University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET

NHS FOUNDATION TRUST

BOARD OF DIRECTORS – PART 1 MEETING

Wednesday 15 July 2026

9:30 – 12:30

Boardrooms at Poole Hospital

and via Microsoft Teams

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

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

AGENDA – BOARD OF DIRECTORS – PART 1 HELD IN PUBLIC

09:30 on Wednesday 15 July 2026, Boardrooms at Poole Hospital

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

Judy Gillow
Interim Trust Chair

Time		Item	Method	Purpose	Lead
	1	**STANDING ITEMS**			
09.30	**1.1**	Welcome, apologies and declarations of interest	**Verbal**		**Chair**
09.32	**1.2**	Notification of any urgent business	**Verbal**	**Review**	**Chair**
09:37	**1.3**	Minutes of the meeting held on 13 May 2026	**Paper**	**Agree**	**Chair**
09:38	**1.4**	Action log and matters arising	**Paper**	**Review**	**Chair**
	2	**TRUST CHAIR AND CHIEF EXECUTIVE OFFICER'S UPDATES**			
09:40	**2.1**	Trust Chair's update • Update from the Council of Governors	**Verbal** **Verbal**	**Note** **Note**	**Chair** **LG**
9:50	**2.2**	Chief Executive Officer's report	**Paper**	**Note**	**CEO**
	3	**STRATEGY**			
10:05	**3.1**	ICB strategic ambition and Trust response	**Paper**	**Review**	**CSTO**
10:20	**3.2**	Transforming Care Together: • Phase 3 Move Timeline and Options • COAST Building Delay Impact	**Paper**	**Agree**	**CSTO**
	4	**PERFORMANCE, ASSURANCE AND RISK**			
10:40	**4.1**	Audit committee assurance report • Committee annual report • Board Assurance Framework 2025/26 and 2026/27 **(CNO)** • Corporate risk register **(CNO)** • Compliance with Provider Licence and Code of governance for NHS provider trusts **(DoCG)** • Data security protection toolkit **(CDO)**	**Paper**	**Assure/ agree**	**Committee Chair**

11:00		**15 MINUTE BREAK**			
11:15	**4.2**	Finance and performance committee assurance report • Integrated Quality, Performance, Workforce, Finance and Informatics report incl. no criteria to reside update **(Exec) (COO)** • Green plan progress **(CSTO)** • Premises Assurance Model (PAM) **– (CSTO)**	**Paper**	**Assure/ agree**	**Committee Chair**
11:35	**4.3**	Quality committee assurance report • Integrated Quality, Performance, Workforce, Finance and Informatics report **(Exec)** • Quality impact assessment report **(CNO, CMO)** • Annual complaints report **(CNO)** • Eliminating Mixed Sex Accommodation Annual Statement 2026/27 **(CNO)**	**Paper**	**Assure/ agree**	**Committee Chair**
11:55	**4.4**	People and culture committee assurance report • Integrated Quality, Performance, Workforce, Finance and Informatics report **(Exec)** • Workforce race equality and workforce disability equality standards (WRES and WDES) and gender pay gap actions **(CPO)** • Medical revalidation annual report **(CMO)** • Annual security report **(COO)**	**Paper**	**Assure/ agree**	**Committee Chair**
12:05	**4.5**	Transforming care together group assurance report • Terms of reference	**Paper**	**Assure/ agree**	**Committee Chair**
12:10	**4.6**	Charitable funds committee assurance report • Committee annual report	**Paper**	**Assure/ agree**	**Committee Chair**
12:15	**4.7**	Integrated Quality, Performance, Workforce, Finance and Informatics report • No criteria to reside **(COO)**	**Paper**	**Assure**	**Exec leads**
	5	**GOVERNANCE**			
12:25	**5.1**	Trust Constitution update	**Paper**	**Agree**	**DoCG**
	6	**MEETING CLOSURE**			
12:25	**6.1**	Reflections on the Board Meeting	**Verbal**	**Discuss**	**Chair**
	6.2	Questions from the Council of Governors and Public arising from the agenda. Governors and Members of the public are requested to submit questions relating to the agenda by no later than 12noon on Friday 10 July 2026 to:			

		uhd.company.secretary-team@nhs.net
12.30	**6.3**	**Date and Time of Next Board of Directors Part 1 Meeting:** Board of Directors Part 1 Meeting on Wednesday 9 September 2026 at 9:30.
	6.4	**Resolution Regarding Press, Public and Others:** To agree, as permitted by the National Health Service Act 2006 (as amended), the Trust's Constitution and the Standing Orders of the Board of Directors, that representatives of the press, members of the public and others not invited to attend the next part of the meeting be excluded due to the confidential nature of the business to be transacted.

* Late paper
[R] Associated item in Reading Room

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

Items for Next Board Part 1 Agenda

Standing Reports

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

Quarterly/Bi-annual/Annual Reports

- Anti-fraud, bribery and corruption policy and statement
- Premises assurance model
- Workforce race equality and workforce disability equality standards (WRES and WDES) reports
- Guardian of safe working report
- Safe staffing: midwifery
- Mortality report
- Annual safeguarding report
- Annual infection, prevention and control report
- Annual health and safety report
- Mixed sex accommodation declaration
- Board meeting and governance cycle

University Hospitals Dorset
NHS Foundation Trust

AGENDA- BOARD OF DIRECTORS – PART 2 HELD IN PRIVATE

12:45 on Wednesday 15 July 2026, Boardrooms at Poole Hospital

Time	Item		Method	Purpose	Lead
	7	**STANDING ITEMS**			
12.45	**7.1**	Welcome, apologies and declarations of interest	**Verbal**		**Chair**
12.47	**7.2**	Notification of Urgent Business or Confidential Escalations	**Verbal**	**Review**	**Chair**
12.52	**7.3**	Minutes of the Board Part 2 Meetings held on 13 May and 17 June 2026	**Paper**	**Agree**	**Chair**
12.54	**7.4**	Action log and matters arising	**Paper**	**Review**	**Chair**
	8	**CHIEF EXECUTIVE OFFICER'S UPDATE**			
12.56	**8.1**	Chief Executive Officer's Update	**Verbal**	**Note**	**CEO**
	9	**GOVERNANCE**			
13.16	**9.1**	Healthset governance arrangements	**Paper**	**Approve**	**CDO**
13.26	**9.2**	Mortuary oversight- Board Assurance Statement	**Paper**	**Approve**	**CNO**
	10	**PERFORMANCE**			
13.36	**10.1**	NHS Oversight Framework 2026/27	**Paper**	**Inform**	**COO**
	11	**ITEMS FOR APPROVAL**			
13.46	**11.1**	Private Patient Oncology Concession	**Paper**	**Approve**	**CFO**
13.51	**11.2**	Supply of IV fluids managed service contract and managed inventory service	**Paper**	**Approve**	**CFO**
13.56	**11.3**	Use of seal: Deed of dedication and dedication agreement	**Paper**	**Approve**	**CSTO**
	12	**MEETING CLOSURE**			
13.58	**12.1**	Reflections on the Board Meeting	**Verbal**	**Discuss**	**Chair**
Date and Time of Next Standing Board of Directors Part 2 Meeting: Board of Directors Part 2 Meeting on 9 September 2026 at 12.30.					
Close					

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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
CMO- Chief Medical Officer
COO- Chief Operating Officer
DoM- Director of Maternity
DoCG – Director of Corporate Governance
LG- Lead Governor

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

BOARD OF DIRECTORS PART 1

Minutes of the Part 1 meeting of the Board of Directors held on

Wednesday 13 May 2026 at 9:30 in Boardrooms at Poole Hospital and via Microsoft Teams.

