by 2030	• To fully deliver the budgeted Efficiency Improvement Programme target with at least 80% achieved recurrently • To have reconfiguration efficiency plans in place

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

Strategic risk description	
There is a risk that the Trust cannot achieve its strategic priority to focus on patient experience due to: • Increased demand due to the impact of deprivation, multi- morbidity and an ageing population, and seasonal variation • Increased demand – unplanned care, emergency department attendances, on patient flow across the system. • Significant growth in the number of patients waiting for elective treatment. • Ageing estate and building/digital	**Lead Executive Director(s): CNO** **Date last reviewed: 30/09/2025** **Strategic objective** All patients at UHD receive quality care which results in a positive experience or them, their families and carers. Every team is empowered to make

infrastructure leading to poor patient experience. • Insufficient workforce due to availability • Lack of system capacity resulting in increased number of patients with NCtR awaiting discharge, increased occupancy impacting flow. • Insufficient system and Trust provision for patients with a mental health disorder • Inconsistent governance processes Resulting in potential harm to patients, impact on outcomes, experience and quality of care, impact on external relations, and regulatory breach (CQC).	continuous improvement by engaging with patients in a meaningful way, using their feedback to make change. **Breakthrough Objectives** • 100% of complaints to be closed within 35 days, with associated action plan. • Increase the number of Early Resolution of complaints by 20% • Reduce the number of complaints received per 100 contacts for clinical services by 10% from baseline. **Linked Corporate Projects** • Organising for Success • Mental health patient pathways • Fundamentals of Care Programme • Shared Decision-Making project **Links to Internal Audit Plan 25/26** Q2 Freedom to Speak up Q1 Local action plans/Trust wide audits

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
Date: 30 June 2025	2052 – Care of patients in non-clinical areas of ED 1460 – Inability to meet UEC 4 Hour standard 1053 – Lack of capacity for elective and non-elective activity 1429 – Ambulance handover delays 1502 – Caring for mental health patients in an acute health environment 1974 – Macular injection treatment delays 1950 - Risk that the trusts Electronic Patient Record (EPR) not fit for purpose for UHD
Date: 30 Sept 25	1460 – Inability to meet UEC 4 Hour standard 1974 – Macular injection treatment delays 1950 - Risk that the trusts Electronic Patient Record (EPR) not fit for purpose for UHD 1970 – Lack of sufficient provision of glaucoma service 1665 - School age neurodevelopmental service 1303 – Therapy staffing 1855 – Lack of breast radiologists

Key Controls **(to manage risks related to goal)**	**Key assurances** **(effectiveness of controls)**

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

Date	Updates (Improvement, Identified gaps in controls and/or assurances) *(to be updated at least quarterly)*	Actions to be taken next quarter *(to be updated at least quarterly)*
30 June 25	Lack of aligned governance processes, variation in learning and impacts from patient feedback Gap in patient engagement	• Standardised reporting from Care Group into Patient Experience Group • Patient Experience Group report to Quality Committee • Patient story to be cascaded across Care Group Leaders forum • Dissemination of learning from the external patient experience review and the patient engagement and experience workshop across the organisation
30 Sept 25	The National Cancer Patient Experience Survey 2024 (data released July 2025). UHD scored 91% for patient satisfaction around their care. This is consistent with our scoring from the last few years and is 6% above the national average. Key achievements include: • 97% of patients reported enough privacy was given when given diagnostic test results • 94% of patients reported that the whole care team worked well together • 89% of patients reported that their treatment options were explained in a way they could completely understand.	• Report presented to QC Sept 25. Action plan in progress to ensure continued improvement.

	UHD scored above the expected range in 11 areas, with only 1 area, 'Patient has had a review of cancer care by GP practice being below the expected range	
	The number of open complaints over 55 days is currently at 8. They continue to be prioritised and are decreasing. Average complaint response timescale August 2025 was a 39.36 working day average for a final response. The 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.	• Further measures to reduce the number of outstanding complaints in place

Risk category and risk appetite statement		
Risk Type and Category	**Risk appetite**	**Relevant to strategic risk**
Workforce		
Leadership and Talent	Cautious	
Workforce capacity	Cautious	
Staff Experience	Cautious	
Recruitment and Retention	Cautious	
People and Function	Cautious	
Sustainable Services		
Business Continuity	Cautious	
Counter-fraud	Averse	
Financial Management	Cautious	
Information Governance	Cautious	
Financial Reporting	Cautious	
Information Technology	Cautious	
Revenue funding and cash management	Cautious	
Supply Chain	Minimal	
Physical Assets	Cautious	
Quality (Outcomes and Safety)		
Health and Safety	Minimal	
Infection Prevention and Control	Minimal	
Legal and Governance	Averse	
Regulatory	Averse	
Patient Safety and Outcomes	Minimal	
Research, Innovation and Development	Open	
Population and System		
Capacity Planning	Cautious	**x**
Partnership Working	Open	
Patient Experience		
Patient Experience	Minimal	**x**

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

Strategic risk description	
There is a risk that the Trust cannot achieve its strategic priority to support and develop our people due to: • Reduced workforce due to financial constraints and the political arena locally and nationally. Impact of budget cuts and workforce cuts at ICB and NHS E. • Reduced workforce availability due to sickness absence • Sustained operational pressures leading to staff burnout; staff fatigue; staff leaving the Trust, senior staff taking early retirement. • Insufficient workforces supply due to national and local workforce shortages. • Industrial action • Ageing estate and digital infrastructure leading to poor staff experience. • Management time, capacity to implement, deliver, and sustain change. • Management support, capability and leadership • Reduced opportunities for staff training and development due to operational and financial pressures. • Inconsistent HR processes relating to recruitment, retention and performance management. • Insufficient support for staff safety and health and well-being This has the potential to result in staff leaving the organisation, inability to recruit to key specialty areas, impact on external relations, and long-term threat to service sustainability, regulatory breach (CQC).	**Lead Executive Director(s): CPO** **Date last reviewed: 30/09/25** **Strategic objective:** To be a great place to work, attracting and retaining the best talent. **Breakthrough objectives:** To deliver improvements in the NHS Staff Survey Results for: • "I would recommend my organisation as a place to work" > 65% • Staff Engagement Score > 7.1 / 10 **Linked Corporate Projects** • Clinical workforce (demand and capacity) **Links to Internal Audit Plan 25/26** Q1-Q4 Ward ID checks Q2 Salary errors (under and over payments) Q1 Consultant Job planning

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
Date: 27 May 2025	1303 - Therapy staffing 1502 – Caring for mental health patients in an acute health environment 1855 – Lack of breast radiologists 1378 – Lack of electronic results acknowledge systems 1950 - UHD Electronic Patient Record Systems 1595 – Financial management systems
Date 30 Sept 2025	1303 - Therapy staffing 1502 – Caring for mental health patients in an acute health environment 1855 – Lack of breast radiologists 1378 – Lack of electronic results acknowledge systems 1950 - UHD Electronic Patient Record Systems 1595 – Financial management systems

Key Controls (to manage risks related to goal)	**Key assurances** (effectiveness of controls)
Prevention Controls (parts of a system of internal controls designed to prevent a risk from occurring) • Trust People and Culture Strategy and 19 plans • Behaviour Charter • HR Policies and Procedures • Workforce Plans • Health and Well Being Plans - THRIVE • Equality, Diversity & Inclusion plan • Learning, Education and Training plan • Digital Strategy • Staff vaccination programme and support • Freedom to speak up policy. • Accountability Framework • People Ready strand of Transforming Care Together programme	• National Staff survey • People Pulse Survey results. • Culture Champions Report • Workforce Committee annual report • CQC inspection report(s) • CQC Regulation 18 - staffing • Internal audit programme • Trust annual governance statement • People and Culture progress reports to People and Culture Committee • Chief People Officers Report • Transforming Care Together – People Ready Assurance Report • Safer Staffing Reports • Guardian of Safe Working Hours Report • Staff Diversity Network Reports • Freedom to Speak up Report. • Integrated Performance Report • Patient First Report • Risk Register Report • Care Group SDR Reports • Staff Partnership Forum Reports • People and Culture Committee Annual Report • Workforce Operational report • Workforce Operational Efficiency & Reduction Plan
Detection controls (those that provide an early warning of control failure) • Escalation process from Care Group SDR to People and Culture Committee • People and Culture Committee oversight of risks related to workforce, staff safety, and health and wellbeing • People and Culture SDR meeting / Culture steering group / workforce steering group and People and Culture Directorate Board Meeting	
Contingency controls (those that help prepare for an effective reaction in response to a control failure or overwhelming event. Designed to maintain resilience) • Bi-monthly workforce steering group meetings to review plans contained in pillars 3&4 of the People Strategy. • Quarterly Culture steering group meetings to review plans contained in pillars 1&2 of the People Strategy. • Quarterly People and Culture Directorate Board meetings to review plans contained in pillars 5 of the People Strategy. • Care Groups Strategic Deployment Review meetings • People Ready meetings	

Date	**Updates (Improvement, Identified gaps in controls and/or assurances)** *(to be updated at least quarterly)*	**Actions to be taken next quarter** *(to be updated at least quarterly)*
27May 25	Reliance and cost of temporary workforce across all staff groups	Temporary staffing controls and roster management mitigations include External review of TSO, re-establishment of e-roster steering board, development of a new e-form for approval of nursing/HCA agency (Lead = CPO) Set up a strategic workforce room to review pay bill spend and use of temporary workforce

30 June 25	Medical staffing job planning and rostering	Medical staffing patient first corporate project - initiated (Lead = CPO)
30th Sept 25	Clear A3's, PiDs and highlight reports aligned to the Workforce Operational Efficiency & Reduction Plan	Develop clear documents to note goals, aims, outputs and achievements aligned to wte, paybill and other efficiencies

Risk category and risk appetite statement		
Risk Type and Category	**Risk appetite**	**Relevant to strategic risk**
Workforce		
Leadership and Talent	Cautious	
Workforce capacity	Cautious	
Staff Experience	Cautious	
Recruitment and Retention	Cautious	
People and Function	Cautious	
Sustainable Services		
Business Continuity	Cautious	
Counter-fraud	Averse	
Financial Management	Cautious	**x**
Information Governance	Cautious	
Financial Reporting	Cautious	
Information Technology	Cautious	**x**
Revenue funding and cash management	Cautious	
Supply Chain	Minimal	
Physical Assets	Cautious	
Quality (Outcomes and Safety)		
Health and Safety	Minimal	
Infection Prevention and Control	Minimal	
Legal and Governance	Averse	
Regulatory	Averse	
Patient Safety and Outcomes	Minimal	**x**
Research, Innovation and Development	Open	
Population and System		
Capacity Planning	Cautious	**x**
Partnership Working	Open	
Patient Experience		
Patient Experience	Minimal	

Trust strategic priority: Population and System - See patients sooner

Strategic risk description	
There is a risk that the Trust cannot achieve its strategic priority to see patients sooner due to: • Lack of system resilience due to workforce and funding pressures in community/primary/social care • Lack of system capacity resulting in increased number of patients with NCtR awaiting discharge • Higher demand due to local patient population profiles, with high level of frailty adding to the demand for ongoing support out of hospital (linking to above bullet). • Sustained operational pressures alongside significant transformation and re-configuration agenda. • Increased demand in specific specialties some of which is due to local and national health promotion campaigns and initiatives. • Insufficient workforce supply due to national and local workforce shortages in specific areas impacting. capacity for diagnostics and planned care. • Lack of sufficient capacity and resources in diagnostic services pending full completion of CDC development programme. • Ageing estate and building/digital infrastructure and lack of uptake of technologies. • Capacity (workforce and physical estate) constraints creating a reliance on high-cost outsourcing / insourcing to deliver elective activity within a restricted financial allocation. • Limits on ISP elective activity contracts due to System financial plan resulting in potential further increases in demand and reduced capacity system-wide • Inefficiencies and variation in systems and processes impacting the productivity of teams to deliver elective and non-elective pathways. • Culture of the organisation is not aligned in all areas to see patients sooner. Resulting in possible harm to patients due to treatment delays, poor experience, impact on external relations, failure to deliver the trust /System transformation programme and failure to meet NHS constitutional performance standards. Long-term threat to service sustainability and regulatory breach (CQC).	**Lead Executive Director(s):** Chief Operating Officer **Date last reviewed: 10/10/2025** **Strategic Objective** Consistently delivering timely, appropriate, accessible care as part of a wider integrated care system for our patients. **Breakthrough Objective:** • To achieve 109% weighted value elective activity against the 2019/20 baseline, including specialist advice and guidance. • No more than 66.1% of patients on incomplete RTT pathways should have been waiting more than 18 weeks (18-week RTT) for treatment • >78% of patients to be treated within 4 hours through the emergency care pathway. **Linked Corporate Projects** • UEC including Alternatives to Admission (A2A) & Transfer of Care Hub (ToC) – emergency care and system working. • Outpatients improvement **Links to Internal Audit Plan 25/26** Q2 Data Quality DM01 Q3 Outpatient DNA processes Q4 External visit action plans

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
Date: 31 Augu 2025	2052 – Care of patients in non-clinical areas of ED 1460 – Inability to meet UEC 4 Hour standard 2132 – Cytoscope provision impacting on cancer pathway capacity 1970 – Glaucoma pathway delays 1053 – Lack of capacity for elective and non-elective activity 1395 – Capacity in cellular pathology causing delays in patient pathways 1429 – Ambulance handover delays 1502 – Caring for mental health patients in an acute health environment 1665 – Insufficient capacity for school age neurodevelopmental service

	1303 – Lack of therapy staffing impacting on patient flow 2070 – Lack of UPS and IPS in Theatres 1961 – Ageing sterilization service 1855 – Breast radiology staffing impacting on patient pathways 1974 – Macular injection treatment delays 2071 – Mosiag prescribing system lack of functionality, impact on SACT timescale
Date: 30 Sept 25	1460 – Inability to meet UEC 4 Hour standard 1970 – Glaucoma pathway delays 1395 – Capacity in cellular pathology causing delays in patient pathways 1665 – Insufficient capacity for school age neurodevelopmental service 1303 – Lack of therapy staffing impacting on patient flow 2070 – Lack of UPS and IPS in Theatres

Key Controls (to manage risks related to goal)	**Key assurances** (effectiveness of controls)
Prevention Controls (parts of a system of internal controls designed to prevent a risk from occurring) • Patient Access policy • Trust Interprofessional standards • Discharge policies and procedures • Internal flow & FutureCare programme in partnership with the wider Dorset system (alternatives to admission & transfer of care hub) • Interhospital transfer policy • Planned Care Improvement programme • RTT training • Workforce plans • Accountability framework including enhanced Support • HR Policies and Procedures • Dorset ICB Working Better Together Strategy • Trust People and Culture Strategy • ICB and Trust activity contracts • Community Diagnostic Centre Programme of works	• Integrated Quality and Performance Report to the Trust Board (IPR) • Finance and Performance Committee deep dive reports • Care Group SDR reports • TMG SDR breakthrough objective reporting • Efficiency Improvement Programme report • Risk heat map • Elective activity reporting • Exec Enhanced support oversight
Detection controls (those that provide an early warning of control failure) • Escalation process from Care Group SDR to Finance and Performance Committee • Finance and Performance Committee oversight of risks related to operational performance • Operational targets: 4hr safety standard, Referral to Treatment standard, elective waits to first activity target and DM01 diagnostics standard • SWASFT handover times Monitoring • COSMOS and Dorset Intelligence and Insights System reporting suite • Elective activity tracker (Trust and System) • Workforce reports • LERNS • Planned Care /Future Improvement Group highlight reports • Equality, Inclusion and Diversity System • Care Group SDR Reports • Waiting list validation • Improvement trajectory and daily reporting providing early indication of risk / threat to delivery.	

Contingency controls (those that help prepare for an effective reaction in response to a control failure or overwhelming event. Designed to maintain resilience) • Waiting list initiatives • Trust Escalation process • Outsourcing/Insourcing • Elective Recovery Funding • System wide UEC Weekly Improvement Group • Daily system overview and action with escalation to Exec / Senior Decision making group (SRG) by exception / escalation. • Virtual Wards / SDEC capacity • DrDoctor Patient Engagement Portal • Community Diagnostic Centre Funding • Waiting list validation • Winter plan / Surge plan • Weekly Senior Huddle to review operational Metrics	

Date	Update (Improvements, Identified gaps in controls and/or assurances) *(to be updated at least quarterly)*	Actions to be taken next quarter *(to be updated at least quarterly)*
30 June 25	Consistent approach to harm reviews Digital Strategy	• Enhanced support meetings in ED – Cultural Program being progressed. • Focus on realising the geographical / environmental benefits of having re-located ED into the Beach. • Weekly regional performance meetings. • Care Coordination Project underway / ward • Transfer of Care Hub and associated ward plans including improvement boards / huddle. • Winter planning in place across the system. • Cancer escalation meetings in plans. • Validation Sprint – Q2. • Digital focus on outpatients. • Review of the 10-year plan and impacts on seeing patients sooner.
	Visibility of SDEC capacity	• SBARN outlining technical solutions in process of being agreed across stakeholders. • Subject to agreement SBARN to be ratified at Data Quality Group for implementation. • Process of review to be embedded into site meetings and wider organization.
30 Sept 25	Improvement: Waiting list validation sprints affecting an increase is removals from the waiting list >5% above the baseline. Year to date reduction of 4.5k in the total waiting list	• Q3 validation sprint to be undertaken.
	Improvement: Elective activity delivered at 118.5% above 19/20 baseline, RTT performance in line with plan and waits for first activity above plan.	• Revise 52 week wait trajectories to ensure aligned to 1% waiting list target. • Implementation of action plans to deliver 52 week wait reduction
	Ed enhanced support meeting to align to the Department patient First Huddles and a focus on 4 of the A3s completed	• Exec huddles in Place fortnightly in the ed department • Site team responsibility assigned to Ready to leave to left department

Risk category and risk appetite statement		
Risk Type and Category	**Risk appetite**	**Relevant to strategic risk**
Workforce		
Leadership and Talent	Cautious	
Workforce capacity	Cautious	x
Staff Experience	Cautious	x
Recruitment and Retention	Cautious	
People and Function	Cautious	
Sustainable Services		
Business Continuity	Cautious	x
Counter-fraud	Averse	
Financial Management	Cautious	x
Information Governance	Cautious	
Financial Reporting	Cautious	
Information Technology	Cautious	x
Revenue funding and cash management	Cautious	
Supply Chain	Minimal	
Physical Assets	Cautious	
Quality (Outcomes and Safety)		
Health and Safety	Minimal	x
Infection Prevention and Control	Minimal	
Legal and Governance	Averse	x
Regulatory	Averse	x
Patient Safety and Outcomes	Minimal	x
Research, Innovation and Development	Open	
Population and System		
Capacity Planning	Cautious	x
Partnership Working	Open	x
Patient Experience		
Patient Experience	Minimal	x

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

Strategic risk description	
There is a risk that the Trust cannot achieve its strategic priority to avoid patient harm and improve patient safety due to: • Increased demand due to the impact of deprivation, multi-morbidity and an ageing population • Increased demand – unplanned care, emergency department attendances, impacting on patient care and treatment across the organisation. • Ageing estate and building/digital infrastructure deficiencies impacting on patient safety. • Insufficient workforce due to availability impacting on patient care and patient safety. • Lack of system capacity resulting in increased number of patients with NCtR awaiting discharge and at risk of deconditioning and higher mortality. • Insufficient system and Trust provision for patients with a mental health disorder • Staff fatigue due to increased demand resulting in increased risk to patient and staff safety. • Gaps in fundamental standards of care. • Lack of time and capacity to fully implement PSIRF and Patient First resulting in lack of learning and improvement. • Political uncertainty around future funding and resources for patient safety and quality improvement • Uncertainty around impact of abolishment of NHS England • Inadequate business continuity arrangements in the event of unavailability of IT systems • Delays in completion of the Transforming Care Together programme including Phase 3 and 4 moves Resulting in potential harm to patients, impact on outcomes, experience and quality of care, impact on regulatory breaches.	**Lead Executive Director(s):** Chief Nursing Officer, Chief Medical Officer **Date last reviewed: 30/09/2025** **Strategic objective:** To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios – HSMR) and patient safety (Patient Safety Incidents - PSIs). **Breakthrough objectives:** • To statistically reduce our rate of Falls per 1,000 bed days • To ensure the % of patients given timely VTE prophylaxis is 95% or higher. • To statistically reduce the rate of pressure ulcers (hospital acquired) per 1,000 bed days. • Doctors to achieve 100% compliance in eMortality reviews. **Linked Corporate Projects** • Medical devices • Transforming care together **Links to Internal Audit Plan 25/26** Q3 Harm investigation action plans Q4 Medical device management Q2 Fire Safety Q1 Critical IT applications Q4 DSP Toolkit

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
30 June 25	2052 – Care of patients in non-clinical areas of ED 1053 – Lack of capacity for elective and non-elective activity 1502 – Caring for mental health patients in an acute health environment 1974 – Macular injection treatment delays 1961 – Aging SSD Sterilisers 1855 – Breast radiology capacity 1214 – Ungoverned Point of Care Devices across UHD 1378 – Lack of results acknowledgment systems across UHD 2071 – Mosaiq SACT prescribing system
30 Sept 2025	1974 - Macular injection treatment delays 1855 – Breast radiology capacity 1214 – Ungoverned Point of Care Devices across UHD 1397 – Provision of 24/7 haematology transfusion lab service 2229 – Obstetric ultasound scanning service 1378 – Lack of electronic results acknowledgement

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

Contingency controls (those that help prepare for an effective reaction in response to a control failure or overwhelming event. Designed to maintain resilience) • CQC Action plans • PSII Action plans • Clinical Audit action plans • Actions from complaints, claims, LERNS, Inquests • Actions from Service Ready escalation Reports, escalations from SRG/BRG/MRG, PRG into TMG	

Date	Update (improvement, Identified gaps in controls and/or assurances) *(to be updated at least quarterly)*	Actions to be taken next quarter *(to be updated at least quarterly)*
30 June 25	CQC inspection report for Surgical core services identified that: • The service did not always detect and control potential risks in the care environment. Staff did not make sure that equipment, facilities and technology supported the delivery of safe care. There were inconsistencies in environmental safety, particularly concerning fire safety, and the timely availability of emergency equipment. • Lack of monitoring and audits meant there was reduced oversight of some areas of the service.	CQC action plan to be submitted 7/7/25 – monitoring via TMG and QC in Q2 Internal Audit review of governance of action plans at Care Group level in progress – to be completed Q2 Fire safety governance review in progress – to be completed Q2. Internal audit of Fire Safety to start in Q2 Medical devices corporate project in progress and to include action plan to review equipment provision, procurement, maintenance and training. To also review POCT governance arrangements and medical device integration into EPR programme. Suction equipment and flowmeters to be installed in clinical areas across both sites in Q2. Bedspace audit to be undertaken.
31 July 25	Delays in completion of the Coast building have caused a delay in the Phase 3 move dates and Poole Phase 4 construction •Issues with Coast subcontractor caused delays and has required contractual management	Escalated management of contractor has lead to a more robust build programme and confirmation of Coast completion date. Regular formal checks on delivery in place, contractual damages being pursued. A revised Phase 3 move date agreed through clinical meetings, engagement with CG's, review at SRG and TMG and a TMG decision to move in the last 2 weeks of July. Further work is required to develop a faster move programme that aims to complete before Aug 26 and associated move planning actions.
30 Sept 25	HSMR Rolling 12 Month: June 2024 to May 2025 is 93.55. HSMR In Month - Latest fully coded position is May 2025 at 89.1. This is below the national average of 100 for the last 8 data points.	Further development of Learning from Deaths process and Mortality Surveillance Group with focus on shared learning and improvement actions.
	Our current UHD Falls (all harm) per 1,000 bed days is 6.2 in August 2025, and within expected range. Falls moderate and above per 1000 bed days is 0.1	Falls Steering Group to be established Oct 25 and will oversee actions from PSIRF Thematic review.
	Progress on medical devices corporate project presented to QC in Q2. Detailed action plan in progress	Implementation of action plan.

	ICE (order comms) - A task and finish group has been established with full care group participation to drive uptake of electronic requesting and reporting.	Implementation of action plan.

Risk category and risk appetite statement		
Risk Type and Category	**Risk appetite**	**Relevant to strategic risk**
Workforce		
Leadership and Talent	Cautious	
Workforce capacity	Cautious	
Staff Experience	Cautious	
Recruitment and Retention	Cautious	
People and Function	Cautious	
Sustainable Services		
Business Continuity	Cautious	
Counter-fraud	Averse	
Financial Management	Cautious	
Information Governance	Cautious	
Financial Reporting	Cautious	
Information Technology	Cautious	**x**
Revenue funding and cash management	Cautious	
Supply Chain	Minimal	
Physical Assets	Cautious	**x**
Quality (Outcomes and Safety)		
Health and Safety	Minimal	
Infection Prevention and Control	Minimal	
Legal and Governance	Averse	
Regulatory	Averse	
Patient Safety and Outcomes	Minimal	**x**
Research, Innovation and Development	Open	
Population and System		
Capacity Planning	Cautious	**x**
Partnership Working	Open	
Patient Experience		
Patient Experience	Minimal	

Trust strategic priority: Sustainable Services - Use every pound wisely

Strategic risk description	
There is a risk that the Trust cannot achieve its strategic priority to return to financial surplus by 2026/27, due to: • Minimal growth funding within local allocations; • Inflation funding below cost of inflation; • Inability to achieve efficiency requirements due to sustained operational pressures; • Ageing population, deprivation, morbidity and health inequalities; • ICS budget position and poor system financial performance; • Political and economic framework, legislation and regulatory changes; • Uncertain political arena. This has the potential to result in a failure to deliver a balanced financial plan including recurrent savings targets, possible harm to patients, poor experience, and a long-term threat to service sustainability.	**Lead Executive Director(s):** Chief Finance Officer **Date last reviewed: 10/10/2025** **Strategic Objective:** To maximise value for money enabling further investment and sustainability in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff. **Breakthrough objectives:** 1. To fully deliver the budgeted Efficiency Improvement Programme target with at least 80% achieved recurrently. 2. To ensure that reconfiguration efficiency plans are in place. **Linked Corporate Projects** • Shared services **Links to Internal Audit Plan 25/26** Q3 KFS Drugs spend Q3 KFS Care group (surgery) financial governance

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
31 May 25	1595: Medium Term Finance Sustainability
30 Sept 25	1595: Medium Term Finance Sustainability

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

Date	**Update (Improvement, Identified gaps in controls and/or assurances)** *(to be updated at least quarterly)*	**Actions to be taken next quarter** *(to be updated at least quarterly)*
30 June 2025	Weaknesses in temporary staffing controls and roster management	Temporary staffing controls and roster management mitigations include External review of TSO, re-establishment of e-roster steering board, development of a new e-form for approval of nursing/HCA agency (Lead = CPO)
	Weaknesses in the alignment of medical job plans, medical staff rotas and financial budgets.	Alignment of medical job plans, medical staff rotas and financial budgets. Medical staffing patient first corporate project initiated Lead = CMO)
	Weakness in high cost drugs spend controls by holding these in a non-directorate cost center.	High-cost drugs spend controls mitigations: Harmonise legacy reporting processes to single data source, reporting spend at Care Group level to improve accountability (Lead + CFO)

30 Sept 2025	Weaknesses in temporary staffing controls and roster management	Temporary staffing controls and roster management mitigations include External review of TSO, development of a new e-form for approval of nursing/HCA agency, enhanced temporary staffing control including review of NHSE grip and control checklist to identify further opportunities (Lead = CPO)
	Weaknesses in the alignment of medical job plans, medical staff rotas and financial budgets.	Alignment of medical job plans, medical staff rotas and financial budgets. Medical staffing patient first corporate project initiated Lead = CMO)
	Weakness in high cost drugs spend controls by holding these in a non-directorate cost center.	High-cost drugs spend controls mitigations: Legacy reporting processes will be harmonised to single data source from November, spend now being reported at Care group level, internal audit underway for further independent assurance (Lead = CFO)

Risk category and risk appetite statement		
Risk Type and Category	**Risk appetite**	**Relevant to strategic risk**
Workforce		
Leadership and Talent	Cautious	
Workforce capacity	Cautious	
Staff Experience	Cautious	
Recruitment and Retention	Cautious	
People and Function	Cautious	
Sustainable Services		
Business Continuity	Cautious	
Counter-fraud	Averse	X
Financial Management	Cautious	X
Information Governance	Cautious	
Financial Reporting	Cautious	X
Information Technology	Cautious	
Revenue funding and cash management	Cautious	X
Supply Chain	Minimal	X
Physical Assets	Cautious	
Quality (Outcomes and Safety)		
Health and Safety	Minimal	
Infection Prevention and Control	Minimal	
Legal and Governance	Averse	
Regulatory	Averse	X
Patient Safety and Outcomes	Minimal	
Research, Innovation and Development	Open	X
Population and System		
Capacity Planning	Cautious	X
Partnership Working	Open	X
Patient Experience		
Patient Experience	Minimal	

BOARD OF DIRECTORS - PART 1 MEETING

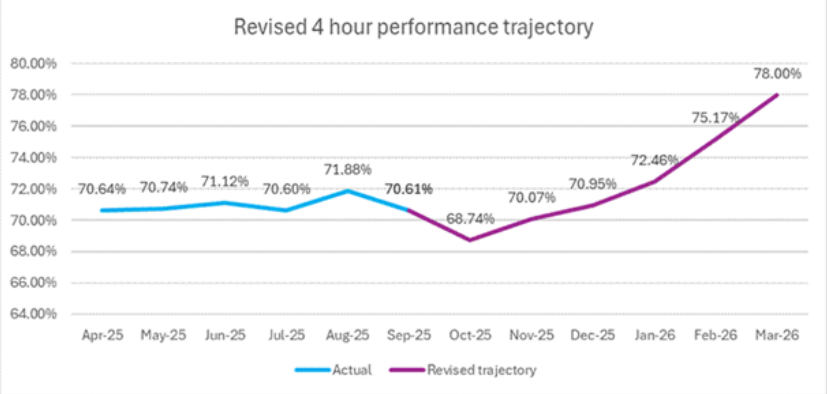
Meeting Date: 05 November 2025

Agenda item: 6.7

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, Adrian Tron, and Tracy Moran
Presented by:	UHD Chief Officers

Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	BAF Risks 1-7 Trust Integrated Performance report for September 2025 - Appendix A
Purpose of paper:	Assurance
Executive Summary:	September saw expected seasonal pressures within our Urgent and Emergency Care (UEC) pathways, primarily driven by system-wide patient discharge challenges ('No Reason to Reside'). We are managing these pressures effectively, with a minor impact on Emergency Department waits and bed occupancy. It is a testament to our focused efforts that our ambulance handover performance remains strong, providing a stable foundation as we enter the winter period. **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** As we move into winter, we recognise the challenging operational environment. Our response is coordinated and proactive, guided by our Trust strategic deployment reviews. We are confident that our focused actions and continued prioritisation will ensure we maintain stability and deliver on our key objectives throughout this period.
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. As part of our commitment against the CQC Well-Led Framework we continue to develop the format and content of the IPR by: • Extending best practice use of Statistical Process Control (SPC) Charts. • Maintaining and updating the indicators that are most relevant to our patients. • 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. • Providing SPC training to operational leads who compile the narrative against the data included within the report. ***We recognise as a Trust Board that behind every single metric discussed in this paper there is a patient.***
Population & Systems **Urgent & Emergency Care** **(1 Alert, 3 Advise, 1 Assure)**	**Strategic goal: To meet the patient national constitutional standards for Planned and Emergency care, supporting reducing inequalities in outcome and access and improving productivity and value.** **Alert (1): No Criteria to Reside:** Deteriorating position since mid- Sept 16. The wider system is also being impacted by a growing number of delays impacting pathways 1 & 2, which is driving up occupancy. This in turn has impacted ambulance handovers and patients over 12 hours within the Emergency Department. **Advise (1): Performance against the 4-hour Organisational standard:** The Trust's position against the standard was finalised at 70.6%. Following receipt of the NHSE letter 19th of September 2025 Mid-Year Review process and expectations the Trust has been asked to re-submit the improvement trajectory for the 4 hour organisational standard



The updated draft trajectory above will form a key part of the discussion in the UHD/system mid-year review meetings on October

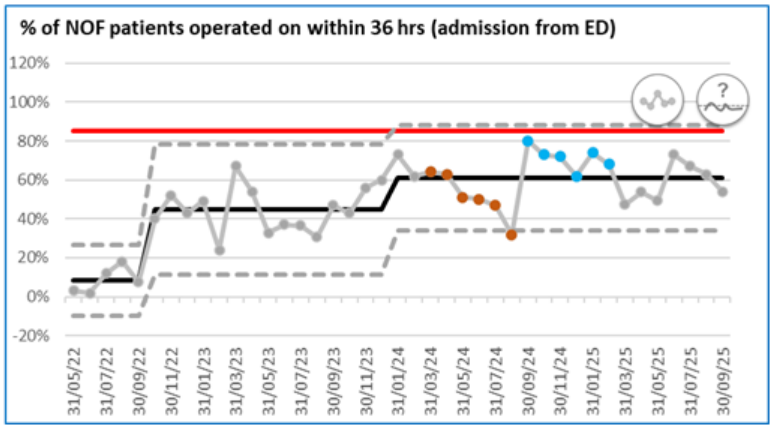
Advise 2: – No Criteria to Reside
Transfer of Care (TOC) hub in place. Key roles remain vacant however mitigating plan in place. TOC lead appointed with start date to be agreed.

Assure (2): Ambulance Performance:
Sustained improvement in handover times since June 2025.

Advise (1): Trauma: September performance for time to theatre for fractured neck of femur (#NoF) patients: 53.6% operated on within 36 hours from ED admission.

Performance fell in September below the process mean however maintains common cause variation and the target continues to all within the process limits indicating it is achievable.

70.7% achieving surgery within 36 hours of being fit for surgery.



The key areas of focus to 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.

Population & Systems

Planned Care including Cancer standards

(1 Assure)
(3 Advise)

Alert (1) Cancer Waiting Times
62 Day performance in August 2025 was finalised at 67.5%, failing to achieve both the Trust Operational Plan of 72% and the national recovery target of 75%. The process remains within common cause variation, indicating a stable but underperforming position that requires process change or intervention to avoid performance remaining consistently below target.

Two key actions are:

- Deep dive into our breach analysis to identify high impact actions; to date this has identified an improvement opportunity linked to prostate active monitoring
- Enhanced support meetings with the Colorectal team.

Advise (1) The percentage of >52 week waits as a proportion of the waiting list reduced triggering a special cause improvement

The percentage in September fell below the lower process control limit and signaled narrowing of the gap to target. Nine patients waited over 65 weeks, 2 of whom were waiting for corneal graft material.

Advise (2) The % of patient waiting >52 weeks for Community Health (neurodevelopmental) services is moving away from the target.

Three new consultants are in place however their capacity is being prioritised to rebook patients from previous Locum caseloads in the short term and therefore near-term improvement in longwaiters is not expected until the backlog of patients is cleared and demand reduces.

Advise (3) Cancer Waiting Times
FDS finalised position for August was 78% which is above national standard of 75% but below operational plan of 78.25%.

Assure (1) 18-week Referral to Treatment (RTT) performance continues to be delivered in line with the operational plan trajectory (-0.3% variance)

The Planned Care Improvement Group has oversight of the improvement projects supporting elective performance.

Planning requirement	Aug 25	September 2025	
Referral to treatment 18-week performance	63.3%	63.3%	National standard 92% trajectory 63.6% Sep 25
Eliminate >65 week waits	13	9 ↓	Plan trajectory 0 Sep 25
Reduce >52+ weeks	1832	1657 ↓	Plan Trajectory 2.5% 1,416 by Sep 25
Reduce Waiting List size	63,172	62,706 ↓	Plan Trajectory 67,191 Sep 2025
Waits for first activity <18 weeks	74.7%	74.3% ↓	Plan trajectory 71.0% Sep 2025

Assure (2) Cancer Waiting Times
Performance against the 31-day cancer waiting treatment time and faster diagnosis standard (FDS) in the latest nationally reported data (Aug 25) has shown sustained improvement.

Population & Systems

Health Inequalities and Primary Prevention

(2 Assure)

Assure (1) The DM01 (Diagnostic) standard performance moved to 1.4% of patients waiting more than 6 weeks for a diagnostic test, achieving the operational planning ambition (5%).

standard: No more than 1% of patients should wait more than 6 weeks for a diagnostic test.

September 2025	Total Waiting List	< 6 weeks	> 6 weeks	Performance
UHD	10,546	10,401	145	**1.4%**

Diagnostic waiting times performance remains strong and waits over 13 weeks are also now showing a sustained reduction.

Assure (2) The RTT waiting list for <18 year olds has shown a sustained reduction and RTT performance for this group is in line with the performance for all age groups.

Waits for children, analysed by deprivation and ethnicity, also illustrate that patients from the 20% most deprived groups and ethnic minorities wait the same or a smaller number of weeks than the rest of the patients on the waiting list.

Population & Systems

Operational Productivity

(1 Advise, 2 Assure)

Advise (1) Capped theatre utilisation (79.5%) is below the operation plan trajectory

This metric is not changing significantly, and performance is showing normal variation, rather than improvement. The target sits outside of current process control limits.

The 3 key actions are:

- Increasing booked theatre sessions in Gynaecology
- Improving Orthopaedic turnaround times and theatre case time allocation
- Reducing elective cancellations with a focus on cancellations 0-72 hours prior to surgery

Assure (1) The Trust is achieving the British Association of Day Surgery (BADS) day surgery rate (85%)

Assure (2) The Trust has delivered 118.5% (provisional value weighted activity) year to date compared to the same period in 2019/20.

Activity is above the operational plan trajectory (107.4%). The month 3 (latest nationally reported data) estimated 25/26 Implied Productivity Growth compared to month 3 2024/25 is 6%, placing UHD as having the 3rd highest productivity growth in the South West Region

Advise (1): There are 3 areas currently identified for focus

- Workforce –sickness rates

Maternity (1 Advise)	• 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 hrs 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: No cases of hospital acquire**d MRSA bacteraemia. • **Alert (2) Clostridioides *difficile* cases**: September saw a decrease in HA C.diff cases • **Advise (1) *E.coli* bacteraemia:** September continued to see a decrease in E.coli cases • **Advise (2) *Klebsiella* bacteraemia**: September saw a decrease in cases • **Advise (3) *Pseudomonas* bacteraemia*:*** September cases remain steady • **Advise (4) Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia:** A decrease in cases compared to the previous month • **Advise (5) Hospital Associated cases trend:** Beginning to see a decrease in hospital acquired gram negative BSI cases • **Advise (6): Outbreaks/cohort of infectious disease:** 1 x ward closure in OPS due to COVID-19 cases in September. Universal mask wearing & enhanced cleaning put in place. 7 x patient cases reported. No staff cases reported. Ward reopened after 6 days.
Clinical Practice Team ***(1 Advise)*** ***(1 Assure)***	**Clinical Practice Team:** **Falls prevention & management**: **Advise (1)**: Inpatient falls remain within expected variation. September 2025 rate: 6.7 per 1,000 bed days. Four falls caused moderate or greater harm (0.1 per 1,000 bed days). 92% of falls were Low/No Harm; 6% lacked harm categorisation, mainly from night shifts. **Assure (1)**: PSIRF SWARM reviews completed for all moderate+ harm falls; no new Trust-wide learning identified. Falls Thematic Review presented to PSIRF Oversight Group and Falls Steering Group relaunched (Oct 2025) to oversee key actions

Organism	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
MRSA	0	0	3	1	0	2	1	0	0	1	0	0
MSSA	5	3	5	3	7	8	4	4	6	2	6	4
C Diff	11	10	14	4	6	8	10	11	5	8	13	5
E Coli	9	12	14	18	14	19	18	13	14	12	7	3
Kleb	8	3	7	8	5	8	3	6	3	4	4	3
Pseudo	5	2	3	4	2	0	3	2	1	2	2	2
Outbreaks	0	0	4	5	5	0	0	0	0	0	2	0

	VTE Prophylaxis: Reporting on this metric has been paused, with agreement from Chief Medical Officer, until logic has been revised. Metric logic is currently under review by a working group consisting of Business Intelligence, Pharmacy and Clinical Leads. It is anticipated this will be live again from November 2025. In the meantime, wards receive automatic emails from EPMA (Electronic Prescribing System) advising of any patients requiring prophylaxis prescribing.
Patient Experience ***(3 Advise)***	**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.** **Patient Experience and Engagement Team Overview:** **Patient Experience (inc. PALS and Complaints) performance September 2025** **Advise (1) The number of open complaints over 35 days** is currently at 24. They continue to be prioritised within the complaints team and care groups and are decreasing, with further measures to reduce the number of outstanding complaints in place. **Advise (2) Average complaint response timescale** August 2025 was a 35.59 working day average for a final response. **Advise (3) 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.
Workforce Performance:	**Strategic goal: To significantly improve staff experience, engagement, and retention.**
CPO Headlines	UHD continues to be off plan against the overall Workforce Plan as at M06: WTE (whole time equivalent) adverse variance above plan; 9100.1 WTE usage against a plan of 8999.21WTE (unrevised), or 9079.64WTE (revised H2). **M06 bank usage detail:** **Medical Care Group:** 256.94 WTE non- medical bank used which was an increase from M05 of 4.37WTE. 99.87WTE usage was for registered adult nursing, which was a slight reduction from M05. However, there was an increase in bank usage for support to nursing and midwifery from 137.64WTE to 144.09WTE (6.45WTE increase from M05). The Urgent and Emergency Care Directorate reduced non-medical bank usage by 6.25WTE compared to M05, whilst Network Medicine and Specialist Medicine increased usage by 4.97WTE and 4.72WTE respectively. **Surgical Care Group:** 105.96 WTE non-medical bank used which was a reduction of 3.12WTE from M05. There was a reduction across all PWR staff groups, except for Total NHS Infrastructure, who saw a small increase of 0.97WTE. **WCCSS:** 93.66WTE non-medical bank used which was reduction of 5.12WTE from M05. There was a reduction across all workforce groups apart from registered/qualified scientific, therapeutic and technical staff where there was a minimal increase of 1.75WTE from M05. Women's Health Directorate saw the biggest reduction

	in bank use across the care group from M05, with a reduction of 6.93WTE. **Operations:** 72.32WTE non-medical bank used which was a reduction of 10.12WTE from M05. This was seen across all directorates, but mostly in Facilities with a reduction of 7.06WTE from M05. UHD has consistently met the agency cap since May 2024.
HR Operations - ***(3 Advise)***	**Advise – Consultant and SAS Job Planning -** As of 1 October 2025, 84% of consultants and 64% 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, there is recognition that significant work has been undertaken to get to this position. Moving forward, Care Groups/departments will focus on team job planning, with the expectation that team job planning is completed by 31 December 2025, and to further develop the provision of support for the SAS workforce specifically to encourage engagement with the job planning process going forward. **Advise – FY1 Resident Doctor Ballot:** The British Medical Association (BMA) have announced that nationally Foundation Year 1 Doctors have voted in favour of Industrial Action. The dispute relates to the numbers of specialty training places available to resident doctors in England and linked career insecurity. No strike dates are currently planned. Talks are ongoing with Government over jobs and pay. **Advise – Consultants and Specialty, Associate Specialist and Specialist Doctors (SAS) Indicative Ballot:** Consultants and SAS doctors nationally have shown as part of an indicative ballot undertaken by the BMA that they are prepared to take Industrial Action. It is understood that the BMA is working with the Government, initially to seek a commitment to work together to address the key issues. Ultimately, if these talks do not progress, the BMA could announce a formal ballot, which will require its members to vote on, before a call for industrial action can be made.
Blended Education & Training **(1 Alert)**	**Alert -** Oliver McGowan training compliance, UHD is an outlier. Mitigation in place to increase training over next six months. No available funding identified for this training after March 2026.
Workforce Systems ***(2 Advise)***	**Advise** – Beginning in October, we will be required to report instances of overpayments and underpayments to NHS England. These submissions will be made via Microsoft Forms. As of today, the specific commencement date in October has not yet been confirmed **Advise** – This month, 38 rosters were not finalised within the required timeframe, resulting in the pay files being submitted on Monday rather than Friday. Additionally, one department was entirely omitted, which had a direct impact on payroll.
Resourcing ***(1 Advise)***	**Advise –** Right to Work SOP completed for final approval and subsequent socialisation; process flows developed for key recruitment stages.