Present:	Judy Gillow	Trust Chair
	Siobhan Harrington	Chief Executive Officer
	Beverley Bryant	Chief Digital Officer
	Sarah Herbert	Chief Nursing Officer
	Tracie Langley	Non-Executive Director
	Femi Macaulay	Non-Executive Director
	Michael Marsh	Non-Executive Director
	Alastair Matthews	Non-Executive Director
	Helena McKeown	Non-Executive Director
	Mark Mould	Chief Operating Officer
	Pete Papworth	Chief Finance Officer
	Sharath Ranjan	Non-Executive Director
	Richard Renaut	Chief Strategy and Transformation Officer
	Claire Whitaker	Non-Executive Director
	Melanie Whitfield	Chief People Officer
	Peter Wilson	Chief Medical Officer
In Attendance:	Benjamin Anjo	Clinical Staff Governor
	Colin Blebta	Public Governor
	Katherine Brereton	Corporate Governance Manager
	Lisa Clarke	Group Director of Operations WCCSS
	Sharon Collett	Public Governor
	Helena Cull	Senior Stakeholder Engagement Officer
	Andrew Doe	Associate Non-Executive Director
	Alison Honour	Associate Non-Executive Director
	Malcom Keith	Staff Governor
	Helen Martin	Freedom to Speak Up Guardian
	Rosie Martin	Public Governor
	Keith Mitchell	Public Governor
	Laura Northeast	Head of Patient Experience
	Diane Smelt	Public Governor
	Carrie Stone	Public Governor
	Lorraine Tonge	Director of Midwifery
	Tara Vachell	Freedom to Speak Up Guardian
	Michele Whitehurst	Public Governor
	Klaudia Zwolinska	Deputy Company Secretary
	(Three members of the public in attendance)	

BoD064/26	**Welcome, Introductions, Apologies and Quorum** Judy Gillow opened the meeting, welcomed Board members, colleagues, governors, staff observers and members of the public, and noted the value of attendance at the public session. No apologies for absence were reported, and Judy Gillow confirmed that the meeting was quorate.
BoD065/26	**Declarations of Interest** No existing interests were declared in conflict with the agenda. Existing interests were noted as recorded in the register. No new declarations were made.
BoD066/26	**Patient Story** Sarah Herbert introduced the patient story, emphasising the importance of end-of-life care and the need to get this right for every patient. She explained that the discussion was based on feedback from Sarah Johns following the death of her uncle, Grant, in Critical Care at Royal Bournemouth Hospital, and outlined the Trust's focus on improving recognition of dying and ensuring appropriate symptom management. Sarah Johns described her uncle's background, including his longstanding alcohol dependency and deterioration prior to admission. She highlighted positive aspects of care, particularly the compassionate communication from a staff member, Adam, who in the Critical Care Unit provided regular updates via text to accommodate with her mother's night shift work and ensured that both Grant and his family were kept informed. She noted that he consistently spoke to Grant, maintaining his dignity, and that this patient centred approach was highly valued. Sarah Johns also described areas for improvement. She explained that the family did not receive timely communication as her uncle's condition deteriorated and were not informed of his transfer to critical care, limiting their opportunity to see him prior to transfer. This was acknowledged by Sarah Herbert as a key learning point regarding communication at the point of deterioration. Sarah Johns suggested earlier and clearer updates in such circumstances. She also identified practical improvements, including the introduction of a coffee machine in waiting areas and better preparation for families attending critical care, particularly information about the environment and what to expect. Judy Gillow thanked Sarah Johns for sharing these insights. Siobhan Harrington reflected on the compassion shown by staff, noting the relevance of the discussion in the context of International Nurses' Day, and sought assurance that communication at deterioration remains a focus. Sarah Herbert confirmed this, referencing ongoing work including Martha's Rule. Michael Marsh asked about the clarity of clinical language, and Sarah Johns confirmed that terminology had been clearly explained. Pete Papworth noted that the practical suggestions, including the coffee machine, could be explored through charitable funding. Claire Whitaker emphasised the importance of preparing families for critical care environments. Alison Honour reflected on how overwhelming clinical environments can be for families and stressed the importance of preparation and support. Tara Vachell proposed the use of virtual walkthrough videos, drawing on successful examples from neonatal services, to better prepare families for critical care. Sarah Herbert confirmed that the Trust would take forward the learning, focusing on improving communication at points of deterioration and enhancing preparation for families.

	In closing, Judy Gillow noted the value of Sarah Johns' story in highlighting both good practice and areas for improvement and suggested sharing the learning more widely across the organisation.
BoD067/26	**Notification of any Urgent Business or Confidential Escalations** No notifications of urgent business or confidential escalations.
BoD068/26	**Minutes and Actions of the Meeting held on 11 March 2026** The Minutes of Part 1 meeting of the Board of Directors held on 11 March 2026 were AGREED as an accurate record following amendments to the Maternity Safer Staffing Review agenda item to better reflect the discussion.
BoD069/26	**Matter Arising – Action List** **BoD003/26** *Oncology Follow up* -Judy Gillow confirmed that the oncology follow up action had been completed and was closed. No further matters arising were raised.
BoD070/26	**Trust Chair's Update** Judy Gillow presented her update. She highlighted the exceptional level of participation in the Trust Staff Awards, noting that over 1,200 nominations had been received. Shortlisting has been completed and published on the Trust website. The awards ceremony will take place on 11 June in the Pavilion Theatre in Bournemouth. Judy Gillow promoted upcoming public engagement initiatives, including a community heart health talk by Chris Critoph at St Saviour's Church on 16 June, which will be open to the public. The Board noted recognition of International Nurses' Day and recent celebrations of midwifery, with Sarah Herbert and her team organises a range of events and talks in celebration of International Nurses Day. Judy Gillow commended the care, compassion and professionalism demonstrated by staff reaffirming the Trust's commitment to compassionate leadership and staff empowerment. Judy Gillow also referenced charity fundraising activity, including the Twilight Walk in support of breast cancer patients, and acknowledged the positive impact of this event. Claire Whitaker echoed praise for the event having participated last year. An update was provided on wider system engagement, including a pan-Dorset governors' event, with the focus on public health and engagement. The event highlighted learning related to health literacy and the contribution of library services in supporting adult literacy. The Board further noted the recent visit of the newly appointed Regional Chair, Gill Morgan, who visited maternity and the ED department at Royal Bournemouth Hospital with positive feedback received, particularly regarding strong staff engagement and openness during discussions on areas for improvement. The Chair's update was NOTED.
BoD071/26	**Chief Executive Officer's Report** Siobhan Harrington presented her report, noting that Board papers reflected performance to March and highlighting the significant pressures experienced between January and March, alongside industrial action in April. She thanked staff, particularly nurses and midwives, for their resilience and commitment, while emphasising that such pressures must not become normalised. She confirmed that patient safety and staff wellbeing remain priorities as the Trust navigates a challenging operational plan, including reconfiguration and the delayed COAST building, within a changing national context. Siobhan Harrington raised concern regarding recent anti-Semitic incidents, reaffirming the Trust's strong stance against discrimination and its commitment to

	being a psychologically safe organisation for all. Claire Whitaker added that, through the Council of Governors, concerns had also been raised that members of the LGBTQ+ community are not feeling safe in light of recent legislative changes, highlighting the importance of visible leadership. Siobhan Harrington agreed to continue this approach, including through engagement with the Pride network. Siobhan Harrington noted progress in elective recovery but identified patient flow as a key ongoing challenge. She confirmed that improvement efforts will focus on flow to support winter planning, financial stability and staff morale. An update on the COAST building confirmed continued delays, with no firm completion date expected before June. This will remain a standing Board item, with scenario planning underway to manage winter capacity and bed availability. Additional updates included the successful rollout of the national uniform across the Trust, confirmation that the financial plan had been achieved, and the establishment of the One Dorset procurement service, strengthening system wide buying power. It was also noted that staff survey results have not yet demonstrated the desired rate of improvement, with a continued focus on staff in the year ahead. The Board welcomed the start of the new Director of Corporate Governance Leonora May. An update was also provided on the ICB, noting the current changes nationally, regionally and across our cluster. Michael Marsh queried the implications of the change in the UK threat level, in relation to a terrorist incident. Mark Mould outlined actions undertaken, including staff communications, reinforcement of visible security measures, and consideration of further work such as tabletop exercises to strengthen preparedness. Michael Marsh also raised Dorset young people's services, with Mark Mould noting the introduction of an additional provider as a positive development, while recognising ongoing challenges relating to waiting times, particularly for neurodivergent young people. Claire Whitaker referenced ICB data indicating increased ED attendances. Mark Mould confirmed this trend, noting an increase around 7% in walk-in activity and the need for further collaboration with NHS 111 colleagues. Sharath Ranjan sought assurance regarding succession planning over the next ten years. Siobhan Harrington confirmed that this work has commenced, supported by Melanie Whitfield, who emphasised the importance of understanding workforce needs as models of care evolve. Peter Wilson added that medical workforce planning remains a key consideration. Femi Macaulay returned to the issue of antisemitism, asking how the Trust is supporting Jewish staff. Siobhan Harrington emphasised the importance of direct engagement, listening to staff experiences and encouraging individuals to speak up to ensure appropriate support is provided. Claire Whitaker supported this approach. Siobhan Harrington further noted that it is essential to understand directly from staff what will help them feel safer. Tracie Langley highlighted the importance of enabling staff to speak up with confidence, ensuring they feel supported and not judged when raising concerns. Siobhan Harrington acknowledged this and reinforced the role of creating a psychologically safe environment. In closing the discussion, it was confirmed that oversight of young people's services would continue through the Quality Committee and the oversight of succession planning through the People and Culture Committee. The CEO's report was NOTED.

BoD072/26	**Annual Operational Plan** Richard Renaut presented the Annual Operational Plan, confirming that it reflects previously agreed strategic objectives and had been updated to incorporate changes to the anticipated COAST building timeline, alongside refinements to workforce, activity and financial assumptions. He noted a minor governance change agreed through TMG and confirmed that the plan is structured around five core objectives, including financial sustainability. He emphasised alignment with the Trust's vision, values and Patient First and the importance of a clear "golden thread" linking organisational priorities to staff objectives, with delivery embedded through appraisal processes and Patient First improvement methodology. Richard Renaut advised that progress against the plan will be monitored through regular reporting, including the Integrated Performance Report. He outlined that delivery will be embedded through organisational processes, with departments aligning to key breakthrough priorities and organisational themes to ensure consistency and visibility. In discussion, Michael Marsh highlighted minor presentational issues within the document. Alastair Matthews queried the continued system-wide commitment to the No Criteria to Reside (NCTR) target, and Siobhan Harrington confirmed that this remains a shared system responsibility, with the Trust accountable for its contribution. The Board considered the balance within the plan across financial, quality and workforce priorities and received assurance that this had been appropriately addressed. Judy Gillow sought assurance on the communications approach for embedding the plan across the organisation. Richard Renaut confirmed that the plan will be cascaded through organisational objectives and staff appraisal processes, ensuring that objectives flow directly from the plan, supported by consistent organisational communications and alignment with wider Trust strategies. The Board APPROVED the Annual Operational Plan
BoD073/26	**One Dorset Procurement Service** Pete Papworth presented the One Dorset Procurement Service. He reminded members that the business case for a single procurement function across Dorset partners had previously been approved and confirmed that implementation has progressed, with staff from partner organisations now operating within a single hosted service. The proposal had been reviewed and supported by both the Finance and Performance Committee and the Audit Committee. Pete Papworth outlined that the service is a single procurement function hosted by UHD, with governance arrangements intended to support collaboration, transparency and shared ownership across partner organisations. Michael Marsh sought clarification on membership and governance arrangements, specifically the representation of partner organisations at Board level. Pete Papworth confirmed that the Procurement Delivery Board would include representation from across disciplines and organisations to ensure a balanced and collaborative approach. Femi Macaulay queried union involvement, Pete Papworth assured that this had been appropriately considered and incorporated. Siobhan Harrington confirmed that relevant stakeholders had been kept updated on progress. Tracie Langley highlighted the importance of ongoing review, particularly in relation to standardisation, to ensure that the service delivers consistent assurance and value across the system. Judy Gillow sought clarity on internal reporting arrangements, and Pete Papworth confirmed that updates would be provided through the Finance and Performance Committee and Audit Committee, with escalation to the Board as required. Alastair Matthews raised the importance of

	having a clear escalation framework, which was acknowledged as part of the governance structure. Tracie Langley closed by thanking the team for the significant work undertaken to deliver the service to this stage. The Board APPROVED the One Dorset Procurement Service
BoD074/26	**Patient Safety Incident Response Framework Plan** Sarah Herbert presented the Patient Safety Incident Response Framework Plan, describing it as a shift towards a proportionate, system-based approach focused on compassionate engagement with patients, families and staff, and embedding learning to deliver sustainable improvement. The plan builds on organisational learning over the past 18–24 months and is informed by data review and stakeholder engagement. She outlined four priority areas: recognition and escalation of deteriorating patients, cross-site transfers and handovers, reducing corridor care, and medication management at discharge, noting these reflect key themes raised in patient safety reporting. Siobhan Harrington welcomed the clarity of the plan, and Michael Marsh noted alignment with Quality Committee discussions while emphasising the importance of maintaining rigour without creating unnecessary burden. Judy Gillow sought assurance on how the priorities would be delivered in practice, particularly the balance between quantitative and qualitative measures within the Patient First approach. Sarah Herbert confirmed that the framework is designed to be meaningful in practice, with a focus on learning and continuous improvement. Michael Marsh reinforced the need for both quantitative and qualitative insights to support effectiveness. Michael Marsh also raised questions regarding digital clinical safety, particularly risks associated with system changes. Beverly Bryant provided assurance that robust arrangements are in place, including oversight from a Chief Clinical Safety Officer and supporting team, with formal sign-off required before systems go live to mitigate risk. Peter Wilson highlighted that governance arrangements will support delivery through structured oversight, use of data and risk registers, and ongoing work to refine metrics, including for deteriorating patients and sepsis, to inform future reporting and improvement priorities. The Board sought assurance regarding organisational capability to implement the framework consistently. Sarah Herbert confirmed that training and oversight arrangements are in place, with progress monitored through the Quality Committee and escalated to the Board as required. The Board APPROVED the Patient Safety Incident Response Framework Plan
BoD075/26	**Maternity and Neonatal Quality and Safety Report** Lorraine Tonge presented the quarterly Maternity and Neonatal Quality and Safety Report, noting ongoing medical workforce challenges expected over the summer months, the impact of litigation, and continued work to support learning and development within the medical workforce, alongside managing staff sickness. Lorraine Tonge highlighted a number of positive outcomes, including an improved stillbirth rate of 2.8 for UHD in 2025 and overall improvements in quality and safety metrics. Sarah Herbert commended Lorraine Tonge and the wider team for their work and noted the importance of recognising this progress in a challenging national context. Andrew Doe sought further understanding of the reduction in midwifery sickness absence and whether learning could be applied more broadly across the organisation. Lorraine Tonge acknowledged the contribution of teams working

	closely with HR to undertake detailed work on sickness management. Sharath Ranjan reflected that effective management and understanding of workforce issues are key indicators of organisational performance. Siobhan Harrington welcomed the report as a strong reflection of the progress made and sought assurance regarding morale within the maternity workforce. Lorraine Tonge confirmed that morale has improved significantly, with staff more settled, more willing to raise issues, and demonstrating improvements in team culture and patient flow, while recognising that further work remains ongoing. Claire Whitaker raised concerns regarding challenges faced by student midwives in achieving competency requirements. Sarah Herbert explained that national requirements, including the need to support a set number of births excluding caesarean sections, present difficulties in the current context where caesarean rates have increased. Alastair Matthews raised concerns regarding the timeliness of post-mortem reports and the limited feedback received from families, noting the importance of learning from patient experience. In response, Lorraine Tonge acknowledged that further work is required to strengthen parent and family engagement and confirmed that increasing feedback and involvement is a key area of focus. She outlined that a range of engagement methods are used, tailored to parental preference, and that additional work is planned to enhance involvement in investigations. Sarah Herbert added that this is a highly sensitive area and emphasised the importance of compassionate, personalised engagement, noting that families may choose how and whether they participate in the process. Further discussion highlighted that delays in post-mortem reporting represent a national challenge. Michael Marsh and Peter Wilson noted wider workforce shortages in paediatric and perinatal pathology, which continue to impact timeliness despite attempts to address this at a national level. The Board were ASSURED by the Maternity and Neonatal Quality and Safety Report
BoD076/26	**Staff Survey Action Plan** Melanie Whitfield presented the Staff Survey Action Plan. She drew attention to updated analysis, including additional focus on equality and the experience of colleagues living with long-term illness, and highlighted the importance of recognising and valuing staff contribution. She also acknowledged the work of the Communications team in supporting the People Promise and staff-facing materials. Melanie Whitfield advised that, while the results reflect a challenging year for staff, the Trust remains in a comparatively strong position against national benchmarks, though there is clear evidence that workload, change and uncertainty have impacted staff experience. Pete Papworth noted that the presentation of benchmarking data should be considered carefully to ensure it accurately reflects the organisation's relative performance. In discussion, Michael Marsh challenged how the organisation can continue to improve from an already strong position, and Richard Renaut emphasised that continuous learning remains essential, with a clear opportunity to align improvements to the clinical strategy and Patient First approach, particularly focusing on how staff can make a meaningful difference over the coming years. Tracie Langley reinforced the importance of learning from others, including considering best practice from organisations such as those in London. Sharath Ranjan raised concerns regarding gaps in appraisal and succession planning processes, highlighting this as a priority area. Helena McKeown emphasised the importance of hearing from less visible staff voices, including those in non-clinical roles or with language barriers, and ensuring that diversity and inclusion issues are fully understood. Melanie Whitfield acknowledged this and confirmed that, while much is already in place under the People Promise, further