Temporary Staffing (3 Advise)	**Advise -** Implementation of Locum's Nest demand and escalation controls have been delayed to end of October **Advise -** Theatre enhanced pay stopped 30th September which may impact fill rates. **Advise -** M06 Weekly requests for Mental Health Support workers have double in number compared to weekly figures in July (from weekly average of 600 to 12800)
Organisational Development ***(5 Advise)***	**Advise - FTSU** 234 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 (112 staff; 48%) followed by policy and procedure (73 staff; 31%). Fifty-five per cent of behaviours are relating to incivility, 15% relating to a miscommunication and 14% relating to intractable behaviours. 31 referrals (13%) were made anonymously and 47 referrals (20%) by staff from our global majorities. Learning includes leadership and management (117 staff; 50%), developing a civil and respective culture (61 staff; 26%), hygiene factors (20 staff; 8%) and wellbeing (15 staff; 6%). **Advise - EDI**. UHD's Black History Month celebrations are scheduled for 24th October at RBH and 30th October at Poole. The listening event on 7th October was attended by DEN colleagues, Executive leads, and allies, with a shared agreement to develop additional plans to promote the Anti-Racism campaign and provide support for Global Majority staff. The monthly Conscious Inclusion workshop is ongoing, with all managers encouraged to attend. In parallel, we are exploring the option of a Bitesize Conscious Inclusion session in collaboration with the BEAT team **Advise –Staff Survey**: Successfully launched on 9th September 2025, closing date 28th November. As of 08/10/25 the % response rate across the trust is **27.5%** meaning that **2784 staff** have completed their survey. Planned support sessions and walkabouts are taking place in addition to the communication campaign. Weekly updates will be provided, including response rates throughout the period the survey is live to both the executive teams, Care groups & Directorates.
Trust Finance Position **(2 Alert, 2 Advise, 2 Assure)**	**Strategic goal: To return to recurrent financial surplus from 2026/27** **Alert (1): Revenue Position** At the end of September the Trust reported a deficit of £9.2 million, being £20,000 better than plan. Whilst **efficiency delivery is ahead of plan** year to date, the financial impact of **operational pressures including the Resident Doctor industrial action** have off-set the majority of this benefit. 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 – except for the financial impact of the delay in 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.

Crucially, this leaves an **unmitigated risk of £14.7 million**, and we are working closely with system partners and NHS England to agree how this resulting financial gap could be covered. **There remains considerable risk, therefore, in the delivery of the full year plan**.

Alert (2): Efficiency Improvement Programme
Efficiency improvement delivery to the end of September is **£1.1 million ahead of plan**. The trust has identified **savings opportunities of £61 million**, however when **adjusted to reflect the risk of delivery in year, this is reduced to £51 million**. Whilst this representing an improvement in month of £1.5 million; it remains £18.9 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 we have **invited NHS England into the Trust during October to undertake a deep dive on our efficiency programme**, to provide additional external assurance and learn from the output of similar reviews undertaken elsewhere in the South West.

Advise (1): Capital Programme
The Trust has reported **capital expenditure of £63.3 million, being £7.0 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.

Advise (2): Public Sector Payment Policy
In relation to the timely payment of supplier invoices, the Trust is currently delivering **performance of 94.8%**, slightly below the national standard of 95% and was above target within September showing signs of recovery. It is anticipated that this will improve following the summer leave period which has impacted the timely authorisation of invoices, and we are targeting support to areas with slow invoice approvals to ensure performance moves above the target in future months.

Assure (1): Cash
As at September 2025 the Trust is holding a consolidated cash balance of £93.2 million which is fully committed against the Trust's reconfiguration programme. This current balance represents 38 days of operating expenditure. However, as the cash balance

	includes national PDC draws which are required for specific capital programme spend items, in reality it covers fewer days of revenue operating expenses.
Sustainable Services **Digital** **(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** A task and finish group involving clinical and operational leads is 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. Currently Dermatology is live but the next 3 specialties are in test and setup. **Assure (1) Did not attend or missed appointment rates are above the Trust's 5% target at 5.4%.** Whilst the increasing trend is not statistically significant at this point action will be taken to understand the trends at specialty level and to evaluate in October/November the impact of DNA prediction, which has been employed through the DrDoctor portal in some services. **Assure (2) ICE for Ordering vs paper - agreed locations to start pilot by 20th October and feedback.** To progress the move from paper requesting to purely electronic pilot wards have been agreed and will move to electronic requesting only with engagement from all locations by the 20th October. This will then feedback into the action plan to move to 95% electronic requesting by end of March.
Key Recommendations:	Members are asked to note the content of the report.
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
Finance & Performance Committee (Operational / Finance Performance)	20/10/2025	Pending
Trust Management Group	21/10/2025	Pending
Quality Committee	28/10/2025	Pending

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	☐





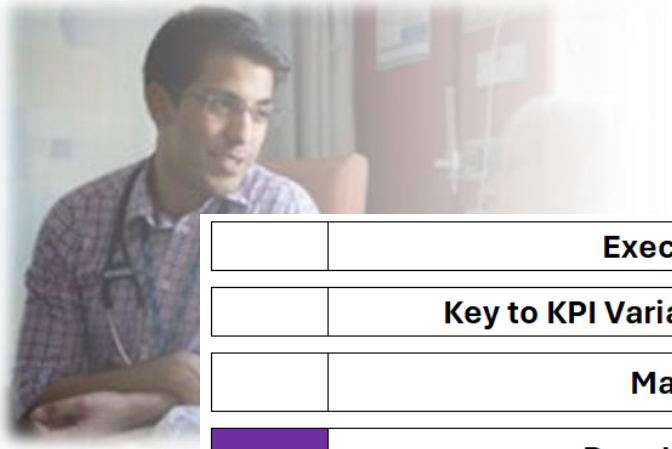


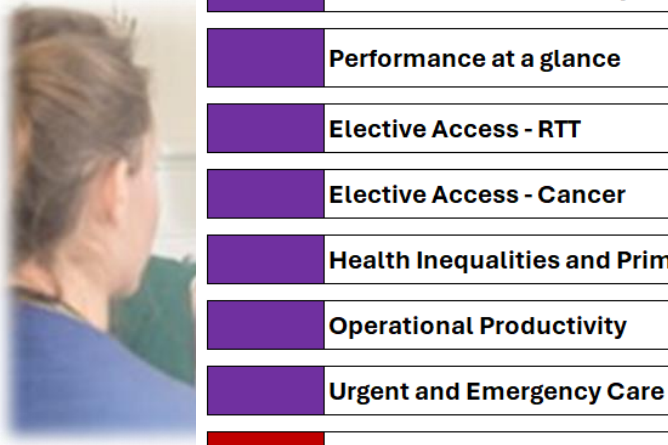
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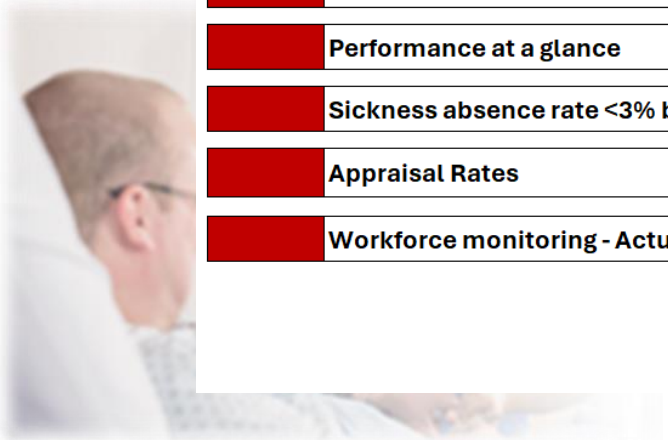
Integrated Performance Report

Reporting month: September 2025

Meeting Month : October 2025







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University Hospitals Dorset
NHS Foundation Trust

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Executive Summary

University Hospitals Dorset
NHS Foundation Trust

September saw expected seasonal pressures within our Urgent and Emergency Care (UEC) pathways, primarily driven by system-wide patient discharge challenges ('No Reason to Reside'). We are managing these pressures effectively, with a minor impact on Emergency Department waits and bed occupancy. It is a testament to our focused efforts that our ambulance handover performance remains strong, providing a stable foundation as we enter the winter period.

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.

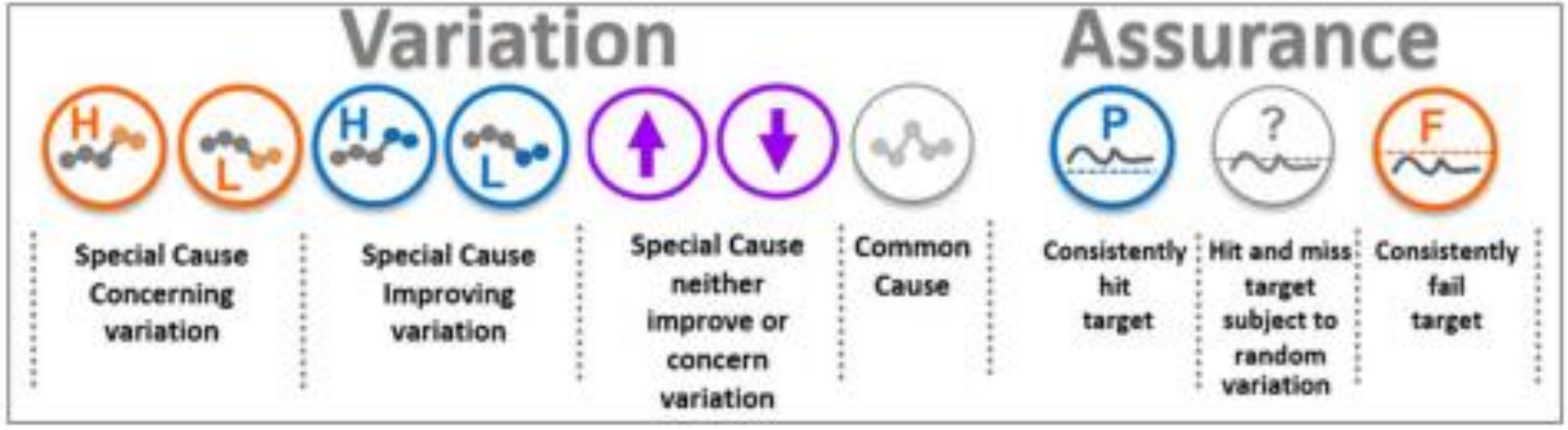
Forward Look: Prepared and Focused
As we move into winter, we recognise the challenging operational environment. Our response is coordinated and proactive, guided by our Trust strategic deployment reviews. We are confident that our focused actions and continued prioritisation will ensure we maintain stability and deliver on our key objectives throughout this period.

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

University Hospitals Dorset
NHS Foundation Trust



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



* scored in NOF

University Hospitals Dorset
NHS Foundation Trust

Population & System



Mark Mould
Chief Operating Officer

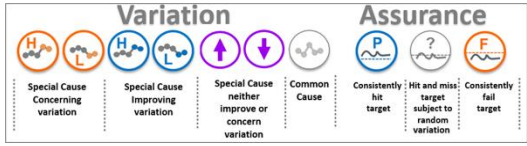
Operational Leads:
Judith May – Director of Operational Performance and Oversight
Mark Major – Deputy Chief Operating Officer
Abigail Daughters – Group Director of Operations – Surgery
Lisa Clarke – Group Director of Operations – Women's, Children, Cancer and Support Services
Adam Morris – Interim Group Director of Operations – Medical

Committees:
Finance and Performance Committee

Performance at a Glance

Population & System

University Hospitals Dorset
NHS Foundation Trust



UHD Elective Care

KPI	Latest month	Measure	Target	Variation	Assurance
RTT Total Waiting List Size	Sep 25	62706	67191		
RTT Performance against trajectory for 18 week standard (92%)	**Sep 25**	**63.3%**	**63.6%**		
Patients waiting >52 weeks	Sep 25	1657	1416		
% Patients waiting >52 weeks (1% std) against trajectory	**Sep 25**	**2.6%**	**2.1%**		
Patients waiting >65 weeks	Sep 25	9	0		
% Patients waiting <18 weeks for 1st attendance	Sep 25	74.3%	71.0%		
Under 18's RTT pathways	**Sep 25**	**4565**	-		
UHD - Total Diagnostic Waiting List	Sep 25	10546	-		
UHD - % waiting over 6 weeks	**Sep 25**	**1.4%**	**5.0%**		
UHD - % waiting over 13 weeks	Sep 25	0.3%			
Community Health Services SITREP % over 52 weeks	**Sep 25**	**63.0%**	-		
Faster Diagnosis Standard (FDS) 28 days	**Aug 25**	**78.0%**	**75.0%**		
31 day standard	Aug 25	96.0%			
62 day standard	**Aug 25**	**67.5%**	**85.0%**		
Trauma Admissions	Sep 25	390	-		
% of NOF patients operated on within 36 hrs (admission from ED)	Sep 25	54.0%	85.0%		
% Outpatient appointments with procedures	Sep 25	22.0%			
UHD - Total Outpatient - Virtual (%)	Sep 25	16.9%	25.0%		
UHD Outpatient DNA rate	Sep 25	5.4%	5.0%		
Theatre utilisation (capped)	Sep 25	79.9%	85.0%		
UHD Theatre case opportunity	Sep 25	12.2%	15.0%		

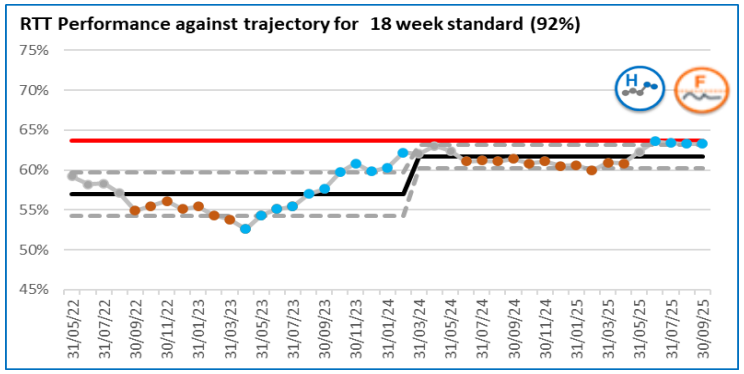
UHD Urgent and Emergency Care

KPI	Latest month	Measure	Target	Variation	Assurance
Arrival time to initial assessment	Sep 25	18	15		
Clinician seen <60 mins %	Sep 25	24%	-		
Patients >12hrs from DTA to admission	Sep 25	192	0		
Patients >12hrs in dept	**Sep 25**	**871**	-		
4 hour safety standard	**Sep 25**	**70.6%**	**75.0%**		
Ambulance handovers - average handover time UHD	Sep 25	26.6	-		
Ambulance handovers - average handover time RBH	Sep 25	30.3	-		
Ambulance handovers - average handover time Poole	Sep 25	22.6	-		
Ambulance handover >60mins breaches	Sep 25	142			
Ambulance handovers	Sep 25	4039	-		
Bed Occupancy (capacity incl escalation)	Sep 25	92%	85%		
Stranded patients: Length of stay 7 days	Sep 25	521	-		
Stranded patients: Length of stay 14 days	Sep 25	322	-		
Stranded patients: Length of stay 21 days	Sep 25	224	108		
Non-elective admissions	Sep 25	6699	-		
> 1 day non-elective admissions	Sep 25	3940	-		
Same Day Emergency Care (SDEC)	Sep 25	2758	-		
Conversion rate (admitted from ED)	Sep 25	29.8%	30.0%		

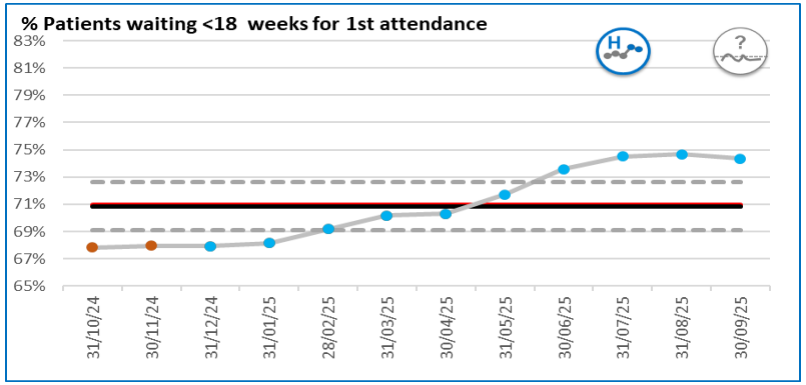
Elective Access - RTT

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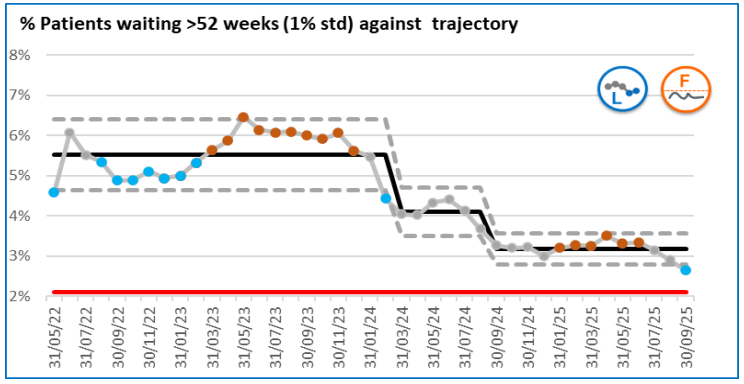
September 25
63.3%
Variance/Assurance
H F
Targeting (Internal)
63.6%
Business Rule
Full CMS



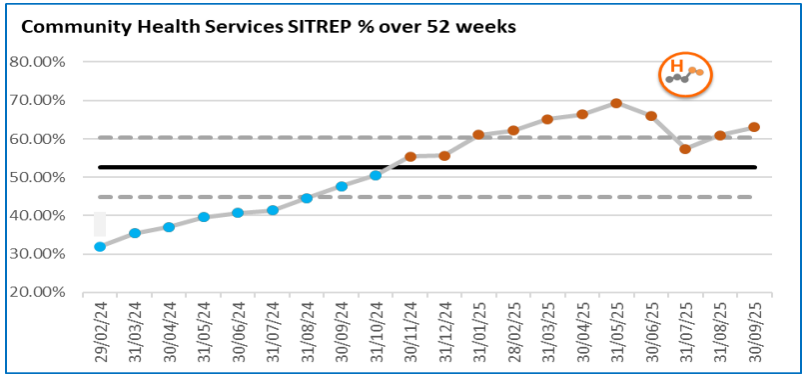
September 25
74.3%
Variance/Assurance
H ?
Targeting (Internal)
71.0%
Business Rule
Note performance



September 25
2.6%
Variance/Assurance
L F
Targeting (Internal)
2.1%
Business Rule
Full CMS



September 25
63.0%
Variance/Assurance
H
Targeting (Internal)
Business Rule
Note performance



Summary

RTT performance shows special cause improvement since June 2025, whilst September performance was marginally below plan by 0.3%. An increase in the % of patients seen within 18 weeks for their 1st attendance (OPA or diagnostic) is supporting an improvement in overall RTT performance.
% of patient waiting >52 weeks also triggered a special cause improvement in falling below the lower process control limit. 1,657 patients breached 52 weeks; 241 above plan. Nine patients waited over 65 weeks, 2 of whom were waiting for corneal graft material.
The % of patient waiting >52 weeks for Community Health (neurodevelopmental) services is above the upper process control limit and requires intervention.

Actions

- Increase validation of the waiting list in line with the national 'validation sprint' initiative, increasing removals >5% above baseline levels.
- Designated Outpatient clinic utilisation team commencing in October to target improved booking rates working to 100% over next 3 months.
- Reduce the number of 52-week breaches due to outstanding admin actions to enable greater clock stops.
- Eliminate >65 weeks waits to enable greater focus on >52 week reduction.
- Implement changes following recent .clinic template standardisation audit to increase clinic slot capacity
- Induct 3 new Pediatricians to reduce waits for paediatric neurodevelopmental assessments.

Assurance & Timescale for Improvement

Planned Care Improvement Group providing oversight and weekly performance huddle in place.
Timescales:

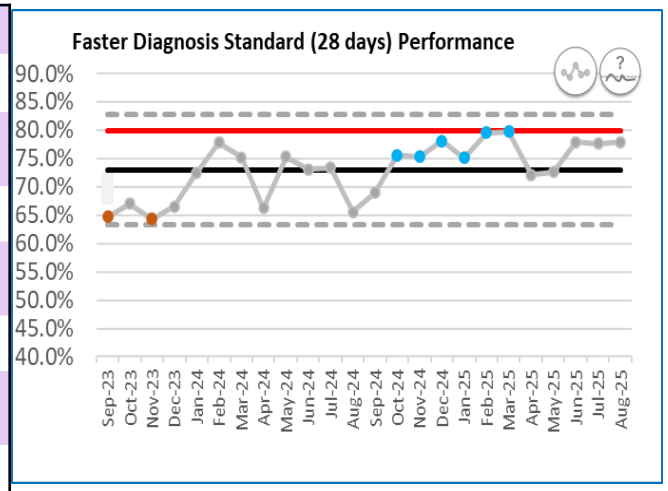
- Elimination of 65 week waits by end October 2025 except for patients awaiting corneal graft material which is dependent on national availability
- Reduce variation to plan for % of waiting list >52 week waits, to 0 by end December 2025 following current trend and return to RTT performance planned trajectory.
- Currently exceeding March 2026 target for waits for 1st activity and no known risks.
  Increase bookings for patients waiting neuro-developmental assessment.

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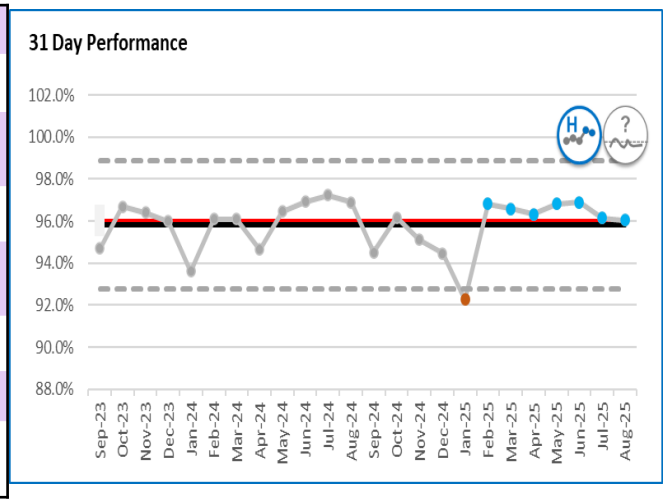
Elective Access - Cancer

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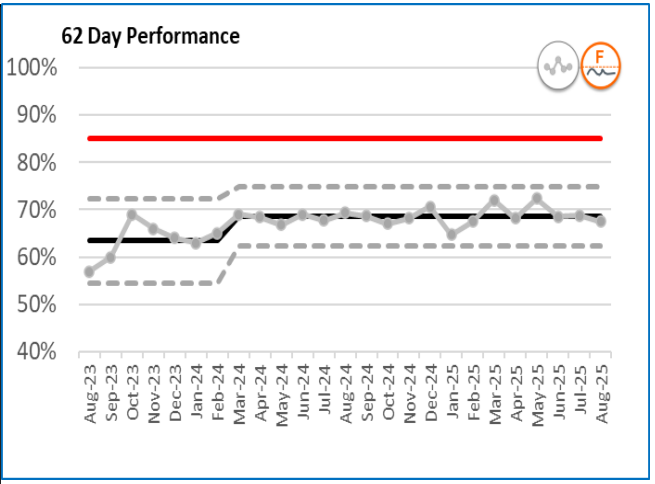
Aug 25
78.0%
Variance/ Assurance
Targeting (Internal)
78.25%
Business Rule
Note performance



Aug 25
96.0%
Variance/ Assurance
Targeting (Internal)
96.0%
Business Rule
Verbal CMS



Aug 25
67.5%
Variance/ Assurance
Targeting (Internal)
72%
Business Rule
Full CMS



Summary

FDS performance in August 2025 was finalised at 78%, which is above the national standard of 75%, but below the Trust Operational Plan of 78.25%. This metric is now demonstrating common cause variation.
31 Day performance in August 2025 was 96.0%, meeting the 96.0% national standard. This is now demonstrating special cause improvement, indicating a sustained positive shift in performance.
62 Day performance in August 2025 was finalised at 67.5% failing to achieve both the Trust Operational Plan of 72% and the national recovery target of 75%. The process remains within common cause variation, indicating a stable but underperforming position that requires process change or intervention to avoid performance remaining consistently below target.

Actions

- **Colorectal** – reorganisation of Middle Grade clinics to reduce the fast-track backlog by mid-October 2025.
- **Breast** – agreement to appoint a locum Breast Radiologist for 3 months, funded by the Cancer Alliance contingency fund to cover two long term sick episodes.
- **Urology** – Targeted actions identified to improve the pathway for Prostate patients who require active monitoring which will enable Urology to meet the 62D standard.
- **Skin** – an extension in Q3 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.

Assurance & Timescale for Improvement

- Enhanced Executive support meetings in place from October 2025 to support Colorectal recovery.
- On track to meet the 80% target for the 28 Day Faster Diagnosis Standard by March 2026.
- 7 consecutive months of achieving the 31 Day standard, with no known risks for the remainder of 2025/2026.
- Specific 62 Day breach analysis by treatment type generated for cross site improvements in the 62 Day Standard to achieve the March 2026 recovery standard of 75%.
- The over 62 Day PTL has remained below 220 patients throughout 2025/2026 with the end of August position reporting 193 patients.

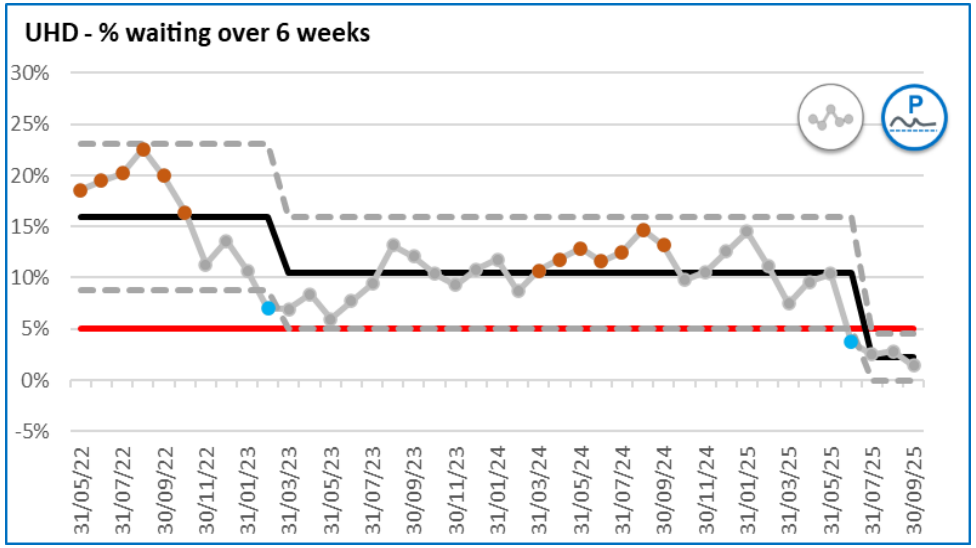
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Health Inequalities and Primary Prevention

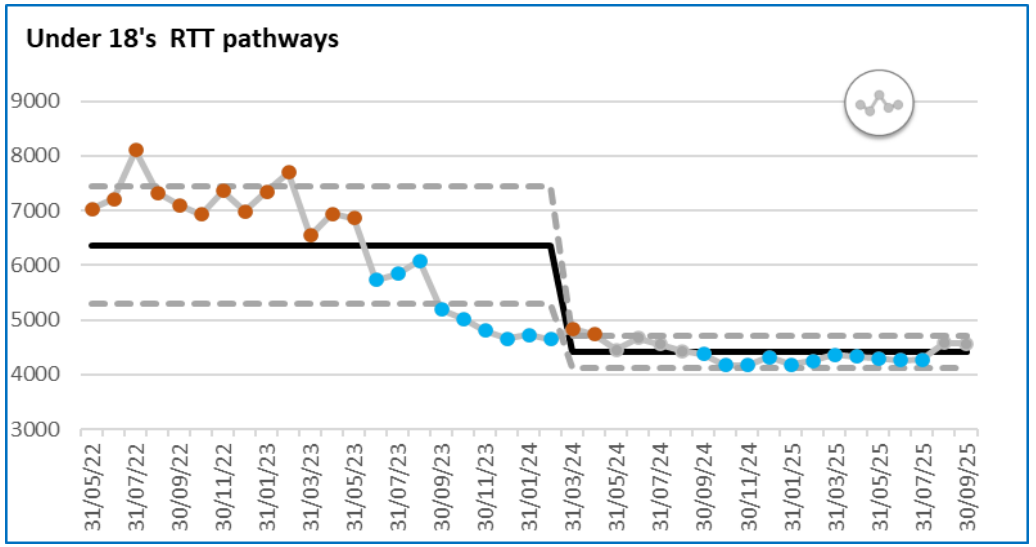
Diagnostic Access and RTT Under 18's waiting

University Hospitals Dorset
NHS Foundation Trust

Sep 25
1.4%
Variance/ Assurance
Targeting (Internal)
5%
Business Rule
Note Performance



Sep 25
4565
Variance/ Assurance
Targeting (Internal)
Business Rule



Summary

There is consistent achievement of the Trust DM01 (Diagnostics) target. Performance in September was just 0.4% above the national constitutional standard, placing the Trust closest of all Trusts in the South West region to the national standard .

The RTT waiting list for patients <18 yrs is within the process control limits and has shown a sustained reduction compared to 2024/25. RTT performance for this group is 63.7%, 0.1% above RTT performance for all age groups.

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 first month of the Quarter. Children within the 20% most deprived groups, on average have 4 weeks less to wait compared to adults. No variation exists in the total waiting list when analysing by ethnicity. However, children from community minority groups are waiting an average of 5 weeks. In contrast, waiting times for White British children have increased to 11 weeks, from 9 seen at the end of Q2.

Actions

Diagnostics:

- Cease use of MRI agency staffing following onboarding of staff into permanent posts within the Trust.
- Increase capacity for Cystoscopy to
- Continue use of 18 Weeks Support for endoscopy pending opening of the new Endoscopy build in 2026.

Data and commentary for "***Percentage of inpatients referred to in-house tobacco treatment services who make a supported attempt to quit stop smoking***" being sourced for inclusion next IPR.

Assurance & Timescale for Improvement

Recover MRI >6 week breaches by end November 2025

The target for DM01 performance has been achieved for 4 consecutive months and now the aim is to continue with sustainable improvement below 5% for the rest of 2025/26.

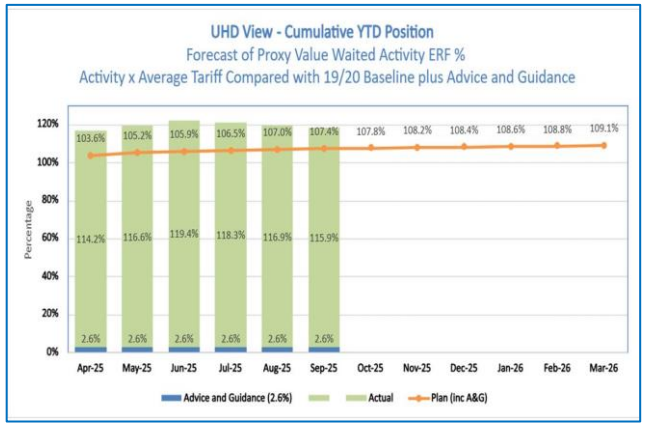
Continued monitoring of waiting list trends by deprivation is needed during the quarter to assess for statistically significant health inequalities.

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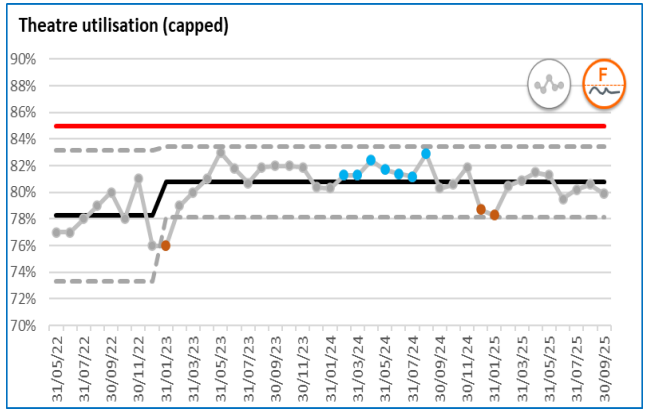
Operational Productivity

University Hospitals Dorset
NHS Foundation Trust

Sep 25
118.5%
Variance/ Assurance
Targeting (Internal)
107.4%
Business Rule
Note Performance

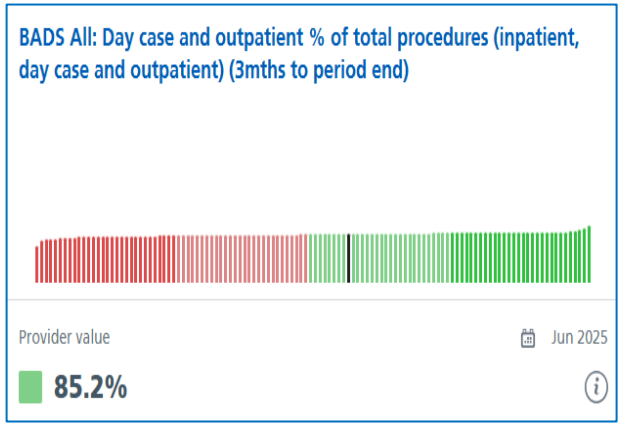


Sep 25
79.5%
Variance/ Assurance
Targeting (Internal)
85%
Business Rule
Verbal CMS



June 25
85.2%
Variance/ Assurance
Targeting (Internal)
Business Rule

British Association of Day Case Surgery - BADS



Summary

- Year to date 118.5% (value weighted) elective activity has been delivered compared to the 2019/20 baseline period. This is above the operational plan trajectory (107.4%).
- Capped theatre utilisation is below trajectory and the national target (85%). A sustained reduction in variation remains, however further action is required to enable delivery of the national ambition. Contributing factors:
  - Reduced utilisation of Gynae lists due to shortages in booking administrative teams to support list planning
  - Orthopaedic theatre turnaround time and planned time taken for cases.
  - Flow and capacity challenges: including ITU capacity and medical outliers in surgical bed spaces impacting elective admissions
- Daycase utilisation is sustained above the 85% target at 85.2%.
- The month 3 (latest nationally reported data) estimated 25/26 implied productivity growth compared to month 3 2024/25 is 6%, placing UHD as having the 3rd highest productivity growth in the South West Region.

Actions

- Weekly meeting with Gynae lead in place supporting increased theatre bookings and utilisation focus - outside of weekly theatre planning meeting
- Trauma & Orthopaedics directorate clinicians are undertaking a weekly review of their case time and opportunity to align with the data set and support fully utilised theatre capacity
- A trajectory for cancelations 0-72 hrs is being developed and associated improvement actions to affect a reduction of 3% against the baseline by March 2026.
- 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, the Theatre Improvement and Daycase programmes.

Theatre improvement programme relaunched in September 2025 and A3 improvement plans requested of each specialty performing below the national target to affect delivery of the planned capped theatre utilisation target – 82.02% in October 2025.

Increase in Orthopaedic day case rates expected in Quarter 3 2025/26.

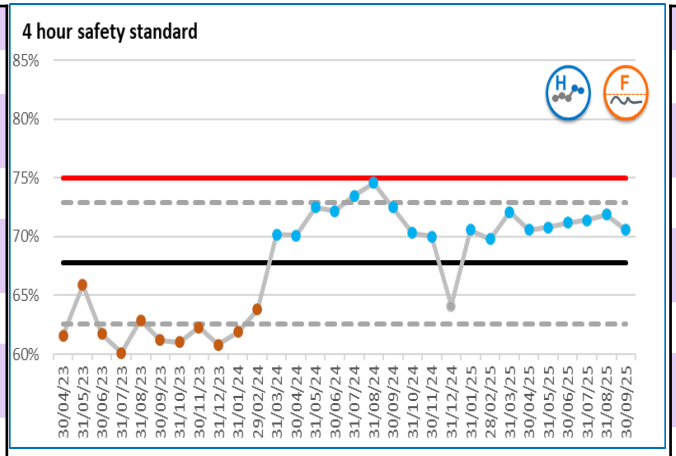
Aiming to maintain or improve the BADS day case rate – Quarter 3, with a focus on reducing variation

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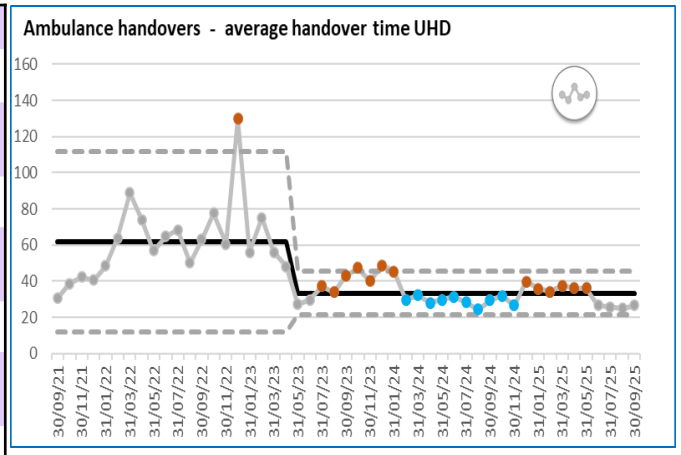
Urgent and Emergency Care

University Hospitals Dorset
NHS Foundation Trust

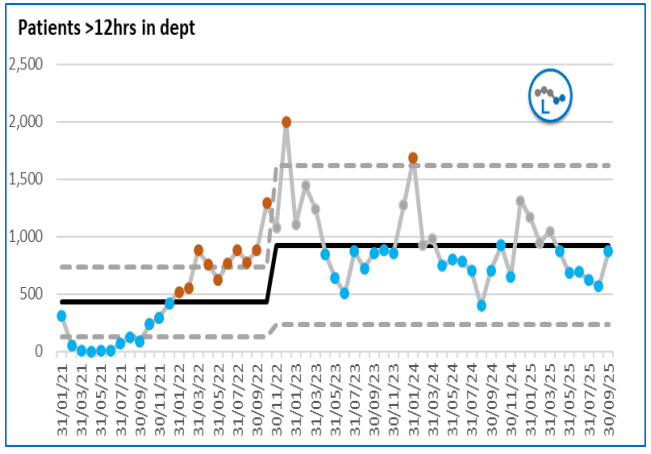
Sep 25
70.6%
Variance/ Assurance
Targeting (Internal)
75%
Business Rule
Note performance



Sep 25
26.6 minutes
Variance/ Assurance
Targeting (Internal)
Business Rule
Note performance



Sep 25
871
Variance/ Assurance
Targeting (Internal)
Business Rule
Verbal CMS



Summary

- Four-hour safety standard demonstrating special cause variation (improvement) @ 70.6% for September, however target remains outside of process limits, therefore will not be achieved without change or intervention to underlying processes.
- Average handover showing improvement and two data points from demonstrating special cause improvement. Following the implementation of Timely Handover Process (THP) target falls within process limits. UHD achieving handover target, however RBH site remains above 30 min @ 31 minutes. Clinical pathways are contributing to RBH position i.e., Cardiac and Stroke.
- Number of patients within the department for less than 12 hours has triggered special cause variation (improvement) and target within process limits. Towards the end of the reporting month the number of patients greater than 12 hours increased but remained within the target range. Strong correlation between the increase and bed occupancy associated with increased No Criteria to Reside (NCtR).