	direct engagement with staff is required to understand what will make a tangible difference. Judy Gillow questioned whether the organisation is being sufficiently ambitious in its response. Siobhan Harrington advised that a realistic but stretching three-year ambition is appropriate given the scale of organisational change and highlighted the importance of deeper analysis of staff feedback, including themes relating to appraisal, psychological safety and experiences across different staff groups. Claire Whitaker suggested benchmarking against organisations that have undergone similar transformation to identify transferable learning. The Board REVIEWED the Staff Survey Action Plan
BoD077/26	**Corporate Risk Register** Sarah Herbert presented the risk register. She reflected on the maturity of risk management within the organisation, noting progress over the past two years in developing a clearer and more consistent understanding of risk. She outlined that a structured cycle is now in place to review risks across care groups and confirmed that, while risks remain, overall risk ratings have reduced compared to previous periods, demonstrating a more developed and responsive approach. Sarah Herbert highlighted recent increases in pressure ulcers and patient falls had been observed during periods of operational and workforce pressure. While these indicators have since improved, she emphasised the need for continued vigilance and cautioned against assuming that improvements would be sustained without ongoing oversight. Tracie Langley commended the progress made in strengthening risk management and wider organisational understanding of risk, noting that the Risk Oversight Committee is supporting more informed and constructive discussions. She expressed assurance that risks are being actively managed both operationally and in a way that reflects public expectations. Alastair Matthews raised concerns regarding the visibility and articulation of certain risks within the report, particularly where they affect large population groups. Sarah Herbert acknowledged the challenge of maintaining conciseness while ensuring sufficient detail and agreed to consider how risks can be more clearly presented without unnecessarily increasing the length of reporting. Judy Gillow supported this, emphasising the importance of ensuring that reports clearly capture direction and trajectory over time. Siobhan Harrington highlighted the importance of ensuring that risk action planning remains dynamic, relevant and reflective of live operational issues, with continued refinement of reporting templates as needed. Michael Marsh added that while actions are often taken, there can be reluctance to de-escalate risks, noting the importance of ensuring risks can move appropriately both up and down based on evidence, and that learning should inform whether actions are effective or require adjustment. Sarah Herbert confirmed that active challenge is in place with teams to ensure appropriate calibration of risk scores. Helena McKeown raised concerns regarding risks potentially being managed in silos and emphasised the importance of cross-organisational visibility, referencing workforce challenges in specialist areas. Mark Mould responded that risks are embedded within business-as-usual processes and are regularly reviewed through governance structures, including consideration of future workforce and service implications. Alison Honour sought assurance regarding confidence in how risks are identified and escalated, including emerging risks. Sarah Herbert confirmed that local governance processes support staff to raise risks appropriately, and that there is increasing recognition of emerging risks, including those on the horizon, within the organisation.

	The Board NOTED the Corporate Risk Register
BoD078/26	**Committee Chairs' Assurance Reports** <u>Quality Committee</u> Michael Marsh presented the report, highlighting an increase in reported pressure ulcers as an area of alert. He advised that further review had identified this may relate in part to documentation processes, with actions put in place to address this. The Committee will continue to monitor closely as a fundamental aspect of quality of care. In terms of assurance, Michael Marsh highlighted positive progress in research governance, alongside strong equality and quality impact assessments supporting the cost improvement programme, noting no evidence of compromise to quality. On areas of advice, he updated on the oncology transfer, confirming a task and finish group is in place to review processes, including wider "go/no go" decision-making. He also noted anomalies in end-of-life coding, which may impact HSMR data, although this is not expected to be of material significance. From the May meeting, Michael Marsh alerted the Board to a temporary power surge affecting maternity services, which was resolved, with affected patients contacted and supported. He also advised that while progress has been made on the medical device replacement programme, further work is required to achieve full assurance. The Committee reviewed the CQC maternity action plan and received assurance that performance metrics support service delivery, despite workforce and regulatory challenges. Good progress was also noted in the rollout of electronic results acknowledgement, with full implementation expected within planned timescales. Michael Marsh noted that a deep dive on VTE prophylaxis is planned, and highlighted effective leadership in the delivery of electronic results acknowledgement as an example of good practice. The Board NOTED the Quality Committee report. <u>Finance and Performance Committee</u> Alastair Matthews presented the Finance and Performance Committee assurance report. He reported that overall financial and operational performance had been maintained, with assurance provided on delivery of the prior year financial plan and progress against key operational metrics, including improvements in waiting list performance. However, he highlighted that a significant challenge remained in achieving the savings target for the current year, with a residual gap of approximately £20 million still to be identified, albeit with plans more advanced than at the same stage in previous years. The Committee noted ongoing operational pressures, including risks associated with patient flow and NCTR, where progress remained limited and required continued system-wide focus. Alastair Matthews further reported on pressures within the Emergency Department, noting the sustained impact on performance and flow, and the need for continued focus on improvement actions. The potential impact of delays to the COAST building programme was also noted, with further financial analysis awaited. The Board NOTED the Finance and Performance Committee report. <u>Audit Committee</u> Tracie Langley presented the Audit Committee report, noting the routine assurance provided through the three lines of audit: external, internal and counter fraud. She confirmed that there were no new alerts to report. Tracie Langley highlighted the positive assurance received from auditors, both formally and through independent discussions, noting their consistent recognition

	of the organisation's engagement, capability and capacity. She emphasised that this provides strong assurance to the Committee. Tracie Langley also commended the organisation's approach to audit, highlighting improved follow-up of recommendations and a proactive approach to using audits to identify areas for improvement. No new significant risks were identified beyond those already known. Tracie Langley noted that work relating to ward identification checks would transition from the Audit Committee to the People and Culture Committee to ensure continued oversight. She also referenced ongoing independent assurance work in relation to the COAST programme. The Board NOTED the Audit Committee report. <u>People and Culture Committee</u> Sharath Ranjan presented the report from the meeting held on 6 May and highlighted learning from a staff story relating to the endoscopy service transformation. He noted that while staff are highly motivated to deliver patient care, organisational barriers can impact their ability to do so, and earlier escalation of such issues is required. Sharath Ranjan reported that while workforce reduction targets had not been achieved this year, assurance was provided on plans for next year, including clearer workforce restructuring aligned to the operational plan. He highlighted appraisal completion as a key priority, emphasising that accountability sits across the Executive team to ensure delivery. Sickness absence was noted as improving from previously high levels and is now at 4.7% against a 4.1% target, with improvement attributed to stronger management focus. Assurance was also noted in relation to staff survey action planning, although further progress is required as plans are embedded. The Committee received an update from the Health and Safety Group, with recognition that further maturity is required in the depth of discussion and oversight. Sharath Ranjan also acknowledged the breadth of work underway within the HR directorate, noting that not all activity is fully visible at Board level. The Board NOTED the People and Culture Committee report. <u>Transforming Care Together Group</u> Judy Gillow provided an update from the Transforming Care Together Group, noting the report reflects the April position, with some progress since. The Group reviewed the COAST building programme, highlighting continued uncertainty on delivery timelines and the impact on staff morale, with further clarity expected in June. People Ready workforce planning remains behind schedule, and it was agreed that associated risks should be incorporated into the programme risk register to strengthen oversight. Progress on enabling projects and governance arrangements was noted. Key risks include emergency department capacity and wider operational dependencies. Agreed actions include refreshing the communication and engagement plan, reviewing digital readiness, and updating the programme risk register. Judy Gillow recognised the efforts of staff supporting the programme. Beverly Bryant confirmed ongoing work between digital and estates, with a further update to follow. The Board NOTED the Transforming Care Together Group.

BoD079/26	**Integrated Quality, Performance, Workforce, Finance and Informatics Escalation Report** Population and System Mark Mould introduced the report, highlighting two key areas of escalation: patient flow and patients with NCTR. He advised that work is focused on what is within the Trust's control, including a renewed emphasis on ensuring patients are discharged safely and without delay. A corporate project has been established within the operational plan, with strengthened discharge processes such as weekly multidisciplinary discharge meetings. The current trajectory is under review, with a clear focus on achieving the target of 110 patients or fewer with NCTR. The Board noted wider improvement activity, including over 400 admission reviews led by Dr Ian Strugess, supporting a Trust-wide understanding of patient pathways, and a forthcoming clinical workshop scheduled for 27 May. Mark Mould also highlighted the ongoing challenge of the care in non-clinical areas, reiterating a zero-tolerance ambition, and noted that increasing demand, with 15% more patients treated, continues to place pressure on flow and capacity. Claire Whitaker raised concerns regarding the presentation of fractured neck of femur performance data, noting that the graph was difficult to interpret. In response, Mark Mould clarified that the national standard requires surgery within 36 hours of admission and confirmed this had been reinforced with clinical teams. He acknowledged a recent plateau in performance, linked to increased demand and capacity pressures, and confirmed this remains an area of focus. Michael Marsh added that performance variability suggests process-related issues rather than structural limitations and emphasised that recovery to the national standard remains achievable. He confirmed that further review and discussion will be undertaken through the Quality Committee to support improvement. Our People Melanie Whitfield highlighted a small variance between the workforce establishment and the financial plan whole time equivalent, noting that work is already underway to reconcile this. She advised that, despite this, staff experience continued pressure, with concerns that there is insufficient capacity, time and space to deliver the quality of work expected. This reflects the challenge of balancing workforce controls with operating within financial limits, which will remain a focus over the year ahead. Melanie Whitfield reported that vacancies are improving, with reduced time to hire, although there remains a number of hard-to-fill roles, particularly those vacant for over six months, which are linked to key organisational risks. She concluded on a positive note, highlighting a significant improvement in staff turnover, emphasising the importance of effective line management and staff retention in supporting team performance and overall workforce stability. Quality Outcomes and Safety Sarah Herbert highlighted that infection prevention and control metrics remain below target, with hand hygiene continuing to be a key area of focus. She noted that the introduction of new uniforms provides an opportunity to reinforce compliance standards. She reported year-end improvements, including a reduction in MSSA cases from 13 to 6, C. difficile below the national trajectory, and E. coli slightly below target, though further improvement is required. Robust action plans and ongoing audit activity are in place. Sarah Herbert also noted that increases in pressure ulcers and patient falls were linked to periods of operational and staffing pressure. While these have since improved, she emphasised the need for continued vigilance to sustain progress.

	Sustainable Services – Finance Pete Papworth reported that the Trust delivered a small year-end surplus of £33,000, with capital expenditure in line with plan and strong cash performance. He outlined the new year efficiency programme, noting an ambitious target of 6.8% (£68.5 million), with 70% of the target currently identified, of which 56% is recurrent. A remaining £20 million gap was highlighted, with a particular focus on urgent and emergency care flow pathways. Pete Papworth also reported ongoing system-wide work across Dorset to explore consolidation of four services into single service models. Additional areas of focus include strategic work commissioned by the ICB in relation to Vista Health, detailed GIRFT reviews in maternity and orthopaedic surgery, workforce redesign, and further development of private patient opportunities and joint ventures. Sustainable Services – Digital Beverly Bryant noted that the organisation is currently in an interim phase while new analytical capability is being developed. Claire Whitaker asked about the potential use of advanced voice technology. Beverly Bryant confirmed that ambient voice technology is being explored through EPIC, with plans for a trial period and further consideration through the Finance and Performance Committee. The Board NOTED the Integrated Quality, Performance, Workforce, Finance and Informatics Escalation Report.
BoD080/26	**Assurance Reports to Approve** Freedom To Speak Up annual report Helen Martin presented the Freedom To Speak Up annual report. She advised that the service is well embedded within the organisation and continues to be positively benchmarked both internally and externally. While the overall number of cases has reduced, the complexity of concerns has increased, requiring more in-depth engagement with care groups and senior leaders. Noting that they had been well rated from the service users, and external and internal benchmarking. Pete Papworth highlighted that 43% of staff came to the Freedom To Speak Up in relation to to concerns about line management, either where managers were directly involved or where issues had not been addressed appropriately. He emphasised the importance of strengthening management capability to ensure concerns are handled early and compassionately. Helen Martin confirmed that analysis of this data is informing leadership development activity. Siobhan Harrington commended the quality and detail of the report and noted the increasing use of artificial intelligence in complaints and concern raising, adding complexity to interactions. Tracie Langley sought clarity on how this is managed in practice. Helen Martin advised that the team prioritises direct engagement with individuals wherever possible, recognising that AI-generated content can lack clarity of intent. Tara Vachell highlighted the need to recognise both the opportunities and challenges associated with emerging technologies in this area. The Board APPROVED the Freedom to Speak Up Annual Report. Independence of Non-Executive Directors Judy Gillow presented the Independence of the Non-Executive Directors which was APPROVED by the Board. Annual Certificates: availability of resources; training of governors Pete Papworth presented the Annual Certificates, adding that the Trust has a reasonable expectation of sufficient resources, noting that while a balanced

	financial plan has been set, there remains recognised risk within the efficiency programme, mitigated by strong cash reserves. The Board APPROVED the Annual Certificates: availability of resources; training of governors. Board Committees – Effectiveness Reviews The Committee Chairs presented their respective effectiveness reviews, which were APPROVED by the Board.
BoD081/26	**Assurance Reports to Note** Mortality Report The Mortality Report was presented by Peter Wilson, who highlighted this as a strong example of the Trust's "Patient First" approach in practice, demonstrating effective use of governance processes to identify learning and support continuous improvement. The Morality Report was NOTED. Quality Impact Assessment Overview Report Sarath Herbert presented the Quality Impact Assessment Overview Report. Alastair Matthews raised concerns regarding the potential impact of cost improvement programmes on safety. Sarah Herbert provided assurance that risks are being appropriately assessed at a local care group level, with lower-risk QIAs managed locally to avoid delays, and that additional oversight mechanisms are in place to support transformation activity. It was noted that further feedback on progress, including management of the current backlog, will be brought to a future meeting. **ACTION:** To provide assurance on the application of the QIA process, including management of the current backlog and confirmation that low-risk QIAs are being appropriately handled at care group level without delaying delivery or compromising quality. **Sarah Herbert** The Quality Impact Assessment Overview Report was NOTED. Guardian of Safe Working Hours Report Peter Wilson highlighted an increase in exception reporting, noting this as a positive indicator of transparency. Peter Wilson added that our new guardian of safe working Rachel Ford is working through this. Michael Marsh sought clarification on whether advice extended to broader workforce initiatives, including the 10-point junior doctors training plan. Peter Wilson confirmed that the 10-point plan is separate and that we are at 94% on the plan. The ones outside of our gift are a range of issues are being addressed, including carry-over of annual leave, accommodation and car parking arrangements for resident doctors, with progress being made, including achieving full compliance in some areas. The Guardian of Safe Working Hours Report was NOTED. Patient Safety Event Report The Patient Safety Event Report was discussed, with particular focus on Never Events within theatres. It was noted that there is a specific piece of work being undertaken by Jess Wiggins, which is progressing well, although further assurance will be required once actions are fully embedded. Peter Wilson also advised that, while Duty of Candour conversations are taking place, recording remains inconsistent, meaning full assurance cannot yet be provided. It was confirmed that this will continue to be monitored and reported through the Quality Committee.