Actions

- Cultural plan to be rolled out across the department by Oct 31st.
- A3 / improvement huddles in place focusing on underlying processes.
- Executive supported GEMBAs to take place through October 25.
- Full review of handover process including entry points outside of ED.
- Internal dashboard in flight increasing visibility of handover times.
- Establishing dual – sign off process to improve data quality.
- Determine % of handovers > 30 mins due to clinical reasons.
- Establish consistent and structured huddles improving situation awareness, effective interface with the site teams and robust planning.
- Fully embedding national UEC mental health card.

Assurance & Timescale for Improvement

- Revised improvement trajectory outturning 78% compliance by 31st March 2025.
- All driver metrics linked to underlying processes are aligned to outturn 78% by March 2025.
- Front Door Improvement Group and Care Coordination Group established with oversight from UEC Group.
- Four months sustained improvement against ambulance handover average of 30 mins. Improvement plan focused on RBH site.
- Dual sign off in place resulting in robust handover time capture.
- UHD consistently below 5% target for patients > 12 hours in Emergency Department. Focus on patients presenting on mental health difficulties.

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

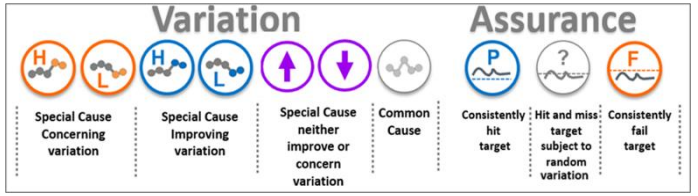
Performance at a Glance

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	Aug 25	7.4%	-			7.1%	4.6%	9.6%
In Month Sickness Absence	**Sep 25**	**5.0%**	**3.0%**			**4.9%**	**3.8%**	**5.9%**
Mandatory Training Compliance at end of each month	Sep 25	90.3%	90.0%			88.4%	87.2%	89.7%
Temporary Hours Filled by Bank	Sep 25	68.6%	-			57.5%	52.4%	62.6%
Temporary Hours Filled by Agency	Sep 25	9.8%	-			19.3%	15.9%	22.8%
Agency Pay as Proportion of Total Pay	Sep 25	0.7%				3.5%	2.3%	4.7%



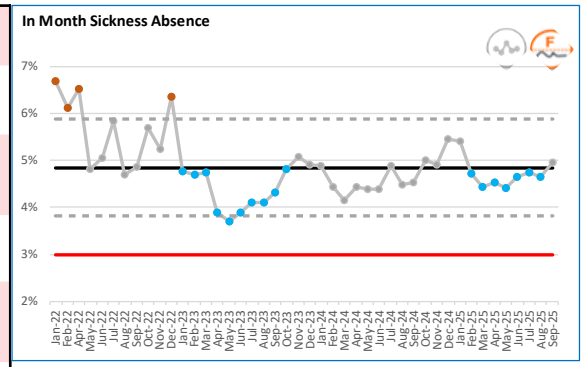
NHS Staff Survey Results will be reported annually

- "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

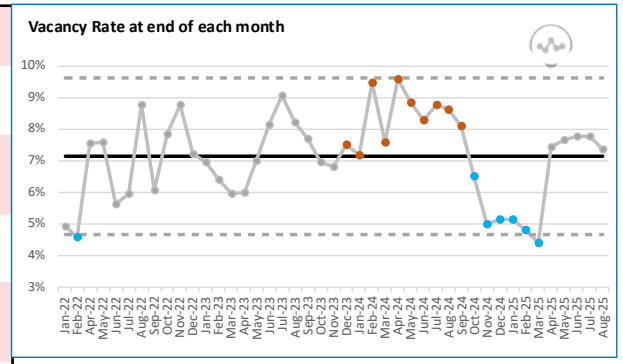
Sickness absence rate <3% by March 2024
Vacancy Rate
Turnover

University Hospitals Dorset
NHS Foundation Trust

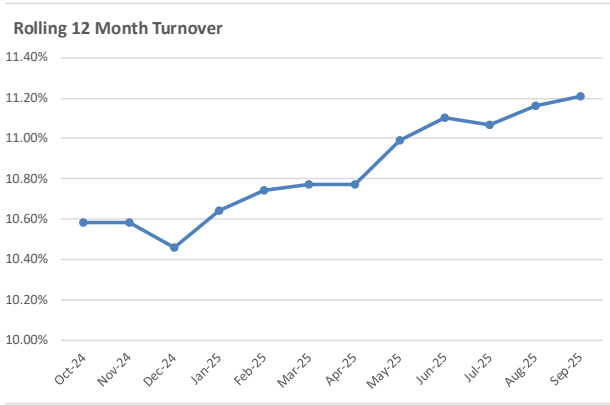
September 25
4.7%
Variance/ Assurance
Targeting (Internal)
3.0%
Business Rule
Verbal CMS



August 25
7.4%
Variance/ Assurance
Targeting (Internal)
5%
Business Rule
Verbal CMS



September 25
11.2%
Variance/ Assurance
N/A
Targeting (Internal)
10%
Business Rule
Verbal CMS



Summary

Occupational Health Pre-placements received - 280 in September that were cleared on average to 1.9 days. 95 management referrals were received in September 75% were seen within 10 days of the referral being consented.
Psychological Support and Counselling Service (PSC) Self-referrals to PSC increased by 44% compared to the previous month, to an average of 13 per week in September. The primary reasons reported for referral remain high stress (↓80%) and depression (↓35%) with ↑16% reported as signed-off work by their GP. Waiting times for an initial assessment remain within the target of less than 2 weeks.
The Admin & Clerical (A&C) vacancy pause continues, with a regular flow of Executive 'exception' requests being received by the Recruitment team. Time-to-Hire remains high at >57 days (target 30).

Actions

Care Groups to ensure support is in place for all individuals off with long term sick absence.
Stress assessments are completed (by manager with staff member) and recorded for all staff off with reasons aligned to stress, anxiety and depression

Stage-level metrics and escalation triggers have been introduced, but delays persist in early stages (shortlisting/interviews) and pre-employment checks.

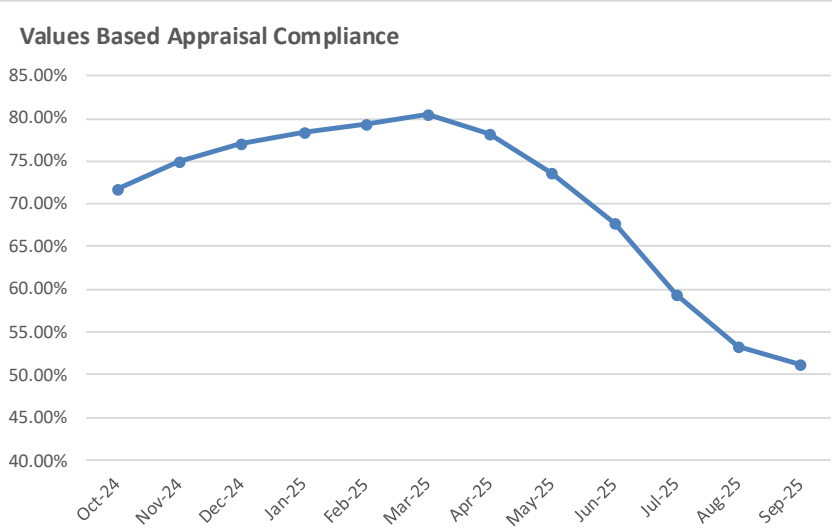
Assurance & Timescale for Improvement

The Vacancy Recruitment Panel (VRP) process is undergoing continual improvement, supported by the new weekly Vacancy & Staff Movement data pack, which is now embedded and continues to evolve to strengthen workforce oversight

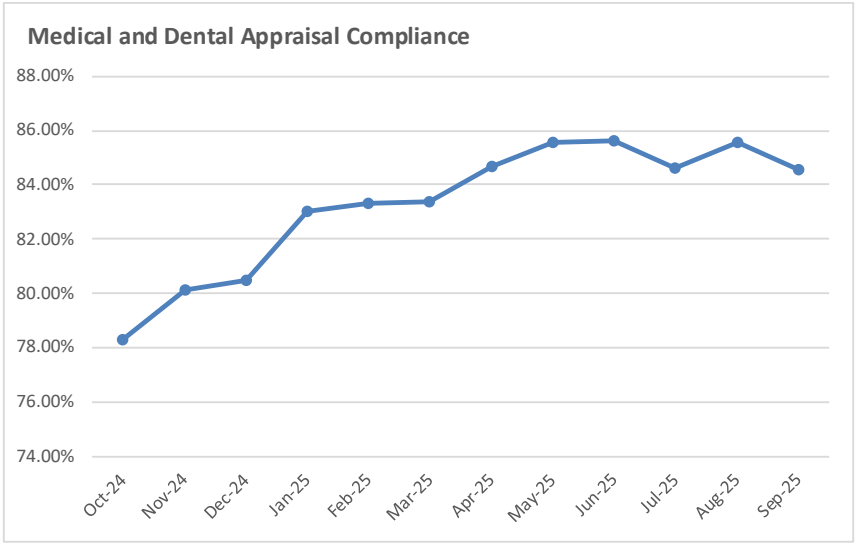
Appraisal Rates

University Hospitals Dorset
NHS Foundation Trust

September 25
51.3%
Variance/Assurance
N/A
Targeting (Internal)
90%
Business Rule
Full CMS



September 25
84.6%
Variance/Assurance
N/A
Targeting (Internal)
90%
Business Rule
Full CMS



Summary

Appraisals are not within target range. Historically this has been due to carrying out appraisals within a defined time periods. Target is now shown as rolling 12 months.

Actions

All teams to ensure all staff have protected time to ensure compliance is always achieving the 90% target structured appraisal is completed.

Assurance & Timescale for Improvement

Q3 All trust teams to ensure improvement in levels achieving compliance rate enabling all staff to have had an appraisal.

Workforce monitoring - Actual vs plan

University Hospitals Dorset
NHS Foundation Trust

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	9098.9						
	Plan	9086.0	9099.0	9072.3	9064.3	9055.3	8999.2	8979.2	9015.2	8965.6	8903.6	8855.6	8770.9
Bank	Actual	643.3	647.5	669.5	678.2	651.2	627.6						
	Plan	609.0	591.0	564.0	565.0	560.0	557.0	495.0	495.0	492.3	543.6	541.6	520.6
Agency	Actual	135.8	148.1	129.3	83.4	87.8	90.7						
	Plan	158.0	135.0	135.0	136.0	137.0	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	9817.1						
	Plan	9853.0	9825.0	9771.3	9765.3	9752.3	9695.2	9615.2	9656.2	9609.0	9591.2	9525.2	9408.3

Summary	Actions	Assurance & Timescale for Improvement
UHD continues to be off plan against the overall Workforce Plan as at M06: WTE adverse variance above plan; 9100.1 WTE usage against a plan of 8999.21WTE (unrevised), or 9079.64WTE (revised H2). Agency spend has continued to reduce Bank spend reduced in month but remains above plan YTD with an adverse variance to plan Both agency and bank spend are showing a reducing trajectory at M6. Pay costs overall also improved in M6 and are now showing a small favorable variance to plan YTD	Work has commenced on a workforce operational efficiency and reduction plan aligned to the national NHSE Grip and control activity list. This will support continued work to secure oversite on actual wte and pay bill costs aligned to the trust plan	Revised systems agreed workforce monitoring trajectory to come into place for M07

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

Quality IPR

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Patient Safety Incidents (All) per 1,000 beddays	Sep 25	37.70	-			37.06	30.28	43.84
Patient Safety Incidents (Moderate +) per 1,000 beddays - Closed only	Sep 25	0.20	-			0.46	0.06	0.85
Medication Incidents (All) per 1,000 beddays	Sep 25	4.70	-			4.96	3.24	6.68
Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays	**Sep 25**	**0.20**	**-**			**0.31**	**0.03**	**0.59**
Inpatient Falls (Moderate +) per 1,000 beddays	Sep 25	0.10	-			0.17	-0.05	0.38
Hospital Associated Infections - MRSA	**Sep 25**	**0**	**-**			**0**	**-1**	**2**
Hospital Associated Infections - MSSA	Sep 25	4	-			4	-1	9
Hospital Associated Infections - C Diff	**Sep 25**	**5**	**-**			**8**	**-2**	**17**
Hospital Associated Infections - E Coli	**Sep 25**	**3**	**-**			**10**	**0**	**20**
Hospital Associated Infections - Kleb	Sep 25	3	-			4	-3	11
Hospital Associated Infections - Pseudo	Sep 25	2	-			2	-2	5
Hand Hygiene Compliance	Sep 25	94.1%	-			96.4%	94.3%	98.4%
Infection Control Mandatory Training Compliance	Sep 25	89.8%	-			89.5%	88.8%	90.1%
HSMR In Month - UHD (Source: HED)	**Jun 25**	**101.20**	**100.00**			**92.69**	**79.72**	**105.66**

NHS Staff Survey Results will be reported annually

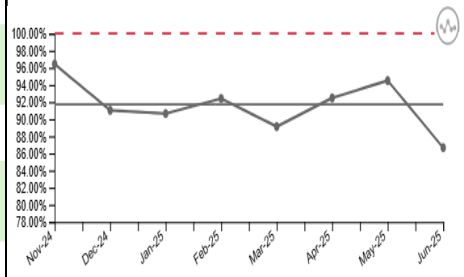
- Improved NHS Staff Survey culture questions by 5% - raising concerns sub-score

eMortality Consultant Review Compliance
HSMR < 100

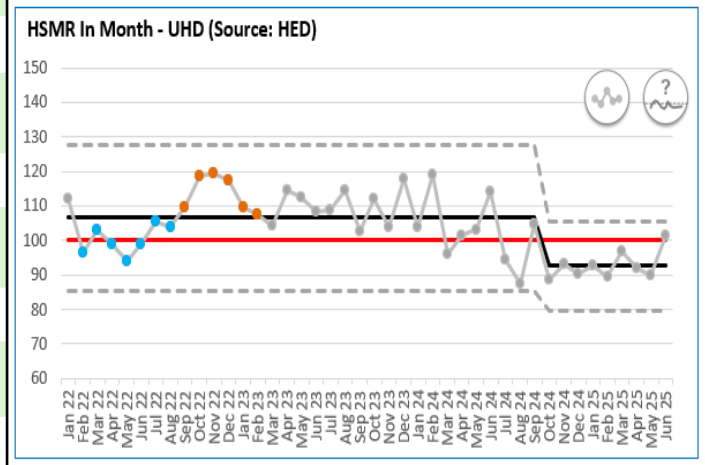
University Hospitals Dorset
NHS Foundation Trust

Jun 25
86.7%
Variance/ Assurance
Targeting (Internal)
100%
Business Rule
Full CMS

Mortality Reviews

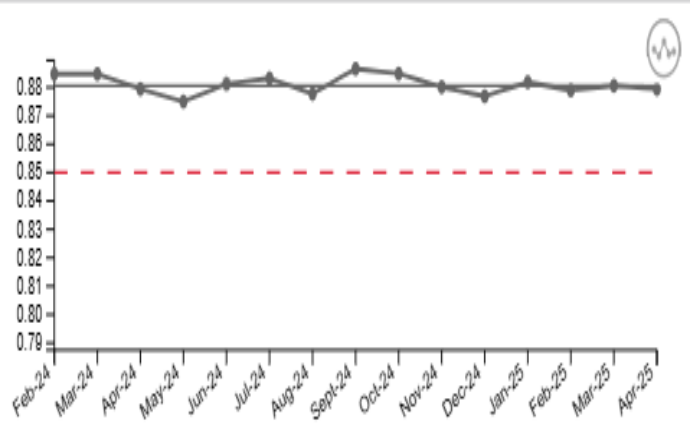


June 25
101.20
Variance /Assurance
Targeting (Internal)
100
Business Rule
Note Performance



April 25
0.88
Variance /Assurance
Targeting (Internal)
1
Business Rule
Verbal CMS

SHMI – Summary Hospital Level Mortality Indicator



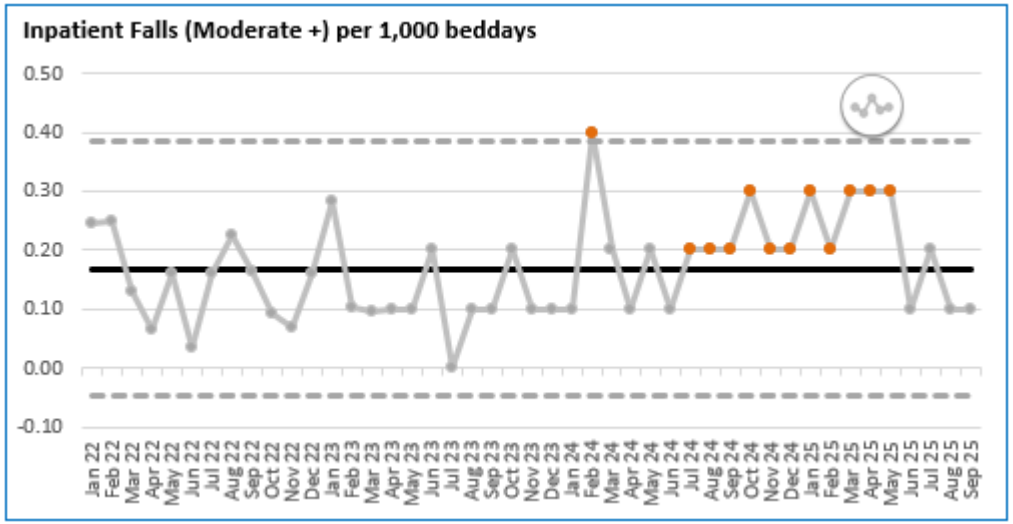
Summary	Actions	Assurance & Timescale for Improvement
E-Mortality review compliance remains below target at 86.7%	Continued education and engagement of consultants Working to ensure that the reviews are completed by the most appropriate team for learning e.g. ITU Ongoing issues around identifying the correct consultant delay reviews.	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. Consistently below target of100 since October 2024 with expected variation. In month HSMR for June 2025 has increased to 101.2 but this remains within expected variation. SHMI remains below target and stable at 0.88	Audit of mortality coding in progress to review codes and accuracy. HED alerts reviewed through newly developed standardised process to ensure any concerns are identified. A continued upward trend in HSMR in month will warrant further review.	No HSMR or SHMI alerts since period to March 2025

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Patient Safety – Falls

University Hospitals Dorset
NHS Foundation Trust

Sept 2025
Variance/ Assurance
Targeting (Interna)
Business Rule
Full CMS



Summary

Statistical process control remains within expected variation. In September 2025, the overall inpatient falls rate was **6.7 per 1,000 bed days, within expected limits.**

Four inpatient falls resulted in moderate or greater physical harm (rib and hip fractures, and a head injury), equating to 0.1 per 1,000 bed days.

92% of all falls were recorded as Low or No Harm, while 6% were submitted without a harm level—predominantly during night shifts.

Actions

PSIRF Falls SWARM reviews completed for all moderate or above harm incidents; no new Trust-wide learning identified. LERNs pending Matron sign-off and final Duty of Candour by wards/departments.
Falls Thematic Review and recommendations presented to the PSIRF Oversight Meeting.
UHD Falls Steering Group relaunched with a revised quarterly format from October 2025. Care Groups will present falls prevention countermeasure summaries.
Fundamentals of Care workstreams (*Safer Activity* and *Continence*) are progressing toward a soft launch.

Assurance & Timescale for Improvement

Assurance: All moderate and above harm falls have undergone structured PSIRF learning responses. Oversight is maintained through the PSIRF Oversight Group and the relaunched Falls Steering Group.

First revised Quarterly **Falls Steering Group** meeting: **October 2025** Will oversee actions from the Falls Thematic Review, including:

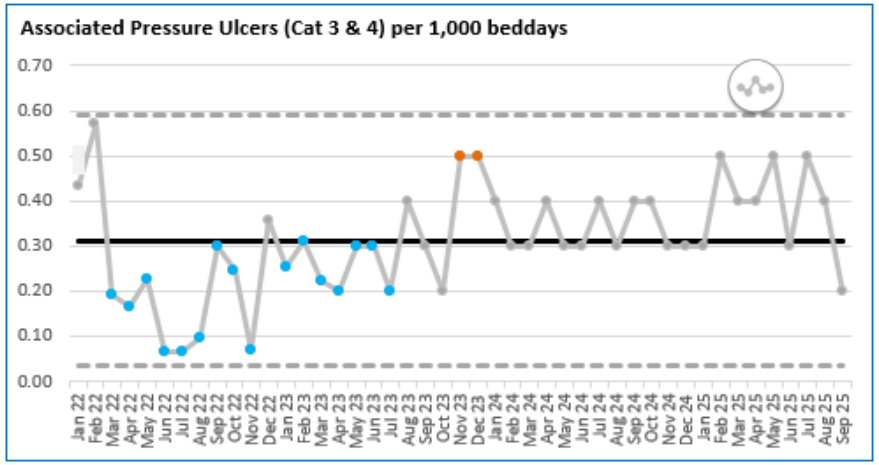
- Redesign of falls/safer activity assessments
- Electronic lying/standing BP recording
- Reducing reliance on non-slip socks
- Improving access to walking aids (e.g. WZFs)

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Patient Safety – Pressures Ulcers

University Hospitals Dorset
NHS Foundation Trust

September 2025
%
Variance/ Assurance
Targeting (Internal)
Business Rule
Verbal CMS



Summary	Actions	Assurance & Timescale for Improvement
Statistical process control remains within usual variation with a total of 13 Hospital Acquired pressure ulcer of Category 3 during August 2025. This equates to a rate of 0.37 per 1,000 bed days. There were no category 4 pressure ulcers reported	Pressure ulcer training sessions continue to be delivered and are booked via ESR Fundamentals of care work (Skin integrity group) will focus on the introduction of a Trustwide aSSKINg bundle for the documentation of planning and delivery of pressure ulcer preventative care	The UHD aSSKINg bundle will be introduced initially within the Medical Care Group followed by the Surgical Care Group and WCCSS. Implementation is scheduled to commence 27th October, 2025 (provisional).

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

University Hospitals Dorset
NHS Foundation Trust

Perinatal Quality Surveillance

Maternity and Neonatal Dashboard

Provider	UHD			
MetricName	Value	Target	Variation	Assurance
Midwife vacancy rate	3.54%			
Midwifery turnover - % midwives leaving (rolling 12-month period)	8.11%			
Midwifery sickness rate (% FTE days absent)	6.79%	3%		
% of women with a CO measurement at time of 36 weeks' gestation	89.3%	95%		
% of women with a CO measurement at time of booking	100%	95%		
% of women smoking at delivery (previous month)	5.52%	6%		
% of women smoking at booking	3.70%			
% of babies born below 34 weeks of gestation who receive their own mother?s milk in the first 2 days of life	60%	60%		
% 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	80%	80%		
% of babies born below 34 weeks' gestation who have their umbilical cord clamped at or after on minute after birth	77.5%	75%		
% of babies born before 30 weeks' gestation who receive magnesium sulphate within the 24 hours prior to birth	85.7%	90%		
% babies born <34 weeks' gestation who receive full course of AN steroids within 1 week of birth	37.5%	55%		
% infants born outside of a NICU: singleton 27 weeks' gestation or multiples <28 weeks' gestation or birthweight <800g any gestation	0%			

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** at <10 weeks
- **ATAIN** continues to have improved for the 7th month in a row with the admission rate now being lower than the targets set nationally and locally.
- **3rd and 4th degree tears** rates remain overall low for rolling 12 months however fluctuation seen in July and August – Action taken and improvement seen in September

Key Areas of 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 hrs prior to birth and
2. % of babies born <34 week's gestation who receive full course of steroids within 1 week of birth.

Perinatal Quality Surveillance

Maternity and Neonatal Dashboard

Provider	UHD			
MetricName	Value	Target	Variation	Assurance
Incidence of women with singleton pregnancy giving birth (live/stillborn) in the late 2nd trimester (16+0 to 23+6 wks) as a % of all singelton births	0.338%	1%		
Rate per 1,000 births which are preterm (< 37 week's gestation)	73.0	60		
No. of singleton babies born <27 weeks' or multiples born <28 weeks' gestation or birthweight <800g	5			
% of babies who died below 32 weeks gestation, or 44 weeks post-menstrual age (whichever occurs sooner)(rolling 12-month period)	10.3%			
Rate per 1,000 of live birth babies who died within 28 days of birth - rolling 12mths	3.23			
Annual rate of stillbirths per 1,000 births - rolling 12mths	3.76	2.5		
No. of neonatal deaths < 28 Days	1			
No. of still births per month	1			
% of babies born < 32 weeks gest. age with Germinal matrix/ intraventricular haemorr. / Post haemorr. Vent. Dil. / Cystic peri. leuk.	0%			
Rate per 1,000 babies born at term with an Apgar score <7 at 5 minutes (CQIMApgar)	22.7	13		
No. of Hypoxic-Ischemic Encephalopathy (HIE) incidents	0			
% of babies <3rd birthweight centile, born >37+6 weeks	75%			
% of term babies admitted to NNU	4.68%	5%		
Number of women admitted to ITU associated with birth up to 28 days post-natal (any birth, not including any other trust birth)	0			

Perinatal Quality Surveillance

Maternity and Neonatal Dashboard

Provider	UHD			
MetricName	Value	Target	Variation	Assurance
Number of women admitted to ITU associated with birth up to 28 days post-natal (any birth, not including any other trust birth)	0			
Maternal death - number of deaths of women during or up to 1 year following the end of pregnancy (irrespective of place/circumstances of death)	0			
Rate per 1,000 women with 3rd/4th degree tears (current three months aggregated)	14.8	28		
Rate per 1,000 Women with >= PPH 1500ml(previous 3 months aggregated)	34.1	30		
% babies receiving breast milk at discharge from midwifery care to HV/GP (10 - 28 days PN)	73.8%			
% of babies receiving breast milk at first feed	81.2%	72%		
% of women (IMD-1) placed on a continuity of carer pathway	1.12%			
% of Black and Asian women on continuity of carer pathway by 28 weeks' gestation	82.6%			
% of women on continuity of carer pathway by 29 weeks' gestation	6.44%			
% bookings completed <10 weeks gestation	100%	65%		
Total number of bookings	27			
No. of registrable babies born	323			

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

MBRRACE reportable cases:
There was 1 antenatal stillbirth new PMRT (MBRRACE reportable) cases in September 2025:
#1 – 35+1 antenatal stillbirth with reduced fetal movements – gestational diabetic, for PMRT review in November.

MNSI
There were no new MNSI cases in September 2025 and no ongoing or outstanding MNSI cases.

Matters for Board information and awareness

Patient Safety Incident Response Framework (PSIRF) has been implemented in maternity.
In September there were 2 incidents requiring escalation through PSIRF.

1. #2 - 3.1L Major Obstetric Hemorrhage (MOH) following Forceps delivery in Labour room and transfer to theatre for completion of perineal . Repair and management of MOH
2. #3 Neonatal Death <5 hours of baby born at home following a concealed pregnancy.

Estimated gestation of 33-35 weeks . Case discussed at Insight meeting 04/09/2025.
MDT meeting to share information amongst SWAST, air ambulance and UHD in Sept, followed by further discussion at Insight to agree an appropriate learning response

Top incidences LFPSE:
Term admission to NICU
Readmission for baby
Readmission for mother

Term admissions to NICU – ATTAIN at 4.68 % in September
PPH >1500mls

Safety champions reviews this month:

- Monthly safety champions report
- Quarterly reports PMRT- ATAIN – Maternity claims
- Quarter 2 Trust Board report.

Progress in achievement of maternity improvement plan

CQC action plan -

Assure:
Action Plan now closed as completed – monitoring standards continuously.
Maternity incentive scheme year 7 -
Release of year 7 in April. Standards increased – assurance processes continue ICB mid-point assessment –on target to achieve MIS
Insight and 3-year delivery plan -

Assure
Actions for year 3 in place progress being made
2024 CQC Maternity Survey results published, and the results show continuing improvement since 2022.
Staff survey shown overall staff satisfaction -action plan in place for each area to individualize the improvements in 2025.
Staff survey for 2025 open
Culture improvement plan – Focus on behaviour charter in September with all the teams

University Hospitals Dorset
NHS Foundation Trust

Patient Experience



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
Patient Experience

University Hospitals Dorset
NHS Foundation Trust

Quality IPR

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Friends & Family Test	Sep 25	94.7%	-			92.5%	90.1%	94.8%
Complaints Received	Sep 25	101	-			68	33	104
Complaint Response Rate (Grade Based Target)	Sep 25	51%	-			46%	16%	76%
Mixed Sex Accommodation Breaches	Sep 25	0	-			7	-11	26

Survey Results will be reported annually

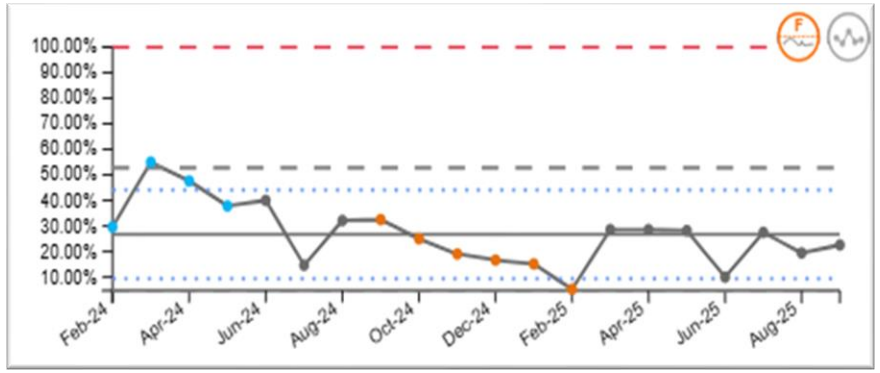
- To increase Have Your Say Survey feedback rates by 30%
- 5% improvement in employees who see patient care as a top priority for UHD

Patient Experience

University Hospitals Dorset
NHS Foundation Trust

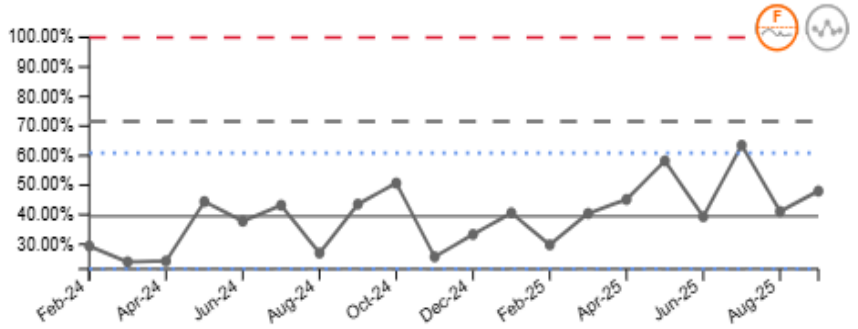
September 25
22.6%
Variance/ Assurance
Targeting (Internal)
100%
Business Rule
Verbal CMS

Number of Early Resolutions

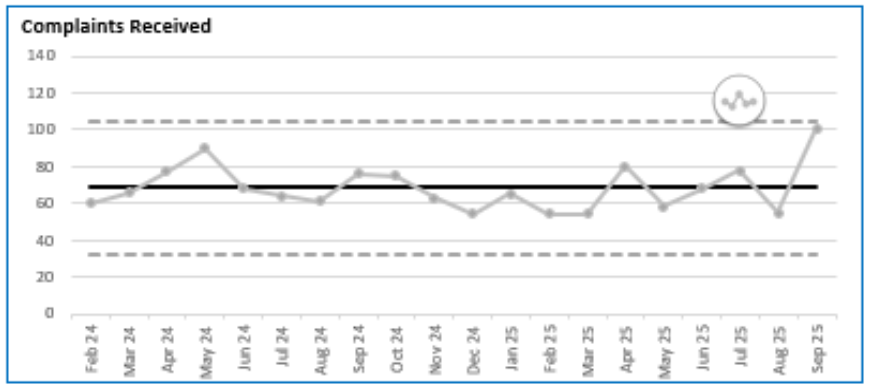


September 25
48%
Variance/ Assurance
Targeting (Internal)
100%
Business Rule
Full CMS

% of total complaints closed within 35 days

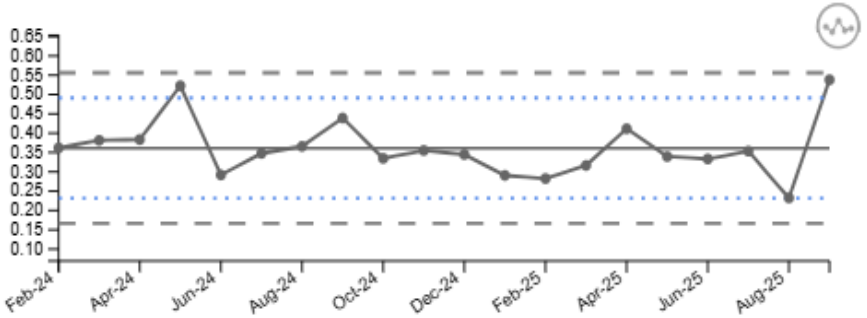


September 25
101
Variance/ Assurance
Targeting (Internal)
-
Business Rule
Note Performance



September 25
0.54
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 = 618 Formal complaints = 52 Early Resolution Complaints = 49 Average Complaint response time = 35.59 days	Increased number of complaints logged in September due to catch up following staff absences in August.	Complaints manager continues to meet weekly with the care groups to discuss the open complaints and any assistance needed to progress them.

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

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	YTD Plan	YTD Actual	YTD Variance	FOT Plan	FOT Actual	FOT Variance
Revenue Control Total Performance	Sep-25	(1,011)	(1,038)	(27)	(9,264)	(9,245)	20	0	(22,437)	(22,437)
Capital Control Total Performance	Sep-25	11,558	12,063	(505)	70,352	63,324	7,028	188,027	188,027	0
Efficiency Programme Performance	Sep-25	4,682	4,598	(84)	25,399	26,484	1,085	69,625	50,687	(18,938)
Cash Balance	Sep-25	58,320	93,237	34,917	58,320	93,237	34,917	74,976	74,976	0
Better Payment Practice Code	Sep-25	95.0%	95.6%	0.6%	95.0%	94.8%	-0.2%	95.0%	95.0%	0.0%

Efficiency Improvement Programme

University Hospitals Dorset
NHS Foundation Trust

September 25
73%
Variance/Assurance
F
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	(4,162)	2,214	(1,949)	(8,551)	4,152	(4,399)	49%	4,811	56%	2,175	1,512	(4,864)	43%
Medical	(5,834)	4,655	(1,179)	(12,524)	8,505	(4,019)	68%	9,263	74%	5,259	1,413	(5,852)	53%
WCCSS	(5,602)	3,862	(1,740)	(11,318)	8,151	(3,167)	72%	8,832	78%	5,185	396	(5,737)	49%
Operations	(968)	1,789	821	(1,875)	2,615	740	139%	2,659	142%	1,130	110	(635)	66%
Corporate	(1,934)	3,269	1,335	(3,875)	5,548	1,673	143%	5,661	146%	3,231	226	(418)	89%
Trust Wide	(6,898)	10,695	3,797	(23,497)	21,113	(2,384)	90%	21,563	92%	11,880	7,030	(4,587)	80%
Dorset wide schemes	0	0	0	(7,986)	604	(7,382)	8%	7,986	100%	0	0	(7,986)	0%
UHD	**(25,399)**	**26,484**	**1,084**	**(69,625)**	**50,687**	**(18,938)**	**73%**	**60,776**	**87%**	**28,859**	**10,687**	**(30,079)**	**57%**

Summary

Efficiency improvement delivery to the end of September is £1.1 million ahead of plan. The trust has identified savings opportunities of £61 million, however when adjusted to reflect the risk of delivery in year, this is reduced to £51 million. Whilst this representing an improvement in month of £1.5 million; it remains £18.9 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, and we have invited NHS England into the Trust during October to undertake a deep dive on our efficiency programme, to provide additional external assurance and learn from the output of similar reviews undertaken elsewhere in the South West.

Assurance & Timescale for Improvement

We will continue to monitor improvements in the identification and delivery of efficiency schemes. The trust plan to recover the year-to-date deficit requires at least a total of £57.9 million of efficiencies to be delivered for 2025/26, an increase of £7.2 million compared to the Month 6 risk adjusted efficiency forecast.

Financial Management – YTD Variance to budget

University Hospitals Dorset
NHS Foundation Trust

September 25
(£22,437)
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	418,441	418,494	53	838,003	838,045	42
Other Operating Income	27,098	28,472	1,375	54,428	58,221	3,792
Charitable Income	1,857	1,655	(202)	3,488	3,224	(264)
Total Income	**447,395**	**448,621**	**1,226**	**895,919**	**899,489**	**3,570**
Employee expenses	(302,460)	(302,397)	63	(600,908)	(607,385)	(6,477)
Clinical supplies expenses	(35,675)	(36,536)	(861)	(71,991)	(73,670)	(1,679)
Drugs expenses	(44,632)	(44,869)	(237)	(88,575)	(88,884)	(310)
Purchase of healthcare and social care	(7,875)	(10,400)	(2,524)	(13,547)	(19,878)	(6,331)
Depreciation and amortisation expense	(17,805)	(17,805)	(0)	(37,081)	(37,081)	(0)
Clinical negligence expense	(9,449)	(9,347)	102	(18,898)	(18,059)	839
Premises & fixed plant	(16,830)	(16,563)	267	(34,378)	(33,402)	976
Other operating expenses	(15,363)	(19,868)	(4,505)	(105,636)	(81,089)	24,547
Operating Expenses	**(450,090)**	**(457,785)**	**(7,695)**	**(971,013)**	**(959,448)**	**11,565**
Net finance costs	(7,302)	(7,114)	187	(11,603)	(11,140)	463
Other adj to control total basis	732	7,033	6,302	86,698	48,663	(38,035)
Control Total Surplus/ (Deficit)	**(9,264)**	**(9,245)**	**20**	**0**	**(22,437)**	**(22,437)**

September 25
£188,027
Variance/ Assurance
P
Targeting (Internal)
£188,027
Business Rule
Verbal Update

Capital	Year to date			Forecast		
	Budget	Actual	Variance	Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Estate Schemes	9,448	8,777	671	19,189	19,189	0
IT Schemes	5,557	5,358	199	10,844	10,844	0
Medical Equipment	2,502	390	2,112	6,053	6,053	0
Total Operational CDEL	**17,507**	**14,525**	**2,982**	**36,086**	**36,086**	**0**
Total Donated Assets	**1,068**	**992**	**76**	**1,401**	**1,401**	**0**
DDP - Digital Pathology	203	203	0	203	203	0
ELR - Elective Recovery	78	63	15	1,483	1,483	0
EPR - Front Line Digitisation	636	339	297	2,784	2,784	0
NHP - FBCa / Enabling / FBCB	7,265	5,985	1,280	33,498	33,498	0
NHP - NHP - FBCA & Enabling Works	5,896	5,455	441	30,327	30,327	0
NHP - NHP - FBCB	1,369	530	839	3,171	3,171	0
SOL - Renewables - Solar Partnership Schem	5,701	5,553	148	21,141	21,141	0
STPW1 - Beach & PH Theatres (ESL & C2)	0	0	0	1,000	1,000	0
UEC - Urgent Emergency Care	0	0	0	1,000	1,000	0
Total Central PDC	**51,777**	**47,807**	**3,970**	**150,540**	**150,540**	**0**
UHD Capital Total	**70,352**	**63,324**	**7,028**	**188,027**	**188,027**	**0**

Summary

I&E : The Trust reported deficit is £9.2 million at Month 6, £20,000 better than plan. However, the unmitigated forecast is a deficit of £22.4 million.
The Trust now has a detailed plan to recover the year-to-date deficit and deliver within the full year budget – except for the financial impact of the delay in the planned Wholly Owned Subsidiary
Capital : The Trust reported capital expenditure of £63.3 million, being £7.0 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

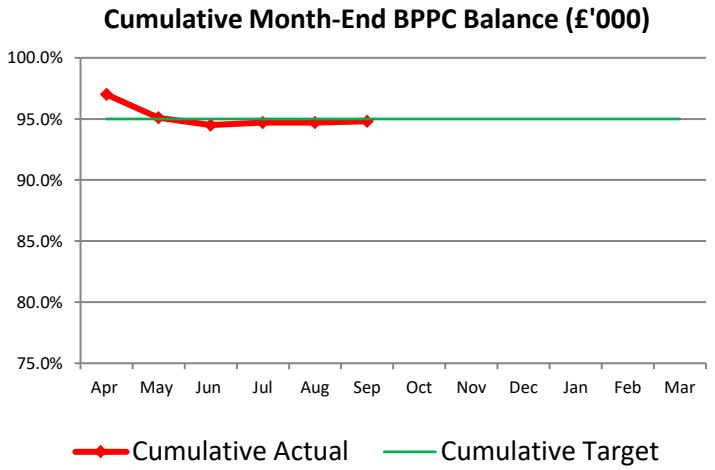
I&E : The plan requires acceleration of identified efficiency schemes currently expected to deliver in 2026/27, a further tightening of workforce controls including considerable reduction in bank expenditure, together with a range of smaller mitigations
Capital : Work is underway to secure additional capital funding and to re-prioritise / re-profile existing schemes to accommodate this additional commitment. Conversely there is a risk of slippage against a small number of national programmes, with work ongoing to accelerate these and open conversations regarding any potential reprofiling opportunities

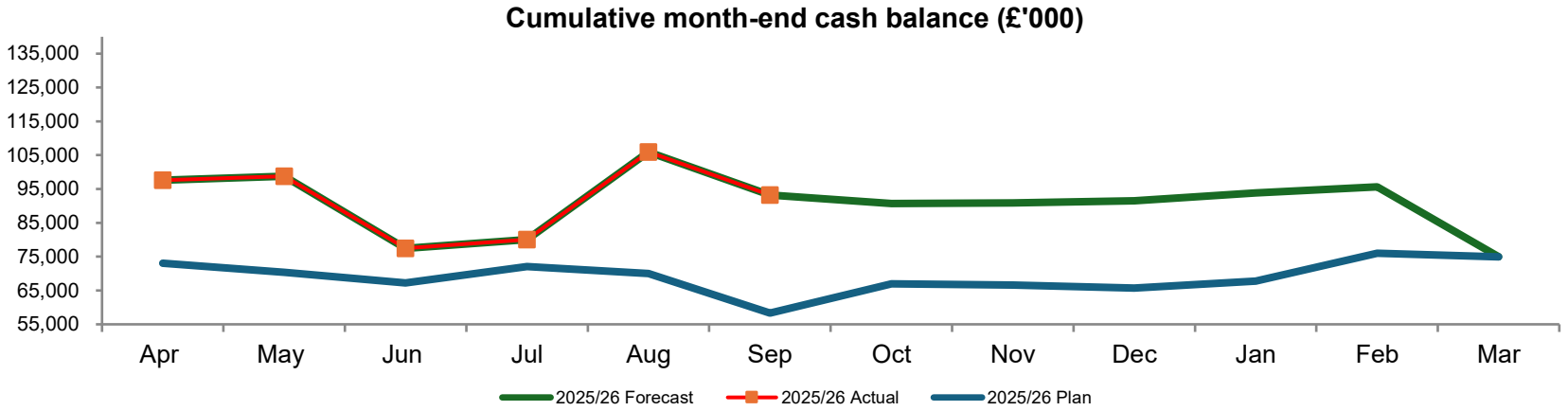
Assurance & Timescale for Improvement

I&E : The actions listed leave an unmitigated risk of £14.7 million, and we are working closely with system partners and NHS England to agree how this resulting financial gap could be covered. 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 94.8%, slightly below the national standard of 95% and was above target within September showing signs of recovery.* ***Cash :*** *As at September 2025 the Trust is holding a consolidated cash balance of £93.2 million which is fully committed against the Trust's reconfiguration programme. This current balance represents 38 days of operating expenditure. However, as the cash balance includes national PDC draws which are required for specific capital programme spend items, in reality it covers fewer days of revenue operating expenses.*	***Public Sector Payment Policy :*** *It is anticipated that this will improve following the summer leave period which has impacted the timely authorisation of invoices, and are targeting support to areas with slow invoice approvals to ensure performance moves above the target in future months.* ***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 underway to improve BPPC performance will result in performance above the target 95% by the end of the financial year. The September performance in month was 95.6%, higher than the target and indicating a recovery in performance as the actions listed begin to impact.* ***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



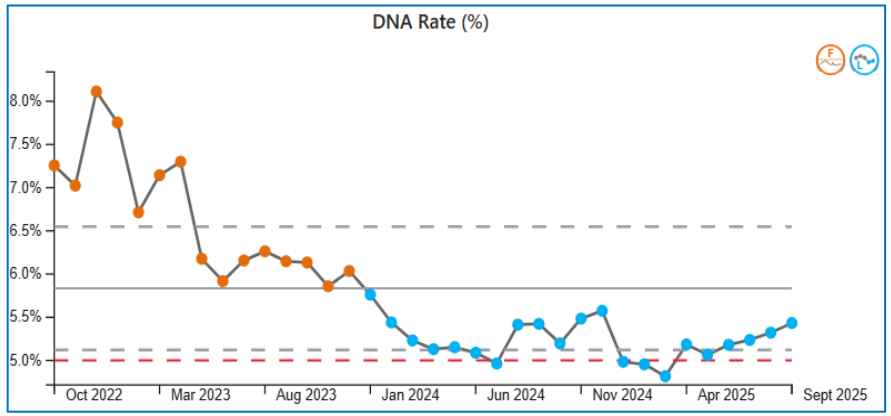
Beverley Bryant
Chief Digital Officer

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	55%	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							

Digital

Sep 25
5.4%
Variance/ Assurance
Targeting (Internal)
5.0%
Business Rule



University Hospitals Dorset
NHS Foundation Trust

Summary	Actions	Assurance & Timescale for Improvement
DNA rates 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. Monitoring to reivew Dr Dr 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.	Productivity leads to review postage costs in the specialties to identify potential areas.	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. Current status is Dermatology is live.	The next 3 specialties are being prepared to go live. Due approximately December go live.	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.	Target areas for the pilot identified and clear communication completed with a go live to start 20th October to then feedback to the project.	Task & Finish Group for ICE Paperless Reporting and Reporting to Monitor and Track this.
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.	UTC Task & Finish Group fortnightly can be used to clarify these due to key attendance.

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University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 6.8

Subject:	Trust Strategy - We are UHD
Prepared by:	Richard Renaut Chief Strategy & Transformation Officer
Presented by:	Richard Renaut Chief Strategy & Transformation Officer

Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Decision/Approval
Executive Summary:	We are presenting for discussion / approval today a new overarching strategy document for UHD. This document is designed to make our strategic themes more accessible and illustrate some of the ways strategy is turned into action – action that makes a difference to patients, staff and our community. Codeveloped with staff, leaders and governors, this digital document is intended to be used to help socialise our strategies and that of our key partners with all interested stakeholders. As an organisation we have a number of strategies currently under development or scheduled for updating in the near future. As primarily a digital resource, this document can be updated as our key documents are refreshed. Printed versions and posters can then be used for specific audiences/events. The feedback from both staff at TMG and our Council of Governors on the document is that this document is very much welcomed. Governors and staff noted how they could use it in their day-to-day conversations with colleagues and the public. Following feedback from TMG we will be working with care groups to develop their own “back page” local practical examples of strategic themes being delivered.

	This will further help demonstrate how strategy into action is how UHD works. We are grateful to all those staff and governors who helped in developing this document and look forward to socialising it as soon as possible.
Background:	At UHD we have a suite of strategies which together set out the future direction for the Trust. Our Patient First triangle brings some of these strategies to the attention of patients/staff/visitors, but these are not a full picture of key strategies at UHD, nor does it reference our place in the Dorset System. Working with Execs, TMG and our Council of Governors, we have developed an overarching document to help link the strategies together (and provide hyperlinks to the key documents from UHD and partners) in one place for the first time. By presenting it in a colorful style with examples of strategy in action (developments around the trust have been completed a result of the strategies set), we hope this document will help our patients, staff and visitors will find it considerably easier to gain a better understanding of who we are and our strategic direction. Also signposted within the document is the work underway to develop the next stage of our strategies. Feedback from staff suggests that further iterations would be useful – we therefore intend to work with teams to develop care group level versions of the document in order that, although the first 5 pages are common to all versions, the examples given on the final page are as relevant as possible to the reader.
Key Recommendations:	Approve document
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
Council of Governors	11/09/2025	Strong support for the document, ideas for further minor improvement noted and actioned.
TMG	02/09/2025	Strong support for draft – request to work with care groups to develop further versions with final page focused on individual care groups in future noted
Board of Directors Part 2	01/10/2025	Support for document – suggestions from board for further minor improvements actioned

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

We Are UHD
Our Trust Strategy 2026-2031

If one word describes our strategy for UHD, it's 'ambitious'.

We are setting out our vision and practical steps for the next five years and how we'll further develop over the next 10 years.

Our goal is to work with our local communities and partners to make Dorset the healthiest place to live in the UK. We will also provide excellent care to our patients and make UHD a great place to work.



We hope you'll join us on our journey.

Siobhan Harrington
Chief Executive





Patient First

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

Mission statement
Provide excellent healthcare for our patients and wider community, and be a great place to work, now and for future generations.

Strategic themes

Population and System	Our People	Patient Experience	Quality Outcomes and Safety	Sustainable Services
See our patients sooner	Be a great place to work	Improve patient experience, listen and act	Save lives, improve patient safety	Use every NHS pound wisely

Enabling programmes
Clinical Strategy | People Strategy | Improvement Strategy | Medium Term Financial Plan | Sustainability Strategy

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

Our goals and how we will achieve them



Many areas have improvement huddles to track progress

Our strategy isn't just nice words on a page, it is a roadmap to success. Our Trust uses Patient First to empower all colleagues and teams to get involved and be part of our improvement.

We have five long term objectives and every month we track our progress against these.

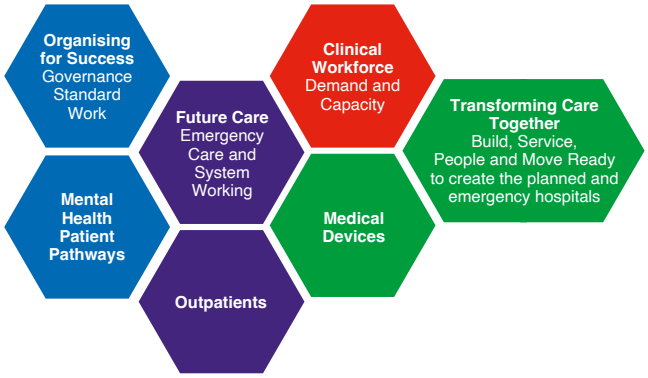
Strategic Theme	Strapline	Vision *LONG TERM*	Strategic Goal *MEDIUM TERM: 3 - 5 YEARS*	Breakthrough Objective *SHORT TERM: 1 YEAR* * (* May be kept another year if not achieved)
POPULATION AND SYSTEM *Mark Mould*	"See patients sooner"	Consistently delivering timely, appropriate, accessible care as part of a wider integrated care system for our patients.	• Meeting the patient national constitutional standards for Planned and Emergency care, reducing inequalities in outcome and access and improving productivity and value	• To achieve 109% weighted value elective activity against the 2019/20 baseline, including specialist advice and guidance • No more than 66.1% of patients on incomplete RTT pathways should have been waiting more than 18 weeks (18 week RTT) for treatment • >78% of patients to be treated within 4 hours through the emergency care pathway
OUR PEOPLE *Melanie Whitfield*	"Be a great place to work"	To be a great place to work, attracting and retaining the best talent.	• Significantly improved staff experience, engagement and retention • NHS Staff Survey results in top 20% of comparator Trusts	To deliver improvements in the NHS Staff Survey Results for: • "I would recommend my organisation as a place to work" > 65% • Staff Engagement Score > 7.1 / 10
PATIENT EXPERIENCE *Sarah Herbert*	"Improve patient experience listen and act"	All patients at UHD receive quality care which results in a positive experience for them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change.	• Rated as Outstanding by CQC as Caring • Over 80% of our employees see patient care as a top priority for UHD • In the top 20% of NHS Acute Hospital Trusts on the 'overall experience' section in all CQC national surveys	• 100% of complaints to be closed within 35 days, with associated action plan • Increase the number of Early Resolution of complaints by 20% • Reduce the number of complaints received per 1,000 contacts for clinical services by 10% from baseline
QUALITY OUTCOMES AND SAFETY *Peter Wilson*	"Save lives, improve patient safety"	To be rated the safest Trust in the country and be seen by our staff, as an outstanding organisation for effectiveness (Hospitalised Standardised Mortality Ratios – HSMR) and patient safety (Patient Safety Incidents - PSIs).	• In the top 20% of trusts in country for Hospitalised Standard Mortality Ratios (HSMR) • Rated as Outstanding by CQC for Safety • Decrease severe/moderate harm Patient Safety Incidents (as a ratio of all incidents) by 30% • Over 80% of employees believe the Trust promotes a safety culture	• To statistically reduce our rate of Falls per 1,000 bed days • To ensure the % of patients given timely VTE prophylaxis is 95% or higher • To statistically reduce the rate of pressure ulcers (hospital acquired) per 1,000 bed days • Doctors to achieve 100% compliance in eMortality reviews
SUSTAINABLE SERVICES *Pete Papworth*	"Use every NHS pound wisely"	To maximise value for money enabling further investment and sustainability in our services to improve the timeliness and quality of care for our patients, and the working lives of our staff.	• Return to recurrent financial surplus from 2026/27 • Rated as Outstanding by the CQC for our Use of Resources • Achieve our Green UHD goals of sustainability for people and planet, and 80% carbon reduction by 2030	• To fully deliver the budgeted Efficiency Improvement Programme target with at least 80% achieved recurrently • To have reconfiguration efficiency plans in place

Major change projects

UHD has an ambitious set of major change projects to help us achieve our goals. These include:

- 'Transforming Care Together', a £550m investment in our services to create our emergency hospital at Royal Bournemouth and the UK's largest planned care hospital at Poole.
- 'Healthset', our £280m new electronic health record linking records across Dorset and Somerset.

For further information on our objectives and projects see our 2025-26 Operational Plan.



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UHD Supporting strategies

We have a number of strategies that support our strategic themes. You can find out more via the links below.

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

Working with partners

UHD is an active part of Dorset Integrated Care System. Our shared strategies include:

- Dorset ICB Strategy
- Dorset ICS Digital Strategy (under development)
- Innovation Strategy - Wessex Health Partners
- Bournemouth University - UHD Partnership Strategy
- Dorset Clinical Services Review

We work with our partners, staff and the public to deliver the priorities outlined in Dorset's Joint Forward Plan 2023-28. Key partner strategies include:

- BCP Council Coporate Strategy
- Dorset Council Plan
- Dorset County Hospital / Dorset HealthCare NHS FT Joint Strategy
- South Western Ambulance Service NHS FT Strategy



Our patients' voice



We actively work with our patients and public to codevelop our services and identify areas for improvement. Our patients are involved in numerous activities, informing our teams how their care should be delivered and giving their valuable insights into service redesign. Consultation on the NHS 10 Year Plan, patient surveys and the '100 Voices' project are three examples. Below are representative patient comments:.

"A future NHS should be Safe, Effective and Efficient"

"Patients need to be listened to, trusted and included in discussions and decisions around care"

"Services should focus on providing easier and earlier access to support"

"Services need to work together so carers don't have to keep repeating the same story"

"Services need to provide appropriate information, tools and techniques to empower people to self-manage their own conditions"

"By taking part in research, we hope we can help future patients"

Our staff voice

Engaging with our colleagues is key to uniting our workforce behind our vision and making our Trust a great place to work.

Our staff tell us they:

- feel safe to report concerns
- want to work in an effective team with strong working relationships
- want to be told about the difference their feedback makes

Staff engagement and creating a positive work environment are crucial to delivering the highest quality patient care. The Trust's NHS Staff Survey results show areas for improvement, such as being informed enough about service changes, wellbeing offers or development opportunities. We intend to change this by progressing the NHS People Promise.





UHD now...







Fact file

- We serve over 750,000 local residents plus visitors, with one of the oldest populations in the UK
- We have almost 10,000 staff, and spend £900m
- We are part way through our £550m capital rebuild programme
- Each year we assess around 160,000 patients in our Emergency Departments, help deliver more than 3,500 babies, perform over 98,000 day case treatments, and care for more than 635,000 people in our outpatient clinics
- We are one of largest hip and knee replacement centres in Europe
- We are the largest non-surgical cardiac unit in the UK
- We deliver the 14th highest number of cancer treatment pathways in England
- Over 3,900 of our patients have been recruited to 37 different research studies via our UHD Research Hub
- We support the training of 100s of students each year via partnerships with Bournemouth University and other local Higher Education Institutions

...and planning our future

Over the next three years we will progress towards our goals. This will be assisted by working with partners to complete:

- Our service reconfiguration, delivering our planned and emergency hospitals.
- Our digital system upgrade by 2028.
- Embedding Patient First continuous improvement methodology across our organisation.

We will become a very different organisation, so we are taking time to review our long term vision. Work with patients, volunteers, public, staff and partners will develop the next chapter of our clinical strategy.

This work is informed by the government's 10 Year Health Plan for England. This describes the three major shifts needed in how we deliver healthcare:

1 From hospital to community: developing our neighbourhood health services.

2 From analogue to digital: delivering power in the patient's hands.

3 From sickness to prevention: giving people the power to make the healthy choices.

We will pull these together as a draft clinical strategy by spring 2026. This will be overseen by our Board and our Council of Governors. This will then inform our next stage of engagement.

To get involved:

- Become a member of our UHD Foundation Trust
- Volunteer at UHD
- Contact a UHD governor via **uhd.company.secretary-team@nhs.net**
- Or send us your comments via **uhd.communications@nhs.net**

We are already delivering our strategy

Population and systems

- Our Beach moves are enabling better maternity, emergency and critical care
- Numbers on our waiting lists are down and waits for appointments have reduced
- Access to our diagnostics have improved
- Reduced unnecessary stays in hospital
- We support our Veteran community
- We have improved support for our global majority patients







Great place to work

- We shine a spotlight on colleagues working hard improve their services
- We celebrate Team UHD at our annual UHD Staff Awards
- Our wellbeing service supports colleagues to Thrive
- We have more permanent staff with less reliance on temporary agency staff





Patient experience

- Cancer patients rate our services much better than others
- We have improved patient parking and promote sustainable transport
- We are leading the way in stroke research



Safety

- Our Patient Safety Incident Response Framework promotes compasionate conversations
- Our mortality rates are better than expected
- Our maternity safety programme is complete
- We have introduced new beds and mattresses



Sustainability

- We have lived within our means for all five years since UHD started
- We have cut carbon and energy costs e.g. £1.3m solar panel funding awarded to University Hospitals Dorset
- We have one of the most improved productivity results in the NHS

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University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 6.9

Subject:	UHD Provider Capability Self-Assessment
Prepared by:	Richard Renaut – Chief Strategy & Transformation Officer
Presented by:	Richard Renaut – Chief Strategy & Transformation Officer

Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Assurance
Executive Summary:	UHD is required to complete the Provider Capability Self-Assessment. The assessment is part of NHS England's approach to understanding provider strength across six domains: ➢ strategy, leadership and planning; ➢ quality of care; ➢ people and culture; ➢ access and delivery; ➢ productivity and value for money; ➢ financial performance and oversight. The self-assessment was reviewed and approved by the Board in October 2025 for submission to NHS England. The Board agreed to delegate to the CEO updating and final sign off to reflect comments from the Board and the updates in line with the guidance being issued by NHSE. This included the additional evidence folders requested by NHSE. Attached is the final submission. We await feedback from NHS England in line with the national timetable and moderation process. This is likely to include a Red, Green, Amber rating against the domains.
Background:	NHS England requires all Trusts to complete an annual self-assessment of organisational capability. This is the first year using this template. It is expected future years will include this assessment as part of the Annual Report.

	The process is designed to give Boards a clear view of organisational strengths, areas needing further development, and readiness to deliver national priorities. It also informs regional oversight and support arrangements. The attached paper captures UHD's self-assessment across the domains. Since the Board's review in October executives and management leads have continued a process of self-assessment and moderating to arrive at the final submission. As this is the first use of this template the level of evidence and scoring compared to other Trusts is not known. Once NHSE has confirmed ratings and collated the supporting evidence and updates will be shared with the Board, and can will inform future years assessments. This self-assessment fits within our wider work for being well-led, including the Good Governance Institute feedback, the work around organising for success, and our Patient First approach.
Key Recommendations:	To note that the UHD Provider Capability Self-Assessment has been submitted to NHS England, under the delegated authority of the CEO. To note the need for the Board's annual development programme to include the capability assessment, and the output from this to be included as part of the Annual Report.
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
Trust Management Group (TMG)	16/09/2025	Approved
Board of Directors	01/10/2025	Approved

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	☐

Provider Capability - Self-Assessment Template

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	*Statement:* *Trust strategies in place or refreshes in development against plan- see Board strategy summary, and prep for 2026/7 and 5 year plans.* *There is a well established process for Strategy Deployment Reviews (SDRs) linking strategy and delivery. This is being expanded and continually improved to ensure alignment, in line with Patient First improvement methodology.* *No enforcement actions from NHSE* *Board fully recruited to, meeting skills framework, and evidence of filling vacancies (CPO, CNO etc), with permanent NED as acting chair.* *Trust working collaboratively through Dorset Provider collaborative with many projects e.g. See ODPC papers* *The CEO chairs the Dorset elective delivery group, and is the SW regional elective learning and improvement Board. Also CEO is a member of the ICB Board and Health and Well Being Board.* *Amber/Green rating as not all strategies fully refreshed - target to complete by spring 26 in line with annual/5 year plans being produced.* *Mitigating/Contextual Factors:* *Amber-green, as some strategies are being updated. Funding allocations and planning guidance being issued over Autumn 2025, will allow multi-year plans to be developed and priorities to be set. Clinical specialty strategy work underway to inform clinical strategy by spring 2026. System refresh of clinical strategy being commissioned. These show active work on planning and strategy, as well as delivery of strategies already agreed (eg reconfiguration strategy: Transforming Care Together).*
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	*Statement:* *Effective arrangements for Quality: The Trust LERN policy and process supports organisational wide learning and staff survey results suggest staff feel confident in raising concerns and that action is taken. Staff are supported to report incidents, no harm events and LERN issues. Support is provided to satff that are involved in patient safety events and there is a culture of ensuring patients and their families are involved in patient safety incident investigations. Insight weekly and oversight monthly chaired by exec (or deputy) as per PSIRF plan. Learning feeds into corporate and care group governance structures (see Quality Committee and Board papers and Care Group SDR process) . The UHD PSIRF Plan identifies priorities and the Trust learning response framework. The UHD Quality and safety strategy is aligned to PSIRF plan and corporate objectives relevant to quality, safety and experience. Watch and Driver metrics are established for the primary strategic objectives.PSIRF Thematic reviews are carried out as per the PSIRF Plan priorities which were identified through qualitiative and quantative metrics. Learning is shared across Trust through governance meetings and structures. All PSII signed off by CMO/CNO prior to finalising. Patient Safety Partners support PSIRF plans and improvement workstreams.* *Areas of focus identified from CQC inspections and associated action plans shared at Trust and Care group governance meetings, with regular updates to trust Management Group.Proactive, regular, planned monitoring occurs via various programmes including Matrons walkabouts, Clinical Accreditation Scheme, Quality Assurance Tool audits and the annual clinical audit plan. NICE guidance, GIRFT, national and local clincial audits are reviewed at local level and overseen at Trust executive level and reported through Quality Committee and Audit Committee.* *Patient Experience: Complaints are thematically reviewed and paper presented through governance processes to Quality committee. Specific complaints driver metrics strategically set for Trust and reviewed at local performance meetings monthly. FFT is well embedded with results feedback to local teams for celebration, learning and improvement. Patient first methodology supports daily huddles and opportunities to discuss results. National patient surveys are discussed through Trust and Care Group governance processes including TMG, Quality Committee and Board.* *Mitigating/contextual factors:* *CQC inspections underway with more expected in the remainder of this financial year. As such the updating of CQC ratings is as yet unknown - thus a "partially confirmed" position as this important third party data is not yet available. There are many action plans being actively progressed, and a Governance project progressing to further improve consistency and effectiveness on quality. There is extensive information showing quality is well managed - see evidence, including mortality approaching statistically significant better than expected.* *Amber-Green self assessment as some quality measures need improving (eg infection control)*
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	*Statement:* *Staff feedback and patient improvement stories are shared through our Patient First Intranet page / regular features in weekly all Trust cascades. Development clusters into three areas : Patient First - our quality improvement programme - full skills rollout to all Care Groups/ ward areas and Specalties by Spring 2026.* *Clinical Training - 410 live Apprentice, 419 resident Drs , 447 Preceptees, 47 newly qualified nurses plus other registants, Early Careers Conference, MLOG initiated and S & M complaince at 90% . Management and Leadership training and Level 7 degree courses via Bournemouth University.* *Staff can express concerns: Trust behavioural charter launched. Staff can express concerns and feedback through numerous channels e.g. formal Staff Partnership Forum, staff governors, and extensive number of staff networks (e.g. Pride, Pro-ability, DEN, Womens, International doctors and armed forces veterans). Reporting systems also include LERNS/Datix reporting on safety and near misses, with good staff survey results on confidence in using these. The Freedom to Speak up Guardians provides an active and well known route to raise concerns, with regular reporting direct to Board. The Sexual Safety Charter and guidance has been fully introduced.* *Mitigating/Contextual Factors:* *Self assessment as Amber/Green - based on systems in place. To note staff survey underway, results from which will allow further evidence for people and culture self assessment.*
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Confirmed**	*Statement:* *Plans to improve access performance* *• Trust improvement programmes for planned care (elective, diagnostic, outpatients and cancer) and UEC in place* *• Corporate improvement plans: Outpatients and Future Care programmes* *• Corporate service projects: Care coordination (UEC) and Theatres* *• Breakthrough objectives for planned care and UEC are defined at a Trust level with supporting driver and watch metrics.* *• Monitoring of waiting times is through the Strategy Deployment review process at Care Group and Directorate level, weekly performance huddles in Operations and at the Operational Delivery Group and relevant Board Committees* *• Reporting happens monthly via the Integrated Performance report, and weekly via a performance summary report. Daily reports for key metrics are shared between operational teams.* *• Patient Access Policy in place.* *• The Trust's Accountability Framework outlines the governance arrangements, roles and responsibilities for management of performance, including the approach to escalation of underperformance.* *Inequalities / Population health* *Reporting of variation in waiting times for adults and children in relation to ethnicity and deprivation occurs monthly within the IPR. The Trust also has access to a system-wide dashboard for the 24 national NHSE health inequalities indicators, which is reviewed for variation.* *• There is a system-wide plan to tackle health inequalities in elective care against the requirements outlined within Reforming Elective Care for Patients (Jan 2025), The Trust also makes an annual submission to the Equality Delivery System to demonstrate improvement to services for its communities.* *• Population health targets for the system are outlined within the Dorset Joint Forward Plan 2023-2028* *Mitigating/Contextual Factors:* *"Confirmed" as plans in place and making progress, but amber-green as league table performance and national targets show room for further improvement, esp on 4hrs and community waiting times.*
Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	*Statement:* *Productivity plans* *•Cost Improvement Plans are in place. The Trust also tracks productivity improvement schemes and outcomes (non-cash releasing)* *•Breakthrough objectives for efficiency improvement are defined at a Trust level with supporting driver and watch metrics.* *•Monitoring of delivery of plans for productivity and efficiency is through the Strategy Deployment review process at Care Group and Directorate level, and at Sustainable Services Group monthly* *•Reporting happens monthly via the Integrated Performance report, and weekly via a Cost Improvement summary report.* *•The Planned Care and UEC improvement programmes also have a focus on delivery of productivity* *•Six priority transforming and valuing administration schemes have been identified, which are Exec lead and operationally delivered.* *•Biannual 'fact packs' are produced for Care Groups and Corporate Directorates outlining the improvement and future opportunities for increased productivity using Model Health and Getting it Right First Time (GIRFT) published data.* *•The Trust also held a productivity and efficiency event for teams this year (April 2025)* *Mitigating/Contextual Factors:* *Productivity growth is performing better than peers, (top 7 in England on latest data). The Model Hospital data is now quite historic, but does indicate there is still room for improvements, and there is a robust programme to progress this at Trust level. A strategic piece of work will review system opportunities beyond those already in place (e.g. Future care for UEC, shared procurement etc).*
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Confirmed**	*Statement:* *Financial Governance and Risk Management* *• Robust governance framework in place, including Standing Orders, Scheme of Delegation and Standing Financial Instructions.* *•Additional financial policies and procedures in place, and regular assessment is made against the HFMA/ National Grip and Control checklists.* *•A comprehensive Quality Impact Assessment policy/ process is in place to ensure financial decisions do not adversly affect patient safety.* *•Rolling annual Internal Audit programme in place to assess the design and operational effectiveness of the financial control environment.* *•Contract management and reporting in place, compliant with the NHS standard contract requirements, with regular formal and 'touchpoint' contract meeting in place with commissioners.* *•Financial risks and opportunities are considered and assessed monthly as part of the in-year rolling forecast at directorate, care group and Trust level. Similarly risks and mitigations are assessed and included within the budget recommendation report.* *System* *•ICS-wide approach to financial allocations & contract values, with appropriate distribution of risk across organisations. A weekly Medium Term Plan meeting assures progress against the in-year and medium term financial plan; focusing on risk, mitigations and holding to account.* *Mitigating/Contextual Factors:* *Trust is on track to achieve year end position, and does not have a finacial over ride. Also has had clean set of accounts (with no qualifications) for many years. However Green-Amber self scoring as underlying system financial deficit is significant, and require even more system working to deliver financial performance.*
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	

Signed on behalf of the board of directors

Signature

Name: Siobhan Harrington

Date: 22 October 2025

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 7.1

Subject:	Workforce Operating Plan Targets and Workforce Plans
Prepared by:	Jo Maple-Roberts Transformation Workforce Lead Irene Mardon Deputy Chief People Offier
Presented by:	Melanie Whitfield, Chief People Officer

Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☐ Sustainable Services ☒
BAF/Corporate Risk Register	BAF Risk **Our People**: Risk of not significantly improving staff experience and retention over the next 3 years (and not being in the NHS staff survey results top 20% of comparator trusts) BAF Risk **Sustainable Services**: Risk of not returning to recurrent financial surplus from 2026/27 and improving the timeliness and quality of care for our patients, and the working lives of our staff
Purpose of paper:	Review and Discussion
Executive Summary:	The Operating Plan framework for 2025/2026 has set targets for workforce by both cost and number of whole-time equivalents (WTE): • Reducing overall WTE employed, by end of March 2026, with a specific target for employees coded as 'Administrative and Clerical (A&C)', returning WTE to March 2022 levels. • Reducing agency expenditure, as far as possible as part of optimising cost and productivity. As a minimum all systems are expected to deliver a 30% reduction in agency usage by WTE / cost based on current spending, with further reductions to follow. • Reducing bank usage, with all systems expected to deliver a minimum 10% reduction by WTE / cost. Bank rates should be optimised as far as possible with collaborative arrangements in place across and between systems. • Reducing 'premium' pay bill costs such as overtime and waiting list initiative (WLI) rates.

	These requirements were analysed for UHD, but following a request from NHSe the trajectory was reviewed in September for M06-M12 and has resulted in agreed, revised targets: • Reducing WTE from a plan of 9086 WTE in month one (M01) of 2025/26 to 8967.99 WTE at the end of M12. • Reducing Bank usage from an actual of 643.28 WTE in M01 to a revised plan of 589.18 WTE in M12. • Reducing Agency usage from a plan of 158 WTE in M01 to a plan of 116.9 WTE in M12. • The M06-M12 trajectory is based on M05 actual WTE: there is no planned reduction in Clinical substantive and Bank WTE. The revised reduction is across non-clinical substantive and Bank • The agency trajectory remains unchanged. Overall, the targets aligned to a reduction that has been triangulated in the trust and agreed as a system. This is noted as • Growth aligned to our transforming care together work of 120 • A revised reduction in our temporary staffing use (Agency and Bank) of circa 97wte • A revised reduction in our substantive infrastructure (A&C growth) of circa 134wte which will be supported through the Transforming and Valuing Administration (TVA) programme of work. • Bed reductions / closures aligned to our Future Care programme circa 105wte reductions. This includes closure of Lulworth Ward in August 2025. These targets are tracked monthly and reported within UHD and to the system (through the One Dorset Provider Collaborative report) and to NHSE (through the Provider Workforce Return). The People Directorate have moved to 'real-time' reporting through the creation of a Workforce Room: this tracks WTE usage by week and seeks to forecast from trends, to give more timely feedback within UHD, to advise on adverse trends as soon as possible and to forecast PWR data before it is submitted (there is a 10 to 14 day lag in PWR submission after the end of each month). Elements of the WTE reductions are included in detailed plans, supported by the '*Workforce Operational Efficiency and Reduction Plan*.' A review of workforce efficiency workstreams will support teams to focus and fully scope on 31 programs of work with improved governance.
Background:	The 2025/26 Operating Plan.
Key Recommendations:	That the Board notes the Operating Plan targets in this respect and supports the work underway to achieve the WTE targets, which are underpinned by the 2025/2026 Financial plan.
Implications associated with this item:	Council of Governors ☐ Equality and Diversity ☒ Financial ☒ 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**
None	N/A	N/A

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

University Hospitals Dorset

Workforce Operational Plan M06 (September)

Board Report

Introduction

- These slides are based on the revised H2 workforce operational plan trajectory that was submitted to the system
- The M06 results show us to be broadly on plan with two main risk – substantive A&C and Bank A&C usage rates
- In M06 there has been an increase in the use of agency Mental Health Support Worker's for Enhanced Care Needs
- M07, forecast increase in substantive wte because of newly qualified nurses, midwives and AHP's commencing in post. This will mean UHD remain above substantive plan.

UHD Operational Plan - Substantive, Bank and Agency

From M06-M12 the workforce operational plan will be monitored against the UHD revised H2 trajectory.
As of M06, the Trust is over plan for total workforce WTE. Whilst ahead of plan for substantive and agency the Trust continues to be over plan for bank WTE.

- Overall: over plan by 42.36wte
- Substantive: over plan by 19.21wte
- Bank: over plan by 13.24wte
- Agency: ahead of plan by 48.34wte

Sum of FTE		Month												Sep-25
Staff_Type	Plan_Actua	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Actual v Mar-26 Plan
Substantive	Actual	9098.12	9070.43	9085.44	9039.27	9106.22	9098.85							130.86
	Plan	9086	9098.96	9072.28	9064.28	9055.28	9079.64	9057.31	9034.98	9012.65	8990.32	8967.99	8967.99	
Bank	Actual	643.28	647.55	669.46	678.21	651.18	627.61							38.43
	Plan	609	591	564	565	560	640.85	630.52	620.19	609.86	599.53	589.2	589.18	
Agency	Actual	135.81	148.11	129.31	83.37	87.76	90.66							-26.03
	Plan	158	135	135	136	137	139	141	146	151	144	128	116.69	
Total Staff	**Actual**	**9877.2**	**9866.08**	**9884.21**	**9800.86**	**9845.17**	**9817.13**							143.27
	Plan	**9853**	**9824.96**	**9771.28**	**9765.28**	**9752.28**	**9859.49**	**9828.83**	**9801.17**	**9773.51**	**9733.85**	**9685.19**	**9673.86**	
In Month Actual v Plan														
Total		***24.21***	***41.13***	***112.93***	***35.58***	***92.89***	***42.36***							
Substantive		*12.12*	*-28.53*	*13.16*	*-25.01*	*50.94*	*19.21*							
Bank		*34.28*	*56.55*	*105.46*	*113.21*	*91.18*	*13.24*							
Agency		*-22.19*	*13.11*	*-5.69*	*-52.63*	*-49.24*	*-48.34*							

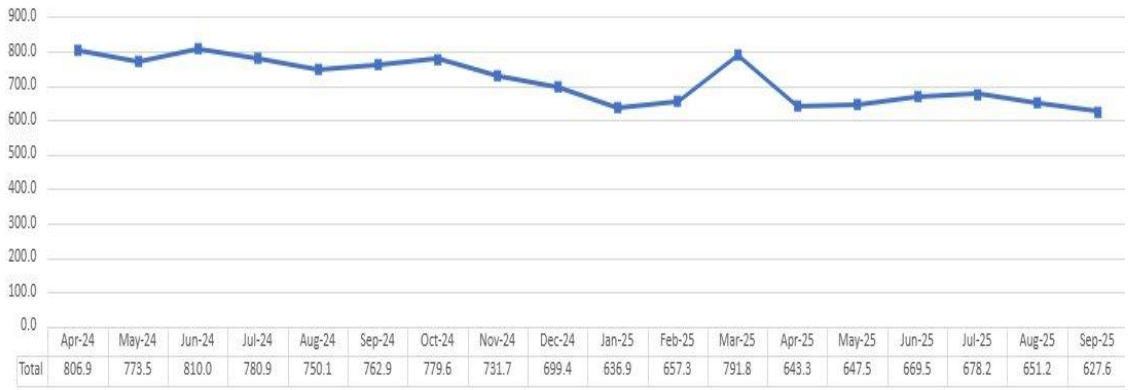
UHD – Current status of total WTE plans by Staff Group (in M06)

- Registered Nursing and Midwifery and Health Visiting staff are ahead of plan by 30.74wte
- Registered/Qualified Scientific, Therapeutic and Technical staff are behind plan by 21.78wte
- Support to clinical staff are ahead of plan in month 59.3wte
- NHS Infrastructure Support are behind plan by 162.71wte
- Medical and Dental are ahead of plan by 3.32wte
- Any Other staff are consistently ahead of plan by 1.4wte
- Total workforce is 133.26wte behind plan against March 2026 position

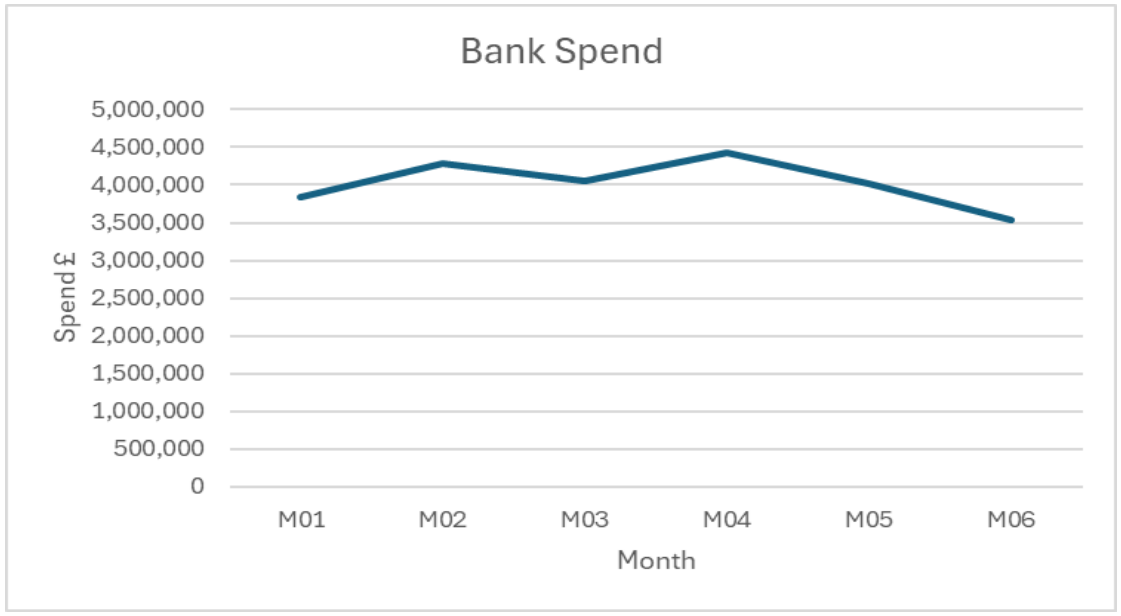
Staff_Group	Plan_Actual	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Registered Nursing, Midwifery and Health visiting staff	Actual	2903.27	2893.47	2910.66	2877.24	2871.94	2855.21						
	Plan	2901.91	2880.91	2858.49	2861.49	2864.49	2885.95	2877.95	2879.95	2814.24	2842.28	2830.28	2817.02
Registered/ Qualified Scientific, Therapeutic and Technical Staff	Actual	1229.16	1229.44	1227.97	1219.13	1229.18	1238.85						
	Plan	1221.49	1219.49	1218.21	1218.21	1218.21	1217.07	1241.5	1242.5	1216.04	1218.35	1218.35	1213.69
Support to Clinical staff	Actual	1926.17	1924.71	1903.35	1848.61	1858.12	1856.18						
	Plan	1955.5	1957.46	1940.47	1932.47	1931.47	1915.48	1888.65	1891.65	1894.65	1895.99	1889.99	1874.89
NHS Infrastructure Support	Actual	2455.76	2444.74	2468.74	2457.46	2448.16	2428.8						
	Plan	2334.93	2329.93	2316.96	2314.96	2303.96	2266.09	2390.24	2356.28	2322.92	2292.26	2257.6	2257.24
Medical & Dental	Actual	1353.44	1364.72	1364.5	1389.41	1428.77	1428.08						
	Plan	1428.76	1426.76	1426.76	1427.76	1423.76	1424.76	1428.28	1428.28	1428.28	1428.28	1428.28	1427.05
Any Other Staff	Actual	9.4	9	9	9	9	10						
	Plan	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4	10.4
Total workforce	Actual	9877.2	9866.08	9879.18	9801.93	9840.92	9807.12						
	Plan	9877.20	9865.61	9884.20	9800.85	9840.91	9859.49	9828.83	9801.17	9773.51	9733.85	9685.19	9673.86

UHD Bank Reporting M06 (medical and non-medical)