	The Patient Safety Event Report was NOTED. <u>7 Days Services Board Assurance Framework</u> The Seven Day Services Board Assurance Framework had previously been reviewed by the Quality Committee. Michael Marsh emphasised that achievement of some standards is dependent on delivery of wider transformation programmes. Judy Gillow raised the impact on outstanding Open Learn items, noting that approximately 2,000 remain open. Sarah Herbert confirmed that targeted work is underway to address this backlog, with a focus on prioritising the most critical actions while accelerating overall progress. The 7 Days Services Board Assurance Framework was NOTED. <u>Seal of Documents Register</u> Judy Gillow presented the Seal of Documents Register which was NOTED by the Board. <u>Register of Directors' Interests</u> Judy Gillow presented the Register of Directors' Interests which was NOTED by the Board.
BoD082/26	**Reflections on the Board Meeting** Referencing the Operational Plan agenda item, Richard Renaut confirmed that, in line with the NHS Foundation Trust Code of Governance, the Trust had sought feedback on the plan from its members and received approximately 20 responses. Judy Gillow reflected on the breadth and pace of the agenda, acknowledging its complexity and emphasising the importance of maintaining adequate time for scrutiny and challenge to support effective governance, noting that no issues should be overlooked despite time pressures. The Board recognised the meeting had been demanding given the volume of business but confirmed they had been able to raise questions and contribute to discussions as needed.
BoD083/26	**Questions from the Council of Governors and Public arising from the agenda.** No questions were raised.
BoD084/26	**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 the next part of the meeting be excluded due to the nature of the business to be transacted. There being no other business, the Judy Gillow thanked all those present and the meeting was closed.
The next standing Board of Directors Part 1 meeting would be held on Wednesday 15 July 2026 at 9:30	

Board Part 1 Action List - July 2026						
Meeting Date	**Minute No.**	**Matter Arising / Action**	**Lead**	**Due Date**	**Progress**	**Status**
13/05/2026	BoD081/26	To provide assurance on the application of the QIA process, including management of the current backlog and confirmation that low risk QIAs are being appropriately handled at care group level without delaying delivery or compromising quality.	**Sarah Herbert**	15/07/2026	15/07/2026: Update on QIA including on the ongoing progress related to the process and care group review was presented to the Quality committee at its meeting in July and is included within the reports for this Board meeting.	Complete

JULY 2026 TRUST BOARD
CHIEF EXECUTIVE UPDATE

1 INTRODUCTION

As I read the Ockenden report, I was reminded that behind every recommendation is a woman, a baby and a family whose experience should have been better. It is a difficult report to read, and one that prompts reflection for every NHS organisation, providing maternity and neonatal care, regardless of where the events occurred. I believe we have a responsibility to approach its findings with humility, openness and a determination to keep improving.

At UHD we are committed to learning and action from the report and the subsequent Amos Review and to continually strengthen our maternity and neonatal services. While we know that our teams provide compassionate skilled and dedicated care, we must never become complacent, listening to women and families, acting on feedback, supporting our staff to speak up and learn, and relentlessly focusing on safety and quality must remain at the heart of our approach.

I also recognise that this report will be deeply unsettling. It may understandably cause anxiety for women, families and our wider community, while also affecting the morale of colleagues who work in a field where things can go wrong, and they have devoted their careers to providing safe care. It is therefore vital that we continue to engage openly with both our staff and the communities we serve, creating space for honest conversations, sharing the improvements we are making, and building confidence, compassion and evidence of sustained improvement. I think the learning is transferable to all the services we provide here at UHD, and as a Board we will continue to embed the voice of our service users in everything we do.

We have also recently experienced an extremely challenging heatwave and had to work hard to maintain the safety of both our patients and staff throughout this period. I took the opportunity to visit teams during this time and was impressed by both the response of our staff and the measures put in place to support colleagues. The resilience and determination shown across the organisation were evident throughout, and I would like to thank everyone for their efforts.

Looking ahead, our focus remains on maintaining safe services through the summer, delivering our key priorities and supporting colleagues. I am grateful for the commitment and care colleagues continue to show, and for the practical support teams are giving one another as we work through this busy summer period.

2 NATIONAL UPDATES

2.1 NHS College of Leadership and Management

NHS England has announced the launch of the NHS College of Leadership and Management, which will become the national home for leadership, management and talent development across the NHS. Alongside this, NHS England and the Department of Health and Social Care have published a new NHS Leadership and Management Framework, establishing a single national standard for leadership and management across all professions and levels. The framework will be incorporated into appraisal, recruitment, talent and development processes during 2026/27, with organisations expected to support leaders and managers to undertake self-assessment and development planning against the new standard.

2.2 Resident doctors' industrial action

The decision by resident doctors in England to accept the Government's latest offer on pay, jobs and working conditions is a welcome development for patients, staff and the NHS as a

whole. Planned strike action in June was called off while British Medical Association members considered the offer, which has now been accepted. The agreement includes an average 6.6% pay uplift to be fully implemented by April 2027, the extension of standard 2016 resident doctor contract terms to locally employed doctors, and a commitment to create 4,500 additional specialty training places over three years. This should support greater stability after a prolonged period of industrial action, although the focus will now need to be on implementation, maintaining constructive engagement with resident doctors, and continuing to support services as they recover from the cumulative impact of disruption. Resident doctors agree deal with government to end strikes - GOV.UK

2.3 Consultants ballot results on industrial action

This week the BMA announced that Consultants across England have voted in favour of NHS strike action in future over pay and pensions. 76% voted in favour and so now they have a mandate for strike action over the next 12 months.

2.4 Ockenden Review of maternity services at Nottingham University Hospitals NHS Trust

The publication of the Ockenden Review into maternity services at Nottingham University Hospitals NHS Trust has set out deeply concerning findings about the care experienced by women, babies and families over a number of years. The report is difficult reading and has had a profound impact on families across England, particularly those who have experienced harm, loss or felt that their voices were not heard. It is important that we do not see this as an issue for one organisation alone. At UHD, we will review our local maternity, neonatal and related processes in light of the findings, with a particular focus on listening to women and families, responding to concerns, strengthening learning and ensuring that improvement work remains visible and accountable. Ockenden Review into maternity services at Nottingham University Hospitals NHS Trust: final report - GOV.UK

2.5 National Maternity and Neonatal Investigation

The final report of the National Maternity and Neonatal Investigation, chaired by Baroness Valerie Amos, was also published in June. This identified wider national themes including listening to women and families, staffing, demand and capacity, inequalities, culture, complaints handling and the need for stronger accountability. NHS England has asked trusts and systems to consider the findings from both reports and has set out a 10 Point Plan for urgent action. UHD will consider the national recommendations alongside existing maternity improvement work and external review activity. National Maternity and Neonatal Investigation: final reports

2.6 New NHS Oversight Framework Published (11 June 2026)

NHS England published its new NHS Oversight Framework for 2026/27 in June, providing greater clarity on how the wider NHS reforms and emerging operating model will be implemented in practice. While earlier announcements focused on the direction of travel for the NHS, including changes to system leadership, provider accountability and integrated care, the new framework sets out how providers and integrated care boards will be assessed against core measures of access, quality, workforce, productivity and financial performance. It also introduces a more transparent approach to benchmarking, oversight and intervention, reinforcing expectations around delivery and improvement while providing organisations with a clearer understanding of how performance will be monitored under the evolving NHS operating model. NHS England » NHS Oversight Framework 2026/27

3 DORSET UPDATES

3.1 **NHS Dorset awarded funding to lead innovative obesity care programme**

NHS Dorset has secured national funding to lead an innovative obesity care programme. The initiative supports the wider prevention agenda and aims to improve outcomes for patients living with obesity, whilst reducing future demand on health services. NHS Dorset: obesity care programme funding

3.2 Significant investment in Dorset mental health infrastructure

Dorset HealthCare has opened a new £23 million inpatient mental health facility at St Ann's Hospital, representing the first phase of a wider £70.6 million programme to expand and modernise mental health services across Dorset. The development increases inpatient capacity and forms part of wider system investment in mental health services. Dorset HealthCare: £23m building heralds new era for mental health care in Dorset

3.3 Neighbourhood Health and Wellbeing Programme funding

Dorset partners have launched a £2.5 million Neighbourhood Health and Wellbeing Programme to support preventative and community-based models of care aimed at reducing demand on acute services and improving population health outcomes. Dorset VCSA: Neighbourhood Health and Wellbeing Programme

4 UNIVERSITY HOSPITALS DORSET

4.1 Clinical Vision of Flow

In June, the Clinical Vision of Flow workshop took place involving multidisciplinary colleagues from across the organisation. The high level of engagement reflects a shared recognition that improving patient flow is fundamental to both patient experience and safety, particularly in the context of sustained pressure across urgent and emergency care pathways. The work now moves into its next phase, focusing on translating that collective insight into a clear, deliverable model for how we operate differently across sites and services. This will require continued clinical and operational leadership, alignment with our existing improvement programmes, and a strong emphasis on practical changes that support patients to move more safely and efficiently through our care.

4.2 Performance Headlines

The latest performance position shows progress in a number of areas, alongside continued pressure in urgent and emergency care flow, diagnostics and cancer recovery. The overall picture includes reasons for confidence, particularly in elective recovery and productivity, while also highlighting areas where sustained improvement and system support remain essential.

Elective Care
RTT 18-week performance exceeded our operational plan at 66.9%, with 65-week waits eliminated and 52-week waits below 1%. Whilst diagnostic waits extended in two areas, endoscopy and echocardiology, other areas achieved close to the constitutional standard. We are also seeing improvements in operational productivity, including theatre utilisation, day case rates and missed appointment rates.

Urgent & Emergency Care
In month 3, the 4-hour standard was met at 70.2%, ahead of trajectory. The areas requiring continued focus are clear. Patients who are medically ready to leave hospital are waiting too long for community and social care provision, with NCtR at around 230 against a target of 110. Some of this challenge is due to our internal processes and also is a system-level challenge with direct consequences for the patients who remain with us beyond their clinical need, and for those waiting to come in.

Cancer
Cancer performance in the first quarter has not met national recovery targets, and while structured recovery plans are in place and improvements are expected from June onwards, we are acutely aware of what these numbers mean for individual patients waiting for a diagnosis or treatment.

4.3 Digital Update - HealthSet Electronic Health Record (EHR) Programme

Following Full Business Case approval in early 2026 and the signing of the Epic contract in March, the HealthSet EHR Programme has now moved into its mobilisation phase. The focus is on recruiting the implementation teams and on starting some of the technical workstreams, such as interface development and third-party contracting. Engagement with clinical specialties is building through clinical SME (Subject Matter Expert) recruitment and will improve significantly once key roles are appointed.

A range of roles have been advertised, open to clinical, operational and digital colleagues. Initial appointments are expected from early July 2026, marking an important step towards scaling up delivery capacity, with further recruitment planned over the coming months.

The programme continues to build capability through engagement with organisations that have already implemented Epic, alongside close working with the supplier, including a recent stakeholder visit to Epic's UK headquarters. Learning from other sites is being incorporated to strengthen planning and oversight.

The HealthSet programme governance is being refreshed ready for the implementation phase. In parallel, the external assurance requirements have been refined and shared, with further market engagement underway to inform the approach. Initial supplier options have been identified, and further review is in progress to ensure the most appropriate coverage.

As the HealthSet programme progresses into mobilisation, there is increasing recognition across the organisation of the scale of change ahead. This is much more than a digital system implementation and will affect how many colleagues work across our hospitals and services. As we move closer to implementation, a key priority is ensuring that everyone understands what this means for them, feels informed about the journey ahead, and has opportunities to ask questions and engage with the programme. We are working hard to ensure colleagues receive the information and support they need as we prepare for this significant change.

4.4 Quality & Safety

Supreme Court ruling linked to DoLS

On 2 June 2026, the UK Supreme Court overturned the Cheshire West 'acid test' as the legal test for determining whether a person is deprived of their liberty. The Court ruled that deprivation of liberty must instead be decided by a multi-factorial assessment, taking into account wishes, feelings, degree of objection, the purpose of the arrangements and the normality of the setting.

Impact: This is a significant adult social care judgments and is likely to trigger a major reassessment of deprivation of liberty practice across England, Wales and Northern Ireland. The judgment is likely to significantly reduce the number of people considered deprived of their liberty and therefore requiring DoLS authorisation. Many individuals currently subject to DoLSauthorisations or Court of Protection orders may no longer meet the revised legal threshold, creating a need for review by local authorities, NHS bodies and the courts. The judgment will require consideration of current DoLS referrals, existing authorisations, community deprivation of liberty applications, assessment processes, workforce planning / training and the recording of wishes and feelings.

NHS Safeguarding are currently engaging national partners to get key messages for health.

Immediate response: importance of oversight and safeguards: It is important for local authorities and NHS bodies to take a cautious and evidence-based approach, ensuring that safeguards and oversight are maintained while the implications are worked through and we await national guidance. There should be no reduction in oversight, scrutiny or safeguards during this period of transition; practice should remain legally robust, person-centred and consistent with existing safeguarding and legal responsibilities

4.5 Finance

At the end of May, the Trust reported a year-to-date deficit of £6.2 million, £1.2 million adverse to plan. This includes unplanned industrial action costs of £0.5 million, with the remaining adverse variance of £0.7 million relating to efficiency savings being below the phased plan for April and May. We continue to see the Efficiency Improvement Programme develop, with schemes totalling £51.1 million identified; however, there remains a residual shortfall in identified savings plans of £17.4 million against the full-year target, which remains a primary focus for the Trust. NHS England has confirmed that there is no funding for industrial action costs, which are expected to be mitigated locally.

4.6 Strategy & Transformation

Transformation Plan

Over the next month, a number of important milestones are expected across the transformation plan. These developments support the continued delivery of our site strategy, improve the environment for patients and staff, and create additional capacity for clinical services and future training.

- The new Endoscopy Unit at Poole is due to open, providing modern, patient-friendly facilities and regional training capacity for the next generation of endoscopists.
- Car parking capacity at RBH is increasing by an additional 240 spaces, providing much-needed additional patient parking. A review of blue badge spaces will also commence.
- Changes to dermatology and rheumatology services will support the development of specialist services and improve how these services are delivered.
- Tringham House is opening for NHS use, releasing space in the main RBH building for clinical staff. It will also be used as the main Epic training centre as we prepare for our new electronic patient record in 2028, and as an emergency flow command centre to support improved system responsiveness.
- The rolling ward refurbishment programme continues, with a focus on improving toilets, showers and ward kitchen pantries.

COAST Building

As reported previously, the COAST building has been delayed. Close work with Darwin, our main contractor, and the New Hospitals Programme is refocusing the programme and strengthening delivery assurance. A wider update on Phase 3 moves will be provided through the substantive Board paper on this topic.

Capital Works

Other capital works continue to progress, including:

- new Acute Medical Unit and Same Day Emergency Care facilities at Royal Bournemouth;
- new CT and MRI capacity at Poole;
- design work for expansion of the cancer treatment village;

- option appraisal for the Community Diagnostic Centre hub, currently located at St Mary's Poole; and

- charity-funded building work to support a major upgrade to the interventional radiology service.

Climate Resilience

Work on climate resilience is progressing as the risks associated with heatwaves, flooding and fire increase. Recommendations and an action plan will be developed with staff and partners to strengthen preparedness for more frequent and extreme weather events. Work is also progressing to create reliable, clean and cost-effective energy supplies for our hospitals, with a major tender underway covering geothermal and energy supply, alongside a wider heating network with local partners.

Shuttle Bus

The shuttle bus service is being re-tendered following the initial one-year pilot. More than 120,000 passenger journeys have been made so far, with 4,166 staff registered on the app, representing around 40% of staff. Many of these journeys would otherwise have been made by car, helping to reduce traffic and parking pressures.

4.7 OUR PEOPLE

Staff Awards Ceremony 2026

In June, we held our annual UHD Staff Awards Ceremony, an important opportunity to recognise colleagues, teams and volunteers from across the Trust. This year's awards followed a strong response to the nomination process, with staff, volunteers, patients and members of the public invited to put forward individuals and teams whose work reflects our UHD values. The ceremony brought colleagues together to celebrate examples of compassionate care, teamwork, leadership and improvement from across our hospitals and services. Congratulations to all winners, highly commended colleagues and shortlisted nominees. My thanks also go to UHD Charity and to our external supporters for helping make the event possible.

Melanie Whitfield, Chief People Officer

Melanie Whitfield has left her role as Chief People Officer at University Hospitals Dorset and will be taking up a new opportunity outside the Trust. We thank Melanie for her contribution during her time with UHD and wish her well for the future. Pete Papworth is currently covering the Board executive lead for our People Services whilst we consider the interim arrangements and run a recruitment process.

Nursing Band 5 job evaluation

In February 2026, the Secretary of State for Health and Social Care set out a commitment to deliver a fairer deal for nursing, including ensuring nurses are paid correctly for the work they are asked to do. The Secretary of State confirmed an employer-led review of all Band 5 nursing roles employed directly by NHS trusts. This builds on existing job evaluation (JE) commitments agreed through the Agenda for Change (AfC) non-pay deal.