Bank WTE workforce



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Total	806.9	773.5	810.0	780.9	750.1	762.9	779.6	731.7	699.4	636.9	657.3	791.8	643.3	647.5	669.5	678.2	651.2	627.6



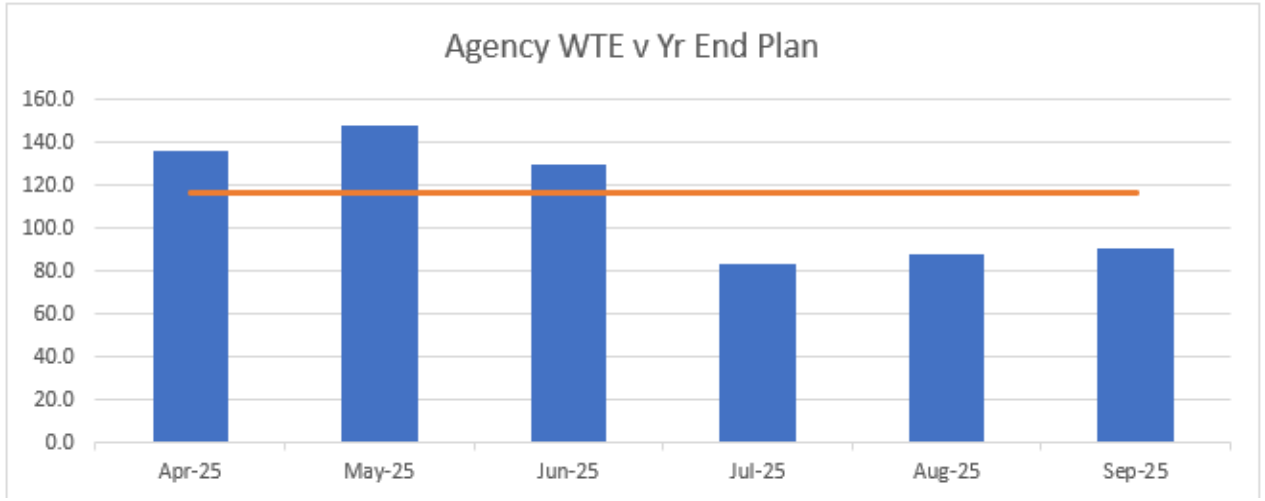
- Bank usage in M06 was 627.6wte, 13.24wte above revised plan, but a reduction of 23.6wte from M05

Bank	M01	M02	M03	M04	M05	M06
Actual	643.28	647.55	669.46	678.21	651.18	627.61
Planned	609	591	564	565	560	640.85

- Bank spend reduced in M06 by £488,733 from M05
- Actual Bank spend was £93k below plan
- M06 bank spend was 7.02% of total pay bill, a reduction of 0.55% from M05

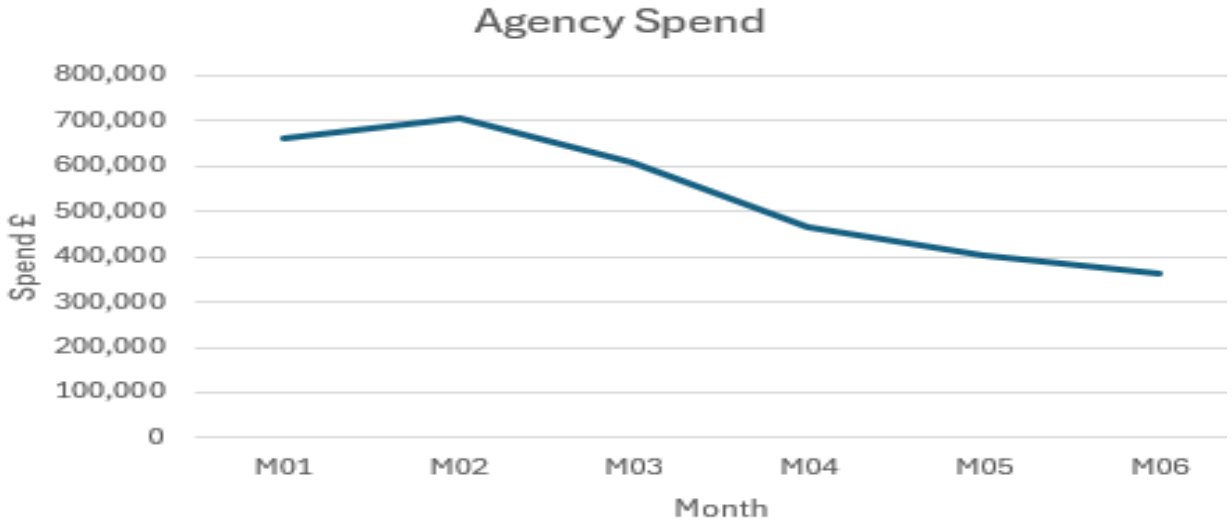
Bank	M01	M02	M03	M04	M05	M06
Actual £	3,834,203	4,277,047	4,056,240	4,427,391	4,109,531	3,535,798
Planned £	3,997,000	3,883,000	3,660,000	3,661,000	3,610,000	3,629,000

Agency Reporting M06



- Agency use in M06 was 90.7wte. Whilst below plan by 48.3wte, there was an increase of 2.9wte compared to M05
- In M06 there was an increase of 1,207 hours filled by agency for Enhanced Care Needs (MHSW) from M05

Agency	M01	M02	M03	M04	M05	M06
Actual	135.8	148.1	129.3	83.4	87.8	90.7
Planned	158	135	135	136	137	139



- Agency spend reduced by £42,087 from M05
- Actual Agency spend was £615,734 below plan
- Agency spend was 0.76% of total pay bill, a reduction of 0.04% from M05

Agency	M01	M02	M03	M04	M05	M06
Actual £	662,651	704,118	610,063	463,259	404,353	362,266
Planned £	1,107,000	902,000	922,000	932,000	953,000	978,000

Infrastructure targets

Administration

Right-size administration – 50% of growth since March 2022

- **Surgical Care Group – administration changes.**
- **Medical Care Group – administration changes.**
- **WCCSS Care Group – administration changes.**
- **Corporate administration - changes:**
  - **CMO Office**
  - **CNO Office**
  - **Finance and BI Directorate**
  - **Digital Directorate**
  - **People Directorate**
  - **Strategy & Transformation**
- **Governance and Exec Support Teams**
- **Administration - Transfer Window and Talent Pools**

- Sustainability targets reassessed at M06:
  - Substantive A&C reduced by 134 WTE by M12 (with plans devised for further change in 2026/27)
  - Bank A&C reduced by 62 WTE by M12
- The Digital team and People teams are working together to help with role re-design, training, multi-skilling, and clearer career pathways.
- The Finance Team, People Team, Care Groups and Directorates are working together to achieve right-sizing administration.

Transforming and Valuing Administration

Improving ways of working for A&C staff, driving digital adoption

- **ICE (Integrated Clinical Environment) 'ordercomms' - paperless requesting and reporting**
- **'DrDoctor' integration to 'Synertec' for patient correspondence**
- **Patient rebook via DrDoctor through NHS App Integration**
- **Paper to digital notes in Outpatients**
- **Advice & Guidance through 'Consultant Connect'**
- **eCaMIS Data Validation**

UHD Governance, successes & next steps

Successes

- Built confidence in our ability to forecast and control workforce usage
- Reduction in Bank WTE and spend
- Review of all workforce efficiency workstreams with improved governance, enabling teams to focus and fully scope
- Revision of workforce operational plan trajectory for H2, with a focus on stability of the clinical workforce and additional efficiencies re: non-clinical workforce

Risks

- Delay in COAST building from January 2026 to July/August 2026 is a potential risk to the Future Care programme and closure of beds
- Impact of removal of enhanced Bank rate for theatre staff has resulted in an increase in requests for agency workers
- Winter pressures and additional risk for clinical workforce usage

Next steps

- A3 completion covering 31 programmes of work within the six pillars of the '*Workforce Operational Efficiency and Reduction Plan*' (slide 9)
- Implementation of enhanced arrangements for administrative workforce with a transfer window and talent pool in November/December
- Job planning and rostering for medical workforce
- SOP's for temporary spend, with tighter controls on non-medical bank usage
- Enhanced focus on attendance management, identifying and managing sickness absence 'hotspots'
- Review of annual leave to ensure correct percentages taken in Q 3 & 4 to avoid uptick in Bank

Workforce Operational Efficiency and Reduction Plan

People Promise

Temporary Staffing

Reduce temporary staffing in line with operating plan

Reduction: -224wte
£10,426,000 (excluding medical bank and agency)

Exec:
Melanie Whitfield & Sarah Herbert
SRO
Irene Mardon & Vivian Alividza

Reduce bank usage and deliver a minimum 18.15% spend reduction
Nursing: Vivian Alividza & GDON's
Medical: Becky Jupp
A&C Jane Dudley
Facilities: Stuart Wiles

Reduce agency usage and deliver a minimum 12.59% spend reduction
Nursing: Vivian Alividza & GDON's
Medical: Becky Jupp

Removal of outstanding off-framework use for Agenda for Change Clinical
Vivian Alividza & GDON's

Review enhanced pay and additional hours
Zandie Mpofu

Administration

Right size Administration - 50% of WTE growth since March 22

Reduction: -134wte
£5,928,000

Exec:
Melanie Whitfield
SRO
Jane Dudley

Surgical Care Group
Abigail Daughters / Lisa Hazlett

Medical Care Group
Adam Morris / Kate Mogg

WCCSS Care Group
Lisa Clarke / Hayley Colley

Corporate services
Corporate Nursing: Vivian Alividza
Corporate Medical: Becky Jupp
Finance & BI: Adrian Tron & David Mills
Digital: Sarah Hill
S&T & Capital & Estates Steve Killen
People : Irene Mardon

Corporate governance and executive support
Jane Dudley / Truda Scriven

A&C Transfer Window and Talent Pool
Jane Dudley / Melissa Duncan

Transforming and Valuing Administration

Improving ways of working for A&C staff, driving digital adoption

Exec:
Melanie Whitfield & Beverley Bryant
SRO
Jane Dudley & Elom Srebi

ICE paperless requesting and reporting

Dr. Doctor Integration to Synertec for Patient Correspondence

Patient Rebook their own Appointment via Dr Doctor through NHS App Integration

Remove Paper Notes in Outpatients

Drive Uptake of Advice & Guidance with Consultant Connect

eCaMIS Data Validation

Workforce Controls

Reduce premium staffing costs (overtime, WLI, negotiated rates, insourcing/outsourcing)

Exec:
Melanie Whitfield & Pete Papworth
SRO
Lisa White & Adrian Tron

Vacancy control panel
Melissa Duncan

Time to hire
Melissa Duncan

Reduction and controls of overtime
Adrian Tron (ADoF's) & Lisa White (HRBP's)

Review of fixed term contracts
Lisa White

Review of payments outside of Agenda for Change
Adrian Tron (ADoF's) & Lisa White (HRBP's)

Review of Recruitment and Retention payments
Lisa White

(a) Insourcing/outsourcing
Mark Major
(b) Temporary staffing
Irene Mardon

Clinical Workforce Transformation

Analysis regarding composition of medical workforce budgeted establishment

Exec:
Melanie Whitfield & Peter Wilson
SRO
Irene Mardon & Becky Jupp

Job planning – trajectory to 95% for Consultants and SAS Doctors
Group Medical Director & Lisa Cain

E-Rostering trajectory to 100% E-Rostering for medical staff
Group Medical Director & Lisa Cain

Outpatients' clinic & Theatre utilisation productivity
Jonathan Wright/Nicola House

Reduction of WLI, agency, locum, bank spend
Group Medical Director & Zandie Mpofu

Workforce establishment
Helen Rushforth & Lisa Cain

Change processes
John Ward

Future Care/Patient First

Closure of 59 beds

-105wte
Annualised cash impact £7,774,500
Cash in year £ 3,133,940
(assuming all bed cost is consistent with OPS and beds come out at mid-point in month)

Exec:
Mark Mould
SRO
Mark Major

- **Closure of beds:**
  Medical care group - Lulworth ward August 2025 with redeployment of 31.24wte
  Surgical care group - 4 beds -October 2025 £86,000 to year end.
- 4 T&O beds - October 0.83wte reduction then a further 4 beds closed in December with 8.5wte reduction totalling £92K to year end
- **WCCSS** - TBC

Reducing number of 'no criteria to reside' patients
A2A – Toby Mulvey
TOC –Antonia Gabrielli

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 7.2

Subject:	Freedom to Speak Up Bi-Annual Report (2025/6)
Prepared by:	Helen Martin; Freedom to Speak Up Guardian (FTSUG)
Presented by:	Helen Martin; FTSUG

Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☐ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	BAF not applicable
Purpose of paper:	Decision/Approval
Executive Summary:	The purpose of exception report is to: • Review our speaking up culture for Qtr 1, 2025/6 and • Understand why our staff are raising concerns and what we have learnt • **Approve:** statement of commitment of Sir Robert Francis principles of the Freedom to Speak up and annual declaration of behaviours
Background:	Every Trust is mandated to have a named FTSUG in post and an expectation as part of the well led domain, to see FTSUG reports submitted at least 6 monthly to enable the board to maintain a good oversight of FTSU matters and issues. Reports are to be presented by the FTSUG in person. Reports must include both quantitative and qualitative information and case studies or other information that will enable the senior team to understand the issues being identified, areas for improvement, and take informed decisions about action.
Key Recommendations:	Having an engaged workforce assists staff retention, improves productivity, and delivers better care. Speaking up is central to this, where staff need not only to have a voice but also knows that it will count (People Promise). The role of FTSU is becoming clearer since the publication of 10-year plan and DASH report. • The responsibility of FTSUG are to be incorporated within provider organisations

	• The role of the FTSUG will remain incorporated into the NHS standard contract for 2026/7. • NHSE will assume responsibility for NGO and this work onwards. FTSU is one way that staff can raise their voice. More than 500 staff used this channel last year. In quarter 1 (2025/6) whilst slightly lower than the same period last year, 107 staff spoke to the team (↓28%). 20% (21 staff) from our global majorities raised FTSU concern. The greatest theme continues to relate to behaviours (50% rising to 62% cases from our global majority) and of those behaviours, 61% relate to uncivil behaviours. Staff use the FTSU channel more for workplace and relational issues than patient safety. The launch of the Behaviour charter is a positive action from our learning and will help us understand the standards of behaviours we expect at UHD but also give us the tools to challenge them when they are poor. This quarter, the learning from our cases tells us the importance of our leaders and managers having the skills and confidence to encourage staff to speak up but when they do to listen and follow up, so to improve our staff experience and be a great place to work. 50% of staff who use FTSU tell us that our line managers are not doing this and a further 9% feel unsafe.
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**

TMG	01/09/2025	For discussion
PCC	8.10.25	For approval and decision
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 ☐	

Freedom to Speak Up (FTSU)

Bi-Annual Report 2025/6

1.0 Introduction:

Speaking up in healthcare is not just about voicing concerns but is it about safeguarding lives, driving improvement and fostering a culture of safety and trust in a setting where decisions affect people's health, silence can be costly. The healthcare landscape in UK is undergoing a profound transformation with aspirations to shift care into our communities, digitally and with a prevention focus (NHS 10-Year Health Plan). The DASH report, also published in July, further facilitates these shifts by focusing on patient safety. DASH concluded that speaking up must be integral to the delivery of all healthcare and that the voice of patients and staff needs to be elevated. The report summarised the need to move speaking up from a peripheral concern to a central pillar of quality and safety by streamlining oversight and accountability and embedding speaking up into strategy (see section 3.0).

Despite all these changes at the national arena, at UHD we continue to embark on our culture journey with speaking up at its core. We have many channels that our staff can speak up including our line managers, occupational health, staff governors, using our LERN forms, chaplains, education team and our HR team. Freedom to Speak Up (FTSU) is another alternative route.

Supporting you to raise concerns
Freedom to speak up

The role of the FTSU team is to highlight the challenges and act as an early warning system of where failings might occur. They are also an ally and a critical friend that works in partnership across an organisation to encourage action to improve culture.

Creating a speaking up culture however requires positive actions at all levels of the organisation. Our refreshed 3-year strategy outlines how speaking up at UHD is everyone's business; as workers, as leaders, as FTSU team and as the wider healthcare; together we can (see section 4).

Twenty twenty-five is the year when we look to mature our speaking up culture where we are not only confident that we give our staff a voice, but that we show this voice counts by acting and following up through a positive interaction. It is acknowledged that interactions are more than a process where someone speaks up and someone listens and acts. Indeed, this not only divides our workforce but is often fraught with difficulties presented by power imbalances, difference, and mindset. Interactions need to bring people together, recognising the important role we all play, encouraging mutual support and, above all, empowering everyone to take action themselves. Research tells us that by doing this, it will have a further impact on staff engagement assisting retention, productivity, and the delivery of excellent care.

The purpose of this paper is to reflect on the important trends and learning that come from staff using the FTSU channel thereby highlighting the challenges ahead for UHD in 2025/6.

- **Approve** – FTSU Strategy 2026-29 and Annual declartaion of Speaking up principles
- **Approve** – Sir Robert Francis Principles of FTSSU an Annual Declaration of Behaviours

2.0 FTSU at UHD

2.1 The Vision of Speaking up and Commitment from the FTSU team

To develop a culture of safety so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.



2.2 Our FTSU team

At UHD we have 2 FTSU Guardians alongside a network of 11 FTSU Ambassadors. Our team help us raise awareness and promote the value of speaking up, listening up and following up thereby addressing challenges posed by organisation size, geography and the nature of their work as well as support workers, especially those who may face barriers to speaking up. All members of the FTSU team have been key to our success.



2.3 Our Senior Leaders and managers

Our Senior Leaders are the core pillar to creating our speaking up culture through their commitment and tone. Speaking up at UHD is visibly supported by our senior leaders in many ways including consistent speaking up messaging and support to the FTSU team.



Our Senior Leaders also every year take time to reflect and publicly commit to the Sir Robert Francis Principles of Speaking Up, alongside a declaration of behaviours. This commitment is made in the Autumn as a visual statement. The declaration of behaviours sets out how the board will role model this and sets the tone of the culture for UHD.

APPROVE Statement of commitment (appendix 1)

2.4 2025 so far at UHD

April-March "Looking in and out" –Networks

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



April – March "Data Submissions" UHD continues to be an active contributor and submits requirements from the NGO. These include quarterly submissions, census information and other surveys.

April: Published national documents

- Guidance on FTSU and Public Disclosure Act. – guidance embedded in UHD FTSU policy

May Published national documents

- Review of speaking up experiences of oversea-trained workers in England
- Universal Job description

May UHD
FTSU Annual report presented to May board.
UHD Board approval of FTSU NHS policy and Behaviour Charter statement

June: The UHD Awards is an important way to recognise each-other. In 2025, over 900 nominations were received. The "Open and Honest" category, recognising an individual or team that works hard to promote an open and safe culture. This year's worthy recipient was Meris Miller, Workforce nurse for her work supporting our international nursing teams.



July: Publication of the 10 Y SH review outlining the disbanding of NGO as a standalone entity.

August: letter from NHSE to reaffirm the role of FTSUG. It also confirmed that the role will be incorporated into the NHS standard contract for 2026/7 and that NHSE will assume responsibility for this work onwards (section 3).

NGO Publication of Culture is a patient safety issue – summary of FTSUG (2024/5).

Sept: NGO publication: FTSUG survey 2025. This review looks at all aspects of the FTSUG role and how it works in practice highlighting the progress and the ongoing challenges (refer to section 3.4).

3.0 The National Perspective of Speaking up - National Guardian Office (NGO)

For over 9 years the National Guardian Office (NGO) has supported the healthcare system to improve workplace cultures, ensuring workers are confident to speak up. They did this by leading, training and supporting a network of FTSUGs.

In July 2025, both the NHS 10-year health strategy and the independent review of patient safety, also known as the DASH report, reviewed the effectiveness of NGO amongst other commissioning support units (CSU). It concluded that significant resources have been invested in safety but with limited measurable improvement. More specifically they felt that there was an overload and often unfragmented number of recommendations from multiple bodies, leading to confusing systems and duplication. In terms of the NGO being hosted within the CQC, they felt that it made NGO distant to the people it needs to support and influence. Consequently, they recommended the disbanding of the NGO as a standalone entity.

Moving forward, the responsibility of FTSU Guardians are to be incorporated within commissioners and provider organisations, so that profiles and staff voices are heard more clearly and responded more rapidly on a more local level. The functions of FTSUGs will remain a core function of CQC as the independent regulator of health and care and it has also been confirmed that the role of the FTSUG will remain incorporated into the NHS standard contract for 2026/7. NHSE will assume responsibility for NGO and this work onwards.

3.1 National Speaking Up Data

UHD continue to submit quarterly information to the NGO. Table 1 below shows how staff at UHD use this service as compared to surrounding healthcare.

Table 1: Quarterly NGO data submissions (latest published data)

		2024/5				
2024/5	**Size**	**Qtr1**	**Qtr2**	**Qtr3**	**Qtr 4**	**TOTAL**
Dorset County	Small	108	148	128	115	**499**
Dorset Healthcare	Medium	33	43	46	59	**181**
Salisbury	Small	21	37	35	36	**129**
Somerset Foundation NHS	Large	80	117	89	126	**412**
University Hospitals Dorset	Medium	137	152	127	119	**535**
University Hospital Southampton	Large	36	18	19	17	**90**

At UHD, we recognise that our staff have historically spoken more with our FTSU team compared to surrounding Trusts. This year, this trend has become less pronounced as other Trusts also see a rise in the number of FTSU referrals. We have acknowledged that our rise in referrals was likely to be in recognition of the significant staff changes through our merger and re-organisational processes. As we move through these changes, the number of referrals received by the FTSU team appear now to be stabilising.



Quarter 1 2025

- 50% of staff reported that they come to the FTSU team because their line manager is the issue or that they believe they are not addressing it.
- 9% staff reported that the reason they came to the FTSU team was because they felt insecure in raising concerns with line managers.
- A continuing trend is staff are using the FTSU route for advice prior to escalating themselves via the correct route. 35% of staff knew what they needed to do but wanted a confidential, impartial viewpoint to draft their thoughts.

3.2 NGO: Freedom to Speak Up training programme.

'Speak Up, Listen Up, Follow Up', are e-learning packages, aimed at anyone who works in healthcare. Divided into three modules, it explains in a clear and consistent way what speaking up is and its importance in creating an environment in which people are supported to deliver their best.

The Speak Up e-learning module was made mandatory in UHD since October 2024. It is to be repeated every 3 years. Nearly 7000 staff have completed the Speak up training over the last 12 month. The training consistently receives an average rating of 4.5/5 stars.

Table 2: Number of staff completed FTSU e-learning

HEE/NGO e-learning modules	April 2021 – Sept 2022	2022/3	2023/4	2024/5	2025/6 Qtr 1
Speak Up	140	61	132	5916	1030
Listen Up	70	42	85	80	9
Follow Up	13	18	46	46	3
TOTAL	**240**	**121**	**263**	**6042**	**1042**

3.3 NGO Publication (August 2025); Culture is a patient safety issue.



This report summarises the data shared by Freedom to Speak Up guardians between 1 April 2024 and 31 March 2025, offering valuable insights into the speaking up landscape across health and care. It is fed into the Model Health System, enabling healthcare leaders to compare speaking up data with other organisational metrics, helping inform reflections on workplace culture and improvement planning.

Key findings include • 2024/25 having the highest number of cases reported to guardians since the programme began. • Workers continue to express positive views about the FTSUG role • Inappropriate attitudes and behaviours remain the most common theme of concern. • Concerns related to worker safety and wellbeing are increasing. • Confidence in organisations to address concerns is in decline.

Challenges ahead • Fear of detriment or a belief that speaking up will not make a difference remains a key barrier of speaking up. • Prolonged investigations and rigid human resource processes contribute to anxiety and negatively impact the wellbeing of those raising concerns. • A lack of outcomes, delayed feedback, and breakdowns in communication weaken trust between workers and organisations. • A perceived lack of compassionate responses from line managers and senior leaders when concerns are raised reinforces the belief that “nothing will change”.

Summary of National data (2024/5)	**National Data (2024/5)**	**UHD data (2024/5)**
Total cases raised	38,158 cases; an increase of 18.6%	535 cases; an increase of 30%
Cases raised with element of pt safety	17.8%	4.5%
Cases with worker safety and wellbeing	38.9%	20%
Cases anonymously raised	11.6%	13%
Cases with inappropriate behaviour	39.7%	38%
Detriment	2.9%	1%

3.3.1 Important points to note from this Annual Report

- The number of cases continue to increase year on year nationally. This increase has also been seen at UHD, increasing by 30% from the previous 12months. The NGO emphasise that there is no optimum number of cases. However, national data correlates FTSUGs in lower rated NHS Trusts receive more speaking up cases each quarter.

  On average, NHS trusts reported 45.9 cases in each quarterly submission (2024/5). At UHD that number is nearly 3 times as much (134 cases/quarter). We need to be curious about this. Is this because:



  - FTSU is a well embedded route to raise concerns?
  - It is a result of a recently invested team now with 2 WTE FTSUGs and now able to do more proactive work?
  - It is a recognition of the significant impact changes at UHD from merger, operational and healthcare re-structuring, and the building work?
  - It is relating to our leadership capacity/skill/confidence as we know 38% of staff reported that they come to the FTSU team because their line manager is the issue or not addressing the issue (2024/5 data; increasing to 50% in qtr 1, 2025/6)

- The number of referrals to the FTSU team which are anonymous is nearly 2% higher than that nationally. There has been an increase of 4% from the previous 12months (See section 6.3), Anonymous concerns can be made through our @UHD app and Pink LERN forms.
- UHD has a lower number of cases where staff feel detriment; 1% of cases. Considerable work commenced at the beginning of this year developing a robust process and outlining what and how to escalate if staff feel that speaking up has resulted in detriment.
- Themes:
  - Cases with elements of inappropriate attitudes and behaviours is similar to the national average.
  - Whilst UHD has seen an increase of cases with worker safety and wellbeing, it remains lower than the national average.
  - Cases relating to patient safety remain lower than national average.

  This all suggests that staff at UHD use the FTSU channel more for workplace and relational issues rather than issues relating to patient safety. It is important that we ensure other routes are well used to raise patient concerns.

The publication made several Calls to Action



For Senior Leaders

- Champion psychological safety by modelling openness, transparency, and responsiveness.
- Invest in full-time guardian roles, in line with recruitment framework recommendation.
- Act on feedback by closing the loop with workers and demonstrating visible change.

For line managers:

- Prioritise compassionate leadership by developing the skills to listen, support, and act.
- Create safe spaces for informal resolution and early intervention.
- Engage in training to understand your role in fostering a culture of trust.



For UHD

- Embed speaking up into strategy priorities, aligning it with patient safety, workforce wellbeing, and quality improvement.
- Strengthen data use to inform proactive interventions.
- Ensure accountability by monitoring resolution rates and follow through on concerns

3.4 NGO: Freedom to Speak Up Guardian Survey – (Sept 2025)

This review draws on findings from the 2025 FTSUG survey, which is an annual survey that explores how the FTSUG role is delivered in practice. Themes include the role, ring-fenced time, available resources and support, job stratification and FTSUG health and wellbeing; all of which contribute to describing the progress of the roles but also the ongoing challenges. Key findings are:

Key Finding	National response	UHD position
Time allocation	Inconsistent access to ring-fenced time	2WTE FTSUG in post, meeting both proactive and reactive workload
Resource infrastructure	Inconsistent funding, private meeting space and communications support to carry out the FTSUG role.	A Small non-staff Budget in place. Strong communications support. Private meeting space is however limited.

Recognition remuneration	Inconsistent alignment of responsibility and pay	Meet NGO job description expectations in pay and role
Support from NGO	More timely, practical and tailored resources requested	Future support and function currently being discussed with NHSE
Influence and engagement	Request for a stronger and more visible national presence with the authority to challenge poor practice, support complex cases and hold organisations accountable	Future support and function currently being discussed with NHSE
Role satisfaction	Despite emotional demands, FTSUG report finding the role deeply rewarding, reinforce the need for robust HWB support	Access to monthly clinical supervision to support HWB.

3.5 FTSU October 2025



Speak Up Week will run 13-17 October and the topic this year will focus on actioning speaking up. UHD is actively planning for this week and is anticipated to involve a campaign of communications, walkabouts and wear green Wednesday (15th).

4.0 Freedom to Speak Up Strategy at UHD (2026-2029)



The FTSU improvement strategy has been in place since January 2023, however in light of the changes to the national picture, it has required a review and refresh. The renewed version will take our speaking up strategy to 2029 and has been built on national and local drivers, based on a diagnosis of speaking up issues within UHD and known areas for improvement. It continues to build on the 4 main pillars of work: our people, the FTSU team, leadership and the healthcare system. A detailed workplan sits beneath this strategy and its progress continues to be updated.

Approve: FTSU strategy 2025-2029

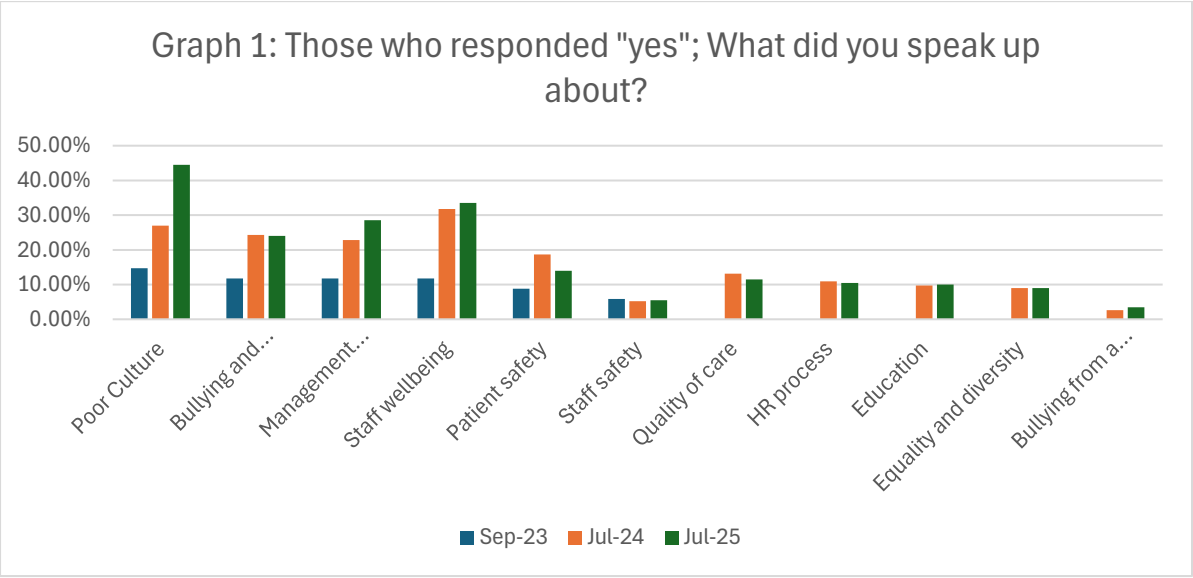
5.0 National Quarterly Pulse Survey (NQPS) – Speaking up Focus; July 2025

The NQPS is a national online pulse survey, developed to support local listening and employee engagement activities in the NHS. As part of the People Promise together with the annual NHS Staff Survey, it allows exploration of various aspects of employee experience and sentiment of our NHS people.

During the July 2025 survey wave, the questions set included core questions but also flexible questions focusing on three People Promise elements including “We each have a voice that counts” (table 3).

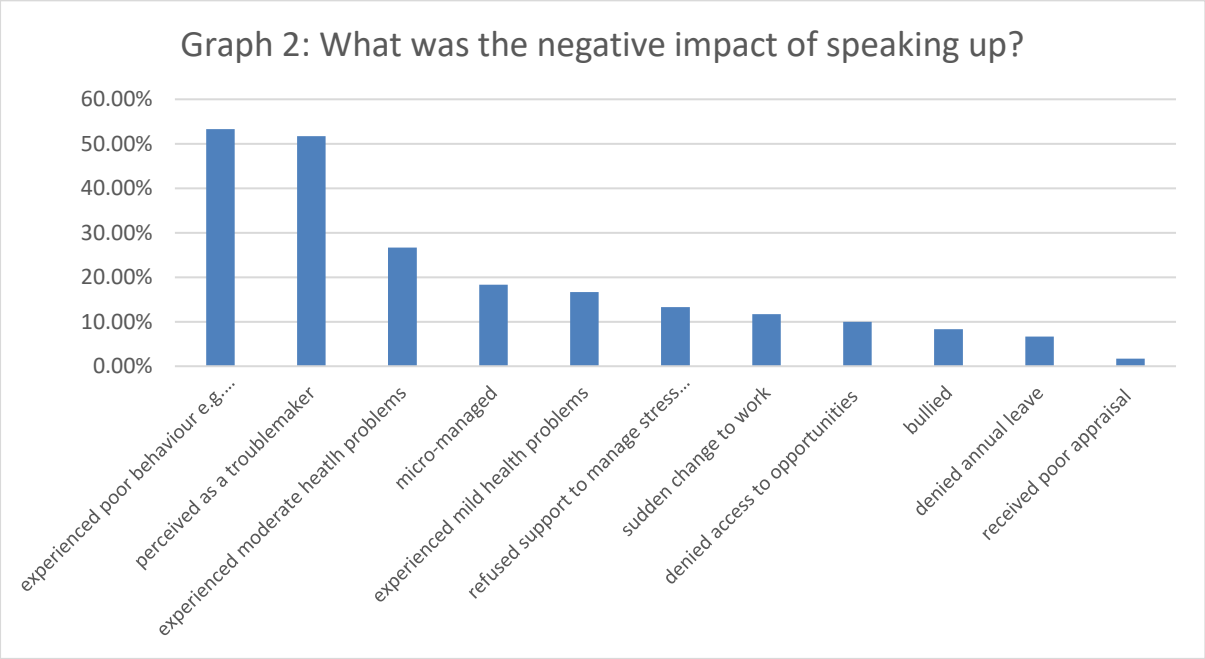
Table 3	**Sep-23**	**Jul-24**	**Jul-25**
No of staff completed	144 staff	1355 staff	953 staff
Has anything happened in your organisation that you wanted to speak up about in the last 12months? YES	52%	31.50%	30.8%

Graph 1 illustrates the issues that were spoken about at UHD. You will notice that poor culture, management behaviour and staff wellbeing continue to increase year on year as reasons to why staff are speaking up.



The focus for this year’s pulse survey for speaking up was around detriment. 30.5% of staff who completed the pulse survey at UHD stated that they experienced a negative impact because of speaking up. This is similar to both pulse surveys carried out in 2023 and 2024 (30% and 28.3%, respectively). The pulse survey further attempted to describe this negative impact, and Graph 2 illustrates our results. Experiencing poor behaviour such as gaslighting and ostracising alongside being perceived as a troublemaker were the top 2 negative impacts

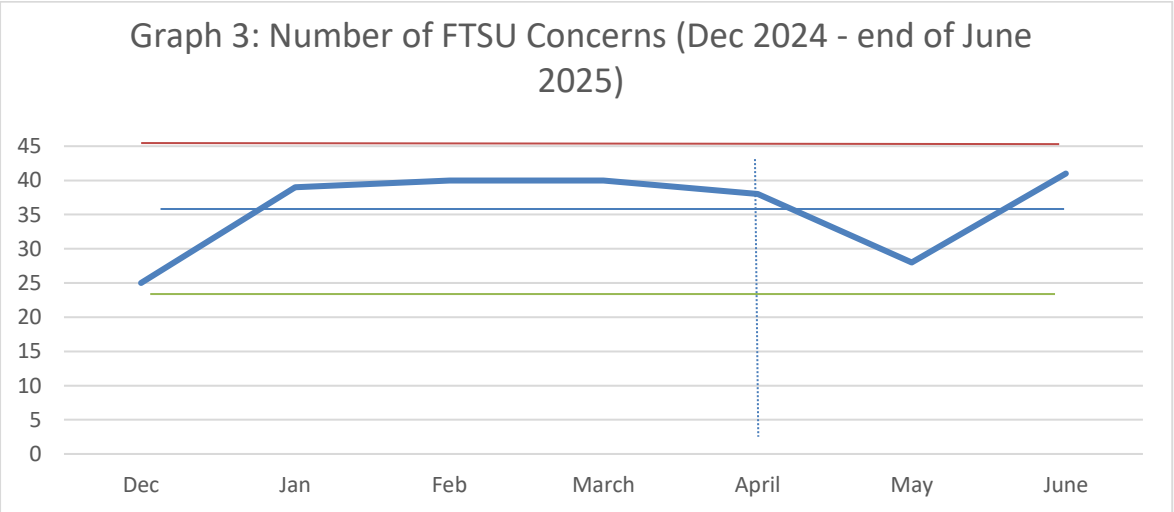
showing us where we need to focus our work if we want to reduce fear as being a barrier to speaking up at UHD.



6.0 Case Referrals – the Headlines

A range of data is collected by the FTSUG. This report will review the data including the key themes of concerns raised, where concerns have been raised and by whom. Referrals come from a number of routes including trust communications, website, signposting from other departments such as OH and HR, word of mouth, LERNs, the UHD app and personal recommendation.

Graph 3 highlights the number of referrals received monthly to the FTSU team over quarter 1 2025. One hundred and seven (107) cases were raised. This is a decrease in average referrals over the last 12 months but higher than the same period 2023/4.



2024/5

Qtr 1, 2025/6

6.1 Key Themes of speaking up concerns

Staff approach the FTSU team for a number of reasons. Graph 4 illustrates the greatest theme had an element of behaviours (54 staff; 50%). This is followed by process and procedures (28 staff; 26%) and then worker safety and wellbeing (13 staff; 12%). Speaking up via the FTSU team continues to be used predominantly for concerns relating to our working environment or relationships rather than patient safety issues (7 staff; 6%) and may be a product of our strong LERN culture in capturing our patient safety issues.

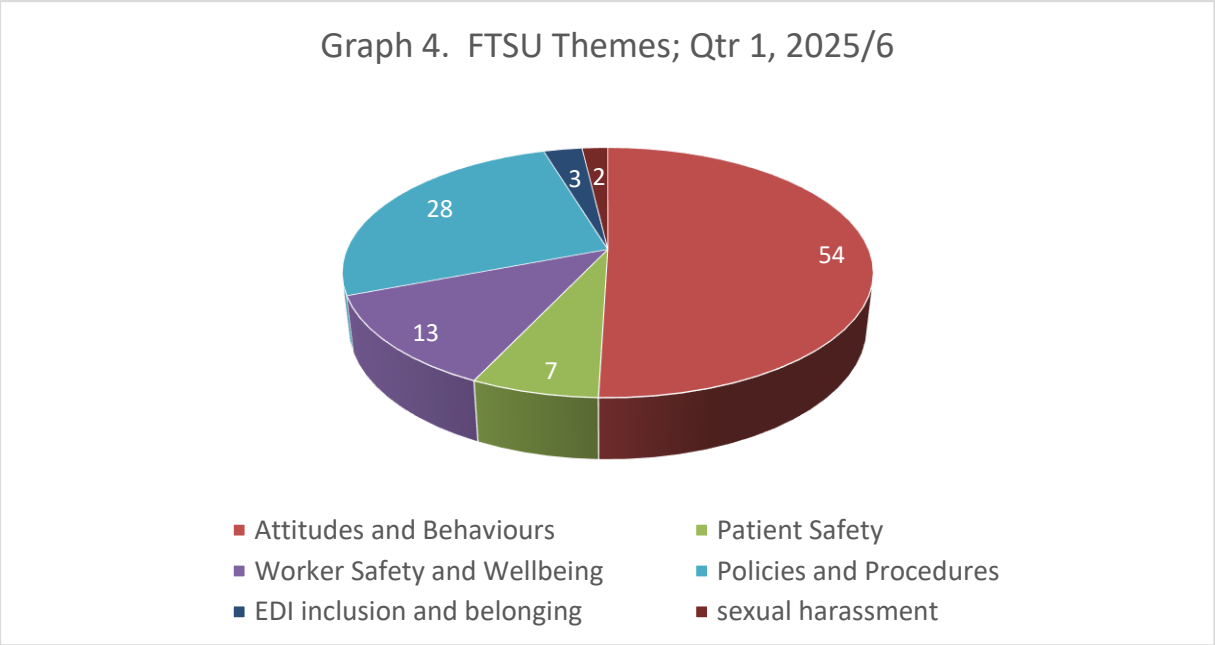
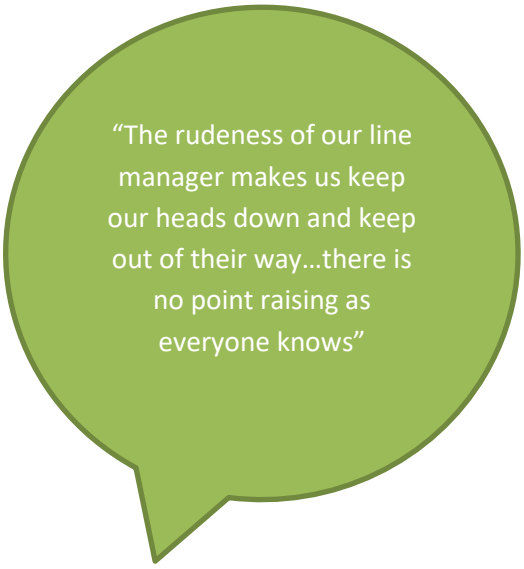


Table 4 shows how these themes differ to that seen in the same period since 2023. You will notice the themes have increased in areas of attitudes and patient safety whereas worker safety, policy and EDI inclusion have decreased.

Table 4: Quarter 1	**Qtr 1 2023**	**Qtr 1, 2024**	**Qtr 1 2025**	**Diff 2024 to 2025**
Bullying and Harassment	0	5	0	
Attitudes and Behaviours	29	37	54	↑ 46%
Patient Safety	0	5	7	↑ 40%
Worker Safety and Wellbeing	8	26	13	↓ 50%
Policies and Procedures	19	59	28	↓ 53%
Other	1	0	0	
EDI inclusion and belonging	0	5	3	↓ 40%
sexual harassment	0	0	2	
Total	**57**	**137**	**107**	

6.1.1 Behaviours and Attitudes (incivility)



Attitudes and behaviours are a recurring theme that the FTSU team hear. Behaviours such as disrespectful attitudes, lack of compassion, gossiping, micro-aggressions, micromanagement, aggressive communication styles, rudeness and unprofessional behaviour are frequently cited (see below).

	%
Cultural breakdown	5
Incivility	61
Intractable behaviours	5
Miscommunication	17
Toxic workspace	11

It is well documented that incivility and being rude directly impacts on the safety of our patients.

6.1.1.1 What are we doing?



The development of a behaviour charter has been key to this work and sets out clear standards that we expect from our staff, patients, and visitors. It also provides tools for us to challenge poor behaviours earlier. Our behaviour statement was approved by Board in May with the launch of the charter in August.

6.1.2 Process and policy – compassionate and inclusive leadership



It is well documented that at times of significant change such as merger, operational re-structuring, healthcare structural changes or building work will increase workloads for FTSU teams. Part of this is due to issues relating to process or procedure (NHSE, 2022).

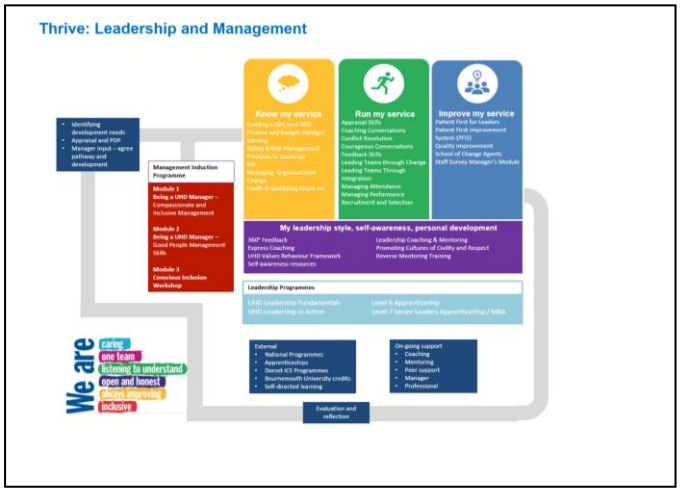
Twenty-six per cent of referrals at UHD had an element of process and procedure. These issues range from requests for agile working, support of staff going through organisational change, assurances that recruitment is both fair with equal access, support through probation and access to study leave.

Since October 2022, these issues have been broken down further into sub themes and are represented in Table 5. 82% of referrals with an element of policy and procedure, are relating to HR issues and how to navigate employment issues. All concerns are signposted to our experts such as HR and our union colleagues. Nationally, this is also seen, and it has been postulated whether a clarity of HR policies and processes may help to reduce the volume of HR issues being raised with Freedom to Speak Up team.

Other issues relating to process and procedure often arises from a conversation or miscommunication often with a line manager/supervisor. When asking staff as to why they are choosing to raise concerns to the FTSU team rather than their line manager, 50% stated that their line manager was the issue of the concern or knew about the issue but not addressing it. A further 9% said it was that they felt insecure in raising this issue.

Table 5	UHD TOTAL
Organisation Change	**1**
Guideline/pathway (clinical)	**0**
HR related issues (regrading, re-deployment, HR policy)	**23**
Recruitment and selection	**1**
Parking	**2**
Education/training	**0**
Non-clinical guideline/pathway	**1**
Health and Safety	**0**
Pension	**0**
TOTAL	**28**

6.1.2.1 What are we doing?



The gift of change lies predominantly with our line managers and clearly in most cases a resolution needs to happen with them. Our People and Culture Strategy see leadership and talent management as a key focus to improve the quality and consistency of leadership at all levels of the Trust, leading to an empowered, well-led workforce that delivers better outcomes and performance for our patients. The aim is that 50% of B6/B7 will attend leadership development training by Dec 2025.

6.1.3 Worker safety and wellbeing

This category was raised during the pandemic, and it remains a key theme for UHD. It relates to cases with a risk on worker safety or wellbeing and can include issues such as lone working arrangements, insufficient access to equipment and wellbeing at work.

At UHD, twelve per-cent of staff who accessed the FTSU team described this theme.



It is well documented that there are considerable system pressures across the healthcare sector alongside the cost-of-living crisis; both having an impact on worker wellbeing. Research tells us that until triggers are addressed such as staffing/working environment, the symptoms of feeling overwhelmed will not improve. This is particularly difficult in a financially challenged healthcare system.

Thrive wellbeing

6.1.3.1 What are we doing?



At UHD there is an aspiration over the next 12-18 Months to significantly increase staff awareness of health and wellbeing provisions/services available to them and improve staff access to all provisions through a single point of access. This will be by developing a brand, developing a Single Point of Access (SPA) for all H&W provisions in UHD, providing support to Managers and Teams in Distress, being pro-active long-term sickness-absence outreach support and supported return to work programme for those staff with stress and musculoskeletal injuries.

6.2 Outcome of referrals

Table 6 illustrates the outcome of referrals once they were made to the FTSU team. You will notice that 48% of referrals occurred for FTSU advice. This outcome has been increasing year on year and often involves staff wanting to use the team as an opportunity to talk through thoughts, reflections and options. Often staff are coached to decide what option meets their outcome best. In 17% of cases, referrals were escalated to the line manager to investigate and action. In 28% of cases, the member of staff was signposted to experts in the field of the concern such as HR, OH, or other including infection control, risk and governance or our networks. Seven percent were escalated to director/executive level which is the same as last year.

Table 6: Outcome of referrals received by FTSU team.

	Total UHD
Line manager	**18**
FTSU advice	**51**
Escalate to Chief/Director	**8**
Signpost	**30**
TOTAL	**107**

Following the Lucy Letby case there were a number of questions raised about how concerns were not listening to or that appropriate and timely action was not taken when concerns were raised. All 119 cases raised to the FTSU team in quarter 4; 2024/5 were all closed with no outstanding action.

6.3 Who are raising concerns?

Table 7: Staff who are raising concerns to the FTSU team.

	Total UHD	
	Qtr 1, 2024	**Qtr 1, 2025**
Additional Clinical services*	4	7
Additional Professional#	3	5
Admin and clerical	39	22
AHP	9	7
Estates and Ancillary	4	3
Healthcare scientists	1	4
Medical and Dental	9	7
Nursing/Midwife	47	40
Students	4	1
Other	1	0
Anon	16	11
TOTAL	**137**	**107**
BAME	23	21

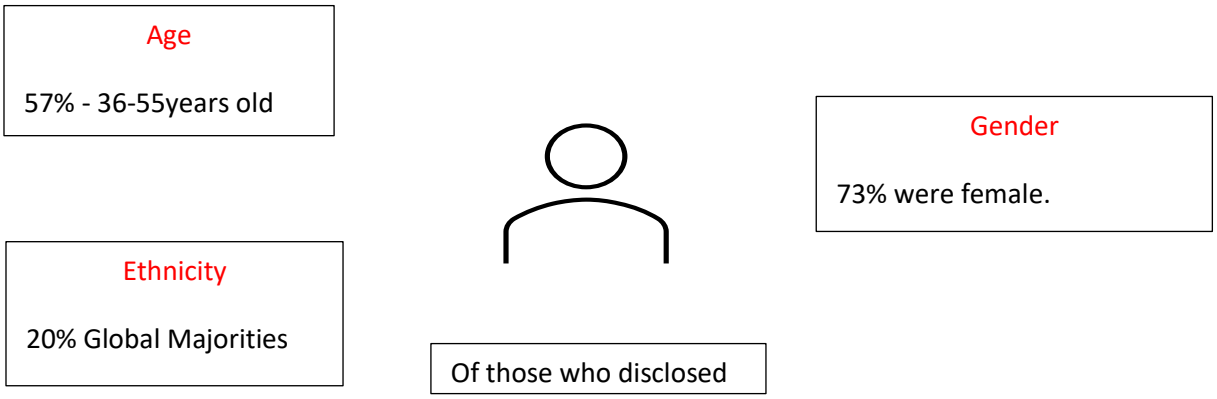
*Additional clinical services include staff directly supporting those in clinical roles such as Health Care Support Workers (HCSWs), AHP support workers. They have a significant patient contact as part of their role.
#Additional professional scientific and technical include scientific staff including pharmacists, psychologists, social workers

Table 7 shows that our nurses and midwives accounted for the biggest portion (37%) of speaking up cases raised with FTSU team and followed by our administrative staff (21%). This is similar to that in quarter 1, 2024.

Eleven staff felt that they needed to remain anonymous (10%; table 8). The number of staff who have used FTSU anonymously has increase since 2023/4 and is now higher to the latest national figures of 11.6% (NGO annual report, 2025). Staff can make anonymous referrals to the FTSU team through our UHD app. Anonymous referrals are those where the person speaking up is unwilling or feels unable to reveal their identity to anyone. Staff speaking up anonymously may be an indicator or fear and mistrust in the system and so is an important measure to monitor.

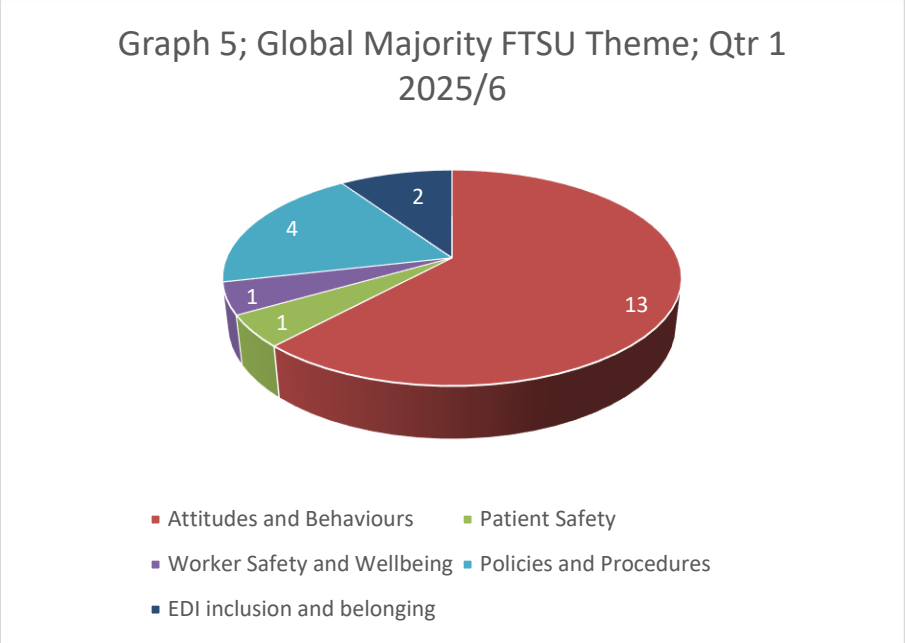
Table 8: Year	**Qtr 1**	**2024/5**	**2023/4**	**2022/3**	**2021/2**
Number of anonymous cases at UHD	11	71	37	14	12
Percent of cases at UHD which were anonymous	10%	13%	9%	5%	5%
Percent of anonymous cases raised nationally		11.6%	9.5%	9.4%	10.4%

6.4 Who are our people speaking up?



Collecting Demographic information, whilst notoriously challenging, is important by giving us a fuller picture that can lead to understanding, inclusion, and representation of those staff who are speaking up. Moreover, it also allows us to understand where our silences are. Megan Reitz (2023) reminds us that "*The silence of missing voices costs careers, relationships and lives*". The data represented above shows us that the voices that are using FTSU are those predominantly of ages 36-55 years old and female. Of those who disclosed, 24% had a disability and 20% described themselves from a global majority. Our most recent data using WRES mapping template, shows the percentage of overall workforce at UHD which is ethnic minority is now 23.87% (March 2024). This data suggests that our staff are well represented from ethnic minority groups at UHD.

The Francis Freedom to Speak Up review recognised back in 2015, that our minority staff, including global majority workers, feel vulnerable when speaking up, as they may feel excluded from larger groups of workers. Data set out in these reviews, also showed that minority staff groups are more likely to suffer detriment for having spoken up. Since then, the NGO has carried out a number of case reviews at different Trusts across the country which has repeatedly validated this observation and therefore encourages every Trust and FTUSG to ensure that work reaches this group of staff and that their voice is also being heard.



Data from graph 5 show the predominant theme from our global majorities staff is attitudes and behaviours (13 staff; 62%). Concerns with elements of process and procedure (4 staff; 19%) then followed by EDI inclusion (2 staff; 9%).



Staff may be signposted to our DEN networks who were also able to support and advise. The FTSU team attend these meetings and forums to support but also to understand and raise issues.

"The way my team treat me is very different. I feel my skills are not valued. In my home I used to be an expert in my field".

6.5 Where are concerns being raised?

Significant effort has been made to ensure that the FTSU team visit and meet all members of staff across each site and the Ambassador model allows for this. Table 9 outlines the concerns raised across our care group structure. The FTSUG monitors this closely so to ensure that all areas are aware of the FTSU service and how to access it.

Table 9: The number of concerns raised in UHD

			Question 25f on NSS (2024)
Care Group	**Directorate**	**Total**	
Medical (21)	Accident and Emergency/UTC	**5**	**53.4**
	Specialist Medicine	**6**	**51**
	Networked Medicine	**2**	**55.8**
	OPS and Acute Care	**8**	**56**
	Corporate	**0**	
Surgical (17)	Surgery	**2**	**43**
	Anaesthetics	**11**	**46.7**
	Head and Neck	**3**	**47.7**
	Trauma and Orthopaedics	**1**	**55.3**
	Private	**0**	
WCCSS (28)	Cancer Care	**3**	**56.4**
	Child Health	**1**	**64.6**
	Women's Health	**6**	**47.8**
	Radiology and Pharmacy	**6**	
	Clinical Support	**5**	**52.7**
	Pathology	**7**	**40.5**
Operations (5)	Clinical Site	**1**	
	Facilities	**3**	**42.6**
	Partnership, integration and discharge	**1**	
	Emergency Planning	**0**	
	Operational Performance	**0**	**69.6**
Corporate (25)	CMO	**0**	
	CNO	**8**	**39.8**
	Executive Board	**0**	**76.9**
	Finance, procurement and BI	**1**	**61.7**
	Informatics, IT and IG	**1**	**46**
	People	**14**	**49.5**
	Strategy, transformation and Estates	**1**	**48.5**
Anon (11)		**11**	
TOTAL		**107**	

Interesting questions can be posed, and future work can be planned when triangulating the data from table 9 looking at the numbers of staff using FTSU route and the speaking up question, 25f on the Staff Survey, which is highly regarded to reflect a speaking up culture. Of concern are those staff who are not using the FTSU route and have low confidence in raising concerns such as strategy, transformation and estates, informatics, and surgery. Further evaluation and future FTSU focus will be key in these areas for 2025.

7.0 Learning and reflections

Whilst each referral will have its own learning, themes can be drawn to help develop and embed into the culture at UHD. The FTSU is working hard to collect data and share this learning throughout the trust. Table 10 Illustrates this learning.

Table 10: Learning Themes from FTSU	Qtr 1			
	2024		2025	
	No.	%	No.	%
Compassionate and inclusive leadership and management	53	39	57	53
Develop a civil and respective culture	33	24	23	21
Wellbeing support	17	12	4	4
Team integration and merger	16	12	7	6
Hygiene factors	12	9	11	10
Psychological safety	5	4	5	5
Being visible	1	1	0	0
TOTAL	**137**		**107**	

- Our **Leadership and Management** skill accounts for 53% of cases (57 cases). This is an increase of 14% from the same period in 2024. Poor leadership can create workspaces with fear and futility. Indeed, 50% of staff who used FTSU stated that their line manager was the issue of the concern or knew about the issue but not addressing it. 9% staff said that they felt insecure in raising this issue with their line manager. This alongside a poorly executed conversation or skill to manage contractual issues, complex relationships are also often cited. Indeed, our data shows 82% of referrals with an element of policy and procedure, are relating to HR issues and how to navigate employment issues. Large management portfolios make a day in the life of a leader/manager very difficult. Being visible with teams is hard and staff tell us that they feel leaders are too busy to speak with them, consequently, issues are not resolved quickly and often escalate.

  At UHD we are aspiring to mature our speaking up culture by not only giving our staff a voice but also showing that that voice counts by acting and following through a positive action. It is about how our leaders act. Furthermore, more recently, researchers from University of Cardiff have also found that leaders with curiosity demonstrating a problem-sensing approach to Freedom to Speak Up and the Guardian role are able to achieve change beyond the surface level. They found that leaders need to be comfortable “with the idea of being challenged, not comfort-seeking all the time”. the study showed demonstrable benefits, including service improvement, but also improvements in the experience of minority communities and workers who may otherwise be seldom heard.

- **Behaviour** is about how someone acts. 23 staff said the learning of their case was about addressing poor behaviours such as disrespectful attitudes, lack of compassion, gossiping, micro-aggressions, micromanagement, aggressive communication styles, rudeness, and unprofessional behaviour. This is similar to that seen in same quarter in 2024 as a percentage. Data collected by FTSU team predominantly tells us that it is acts

of incivility and behaviours within a toxic workspace that heavily impacts on staff morale, wellbeing, stress, and performance at work. We are told our interventions at UHD are often inconsistent, slow, and unsatisfactory for the recipient but also to those doing the behaviour. This then ruins workplace relationships, damaging reputation and increases turnover and work absence. It feeds into the narrative of futility. The way an organisation handles issues like these says a lot about the culture.

In August we launched a Behaviour Charter; the types of behaviours which reflect our values, providing a framework to lead two-way conversations about how we do our jobs as well as what we do. By setting clear expectations, a behaviour charter helps stop misunderstandings and acts as a reference point for team members, helping everyone stay aligned and focused on our vision and goals (section 6.1.1). By doing this we can then build on creating psychologically safe workplaces and contribute to our breakthrough objectives of being a great place to work, attracting and retaining best talent.

- Four staff came to FTSU for **wellbeing support** (4%). This is a decrease on the same period last year and may reflect the health and wellbeing work being done through THRIVE. Fostering employee wellbeing is good for people and the organisation. It is a key leadership skill. To promote wellbeing can help prevent stress and create positive working environments where individuals and organisations can thrive and feel valued. Good health and wellbeing are a core enabler of employee engagement and organisational performance.

- **Merger/transformation/team integration** was cited as learning by 7 staff, again a reduction from 2024. We saw large transformation take place earlier this year with the integration of Critical Care, Maternity and Emergency. It is essential that the learning from our transformation teams are shared in anticipation of the next phased changes in Winter 2025/6.

- **Hygiene factors** are the elements of a job that satisfy basic needs and an issue for 11 staff (10%). We heard similar learning this time last year. When our basic needs are met, employees feel comfortable and satisfied with their roles. Factors such as parking, changing spaces, places to eat and work at are being cited as really important. We often hear that things should not be this difficult and more consultation with those who use/know the services would result in better decisions.

8.0 Looking forward.

Fostering a speak-up culture requires positive actions, at all levels of the organisation, to create psychologically safe working conditions for staff to raise questions and concerns and to have them answered in a responsive way.

More staff are telling us that our speaking up culture is improving, we need also not only to be confident that we give our staff a voice but that we show that this voice counts by acting and following up. Research tells us that by doing this, it will have a significant impact on staff engagement assisting retention, productivity, and the delivery of excellent care.

Appendix 1

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

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

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

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

The key principles the Board is committed to include:

	Principle	**Action**
1	Culture of safety	Every organisation involved in providing NHS healthcare, should actively foster a culture of safety and learning, in which all staff feel safe to raise concerns.
2	Culture of raising concerns	Raising concerns should be part of the normal routine business of any well led NHS organisation.
3	Culture free from bullying	Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.
4	Culture of visible leadership	All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.
5	Culture of valuing staff	Employers should show that they value staff who raise concerns and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.
6	Culture of reflective practice	There should be opportunities for all staff to engage in regular reflection of concerns in their work.
7	Raising and reporting concerns	All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.
8	Investigations	When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.
9	Mediation and dispute resolution	Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.
10	Training	Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.

11	Support	All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality.
12	Support to find alternative employment in the NHS	Where an NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.
13	Transparency	All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.
14	Accountability	Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns.
15	External Review	There should be an Independent National Officer (INO) resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report
16	Coordinated Regulatory Action	There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns
17	Recognition of organisations	CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.
18	Students and Trainees	All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.
19	Primary Care	All principles in this report should apply with necessary adaptations in primary care.
20	Legal protection	Should be enhanced to those who make protected disclosures.

Speaking up BOARD ANNUAL DECLARATION

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

Declaration

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

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

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

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

I have insight into how my power could silence truth

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

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

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

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

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

Supporting you to raise concerns

Freedom to speak up

Quarters 1 and 2 2025/26

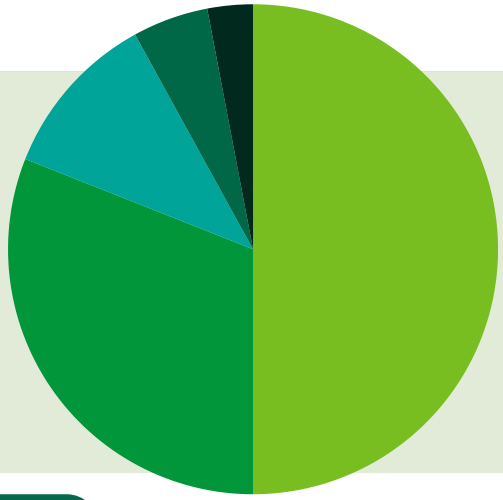
NHS
University Hospitals Dorset
NHS Foundation Trust

234 staff

came to speak to FTSU

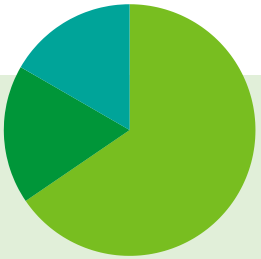
Themes

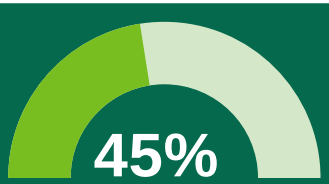
112 referrals for 'attitudes and behaviours'
73 referrals for 'policies and procedures'
25 referrals for 'worker safety and wellbeing''
11 referrals for 'patient safety'
6 referrals for 'equality, diversity and belonging



Behaviours

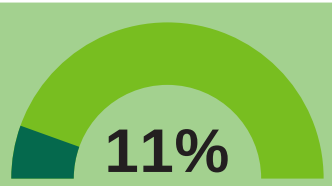
55% of concerns related to incivility
15% of concerns related to miscommunication
14% of concerns related to longstanding poor behaviours





45%

of staff came to FTSU because they felt their manager was the issue or was not addressing the issue



11%

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



20% of referrals came from global majority staff



31 anonymous referrals via the @UHDapp

What have we learnt?

The need for compassionate and inclusive leadership and better management skills (117 cases). The need to have respectful and civil workplaces (61 cases). The need to get the basics right (20 cases). The importance of health and wellbeing and looking after each other (15 cases). The difficulties of team integration and merger (13 cases).

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 7.2

Subject:	Freedom to speak up (FTSU) Strategy 2026-29
Prepared by:	Helen Martin, Freedom to Speak Up Guardian
Presented by:	Helen Martin

Strategic Objectives that this item supports/impacts:	Population & System ☐ Our People ☐ Patient Experience ☐ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	BAF/ not applicable
Purpose of paper:	Decision/Approval
Executive Summary:	This paper sets our an ambitious FTSU improvement strategy, with a clear and robust vision for speaking up in UHD for the next 3 years until 2029.
Background:	It is best practice to have a clear, robust and ambitious FTSU improvement strategy articulating our speaking up vision and goals. NHSE (2022) recommend that this should then be signed off by the senior team/board and full buy in from our leaders to ensure its successful delivery. The strategy was built on national and local drivers, based on a diagnosis of speaking up issues within UHD and known areas for improvement. A detailed workplan sits beneath this strategy which will have planned progress updates.
Key Recommendations:	Contribute to the FTSU strategy for 2026 to 2029 and take to PCC and Board for approval.
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 It is good practice to share our speaking up strategy to our senior leaders and managers to ensure its successful delivery. The strategy sets out why speaking up is important for our people and how it improves the quality of care we deliver to our patients.	☒ ☐
CQC Reference:	Safe Effective Caring Responsive Well Led Use of Resources	☒ ☐ ☐ ☒ ☒ ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
TMG	01/09/2025	Discussed
PCC	8.10.25	Approval
Staff Partnership Forum	8.10.25	Information and discussion

Reason for submission to the Board in Private Only (where relevant)	Commercial confidentiality Patient confidentiality Staff confidentiality Other exceptional reason	☐ ☐ ☐ ☐

University Hospitals Dorset
NHS Foundation Trust

Freedom to Speak Up (FTSU)

Strategy 2026 – 2029

If this document is printed – please check in the Policies, Procedures and Guidelines section of the intranet to ensure this is the most up to date version

A) SUMMARY POINTS
This strategy sets out the Trust's Freedom to Speak Up vision and strategy over the next 3 years.
This strategy aims to improve the experience of speaking up at University Hospitals Dorset (UHD)
It outlines how to measure the success of the strategy
B) ASSOCIATED DOCUMENTS
Policy: Freedom to Speak Up policy for the NHS

B) DOCUMENT DETAILS	
Author:	Helen Martin
Job title:	Freedom to Speak Up Guardian (FTSUG)
Directorate:	People Directorate
Version no:	1
Target audience:	All Trust employees including any healthcare professional, non-clinical worker, contractors, agency workers, temporary workers, students, volunteers and former workers.
Approving committee / group:	Trust Board of Directors
Chairperson:	Chair of Board
Review Date:	September 2028

C) CONSULTATION PROCESS			
Version No.	**Review Date**	**Author**	**Level of Consultation**
1	Sept 2028	Helen Martin	Trust Management Board (16th Sept 2025), staff Side, People and Culture Committee (8th October 2025), Board of Directors (5th Nov 2025)
2			

D) VERSION CONTROL						
Date of Issue	**Ver No.**	**Date of Review**	**Nature of Change**	**Approval Date**	**Approval Committee**	**Author**

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5	5.0 The Local Perspective 5.1 Our Culture at UHD – the creation of our values 5.2 Our Improvement Programme – Patient First 5.3 Our People and Culture Strategy 5.4 Our FTSU team and FTSU Model at UHD 5.5 Aim and Commitment of Speaking Up at UHD	**7** **7** **8** **9** **9**
6	6.0 Speaking Up Strategy at UHD 6.1 Strategic Theme; Our People 6.2 Strategic Theme; The FTSU team 6.3 Strategic Theme; Leadership 6.4 Strategic Theme; The Healthcare	**10** **12** **13** **14**
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1.0 Introduction and Purpose

The benefits to developing a speak up culture is well documented. It promotes innovation and productivity, improves employee engagement and retention but above all stops potential harm. At University Hospitals Dorset (UHD), we have many channels that our staff can speak up including our line managers, occupational health, staff governors, using our LERN forms, chaplains, education team and our HR team. Freedom to Speak Up (FTSU) is another alternative route which is both well used and evaluated by staff who use it.



The role of the FTSU team is to highlight the challenges and act as an early warning system of where failings might occur. They are also an ally and a critical friend that works in partnership across an organisation to encourage action to improve culture.

At UHD, we are aspiring to maturing our speaking up culture. A culture where not only are we confident that we give our staff a voice, but that we show this voice counts by acting and following up through a positive interaction. It is acknowledged that interactions are more than a process where someone speaks up and someone listens and acts. Indeed, it is often fraught with difficulties presented by power imbalances, difference, and mindset. Interactions therefore need to bring people together, whereby we recognise the important role we all play, encouraging mutual support and, above all, empowering everyone to take action themselves. Research tells us that by doing this, it will have a further impact on staff engagement assisting retention, productivity, and the delivery of excellent care.

The purpose of this document is to set out the Freedom to Speak Up vision and strategy over the next 3 years for UHD. This document should be read alongside the Trust's Freedom to Speak Up policy for the NHS.

2.0 Definitions

The following definitions apply to this strategy:

Freedom to speak up	A process encouraging staff to raise concerns and speak up to protect patients and improve the experience of NHS workers.
Freedom to Speak up Guardian (FTSUG)	A named person who acts as an independent and impartial source of advice to staff at any stage of

	raising a concern, with access to anyone in the organisation, including the chief executive, or if necessary, outside the organisation
Freedom to speak up Ambassador	A member of the FTSU team who raises awareness of speaking up and refers cases to the FTSUG if needed.
Vision	An aspirational description of what an organization would like to achieve or accomplish in the mid-term or long-term future.
Objective	A plan that underlies all strategic activities
Strategy	a Board level approved document which identifies the aims and objectives for the Trust in a given subject area

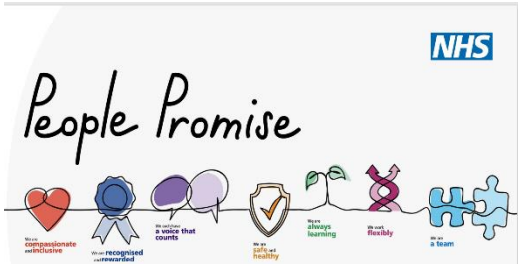
3.0 Roles and Responsibilities

Chief Executive and Chair	Accountable for ensuring that FTSU arrangements meet the needs of the workers in the trust.
Executive lead for FTSU	Lead executive responsible for ensuring latest guidance is applied and ensuring the FTSUG role is implemented and supported.
Non-executive lead for FTSU	Lead non-executive supports the FTSU Team on local and national issues, helping unlock any barriers. Oversees speaking up matters regarding board members.
FTSUG	• empower staff to raise concerns within organisations, • provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concerns have been handled, • ensure that organisational policies and processes in relation to the raised concern are in place and followed correctly, • ensure shared learning amongst local/regional/national Networks,

	• produce reports to monitor the outcomes and impact of FTSU.
FTSU Ambassadors (FTSUA)	Contribute to creating a culture of speaking up where staff feel safe and confident to raise concerns. The FTSUA will work alongside the FTSUG promoting, raising awareness and signposting (including to FTSUG) for support.
National Guardian Office (NGO)	Until July 2025, led, trained and supported a network of FTSUG in England, providing support and challenge to the healthcare system on speaking up

4.0 The National Perspective

4.1 The People Promise



The People Promise sets out, in the words of NHS staff, the things that would most improve their working experience. It is made up of seven elements. One element is we each have "**a voice that counts**". This is where staff feel safe and confident to speak up, knowing that when they do they will be listened to and supported.

At UHD, we are committed to the People Promise so that we can together create a culture that is positive, compassionate, and inclusive. By doing this and improving our working environment for staff, it will in turn lead to better patient care.

4.2 NHS England: A guide for Leaders

In June 2022, NHS England and NGO published Freedom to Speak Up guidance through the development of a reflection and planning tool. This document was designed to help organisations deliver the People Promise by developing a speaking up culture in which leaders value the voice of their staff as a vital driver of learning and improvement. There are 8 principles in this document which help us identify our strengths, our challenges and areas for development at UHD. Our board completed this in January 2024 and then re-assessed in May 2025. The output of this document feeds into our objectives and workplan at UHD.

4.3 The Disbanding of National Guardian Office (2025)

For over 9 years the National Guardian Office (NGO) has supported the healthcare system to improve workplace cultures, ensuring workers are confident to speak up. They did this by leading, training and supporting a network of FTSUGs.

In July 2025, both the NHS 10-year health strategy and the independent review of patient safety, also known as the DASH report, reviewed the effectiveness of NGO amongst other commissioning support units (CSU). It concluded that significant resources have been invested in safety but with limited measurable improvement. More specifically they felt that there was an overload and often unfragmented number of recommendations from multiple bodies, leading to confusing systems and duplication. In terms of the NGO being hosted within the CQC, they felt that it made NGO distant to the people it needs to support and influence. Consequently, they recommended the disbanding of the NGO as a standalone entity.

Moving forward, the responsibility of FTSU Guardians are to be incorporated within commissioners and provider organisations, so that profiles and staff voices are heard more clearly and responded more rapidly on a more local level. The functions of FTSUGs will remain a core function of CQC as the independent regulator of health and care and it has also been confirmed that the role of the FTSUG will remain incorporated into the NHS standard contract for 2026/7. NHSE will assume responsibility for NGO and this work onwards.

5.0 The Local Perspective

5.1 Our culture at UHD – the creation of our values



Speaking up at UHD is the cornerstone of our culture.

This not only emulates the work outlined within the People Promise; “a voice that counts” (section 4.1) but is also reflected in our set of values co-created by our cultural champions back in 2020.

Our people clearly described the need for a learning rather than blame culture, whereby we can make mistakes without feeling afraid to discuss them. Psychological safety and feeling confident to speak up were seen as contributing to safer, excellent quality care.

As a result, UHD are proud to have “I will be open and honest” as one of our values.

5.2 Our Improvement Programme – Patient First

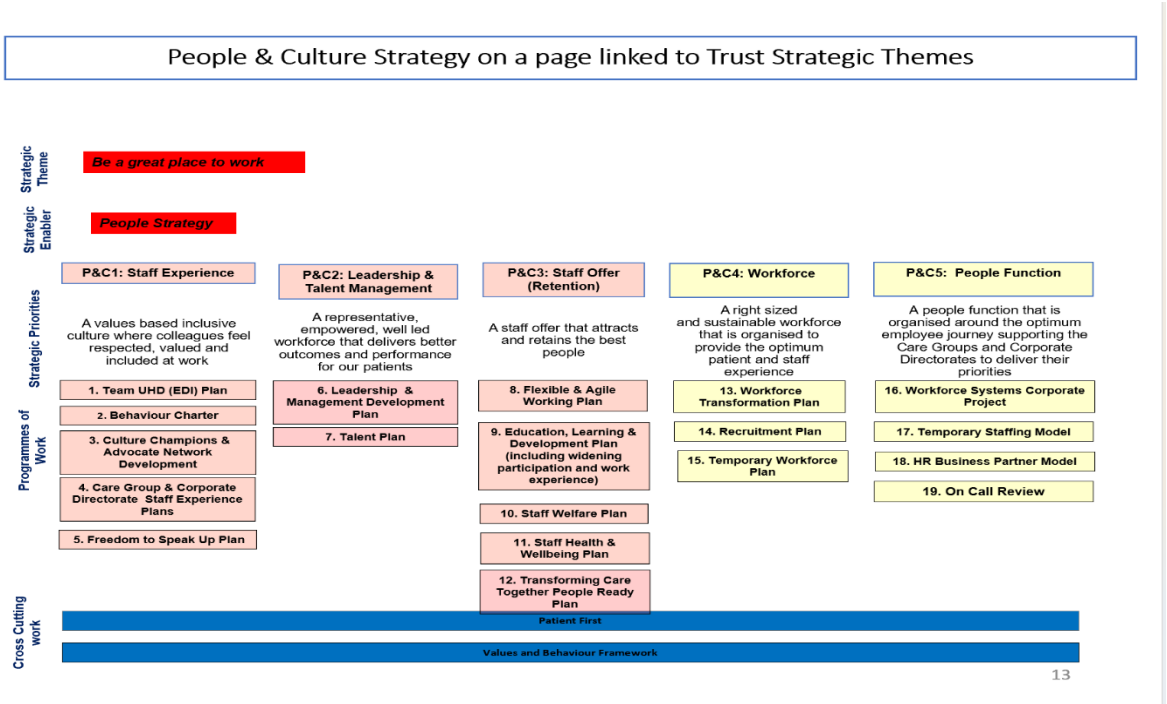
In 2023, UHD commenced a Patient first programme; a recognised and proven system for delivering significant long-term change within the NHS. Patient First will help us all by improving the way we work by giving us the tools, techniques and standard approach to identifying and tracking improvement needed. It will give each of us the time, freedom and skills to make positive and long-lasting changes that will benefit ourselves, our colleagues and our patients.

There are 5 strategic areas that UHD are focusing on, which each have an objective(s). Patient first is a long-term approach to building improvement into everything we do. When staff thrive, our patients thrive. Speaking up is integral to this work and we look forward to supporting this moving forward.



5.3 Our People and Culture Strategy

The People and Culture Strategy was developed in 2024 as an enabler of our strategic theme "Our People". Nineteen key pillars were identified including one workstream devoted to our speaking up work. Our FTSU strategy outlines this work in more detail. It is governed by the People and Culture Committee where its workplan and drivers are monitored so that our strategic goals and improvements of National Staff Survey are met.



5.4 Our FTSU team and FTSU Model at UHD

At UHD we have 2 FTSU Guardians alongside a network of 11 FTSU Ambassadors. Our team help us raise awareness and promote the value of speaking up, listening up and following up thereby addressing challenges posed by organisation size, geography and the nature of their work as well as support workers, especially those who may face barriers to speaking up. All members of the FTSU team have been key to our success.



5.4.1 Aim and Commitment of Speaking Up

We want our workers at UHD to feel valued and respected at work and to know that their views are welcomed. By meeting the needs of our staff, we recognise that this will enable us to deliver excellent care. Consequently, we are committed to providing the best working environment where speaking up is not only welcomed but valued as an opportunity to learn and improve.

> To develop a culture of safety so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

There are many ways that our people can speak up at UHD. This includes your line manager, human resources, using our LERN forms, staff governors, occupational health and our staff networks. You can also speak up with our FTSU team and if you choose this route, they will provide the following commitment to each conversation.

The Freedom To Speak Up commitment

S You're safe and secure to talk to us; we'll support you every step of the way to raise concerns.

P We are all about our people. When we look after each other we give the best to our patients. FTSU are here for you and hearing your voice is our priority.

E We treat all staff equally, empower you to make concerns and enable the trust to make change.

A We will listen and act with integrity to ensure your concerns are heard. We are approachable and here for you.

K We treat you kindly; we know what steps need to be taken when you raise a FTSU concern, we have the knowledge to help make a difference.

Supporting you to raise concerns
Freedom to speak up

6.0 Speaking Up Strategy at UHD

Our strategy for the next 3 years builds on that from our previous 3 years. This strategy sets our vision for the second half of the 2020s, outlying our ambition and aims based on a diagnosis of issues facing the trust today. A detailed work plan to measure its delivery within the terms of objectives and all were met.

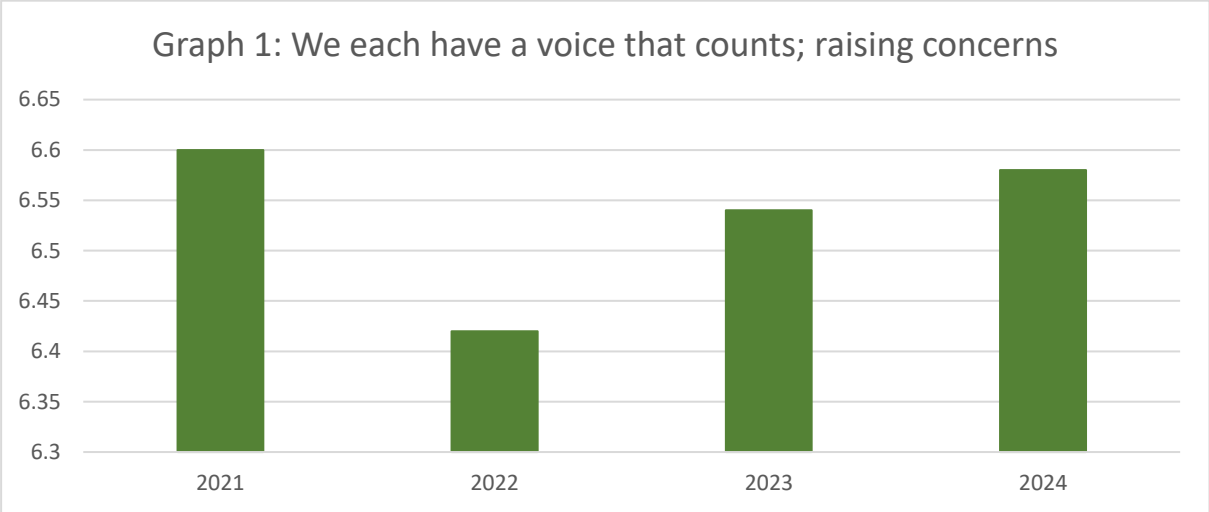
This strategy aligns itself nationally and locally, focusing on our staff, our FTSU team, our leaders, and collaborating with our wider healthcare.

Mission	To develop a culture of safety so that we become a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.
Strategic Theme	
Enabling programmes	People and Culture Strategy FTSU Strategy
Driver& Watch Metrics	1. Delivery of 5 strategic goals from NHSE reflection and planning tool 2. Improvement of NHSSS "speaking up" question from Baseline of 50.6% to 53% in 20205 and 56% in 2026 3. Reduction of FTSU referrals from baseline of 600 2024/25

6.1 Strategic Theme: Our People

It is recognised nationally that more needs to be done to foster a speak up, listen up, follow up culture, where workers are listened to and appropriate action taken as a result. Fear of speaking up and futility, that nothing will change, are still being reported as being the main barriers preventing people to speak up.

At UHD, we are seeing year-on-year improvements with staff telling us that they are feeling more secure, more confident, and safer to speak up (National Staff Survey, 2025. See Graph 1). Indeed, question 25f, which is highly regarded to reflect a speaking up culture, shows that 51.8% of staff who completed the staff survey felt UHD nurtured a speaking up culture as compared to 46.3% in 2022. This is a 5.5% increase.



Whilst this data is encouraging, not all staff feel this way. Our FTSU data shows that we are used as a channel because there is a:



- fear when speaking up (15% staff told us that they come to FTSU as they feel unsafe to speak up; 2024/5)
- speaking up is futile (48.2% staff in staff survey tell us that they are not confident that the organisation would address concerns, 2024)
- a lack of confidence that their manager will address the issue or feel they are in fact the issue (38% of staff came to FTSU telling us this; 2024/5).

Clearly, there is work still to do.

Creating a speaking up culture is more than implementing a speaking up policy or having a FTSU team. It requires positive actions, at all levels of the organisation, to create psychologically safe working conditions for staff to raise questions and concerns and to have them answered in a responsive way.

Consequently, we have a vision that **Speaking up at UHD is everyone's business.**

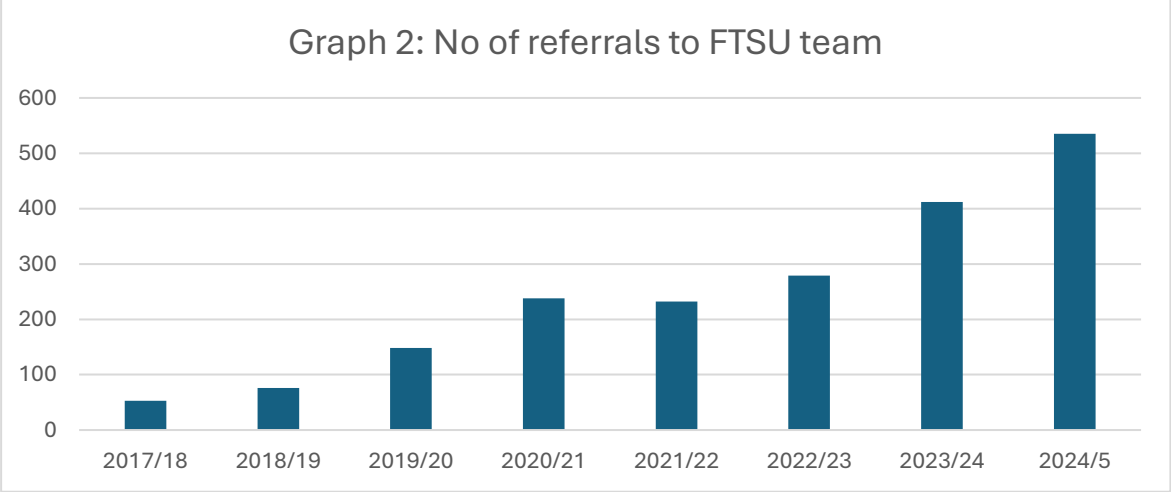
To address this, we will

- Champion speaking up, encouraging that speaking up is everyone's business. #FTSUforEveryone
- The FTSU team will support staff by reflecting the voice of staff in speaking up reviews, board reports and senior development.
- The FTSU team will support the themes and proactively address the barriers to speaking up
- The FTSU team will support and contribute to the wider cultural and transformation programme "patient first" to ensure speaking up is embedded in its programme going forward.
- Speaking up drives action and change – by sharing staff stories, you said we did, celebrations and learning messages helps create a culture where speaking up is not viewed as futile.
- Speaking up contributes to our wider cultural programme, where our FTSU data is embedded in our cultural dashboards and shared across the Care Groups and organisation so that we are all part of this journey to making UHD a great place to work.
- Lead the delivery of Behaviour Charter, a key workstream of the People and culture Strategy.
- Be a key ally and friend to our Staff networks working together to make UHD a great place to work.
- Ensure that all staff have access to Speak up, Listen Up and Follow up e-learning tool to share the importance of speaking up in our roles.



6.2 Strategic Theme: The FTSU team

The FTSU team perform a vital function in the workplace, as evidenced by the year-on-year increase of referrals at UHD (Graph 2).



Speaking up is about more than listening to concerns as it will not become business as usual if FTSUG are spending all their time acting as an additional channel. Instead the team will

work together with our organisation to overcome the barriers that result in workers feeling that they must come to a guardian in the first place.

At UHD we have 2 FTSU Guardians alongside a network of 11 FTSU Ambassadors. Our team help us raise awareness and promote the value of speaking up, listening up and following up thereby addressing challenges posed by organisation size, geography and the nature of their work as well as support workers, especially those who may face barriers to speaking up. All members of the FTSU team have been key to our success.

It is therefore essential that this strategy provides assurance that the FTSU team are supported, developed so that they meet the needs of our people. This will be done by;

- Regularly reviewing and updating the training, guidance and support to the FTSU team, nationally but also locally from the board.
- Attend and participate in FTSUG training including induction, annual refreshers, conferences, regional networks and webinars.
- Lead monthly check ins with FTSU team providing local data but also support.
- Support the FTSU model to reflect both reactive and proactive functions of the role.
- Deliver annual training programme for FTSU team
- Review and refresh FTSU model by 2029 to be assured meeting best practice in the changing healthcare climate.

6.3 Strategic Theme; Leadership



Our leaders play a significant role in setting the tone for fostering a healthy speak up, listen up and follow up culture. Whilst the insights from our FTSU team can act as an early warning system of where failings might occur and help understand the behaviours and culture that workers experience in practice, it is our leaders who are integral to how we learn, develop and improve.

At UHD, we are committed to developing of leaders. However, currently thirty-eight per cent of those staff who come and speak with our FTSU team tell us that it is because either their line manager was the issue of the concern or that the line manager was aware of the issue but not addressing the issue (FTSU data; 2024/5). Furthermore, 15% staff report that the reason is because they feel insecure in raising concerns with line managers. A culture of speaking up needs a strong foundation of psychological safety created by our leaders for it to truly be embedded.

At UHD we aspire to all leaders playing a vital role for setting the right cultural tone for speaking up and for handling speaking up matters effectively. Our leaders influence how teams and our peopel behave and so it is essential that they have to role model the speaking up principles. We also aspire our leaders to also be curious and take a problem-sensing approach to Freedom to Speak Up and the Guardian role. By being comfortable “with the

idea of being challenged, not comfort-seeking all the time", allows an issue to be seen before it becomes a crisis.

Are we an organisation that wants to comfort seek or problem sense?

This strategy will therefore support our leaders and encourage speak up, listen up and follow up to be a natural leadership behaviour by:

- Supporting the delivery of universal guidance and supportive tools for leaders to enable them to improve speaking up culture within UHD and across the system
- Provide learning to support leaders to recognise and utilise the potential for speaking up to accelerate improvement
- Provide training for our staff, including leaders, to promote a speak up, listen up, follow up culture
- Promoting the use of data and intelligence to inform good practice, describing trends and challenges, and encouraging improvement
- Speaking up contributes to our wider cultural programme, where our FTSU data is embedded in our cultural dashboards and shared across the Care Groups and organisation so that we are all part of this journey to making UHD a great place to work.
- Complete internal speaking up audit and implement actions.
- Annual review of roles and responsibilities of speaking up.
- Submit and present six-monthly board reports
- Engage with CQC engagement team
- Skill all our leaders to listen up and follow up through our management and leadership programmes and completion of HEE/NGO training modules
- Skill our leaders to create psychological safe working environments for our people to speak up.



6.4 Strategic Theme: The Healthcare

Good practice fails to flourish when it is not supported by each-other. Systemic drivers need to promote effective co-ordinated and consistent speak up, listen up, follow up cultures. At UHD the FTSUG is the chair for our Dorset Network and recently stepped down as co-chair for the southwest FTSUG. Taking the lead in these roles allows UHD to shape our healthcare system and share/learn from best practice. Other roles taken include national mentoring of new FTSUGs and providing guidance to national policy.

We will;

- Promote universal principles for speaking up and their application across the system
- Produce information on good practice and guidance
- Seek to establish a consistent set of metrics that allows speaking up culture to be understood at the organisational, system, and national level
- Bring national bodies together to develop a consistent and supportive response when workers speak up

7.0 Measuring Success

There are a number of ways to measure the success of the speaking up strategy. These include:

- increase effective awareness training for all staff so they are clear about what concerns they can raise and how to raise them.
- provide regular communications to all staff (including those permanently employed on a full-time/part-time basis, temporary/ contracted workers and volunteers) to raise the profile and understanding of our speaking up arrangements.
- communicate key findings to staff about the level and type of concerns raised and any resultant actions taken, as is appropriate under the scope of confidentiality.
- share good practice and learning from concerns raised, with the key aim of fostering openness and transparency, such as staff briefings, team meetings and the intranet.
- actively seek the opinion of staff to assess that they are aware of and, are confident in using local processes and use this feedback to ensure our arrangements are improved based on staff experiences and learning.
- use local intelligence to understand and support staff and provide additional information on how culture can continue to be improved
- obtain feedback from staff who use the service for critical feedback and improvement.

8.0 Summary

Speaking up enhances our working lives and improves the quality and safety of care. Indeed, speaking up benefits everyone as it acts as a valuable early warning system. This strategy provides a clear and sustainable direction for UHD, meeting the local and national requirements. Speaking up has never been as important as it is today especially if we are to meet the challenges felt across healthcare. Speaking up needs to be everyone's business.



APPENDIX 1: Equality Impact Assessment

1. Title of document	**Freedom to Speak Up (FTSU); Strategy 2026 - 2029**		
2. Date of EIA	2.9.25		
4. Directorate/Specialty	People Directorate, Organisational Development		
5. Does the document/service affect one group less or more favorably than another on the basis of:			
		Yes/No	**Rationale**
• Age – where this is referred to, it refers to a person belonging to a particular age or range of ages.		No	The strategy applies to all staff working for the trust
• Disability – a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal daily activities.		No	The strategy can be in braille or larger print if needed
• Gender reassignment – the process of transitioning from one gender to another.		No	The strategy applies to all staff working for the trust
• Marriage and civil partnership – marriage can include a union between a man and a woman and a marriage between a same-sex couple.		No	The strategy applies to all staff working for the trust
• Pregnancy and maternity – pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavorably because she is breastfeeding.		No	The strategy applies to all staff working for the trust
• Race – refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.		No	The strategy applies to all staff working for the trust. The strategy can be made available in an alternative language
• Religion and belief – religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (such as Atheism). Generally, a belief should affect your life choices or the		No	The strategy applies to all staff working for the trust.

way you live for it to be included in the definition.		
• Sex – a man or a woman.	No	The strategy applies to all staff working for the trust
• Sexual orientation – whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.	No	The strategy applies to all staff working for the trust
7. If you have identified potential discrimination, are the exceptions valid, legal and/or justified?	N/A	
8. If the answers to any of the above questions is 'yes' then:		**Rationale**
Demonstrate that such a disadvantage or advantage can be justified or is valid.	N/A	
Adjust the policy to remove disadvantages identified or better promote equality.	N/A	

University Hospitals Dorset
NHS Foundation Trust

hello

my name is…



Deepa Pappu

Equality Diversity Inclusion Lead

Professional Nurse Advocate

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

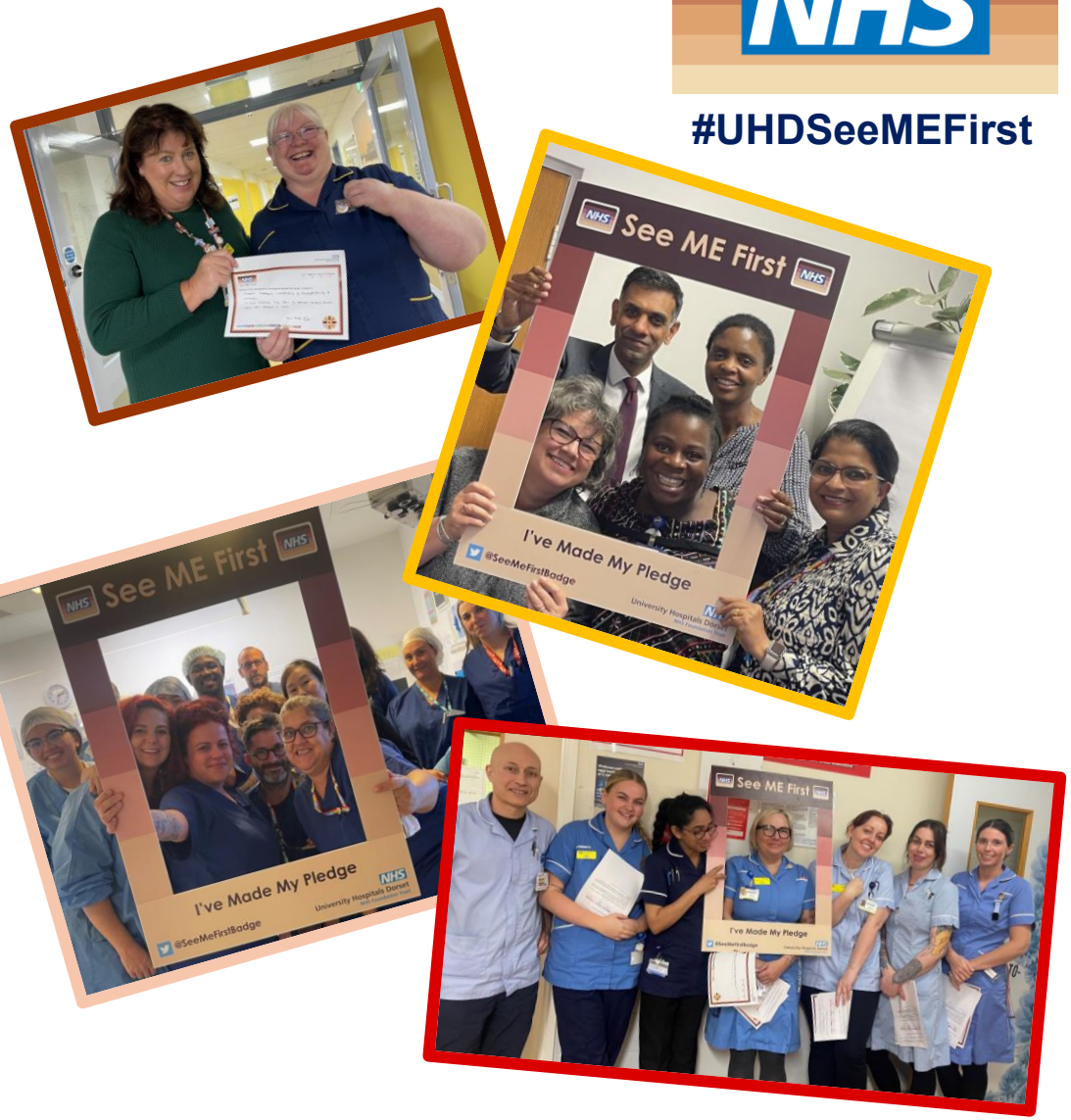
People should "not be judged by the colour of their skin but by the content of their character"

Martin Luther King Jnr

- August 1963

See ME First

#UHDSeeMEFirst



What is it?

See ME First is a staff-led initiative to promote equality, diversity, and inclusivity. It requires colleagues to challenge and work together towards ending racism and discrimination in the workplace.

The initiative aims to change our organisation's culture, creating a more inclusive, open, and non-judgmental work environment in which all staff are treated with dignity and respect.

Will you pledge to support any colleagues who experience discrimination?

The See ME First initiative was first launched in October 2020 by Whittington Health NHS Trust.

Racism makes me feel…

Shared by UHD Colleagues:



What is See ME First?

- Staff-led initiative to promote equality, diversity and inclusivity with specific support to our Global majority staff.
- It requires colleagues to challenge and work together towards ending racism and discrimination in the workplace.

- The aim of the initiative is to make real change to our organisation's culture, creating a more inclusive, open, and non-judgemental work environment in which all staff are treated with dignity and respect.

- Staff will pledge to support any staff that experience racism or discrimination, by encouraging them to Speak Up.

- Once they have pledged, they will receive a See Me First badge to signify they have made this commitment and ensure their support is visible to colleagues and patients.

The See ME First initiative was first launched in October 2020 by Whittington Health NHS Trust.

The UHD See ME First campaign has been developed in conjunction with the UHD DEN -Staff Network.

What can YOU do?

- **LISTEN**



Listen non-judgementally, be an open ear for any colleagues experiencing racism or discrimination and who may need advice or information for support.

- **SPEAK UP**



Speak up and encourage others to also do so using the UHD channels.

- **SUPPORT**



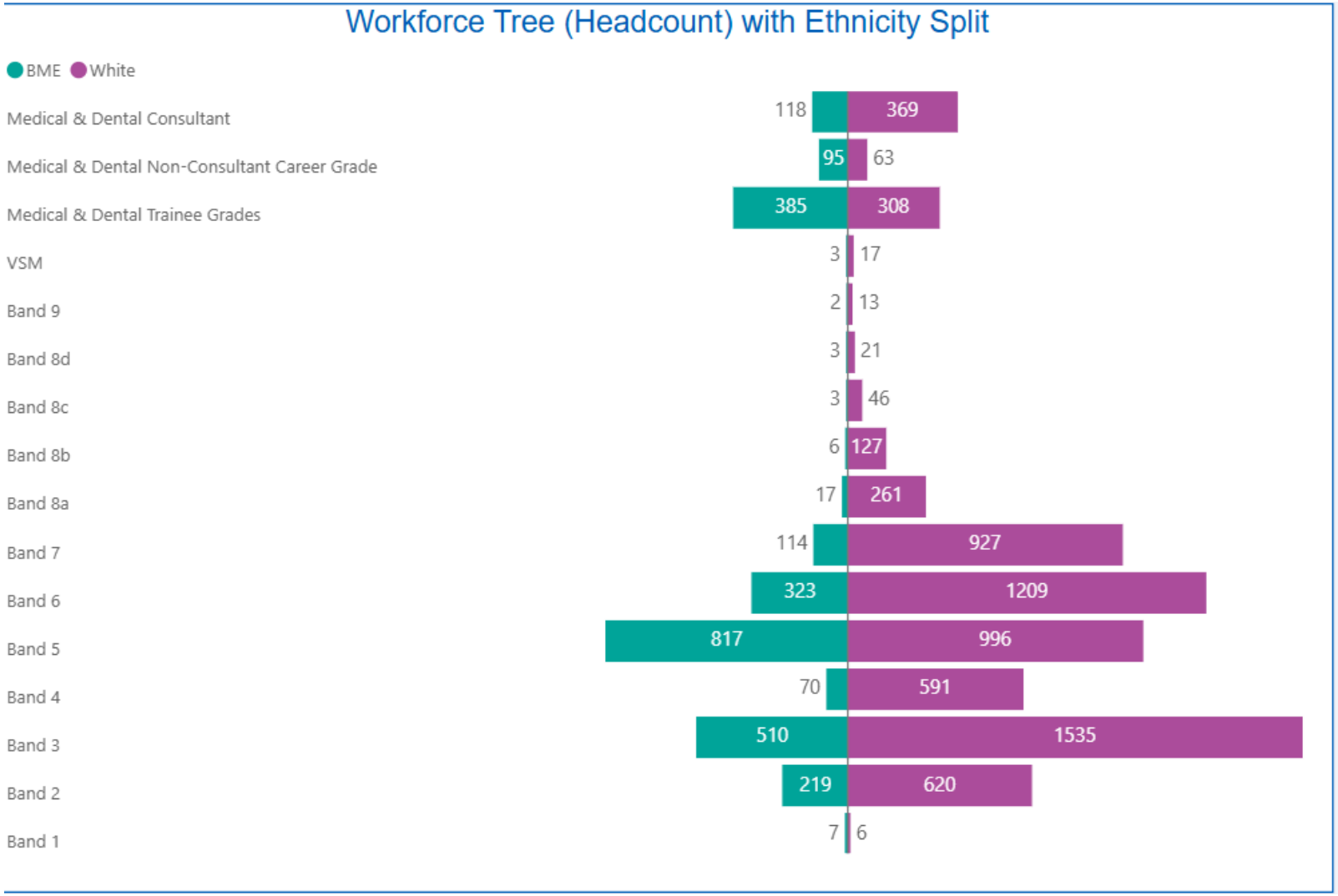
Support colleagues by learning from each other's cultures and being aware of where to signpost.

- **CHALLENGE**

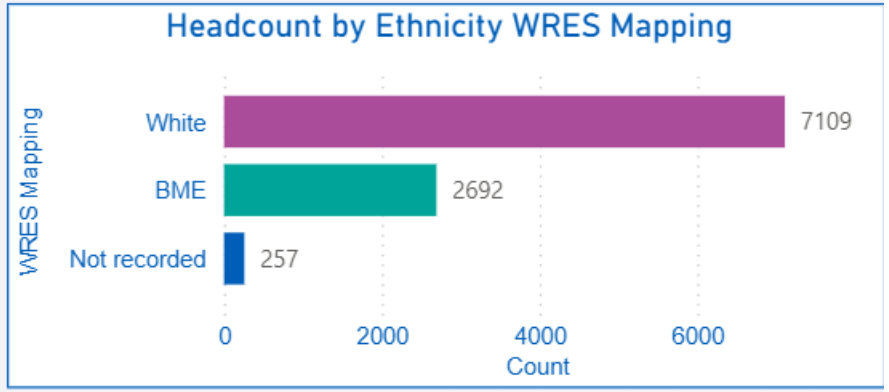


Challenge where you observe inappropriate behaviour linked to racism and discrimination, if safe to do so. Foster a culture where all experiences, skills and ideas are valued.

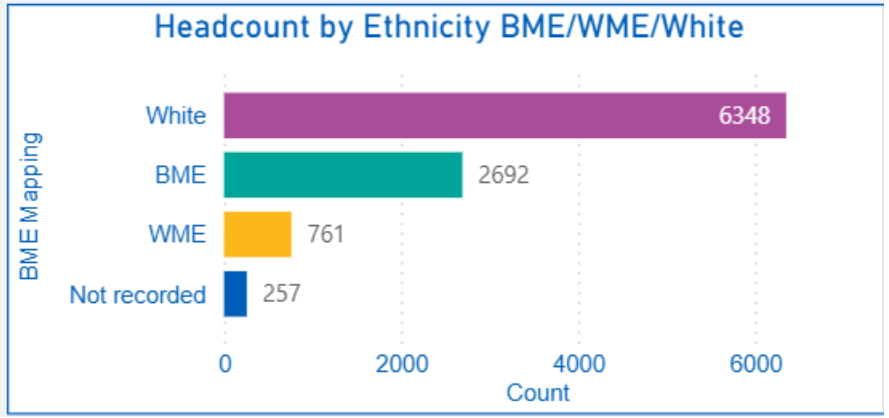
Workforce Profile UHD [on 30th Sept 2025]



This chart is using the ethnicity mapping in line with national WRES guidance



This chart is using BME ethnicity mapping which differs to WRES. For example, White Other European is grouped as BME in this chart, but under White in the WRES chart



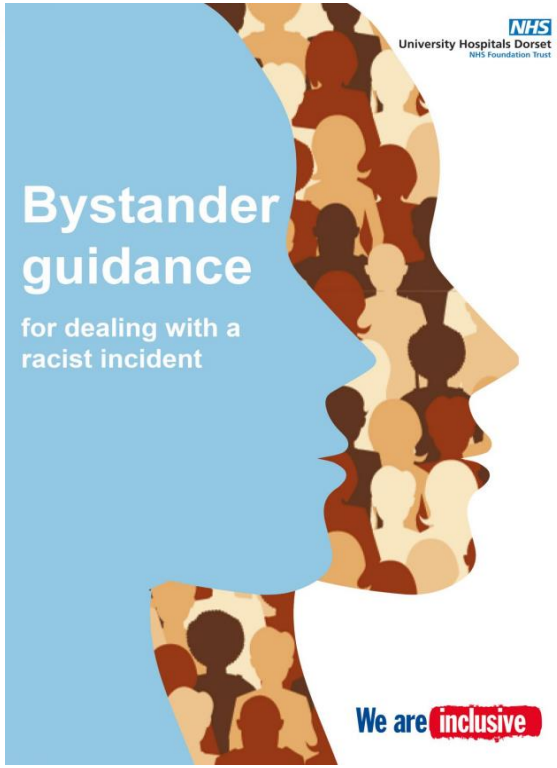
We are caring one team listening to understand open and honest always improving inclusive

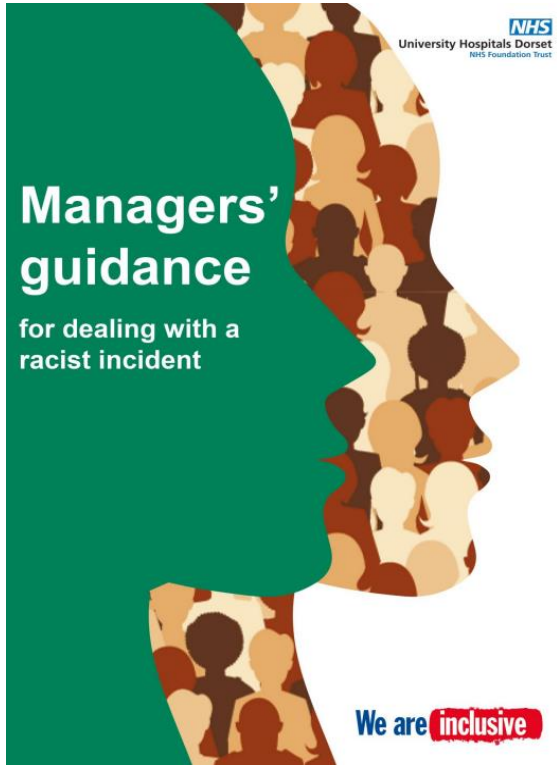
UHD Workforce Race Equality Standard

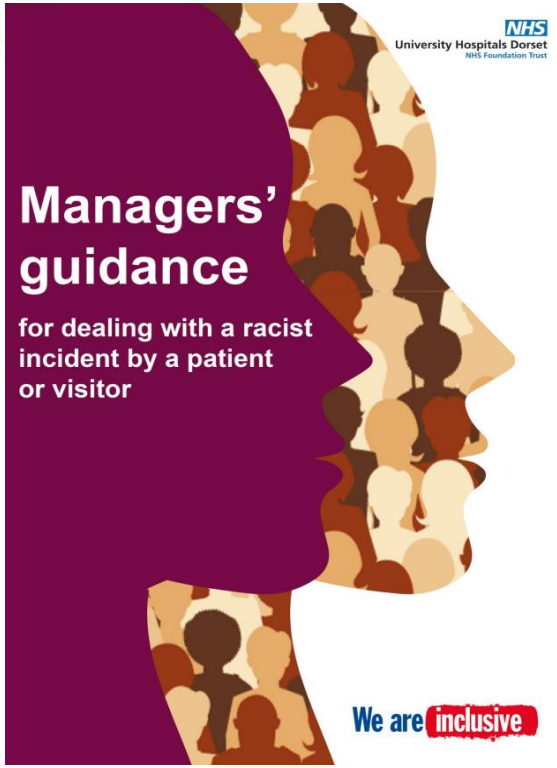
WDES indicators		2022	2023	2024	National 2024	2025	UHD Trend
1.Percentage of black and minority (BME) staff [See also WRES metric 1 charts]	Overall %	18.7	21.5	23.87	26.4	26.06	↑
2. Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME		2.09	1.90	1.78	1.59	2.49	↓
3. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff		1.22	1.00	1.97	1.03	2.09	↓
4. Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff		0.79	0.90	0.91	1.12	0.88	↑
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	BME %	30.00	34.10	30.25	30.50	27.36	↑
	White %	26.30	27.90	25.62	26.90	21.86	
6. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	BME %	31.10	31.70	24.97	27.50	23.92	↑
	White %	23.90	25.50	18.26	21.70	17.74	
7. Percentage of staff believing that Trust provides equal opportunities for career progression and promotion	BME %	44.50	45.73	46.12	46.70	48.38	↑
	White %	59.97	60.07	60.72	59.40	61.60	
8. Percentage of staff personally experiencing discrimination at work from a manager/team leader or other colleague	BME %	16.83	20.27	15.79	16.40	15.21	–
	White %	7.40	5.41	5.43	6. 60	5.14	
9 BME board membership [% difference]	% difference	12.20	15.00	11.00	15.60	9.36	↑

UHD Anti-Racism Guides









Everyone has a responsibility to create and uphold an anti-racist culture at UHD.

These guides have guidance on handling and reporting incidents for staff and for managers. We encourage you to review the guidance, educate yourself by watching the videos and support UHD in developing an anti-racist culture.

The **sentiments, principles and suggestions** in this anti-racism guide apply equally to all our staff including those with other protected characteristics including disability, gender, religion, age or sexual orientation.

Statement from the UHD board of directors

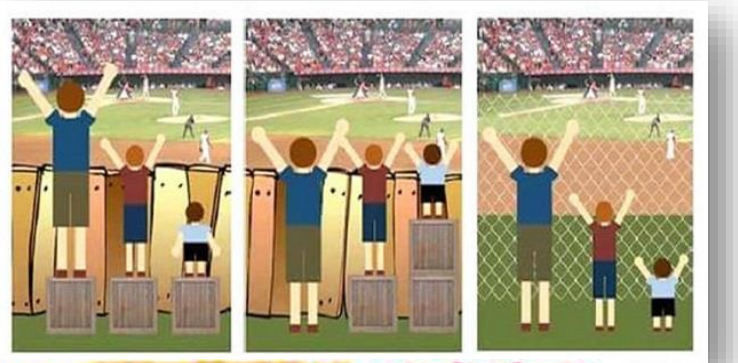
NHS
University Hospitals Dorset
NHS Foundation Trust



"University Hospitals Dorset will not tolerate racism, discrimination or abuse. We celebrate the diversity of our staff and community. We treat all our staff with dignity and respect, irrespective of their race, gender, religion, age, disability or sexual orientation."

INEQUALITIES should not be the burden of the disadvantaged, but of those who hold POWER

- Chair and CEO to set and review measurable EDI objectives for all Board members (NHS HIA 1)
- Sponsorship for the Inclusive Recruitment project
- Advocacy to reduce the bullying, harassment, and disciplinary process for Global Majority staff
- Promote the See ME First campaign and Conscious Inclusion Workshop
- Host or attend at least two listening events per year to identify and remove barriers to staff wellbeing.




Thank you

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 8.1

Subject:	Risk Register Report - risks rated 15 and above
Prepared by:	Jo Sims, Associate Director for Quality Governance and Risk 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:	As at the 2/10/25, there were 229 approved risks on UHDs Risk register, of which 14 were rated as 15 and above.	
Background:	The report is provided in accordance with the UHD Risk Management Strategy. To provide details of the risks rated 15 and above on the UHD NHS Foundation Trust risk register.	
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	☐
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	27/10/2025	Risks breaching risk tolerance discussed with Medical Care Group and actions requested to review risk ratings, controls, gaps in control and mitigations.

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 end September 2025 (as on 02/10/2025)

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 229 approved risks on UHDs Risk register, of which 14 are rated as 15 and above.

Rating movement key

- **Stayed the same**
- **Increased**
- **Decreased**
- **New**

Action status key

Overdue	Due in month	Not due

Risk Type - Population & System **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 • Performance review against metrics • Daily breach analysis • Efficient patient pathways and streaming process to SDEC's and UTC • Link to Risk 1426(Ambulance Queues) • Link to Risk 1387 and 1131 (Beds and Flow) • Patient assessment form (SHINE) • ED Trigger tool/ Delayed Care pathway

<table>
<tr><td></td><td>

TAD Process evoked
Compliance with Trust and ED Escalation plans/SOPs
Avoidable lost time and patient delay
ED Primacy
IPS optimisation
All elements of initial assessment: TTT, TT first clinician and TT decision are all within 3 hrs of arrival
Diagnostic delays standards (blood tests/x-ray and CT)
Surge Management’ criteria and plan
External transfers procedures compliant with patient category
Implementation of 4 and 12 hour escalation process and UHD ambulance divert policy.
4 hour performance metrics linked to ED escalation
Escalation email/text process along with ED shift report template improvement

</td></tr>
<tr><td>Gaps in controls</td><td>Gaps in assurance for sustainable delivery of 4-hour standard:

SDEC pathways not in place 12 hours a day 7 days a week across all services.
Revised Escalation processes (ED and wider organisation) not yet embedded.
Gaps in recruitment remain a key challenge.
Capacity across the organisation to respond to the issues and take necessary action, including change management capacity, noting deployment of new ED IT System in June 2023 requiring priority.
UEC growth, MRTL numbers and industrial action could expose the Trust to reduced patient flow and performance
Type 3 data from MIU and UTC remains a manual process needs to be automated for new standards
Executive Enhanced support meeting has been put in place for the emergency department (Chief Medical Officer/Chief Nursing Officer & Chief Operating Officer).
ED Action plan to be reviewed and recast to reduce to a smaller number of actions over 30/60/90 days.
Clinical Engagement on supporting the Trust 4hour safety standard and further work on ensuring the Interprofessional standards are being followed.
Revised structure, focus and workplan for the Improving Hospital Flow Group developed for TMG review on 12th September.
IT ED System: Review of the operational configuration to ensure it supports the operational flow.

</td></tr>
<tr><td>Action plan(s)</td><td>
<table>
<tr><th>Action</th><th>Due date</th></tr>
<tr><td>System Exec meeting to review pressures, agree action and implementation plans</td><td>Closed</td></tr>
<tr><td>Revise and implement ED Action Plan (attached)</td><td>Closed</td></tr>
<tr><td>Improving Hospital Flow Programme report and actions</td><td>Closed</td></tr>
<tr><td>ED 4 Hour Safety Standard Implementation Plan</td><td>Closed</td></tr>
<tr><td>4-hour standard 60 day plan</td><td>31/08/2023</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>Ongoing work through the trust accountability process focussing on UEC performance with ongoing trust enhanced support process in place.
Development and socialising of the people and process improvement plan utilising the trust PF methodology.
A3's development around key performance indicators of the ED</td></tr>
</table>

	- TTIA - WTBS - Time to DTA - DTA to Move. As well as focus on process development in - Ambulatory Care Area - Rapids assessment (RATs) - Operational Oversight processes Trajectories in development with through the Med Care group UEC programme. Current performance for August at 71.9%.

Risk Type - Population & System **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 
Risk Description	Very significant demand and capacity gap in department since 2019 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	• Outsourcing • Action Plan in laboratory • Automation business case being finalised for review at this meeting • Scoping NHSE consulting support • Digital program on track (RBH medical staff completed validation Poole staff scheduled by end of calendar year) • SBAR for repurpose the medical budget on pause to review in context of automation • Job planning senior BMS time • Sickness review with OH HR (35% staff) • 1 B5 locum recruited into B5 F/T post (funded by WCA) • 1 B5 locum still supporting service • Exception report for 2 A&C posts (funded by WCA) has executive approval to recruit
Gaps in controls	• Business case for additional staff has not yet been approved

<table>
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significant gaps in staff structure
Not meeting TAT's, has a significant impact on the rest of the hospital, patient waiting times and potential clinical impact.

</td></tr>
<tr><td>Action plan(s)</td><td>
<table>
<tr><th>Action</th><th>Due date</th></tr>
<tr><td>Monitor TATs</td><td>Closed</td></tr>
<tr><td>Report for Finance committee</td><td>Closed</td></tr>
<tr><td>Trust to support demand management initiative</td><td>Closed</td></tr>
<tr><td>Department to implement digital pathology</td><td>30/12/2025</td></tr>
<tr><td>Department to implement AI</td><td>30/01/2026</td></tr>
<tr><td>Department to implement order comms</td><td>30/03/2026</td></tr>
<tr><td>Adress demand and capacity staffing issues in Cellular Pathology</td><td>30/03/2026</td></tr>
<tr><td>Funding Stream</td><td>30/03/2026</td></tr>
<tr><td>Trust to initiate cultural review with a view to optimising productivity in consultant body</td><td>31/03/2026</td></tr>
<tr><td>Department to accelerate BMS cut up training programmes</td><td>30/04/2026</td></tr>
<tr><td>Report delays in recruitment</td><td>30/06/2026</td></tr>
<tr><td>Trust to review MDT requirement to reduce commitment from pathology and radiology</td><td>30/06/2026</td></tr>
<tr><td>Department to accelerate BMS reporting training programmes</td><td>30/07/2026</td></tr>
</table>
</td></tr>
<tr><td>Tolerance breach?</td><td>Yes</td></tr>
<tr><td>Target Risk Rating</td><td>4</td></tr>
<tr><td>Progress update</td><td>

Automation Business Case cover sheet approved by CFO. Local automation BC filed for assurance at Sept SDR 30/09/25 seeking signature from Finance BP (CS) to procure.
Recruited 1 of 2 locums to band 5 post (WCA), Second locum still supporting service
Exception request completed for the 2 admin posts approved by COO. HR situation with staff on workplace adjustments remains the same. Local business case for automation is being finalised, ready for review at Sept SDR. MOU ready for drawdown subject to business approval. medical Staff at RBH have completed their digital validations, Poole staff are scheduled to complete by end of calendar year. this will help streamline and optimise report processes and improve TAT. Small improvement on all cases of 76% in 10 days. continue to outsource so the risk remains the same.

</td></tr>
</table>

Risk Type - Population & System Risk Category - Capacity Planning	Appetite = Cautious Tolerance = 9-15
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. There is also a risk to the Trust of litigation.
Executive sponsor	Chief Medical Officer
Controls in place	• 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. • 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. • SOP - Technicians ask a series of questions which will inform them whether to flag the patient as a concern. • Timetable review for Glaucoma Nurse Specialists to enable them to support with virtual reviews. • Monitoring the number of overdue patients • Additional clinics run every weekend (8 additional clinics each weekend) - insourcing team are supporting this process • CD's PA time - supporting the review process and clinical outcomes • Risk rating is assigned to all patients being reviewed - a system helps to manage these appointments • LERNS and complaints monitoring • Admission clerk is prioritising glaucoma operations over cataract • 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 • Plan to visit the Exeter clinics to review their process
Gaps in controls	• 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. • No nurse specialist in post to help to manage the reviews • No additional substantive/locum glaucoma consultant in post - there should be 2 additional consultants supporting the service • GIRFT recommendation re LCAD (latest clinically acceptable date) - if the pt is delayed it needs to be reported • Lack of capacity to grade all patients • Backlog of emails/admin work due to the lack of PA support - admin freeze in UHD

Action plan(s)	**Action**	**Due date**
	To present the plan to set up additional clinics to the directorate	Closed
	Recruit locum Glaucoma Consultant	Closed
	Ophthalmology Nurse Specialist to commence (glaucoma module) training course.	13/10/2025
	Monitor number of patients waiting to be reviewed/followed up	31/10/2025
	Succession plan for Glaucoma Nurse Specialist	31/10/2025
	Glaucoma POD Virtual Review Clinic Model to be Implemented	31/10/2025
	Visit to Exeter	31/10/2025
	Ophthalmology Nurse Specialist to support with Glaucoma Virtual Reviews	31/10/2025
	Recruit substantive Glaucoma consultants x2	01/09/2026
Tolerance breach?	Yes	
Target Risk Rating	6	
Progress update	The risk was reviewed and noted to be greater than initially assessed. Staffing levels within the glaucoma service at UHD have been adversely affected by staff retirements and departures. Consequently, there is limited capacity to manage identified high-risk patients, provide timely appointments, and undertake necessary surgical interventions. Reviewed and updated risk description, risk background, action plan, controls and gaps in controls. Changes to the risk to be noted at the next H&N Governance meeting on 17.09.2025. Surgical Care Group Governance manager to contact H&N team to add to the agenda. Risk owner and service manager to provide evidence for the risk rating of 16 (waiting lists metrics etc)	

Risk Type - Population & System **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: - medicated and monitored to manage neurodevelopment issues - referred to the school age Neurodevelopmental service for advice, guidance and treatment. There remains an untriaged cohort of referrals (approx. 7 months behind) and this may hold unknown risk.
Executive sponsor	Chief Operating Officer

<table>
<tr><td>Controls in place</td><td>

National targets in place-RTT zero tolerance 78 week waits, 65-week target from March 2024
Local contractual expectation (provision of service and rejection of referrals) in place
Monitor of patient satisfaction via Complaints and claims
Escalation process in place and compliance monitored
Dorset Pathway in place and compliance monitored
Workforce template agreed
Monitoring of staff wellbeing through Absence, sickness & turnover
Triage of referrals being received to ensure visibility of activity on eCamis & effective management of the waiting list.

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

National target achievement
Local contractual expectation (provision of service and rejection of referrals)
Poor patient satisfaction
Poor staff wellbeing
Lack of capacity to triage referrals in a timely fashion.

</td></tr>
<tr><td>Action plan(s)</td><td>
<table>
<tr><th>Action</th><th>Due date</th></tr>
<tr><td>Dedicated admin support for referral screening process</td><td>Closed</td></tr>
<tr><td>Reduce backlog of un-triaged referrals</td><td>Closed</td></tr>
<tr><td>Listening events & senior leadership visibility</td><td>Closed</td></tr>
<tr><td>Recruitment of nurse specialist to support workforce</td><td>Closed</td></tr>
<tr><td>Supporting SENCo's with regards to referrals</td><td>Closed</td></tr>
<tr><td>Medical recruitment</td><td>Closed</td></tr>
<tr><td>Process mapping exercise</td><td>Closed</td></tr>
<tr><td>To monitor the CDC School age service transformation plan</td><td>Closed</td></tr>
<tr><td>Engagement with ICB All Age Autism Pathway review</td><td>Closed</td></tr>
<tr><td>Medical / AHP recruitment</td><td>Closed</td></tr>
<tr><td>Review delay in uploading referrals to eCamis</td><td>Closed</td></tr>
<tr><td>Medical / AHP recruitment</td><td>30/09/2025</td></tr>
<tr><td>Engagement with ICB All Age Autism Pathway review</td><td>31/12/2025</td></tr>
<tr><td>Monitor backlogs of referrals</td><td>31/12/2025</td></tr>
</table>
</td></tr>
<tr><td>Tolerance breach?</td><td>No</td></tr>
<tr><td>Target risk rating</td><td>3</td></tr>
<tr><td>Progress update</td><td>Further review at Child Health Q&R meeting. Agreement to keep at current rating. High number of untriaged referrals and staff well-being impacted.</td></tr>
</table>

Risk Type - Population & System Risk Category - Capacity Planning	Appetite = Cautious Tolerance = 9-15
Risk ID	1303
Risk Title	Therapy Staffing impacting on quality and flow
Date risk raised on the risk register	10/09/2019
Date risk approved as 15+ risk	17/12/2024
Risk Rating	15 
Risk Description	If we continue with the current Therapy staffing template and do not address the capacity and demand gap of Physiotherapists & Occupational Therapists across the organisation, then this will negatively affect patient care & outcomes, optimisation of therapy treatments and the flow of patients through the Trust.
Executive sponsor	Chief Operating Office
Controls in place	• Staffing template • Recruitment policy • Sickness absence policy and procedures • LERN policy • Regional benchmarking-Critical Care provision standards • GPICS compliance • Provision of 7 day service in Critical Care standards • NICE & CSP guidance on therapy input for fractured neck of femur patient
Gaps in controls	• Staffing templates not increased in 15+ years despite year on year increased admission rates and increased flow through hospital beds. • Business cases not given financial support - both to increase critical care staffing to meet GPICs standards and to fund the crucial workforce pipeline of apprenticeships. • Additional medical and OPS beds opened without therapy staffing budget or template driving existing demand further beyond capacity.

Action plan(s)	**Action**	**Due date**
	Business case to request additional financial support for band 6 roles	Closed
	Two locums have been sourced and the third one still being sought: start date of three months each from late July – late October 2019.	Closed
	Ensure induction processes and training plans for new graduates is comprehensive and timely.	Closed
	Seek appropriate funding for therapy establishment	Closed
	Recruitment	Closed
	Operational management of therapy demand and capacity	Closed
	Launch electronic referral	02/12/2025
	Development of a data dashboard reporting response rate, clinical activity and unmet need.	02/12/2025
	Trauma to complete a Audit review against our NOF standards- this will be completed October to December. This Audit will be to compare against audit from 2023.	30/01/2026
Tolerance breach?	No	
Target risk rating	6	
Progress update	E-referral pilot continues - plan to evaluate & roll out in Oct if successful. Durlston options appraisal completed & testing undertaken for a trial week of pulling staff from A wards. Plan to evaluate & write up. IP dashboard continues to be built by BI. Two new IP managers to start & be inducted through October (OPS and Ortho). Planning to implement new patient first performance & risk reporting from Nov onwards.	

Risk Type - Population & System **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

<table>
<tr><td>Controls in place</td><td>
Poole
rn and Level 1 theatres have UPS back up - any patients needing to continue surgery will be transferred to these areas safely
ve to open surgery if loss of stack/robotic systems
tients are to be made safe, woken and taken to recovery area
aesthetic machines, theatre lights have approx 30 mins back up
surgery will continue unless life or limb in Level 1 or barn theatres
RBH
ve to open surgery if loss of stack/robotic systems
tients are to be made safe, woken and taken to recovery area
aesthetic machines, theatre lights have approx 30 mins back up
Surgery will continue unless life or limb
</td></tr>
<tr><td>Gaps in controls</td><td>
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 a 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.
</td></tr>
<tr><td>Action plan(s)</td><td>
<table>
<tr><th>Action</th><th>Due date</th></tr>
<tr><td>UHD Theatres Team to investigate if a local UPS solution is available and then put it in place</td><td>Closed</td></tr>
<tr><td>The Surgical Care Group to escalate the risk to the Trust Board and Clinical Governance Group</td><td>Closed</td></tr>
<tr><td>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).</td><td>31/07/2025</td></tr>
</table>
</td></tr>
<tr><td>Tolerance breach?</td><td>No</td></tr>
<tr><td>Target risk rating</td><td>4</td></tr>
<tr><td>Progress update</td><td>Theatre management team and deputy director of estates met to discuss power unit options
Small battery portable units agreed as a viable option
11 units requested for UHD theatres (RBH and PH)
Executive risk lead to be consulted regarding funding
Risk to be reviewed at directorate governance meeting with review of grading</td></tr>
</table>

Risk type - Quality (Outcome and Safety) 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 Medical Officer
Controls in place	• MHRA standards • Compliance with national standards • Service contracts • Point of Care co-ordinator • Contingency policy for majority tests by sending sample to the laboratory • Incidents • MDI procedures • Medical devices policy
Gaps in controls	• Ungoverned POCT devices non-compliant with MHRA standards • Non-compliance with national standards • Point of Care co-ordinator - single point of failure as insufficient staffing and succession planning not in place • No POC policy and standards • 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 – 31/12/2024
Tolerance breach?	Yes

Target risk rating	6
Progress update	Risk ownership discussed at Risk Oversight Group 29/09. Agreed that this should no longer sit at WCCSS Care Group level. Ownership changed to Clinical Engineering Services with assignment to Associate Director of Estates and Site Services.

Risk type - Quality (Outcome and Safety) **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. • Appointed a fourth Macular Nurse Practitioner (training and education will be required to ensure competencies are met and signed off). • Additional lists added, when staffing allows • Ophthalmology ED for emergency cases • An email account has been set up for the consultants to review referrals from Opticians, to ensure that only appropriate patients are seen by the macular team. • First appointments are being triaged out to the Health Village where they are seen by an Ophthalmic Technician for imaging and other diagnostic tests, not a clinician. Patients then await virtual review from a clinician. • 2 x macular coordinators reviewing patient wait times and prioritising • Direct line to macular coordinators who can escalate to Clinicians • Spreadsheet available for range of clinicians to review for oversight. • Regular Macular meeting to focus on long waiters and agree actions required (monthly and weekly meetings) • Creating a 'core team' within outpatients to work in macular • training needs identified and started to roll out. This will also support retention • Contacted reps to identify if they can support training and funding
Gaps in controls	• Additional sites to be identified to undertake additional lists/ full lists that has a 'clean' space, accessible (for staff and patients) and large enough waiting area • Budget to be identified to enable estates work to be completed and training to be given

	• The 4th Macular Nurse Practitioner will require a full training program. • Recruitment for replacement consultant needs to be undertaken (finance agreed)
Action plan(s)	

Action	Due date
Recruitment of consultant	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
support recruitment and retention	01/10/2025
Submit A3 for Macular Workforce	01/10/2025
Increase number of patients in macular One Stop clinics	10/10/2025
Digital improvements in macular	31/10/2025
Identify additional space to provide macular assessments and treatments	03/11/2025
Monitor number of patients waiting for appointment	31/12/2025
POD virtual review clinic model	31/12/2025
Ophthalmology Practitioner Training (OPT) - macular module, for all Macular Nurse Specialists	01/05/2025

Tolerance breach?	Yes
Target risk rating	9
Progress update	Risk rating to be downgraded at September's CGM. No further evidence of harm received since March 2025. Several actions updated. Macular meeting action closed.

Risk type - Quality (Outcome and Safety) **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.

	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. Risk involves Surgery, Radiology, Pathology, and Informatics.
Executive sponsor	Chief Medical Officer
Controls in place	• Teams based notifications standards • External regulatory compliance standards • Compliance with GMC guidance re: the responsible clinician • Clinical in-patient worklist procedures • Health of the ward procedures • Royal College standard regarding referrers responsibilities • IT strategy • LERN policy
Gaps in controls	• No effective single user interface for clinicians to manage their core care processes.
Action plan(s)	**Action** / **Due date** Referrer awareness — Closed App — Closed
Tolerance breach?	Yes
Target risk rating	4
Progress update	An update has gone to the Quality and Risk Committee proposing a move to paperless requesting and reporting to resolve the closed loop related issues. This has been accepted and a Pathology / Digital Task & Finish Group is now in fortnightly to keep track of this programme and the summary updates will be input here for wider visibility.

Risk type - Quality (Outcome and Safety) **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 • Scan tracker in place to log and monitor workflow • General ultrasound examinations being conducted by outsourcing company (they do not offer obstetric services) • Substantive staff being offered bank shifts and Wait List Initiative (WLI) at weekends to increase capacity • Prioritisation of those areas measured for Maternity Incentive Scheme (MIS) audits. • Radiology management team in discussion with radiologists to look at supporting enhanced practice for sonographers to help with staff retention long term • Longer term planning completed to identify when staff/students that are currently undergoing Obstetrics training will be available to commence scanning services from Summer 2026
Gaps in controls	• Agency rate cap has meant we are unable to use agency to mitigate the risk • Limited numbers of substantive staff with obstetric competencies mean there is little appetite for more sessions in obstetrics. • Plans in place to upskill staff already in post will add limited capacity over next three months; quote requested from external insourcing company to see if the staffing issues could be addressed using them in the short term. • Prioritisation of those areas measured for MIS audit may reduce risk of losing this funding but will not necessarily help most urgent patients and so will not mitigate risk of loss of reputation
Action plan(s)	**Action** / **Due date** Insourcing support for obstetrics – Closed Align Preceptorship SOP – 17/10/2025 Upskilling of substantive staff – 01/09/2026 Sonographer enhanced practice. – 01/09/2026
Tolerance breach?	Yes
Target risk rating	6
Progress update	Discussed as noted for review at next RQE meeting 16/10/25. Risk accepted at Risk Oversight Group on 29/09/2025 at a risk score of 15.

Risk type - Quality (Outcome and Safety) **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. 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	• Robust and timely rota management to optimise safe staffing BCP initiated for gaps in rota • Proactive ongoing recruitment to maximise opportunities • Locum in place working core hours only to free up staff resource for training to try and fix the underlying issue • Ongoing staff support to optimise retention • Sickness and absence procedures • JACIE, MHRA and UKAS accreditation standards. • laboratory closure OOH procedures • SOP in place at both sites for service delivery • 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	Another resignation has been received from member of staff currently on the OOH. Mitigation is Band 7 staff having to backfill shifts but this impacts quality of service during core hours. Additional locum is being sought through Trac. BCP initiated for gaps in rota. Locum in place for core hours to support training to fix underlying issue

Risk Type - Sustainable Services Risk **Risk Category - Financial Management Risk** **Appetite = Cautious** **Tolerance = 9-15**	
Risk ID	1595
Risk Title	Medium Term Financial Sustainability

Date risk raised on the risk register	27/05/2021
Date risk approved as 15+ risk	28/06/2021
Risk Rating	16 ⟷
Risk Description	There is a risk that the Trust cannot achieve its strategic priority to return to a financial surplus by 2026/27. Failing to deliver a financial break-even position would result in regulatory intervention, an unplanned reduction in cash and the inability to afford the medium term capital programme.
Executive sponsor	Chief Finance Officer
Controls in place	• Budgets developed with directorate teams, formally accepted at Care Group level and fully devolved to named budget holders. • Dedicated financial support in place including additional variance analysis and reporting. • Scheme of delegation, Standing Financial Instructions, and other finance policies and procedures in place. • Monthly reporting to Trust Management Group, Finance and Performance Committee and Board highlighting risks and mitigating actions. • Patient First 'driver' and 'watch' metrics agreed and monitored monthly. • Alignment of approved nursing templates, e-roster templates, and budgeted establishment. • Enhanced vacancy and non pay controls implemented to support financial recovery. • Financial planning with system partners • Efficiency Improvement Programme in place with oversight by Finance and Performance Committee. • QIA policy and process in place. • Regular contract performance meetings with commissioners. • Weekly MTP meetings. • Regular System triple lock meetings. The trust is not authorised to approve new investments above £25k, subject to triple lock process. • Detection control NHSE regulatory assessment (Risk Of Non Delivery Assessment (RONDA)) • 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). • 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). • 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) • 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** 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 **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 
Risk Description	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.
Executive sponsor	Chief Digital Officer
Controls in place	• 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, an update was provided to the Board in January 2024. The majority of the trust IT systems that make up the EPR ecosystem have the following controls in place: • Underpinning legal contracts with software suppliers • Immutable backups (i.e. cannot be affected by malware) • Staff training programmes • Active Information Asset Owners who undertake appropriate audits in line with the Data Security and Protection Toolkit • UHD wide Business Continuity Plan • Dedicated Subject Matter Experts in the clinical applications who maintain them in their optimal state • Teams of people working to ensure that the underlying IT Infrastructure is maintained in an optimal state
Gaps in controls	• 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). • No effective single user interface for clinicians to manage their core care processes. • Local departmental Business Continuity Plans are not yet in place – these are in development with a plan to develop by March 2024.

Action plan(s)	**Action**	**Due date**
	Option appraisal	Closed
	Business continuity Plan	Closed
	EPR internal mitigation	Closed
Tolerance breach?	No	
Target risk rating	6	
Progress update	EDM IT meeting is well underway to ensure the programme is clearly defined to move the trust away from the current EPR system and onto EDM until the new [redacted] EHR is implemented in 2028. A monthly IT / Clinical governance meeting is now in for oversight and clear visibility of decisions and status of this programme has now formally commenced with a plan to move off of the EPR and onto the EDM system in the next 12 months. This work has now commenced.	

Risk type - Sustainable Services **Risk Category - Information Governance and Security Risk Appetite = Cautious Tolerance = 9-15**	
Risk ID	2080
Risk Title	Cyber Attack
Date risk raised on the risk register	17/06/2024
Date risk approved as 15+ risk	22/01/2025
Risk Rating	15 
Risk Description	If we fail to implement a cyber improvement plan at UHD to address the gaps in our cyber security, we risk a successful attack that could cause all IT systems to be inaccessible and lead to a substantial impact on patient care.
Executive sponsor	Chief Digital Officer
Controls in place	• Regular monitoring and patching of all systems to ensure they are on supported and secure platforms • Password policies accepted and adhered to • Retiring of old systems on time before becoming out of support. Implemented SIEM (Security Information and Event Management) • Next Gen firewalls implemented. • Regular Penetration Tests with action plans. • Cyber Improvement Plan approved and actions in progress
Gaps in controls	• The Cyber Improvement plan details approx. 40 gaps that require action, 15 have been completed • There are specific risks that exist in relation to IT systems that have been purchased by departments directly in that external suppliers may not have had sufficient cyber security checks completed. This relates to all shadow IT.
Action plan(s)	

	Action	Due date
	Completion of actions detailed in the Cyber Improvement plan	28/02/2025
Tolerance breach?	No	
Target risk rating	10	
Progress update	We are still waiting for the AI policy to be completed and approved.	

1. 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)	1	22	26	5	0
	Possible (3)	2	37	50	10	4
	Unlikely (2)	0	5	28	12	2
	Rare (1)	0	1	2	6	1

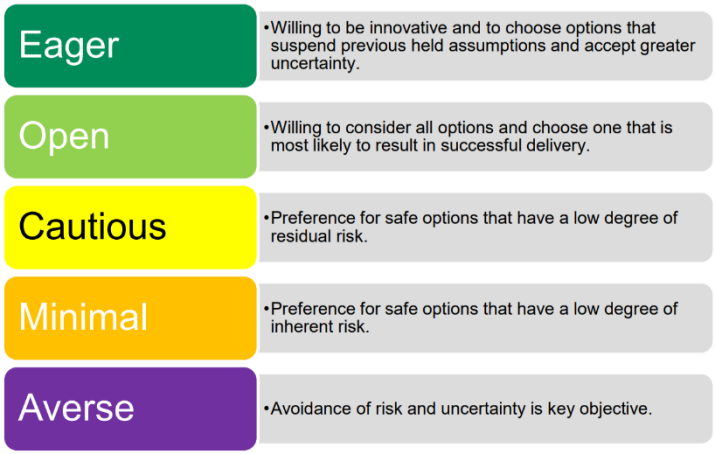
Current Risk score by month – rolling year (at the point of report date – taken as preceding month)

Current Risk Score– UHD total	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
Very Low (1-3)	6	6	4	3	4	6	6	5	6	5	5	5
Low (4-6)	68	73	72	73	74	71	72	72	75	71	79	79
Moderate (8-10)	107	105	111	107	99	96	94	93	92	92	93	95
Moderate (12)	44	43	38	42	41	40	45	46	44	44	43	36
High (15 -25)	16	18	20	19	21	19	19	19	19	14	14	14
Total number of risks under review	241	245	245	244	239	232	236	235	236	226	234	229

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. 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. • Peripheral element of treatment or service suboptimal • Informal complaint/inquiry	• Overall treatment or service suboptimal • Single failure to meet internal standards • Minor implications for patient safety if unresolved • Reduced performance rating if unresolved • Breech of statutory legislation • Elements of public expectation not being met • Loss of 0.1–0.25 per cent of budget • Claim less than £10,000 • Loss/interruption of >8 hours • Minor impact on environment	• Treatment or service has significantly reduced effectiveness • Repeated failure to meet statutory or contractual standards • Major patient safety implications if findings are not acted on • Challenging external recommendations/ improvement notice • 5–10 per cent over project budget • Local media coverage – long-term reduction in public confidence • Loss of 0.25–0.5 per cent of budget	• Major injury leading to long-term incapacity/disability • Non-compliance with national standards with significant risk to patients if unresolved • Multiple complaints/ independent review • Low performance rating • Uncertain delivery of key objective/service due to lack of staff • Enforcement action • Multiple breeches in statutory duty • Improvement notices • National media coverage with <3 days service well below reasonable public expectation • Non-compliance with national 10–25 per cent over project budget • Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget • Claim(s) between £100,000 and £1 million	• An issue which impacts on a large number of patients, increased probability of death of irreversible health effects • Gross failure to meet national standards • Multiple breeches in statutory or regulatory duty • Prosecution • National media coverage with >3 days service well below reasonable public expectation. • Incident leading >25 per cent over project budget • Non-delivery of key objective/ Loss of >1 per cent of budget • Loss of contract / payment by results • Claim(s) >£1 million • Permanent loss of service or facility • Catastrophic impact on environment

Table 2 Likelihood score (L)

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

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

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 8.2

Subject:	Composition of Board of Directors: Amendment to Trust's Constitution
Prepared by:	Judy Gillow, Interim Trust Chair
Presented by:	Judy Gillow, Interim Trust Chair

Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☒ Patient Experience ☐ Quality Outcomes & Safety ☐ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Decision/Approval
Executive Summary:	The purpose of this paper is to present a minor amendment to the Trust Constitution, aimed at ensuring the effective functioning and decision making of the Board of Directors in its current composition
Background:	<u>Responsibilities of the Nominations, Remuneration and Evaluation Committee:</u> Further to Annex 5, clause 21.9.3 of the Trust's Constitution, the Committee is to review the structure, size and composition of the Board of Directors from time to time and make any recommendation to the Council of Governors. This is additionally reflected in section 1.2 of the Committee's Terms of Reference, which provides that the Committee is responsible for advising and/or making recommendations to the Council of Governors relating to the composition of the Board of Directors and the skill mix of the Non-Executive Directors. A change to the constitution was requested by the previous chair in 2022 to make the chair additional to the executive (including CEO) and Non-Executive numbers i.e. 8 executives and 8 non-executives plus chair. The proposal is to revert to the board comprising of 8 executives and 8 non-executives (including the chair) with the chair having the casting vote if there was an impasse in decision making

	Current composition of the Board of Directors Under Clause 21 of the Trust Constitution, the Board of Directors is composed of 17 members: 8 Executives and 8 non-executives plus chair. Following recent changes to the Board's composition, the number of Executive Directors and Non-Executive Directors (including the CEO and Trust Chair) is now equal. This equal representation could pose a potential risk of impasse during decision-making, as it may hinder the Board's ability to secure a majority vote if the chair does not have the casting vote. Given the current financial climate, appointing an additional Non-Executive Director to restore balance is not considered a viable option. Therefore, it is proposed that the Trust Chair's casting vote be reinstated to ensure the Board can continue to function effectively and make timely decisions. Amendments to the Trust's Constitution Should the Committee consider that it wishes to recommend the changes outlined above, the amendments to be proposed to the Trust's Constitution would be as follows: 21.2 The Board of Directors is to comprise: • 21.2.1 a non-executive Chair (who shall have a casting vote) And to Annex 7 – Standing Orders for the Practice and Procedure of the Board of Directors as follows: 3.1.1 In accordance with Clause 21 of the Constitution, the composition of the Board shall be: (a) a non-executive Chair; (who shall have a casting vote) Under clause 41, the Trust may make amendments to its Constitution only if: • More than half of the members of the Council of Governors of the Trust voting approve the amendments; and • More than half of the members of the Board of Directors of the Trust voting approve the amendments. In addition, the Council of Governors should present to the 2026 Trust's Annual Meeting any proposed changes to the policy for the composition of the Non-Executive Directors (Annex 8, clause 7.7.3 to the Trust's Constitution).
Key Recommendations:	The Board of Directors is asked to consider and, if thought fit, approve the proposed amendments to the Trust Constitution.
Implications associated with this item:	Council of Governors ☒ Equality, Equity, Diversity & Inclusion ☐ Financial ☐

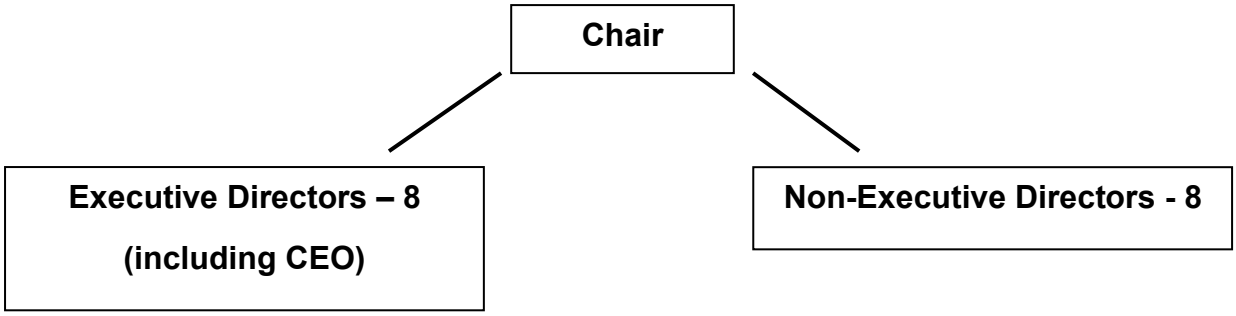
	Health Inequalities	☐
	Operational Performance	☐
	People (inc Staff, Patients)	☐
	Public Consultation	☐
	Quality	☐
	Regulatory	☒
	Strategy/Transformation	☐
	System	☐
CQC Reference:	Safe	☐
	Effective	☐
	Caring	☐
	Responsive	☐
	Well Led	☒
	Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Nominations, Remuneration and Evaluation Committee	24/09/2025	The Committee endorsed the report and recommended to the Council of Governors to approve.
Council of Governors	02/10/2025	Council of Governors approved the proposed amendments to the Constitution.

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

Appendix A

Board of Directors' composition under current Constitution (amends made in 2022):



Total: 17

Board of Directors' composition under proposed amendment to the Constitution from November 2025:

Executive Directors - 8	Non-Executive Directors - 8
Siobhan Harrington – Chief Executive Officer	*Judy Gillow – Interim Trust Chair
Beverley Bryant – Chief Digital Officer	Tracie Langley
Sarah Herbert- Chief Nursing Officer	Alastair Matthews
Mark Mould – Chief Operating Officer	Femi Macaulay
Pete Papworth – Chief Finance Officer	Michael Marsh
Richard Reanut- Chief Strategy and Transformation Officer	Helena McKeown
Peter Wilson – Chief Medical Officer	Sharath Ranjan
Melanie Withfield – Chief People Officer	Claire Whitaker
	Andrew Doe – Associate Non-Executive Director

Total: 16

*Chair to have casting vote

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 05 November 2025

Agenda item: 8.4

Subject:	Board and Committee Meeting Schedule 2026
Prepared by:	Klaudia Zwolinska, Corporate Governance Manager
Presented by:	Judy Gillow, Interim Trust Chair

Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	All
Purpose of paper:	Decision/Approval
Executive Summary:	The purpose of this paper is to present the proposed meeting dates for the Board and its Committees for 2025.
Background:	This paper is for the Board to consider the proposed dates for its meeting and those of its Committees for 2026.
Key Recommendations:	To consider and, if thought fit, approve the proposed meeting dates for 2025 (noting that there may be subsequent minor modifications to such date at the discretion of the Trust Chair and, for the Committee meetings, the Committee Chairs in consultation with the Committee members).
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
N/A	N/A	N/A

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

University Hospitals Dorset NHS Foundation Trust

Board of Directors and Committee Meetings Schedule 2026

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
BOARD OF DIRECTORS PART 1	14/01/2026 9:30 (F)	-	11/03/2026 9:30 (F)	-	13/05/2026 9:30 (F)		15/07/2026 9:30 (F)	-	09/09/2026 9:30 (F)	-	11/11/2026 9:30 (F)	-
BOARD OF DIRECTORS PART 2	14/01/2026 12:30 (F)	11/02/2026 9:30 (F)	11/03/2026 12:30 (F)	08/04/2026 9:30 (F)	13/05/2026 12:30 (F)	17/06/2026 10:00 (F) *Annual Report and Accounts*	15/07/2026 12:30 (F)	-	09/09/2026 12:30 (F)	14/10/2026 9:30 (F)	11/11/2026 12:30 (F)	09/12/2026 9:30 (F)
BOARD DEVELOPMENT	14/01/2026 14:30 (F)	11/02/2026 11:00 (F)	11/03/2026 14:30 (F)	08/04/2026 11:00 (F)	13/05/2026 14:30 (F)	17/06/2026 11:00 (F)	15/07/2026 14:30 (V)	-	09/09/2026 14:30 (F)	14/10/2026 11:00 (F)	11/11/2026 14:30 (F)	09/12/2026 11:00 (F)
AUDIT	15/01/2026 9:00 (F)	-	-	16/04/2026 9:00 (F)	-	03/06/2026 9:00 17/06/2026 9:00 *Joint Audit and FPC*	16/07/2026 9:00 (F)	-	-	15/10/2026 9:00 (F)	-	-
FINANCE & PERFORMANCE	05/01/2026 9:00 (F)	02/02/2026 11:30 (F)	02/03/2026 9:00 (F)	08/04/2026 11:30 (F)	06/05/2026 9:00 (F)	01/06/2026 11:30 (F)	06/07/2026 9:00 (F)	03/08/2026 11:30	07/09/2026 9:00 (F)	05/10/2026 11:30 (F)	02/11/2026 9:00 (F)	07/12/2026 11:30 (F)
PEOPLE AND CULTURE	05/01/2026 12:00 (F)	-	02/03/2026 12:00 (F)	-	06/05/2026 12:00 (F)	-	06/07/2026 12:00 (F)	-	07/09/2026 12:00(F)	-	02/11/2026 12:00 (F)	-
QUALITY	06/01/2026 9:00 (F)	03/02/2026 9:00 (F)	03/03/2026 9:00 (F)	07/04/2026 9:00 (F)	05/05/2026 9:00 (F)	02/06/2026 9:00 (F)	07/07/2026 9:00 (F)	04/08/2026 9:00 (F)	01/09/2026 9:00 (F)	06/10/2026 9:00 (F)	03/11/2026 9:00 (F)	01/12/2026 9:00 (F)
CHARITABLE FUNDS	-	16/02/2026 10:00 (F)	-		18/05/2026 10:00 (F)	-		05/08/2026 10:00 (F)	-	-	18/11/2026 10:00 (F)	
TRANSFORMING CARE TOGETHER	-	02/02/2026 9:00 (F)	-	08/04/2026 9:00 (F)	-	01/06/2026 9:00 (F)	-	03/08/2026 9:00	-	05/10/2026 9:00 (F)	-	07/12/2026 9:00 (F)

University Hospitals Dorset NHS Foundation Trust
Council of Governors Meetings Schedule 2026

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
COUNCIL OF GOVERNORS PART 1	15/01/2026 16:00 (F)	-	-	09/04/2026 16:00 (F)	29/05/2026 10:00	-	09/07/2026 16:00 (F)	-	-	15/10/2026 16:00 (F)	-	-
COUNCIL OF GOVERNORS PART 2	15/01/2026 18:15 (F)	-	-	09/04/2025 18:15 (F)	29/05/2026 11:00	-	09/07/2026 18:15 (F)	-	-	15/10/2026 18:15 (F)	-	-
NOMINATIONS, REMUNERATION AND EVALUATION	07/01/2026 9:00	-	-	01/04/2026 9:00	29/05/2026 9:00	-	01/07/2026 9:00	-	-	07/09/2026 9:00	-	-
KEY THEMES FROM BOARD PART 2 MEETING	-	12/02/2026 10:00	12/03/2026 10:00 (F)	-	-	18/06/2026 10:00 (F)	-	-	10/09/2026 10:00 (F)	-	12/11/2026 10:00 (F)	10/12/2026 10:00 (F)
COUNCIL OF GOVERNOR DEVELOPMENT SESSIONS	-	-	12/03/2026 10:30 (F)	-	-	18/06/2026 10:30 (F)	-	-	10/09/2026 10:30 (F)	-	12/11/2026 10:30 (F)	-
QUALITY GROUP	-	17/02/2026 10:00	-	-	19/05/2026 10:00	-	-	-	22/09/2026 10:00	-	-	-
EFFECTIVENESS GROUP	-	-	26/03/2026 10:00	-	-	25/06/2026 10:00	-	-	-	01/10/2026 10:00	-	03/12/2026 10:00
MEMBERSHIP AND ENGAGEMENT GROUP	-	-	-	02/04/2026 10:00	-	-	02/07/2026 10:00	-	-	08/10/206 10:00	-	10/12/2026 10:30

Key
Green text indicates known school holidays

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Risk Oversight Committee

DOCUMENT DETAILS

Author:	Jo Sims
Job Title:	Associate Director Quality Governance and Risk
Signed:	
Date:	26/08/2025
Version No: (Author Allocated)	1.0
Next Review Date:	01/09/2025

Approving Body/Committee:	Board of Directors
Chair:	Chair
Signed:	Insert e-signature of Chair of Approving Committee/Group
Date Approved:	Insert date of approval of these ToR
Target Audience:	Care Group Leads, TMG, Executive Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Person responsible for Change	Nature of Change
Sept 25	1	Sept 26			

TERMS OF REFERENCE

COMMITTEE/GROUP NAME:	Risk Oversight Committee
PURPOSE *(1.2)*:	An executive-led management committee accountable to the Board and through its work shall: • foster an open, anticipatory, adaptive and proactive risk-aware culture in which people are actively engaged. • keep risk under prudent control on behalf of the Board and in accordance with the Board's risk appetite - maintaining an effective control system and minimising over exposure to harm. • horizon scan, always challenging and keeping material risk under review
RESPONSIBILITIES *(2.1)*:	• Receive and consider reports on risks following relevant investigations or failures in healthcare provision (within or external to the Trust) and to discuss and agree subsequent action required to keep the residual risk under prudent control. • Systematically review, scrutinise and challenge risk profiles across all Care Groups and Corporate Directorates ensuring the correct strategy is adopted for managing each key risk, and verifying controls and action plans are in place and effective for those risks which remain intolerant. • Satisfy itself and the Board that the structures, processes and responsibilities for identifying and managing key risks to patients, staff and the organisation are adequate. • Monitor, evaluate and scrutinise all risks recorded on the risk register with a current risk rating of 15 or more, escalating to the Board those that pose a significant threat to the operations, safety, financial health or reputation of the Trust. • Monitor, evaluate and scrutinise all risks recorded on the risk register with a current risk rating that breach risk appetite and/or risk tolerance escalating to the Board those that pose a significant threat to the operations, safety, financial health or reputation of the Trust. • Oversee the population and management of the Board Assurance Framework, which is presented to the Board of Directors and Audit Committee at least twice a year. • Review and approve the Trust's Risk Management Strategy and related policies and procedures. • In accordance with requirements of the Regulator, formally review the capacity to handle risk ensuring all requirements are met for the Chief Executive to sign the Annual Governance Statement. • Work closely with the Board's Quality Committee, Finance and Performance Committee, Audit Committee and People and Culture Committees to understand the corporate risk profile and, where necessary, to clarify the arrangements for dealing with those risks between committees. • To ensure all risks are escalated, reviewed and managed in line with the Trust's Risk Management Policy.

<table>
<tr><td></td><td colspan="4">To provide an annual report on the effectiveness of the Committee and fulfilment of its objectives.</td></tr>
<tr><td>MEMBERS (3.1):</td><td colspan="2">Chief Executive (Chair)
Chief Nursing Officer (Deputy Chair)
Chief Medical Officer
Chief Operating Officer
Chief Finance Officer
Chief People Office
Chief Strategy and Transformation Officer</td><td>STANDING ATTENDEES (3.2):</td><td>Associate Director Quality Governance and Risk
Head of Patient Safety and Risk
Care Group triumvirate leads (as part of rolling programme)
Non-Executive Director (Chair of Audit Committee)</td></tr>
<tr><td>CHAIR (3.3):</td><td>Chief Executive</td><td>DEPUTY CHAIR (3.3):</td><td>Chief Nursing Officer</td><td>SECRETARY (5.5):</td><td>Company Secretary Office</td></tr>
<tr><td>MEETING TIMING (FREQUENCY AND DURATION) (5.1):</td><td colspan="2">Monthly</td><td>QUORUM (5.2)</td><td colspan="2">This will consist of three members of the Committee being present at the point when any business is transacted.</td></tr>
<tr><td>ACCOUNTABLE TO: (the Accountable Group) (6)</td><td colspan="2">Board of Directors</td><td>REPORTING GROUPS (6.5):</td><td colspan="2">None</td></tr>
</table>

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

TERMS OF REFERENCE

1. PURPOSE

1.1 The Trust's vision is to positively transform its health and care services as part of the Dorset Integrated Care System. Its mission is to provide excellent healthcare for its patients and wider community and be a great place to work now and for future generations.

1.2 The purpose of the Committee/Group and how it will achieve its purpose is as set out above.

1.3 This paragraph 1.3 applies to Board Committees/Groups. The Committee/Group has no executive powers other than those specifically delegated in these terms of reference.

2. RESPONSIBILITIES

2.1 The responsibilities of the Committee/Group are set out above.

3. MEMBERSHIP/ ATTENDANCE

3.1 Membership of the Committee/Group is set out above.

3.2 Standing attendees are set out above. In addition, other individuals may be invited to attend with agreement of the Chair (or in their absence the Deputy Chair).

3.3 The Committee/Group will be chaired by the role holder above. A Deputy Chair may be nominated. In the absence of the Chair and/or an appointed Deputy Chair, the remaining members shall elect another member to present to chair the meeting (which, in the case of a Board Committee shall be a Non-Executive Director).

3.4 Subject to paragraph 3.2 above, only members of the Committee/Group have the right to attend meetings. If a standing member is unable to attend, they may exceptionally send a deputy to the meeting. (In the case of a Board Committee, a deputy will not have voting rights at the meeting). The Chair or other person chairing the meeting may ask any or all of those who attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

3.5 Committee/Group members should aim to attend all scheduled meetings but in any event are expected to attend a minimum of three quarters of all meetings. For the purposes of calculating attendance, a deputy attending on behalf of a member shall not count towards the members' attendance. A record of members' attendance shall be maintained.

4. AUTHORITY

4.1 The Committee/Group is authorised to approve its governance cycle.

4.2 This paragraph 4.2 applies to Board Committees/Groups. The Committee/Group is authorised by the Board to investigate/review any activity within the Terms of Reference.

4.3 This paragraph 4.3 applies to Board Committees/Groups. The Committee/Group is authorised by the Board to obtain any external advice it requires to discharge its duties and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

4.4 This paragraph 4.4 applies to Board Committees/Groups The Committee/Group is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

5. CONDUCT OF BUSINESS

5.1 The Committee/Group will normally meet at the frequency set out above and at such other times as the Chair shall require.

5.2 Meetings of the Committee/Group shall be quorate if there are at least the members present set out above for a quorum.

5.3 If a meeting of the Committee/Group is inquorate, then the meeting can progress if those present determine. However, no business shall be transacted.

5.4 Meetings of the Committee/Group shall be called by the Secretary at the request of the Chair. The Secretary of the Committee/Group shall be as stated above.

5.5 The Secretary (or their nominee) is responsible for preparing the agenda for agreement by the Committee/Group Chair. The Secretary (or their nominee) shall collate and circulate papers to Committee/Group members. Unless otherwise agreed by the Committee/Group Chair, papers should be provided not less than seven working days before the meeting and the agenda and papers should be circulated not less than five working days before the meeting.

5.6 Under exceptional circumstances, in the case of emergency or urgency, items of business may be conducted outside of formal meetings. This should normally be agreed by the Committee/Group in advance and carried out either by: Chair's action, calling an extraordinary meeting or reaching consensus on a decision by e-mail. Any decisions made in this manner must be formally ratified by the Committee/Group at the next meeting.

5.7 Committee/Group business may be transacted through virtual media (including, but not limited to video conferencing). At the start of each meeting taking place without all parties physically present, the Chair shall be responsible for determining that the meeting is quorate.

5.8 Proceedings and decisions made will be recorded in the form of minutes or notes (as specified above), which will be submitted to the next meeting of the Committee/Group for approval.

5.9 Members will be expected to conduct business in line with the Trust's values and objectives.

6. RELATIONSHIPS AND REPORTING

6.1 The Committee/Group shall be accountable to the group set out above (the Accountable Group), to whom it shall make recommendations in relation to issues that require decision or resolution.

6.2 The Committee/Group shall present a report summarising the proceedings of each of its meetings at the next meeting of the Accountable Group. For the avoidance of doubt, where practicable, this shall be a written report, with a verbal update being provided as necessary.

6.4 The Committee/Group may refer to the other groups specified above any matters requiring review or decision in such forum(s).

6.5 The Committee/Group shall receive reports from the Reporting Groups set out above..

7. MONITORING

7.1 Attendance will be monitored at each Committee/Group meeting. A matrix (see example at Appendix A) of membership attendees will be used for monitoring purposes.

7.2 This paragraph 7.2 applies to Board Committees. The Trust's Annual Report will include attendance of members, frequency of meetings and whether meetings were quorate.

7.3 On an annual basis, the Committee/Group will provide a self-assessment report to the Accountable Group detailing how the Committee/Group has discharged its obligations as set out within its terms of reference, specifically incorporating an assessment of its effectiveness and making recommendations for improvement, where appropriate.

8. REVIEW

8.1 These Terms of Reference will be reviewed annually or sooner if appropriate.

8.2 The position of the Chair of the Committee/Group will be reviewed at least every three years.

APPENDIX A - ATTENDANCE AT COMMITTEE/GROUP MEETINGS

NAME OF [Amend as appropriate: **COMMITTEE/**	[Insert name of Committee/Group]											
Present (*include names of members present at the meeting)*	**Meeting Dates**											
In Attendance												
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)												

APPENDIX B – ANNUAL GOVERNANCE CYCLE

Annual Workplan/Operating Cycle

Agenda Item	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
ToR						x						
Risk Profile – Heat Map 12+ risks	x	x	x	x	x	x	x	x	x	x	x	x
Schedule of Care Group Risk Reviews 12+ risks	MCG	SCG	WCCSS	MCG	SCG	WCCSS	MCG	SCG	WCCSS	MCG	SCG	WCCSS
Schedule of Corporate Risk Reviews 12+ risks	CPO Directorate	CMO Directorate, Finance (CFO)	Operations (COO)	Estates, Facilities, S&T (CSTO)	Informatics (CIO)	Nursing and Quality (CNO)	CPO Directorate	CMO Directorate, Finance (CFO)	Operations (COO)	Estates, Facilities, S&T (CSTO)	Informatics (CIO)	Nursing and Quality (CNO)
New Risks 15+	x	x	x	x	x	x	x	x	x	x	x	x
Emerging Risks inc. Transformation risks (verbal)	x	x	x	x	x	x	x	x	x	x	x	x
Board Assurance Framework	X		X			X			X			
Policies for Approval (as required)												

Appendix - Attendance at Part 1 Board Meetings

Part 1		07 May 2025	18 June 2025	02 July 2025	08 September 2025
Present	Beverley Bryant				
	Judy Gillow				
	Siobhan Harrington				
	Sarah Herbert				
	Tracie Langley				
	John Lelliott	A			
	Femi Macauley			A	
	Michael Marsh				
	Helena McKeown				A
	Mark Mould				
	Pete Papworth				
	Sharath Ranjan				
	Richard Renaut				
	Cliff Shearman				
	Claire Whitaker				
	Peter Wilson				
	David Broadley				
	Terri Clark				
	Andrew Doe		A		
	Jamie Donald				
	Yasmin Dossabhoy				
	Paul Froggatt				
	Alison Honour				
In Attendance (excl Governors, members of public and non-Standing Invitees)	Eiri Jones				
	Phillipa Knight				
	Deborah Lane				
	Irene Mardon				
	Helen Martin				
	Deborah Matthews				
	Richard Moreman				
	Joanne Sims				
	Lorraine Tonge				
	Tara Vachell				
	Klaudia Zwolinska				
Was the meeting quorate?		Y	Y	Y	Y

Key

	Not in Attendance
A	Apologies
D	Delegate Sent