All organisations will be required to submit a nursing Band 5 job evaluation delivery plan by 31 July 2026 to their region for review. These plans should be realistic and deliverable, and set out how all Agenda for Change Band 5 nursing roles will be reviewed by October 2028,. Communication on this has been shared with the Trust.

NHS Staff Standards launch

On 6 July, NHS England and DHSC launched new NHS Staff Standards, delivering a commitment from the 10 Year Health Plan to improve staff experience. The standards establish a national baseline for what staff should expect from their employer across six key areas: line management, health and wellbeing, violence prevention, sexual safety, tackling racism and flexible working. Delivery against the standards will be measured nationally, with organisations expected to demonstrate action where expectations are not met.

Pride Month and Bourne Free

Throughout June, colleagues marked Pride Month across UHD, supported by members and allies of the UHD Pride Network. The network continues to provide an important space for LGBTQIA+ colleagues and allies, helping to promote belonging, respect and representation across our hospitals. Activity during the month included opportunities for colleagues to listen, learn and show visible support, with the network also preparing to represent UHD at the Bourne Free Parade in July. My thanks go to everyone involved in supporting this work and to colleagues who continue to help make UHD a more inclusive place to work and receive care.

Cultural Celebrations

UHD's Cultural Celebrations will take place across our sites on 15 and 18 July, supported by UHD Charity. Previous events have included story sharing, music, dancing and entertainment, with staff networks helping to recognise the many cultures that make up #TeamUHD. These events provide an important opportunity for colleagues to come together, learn from one another and celebrate the diversity of our workforce and communities.

Team Support

The Team Engagement and Development toolkit has also now been launched, with the first team leader pilot training session completed. New UHD team development intranet pages have been launched through The Brief, giving staff easier access to resources and guidance. This work is particularly important as teams continue to manage service change and transformation, and I am pleased to see increasing use of team development support, including input from the Psychological Support and Counselling team.

People and Culture Champions

The People and Culture Champions programme continues to focus on engagement at both Trust-wide level and within local directorates and teams. Conversation Cafés are being launched during July and August to raise awareness of who the Champions are, what they do, and how colleagues can access support. This remains an important part of strengthening staff voice, listening to local feedback and making sure colleagues feel able to contribute to improvements in their teams and working environment.

4.8 Trust Management Group (TMG) Update

Trust Management Group considered a number of governance, workforce and patient safety papers. These included:

- Winter Plan Capacity
- Policy on Undertaking Private Professional Services in Schedule C
- Discharge Communication Processes
- Green UHD Bi-Annual Report
- Phase 3 Move Timeline & Options
- Business cases approved via Sustainable Services Group, including:

- 2nd Paediatric GA MRI list
- Dorset Breast Screening
- Radiotherapy Staffing
- UHD MEPV Security Staffing
- Implementation of NICE Tas
- Non-emergency Step-down Transport (NEPTS)
- Surgical CG phase 3 workforce plan recruitment
- XprESS ENT Dilation System

5 INTEGRATED CARE BOARD MINUTES 12 MARCH 2026

There was no ICB Board meeting in May, however, the ratified minutes of the meeting held on 12 March 2026 are attached at Appendix A.

Minutes of the meeting of the Part 1 Public ICB (ICB) Board of NHS Dorset
Thursday 12 March 2026 at 10.15am
in Committee Room 1, County Hall, Colliton Park, Dorchester, DT1 1XJ and via MS Teams

Members Present:		
	Rob Whiteman (RW)	Cluster Chair
	Rhiannon Beaumont-Wood (RBW)	ICB Non-Executive Member
	Dawn Dawson (DD)	Deputy Chief Executive Dorset County Hospital and Dorset HealthCare NHS Foundation Trusts and ICB Board NHS Provider Trust Partner Member (nominated deputy)
	Siobhan Harrington (SH)	Chief Executive University Hospitals Dorset NHS Foundation Trust and ICB NHS Provider Trust Partner Member
	Alison Henly (AH)	ICB Interim Chief Finance Officer (and ICB Cluster Chief Officer Strategic Finance and Resources)
	Jonathan Higman (JH)	ICB Cluster Chief Executive Officer
	Karl Hoods (KH)	ICB Non-Executive Member
	Bernie Marden (BM)	ICB Cluster Chief Medical Officer
	Shelagh Meldrum (SM)	ICB Cluster Chief Nursing Officer
	Kay Taylor (KT)	ICB Non-Executive Member
	Forbes Watson (FW) (virtual)	GP Alliance Chair, Primary Care Partner Member
	Adrian White (AW)	ICB Non-Executive Member
	Dan Worsley (DW)	ICB Non-Executive Member
Invited Participants Present:		
	Laura Ambler (LA)	Corporate Director for Wellbeing, BCP Council
	Louise Bate (LBa) (virtual)	Manager, Dorset Healthwatch
	Paula Bennetts (PB) (virtual)	Programme Director, Dorset VCSA
	Sam Crowe (SC)	Director of Public Health, Dorset Council
	David Freeman (DF)	ICB Deputy Chief Executive Officer (and ICB Cluster Chief Officer for Commissioning and Place)
	Dean Spencer (DSp)	ICB Chief Operating Officer (and ICB Cluster Place Director, Dorset)
In attendance:		
	Liz Beardsall (LB)	ICB Head of Corporate Governance
	Helen Crook (HC) (for item ICBB26/023)	ICB Programme Manager, Transformation Delivery
	Jane Ellis (JE)	ICB Chief of Staff
	Leah Gallon (LG) (for item ICBB26/023)	Associate Director, Health Innovation Wessex
	Hester McLain (HM)	Director of System Co-ordination, NHS England South West
	Marianne Storey (MS) (for item ICBB26/023)	Dorset Women's Community Interest Company Lead
	Louise Trent (LT) (minutes)	ICB Governance Support Officer
	Amanda Webb (AWe) (virtual)	ICB Cluster Chief Officer for Population Health Improvement

Public:		
	There was 1 member of the public present. The meeting was also available via livestream.	
Apologies:		
	Lucy Baker	ICB Place Director for Bath and North East Somerset
	Matthew Bryant (MB)	Joint Chief Executive Dorset County Hospital and Dorset HealthCare NHS Foundation Trusts and ICB Board NHS Provider Trust Partner Member - member
	Rob Carroll (RC)	Director of Public Health, BCP Council
	Aidan Dunn (AD)	Chief Executive, BCP Council (nominated deputy for ICB Local Authority Partner Member – BCP) - member
	Millie Earl (ME)	Leader of BCP Council
	Dawn Harvey (DH)	ICB Chief People Officer
	Caroline Holmes (Cho)	Place Director for Wiltshire
	Catherine Howe (CH)	Chief Executive, Dorset Council – participant
	Nick Ireland (NI)	Leader Dorset Council and ICB Local Authority Partner Member - member
	David McClay	ICB Place Director Somerset
	Gordon Muvuti (GM)	Place Director, Swindon
	Rachel Pearce (RPe)	Managing Director (System Commissioning Development), NHS England South West
	Andrew Rosser (AR)	Chief Finance Officer, SWASFT - participant

ICBB26/019 Welcome, apologies and quorum

The Chair declared the meeting open and quorate and welcomed the new cluster executives to the meeting. There were apologies from Lucy Baker, Matthew Bryant, Rob Carroll, Aidan Dunn, Millie Earl, Dawn Harvey, Caroline Holmes, Catherine Howe, Nick Ireland, David McClay, Gordon Muvuti, Rachel Pearce and Andrew Rosser.

ICBB26/020 Conflicts of Interest

There were no conflicts of interest declared.

ICBB26/021 Minutes of the Part One meeting held on 15 January 2026

The minutes of the Part One meeting held on 15 January 2026 were agreed as a true and accurate record.

Resolved: the minutes of the meeting held on 15 January 2026 were approved.

ICBB26/022 Action Log from the Part 1 meeting held on 15 January 2026

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>

ICBB26/023 Board Story – Women's Health

The NHS Dorset Programme Manager, Transformation Delivery, Dorset Women's Community Interest Company Lead and the Associate Director, Health Innovation Wessex

presented the Women's Health Board Story. The story highlighted the programme's aims, approach, structure, engagement, and delivery of a co-produced online resource, new clinical pathways and training for clinicians.

L Ambler joined the meeting.

The Board welcomed the Board Story and discussed the historical bias in health research and the need to apply the user-led approach to other conditions affecting women. There was ongoing work with Wessex Health Partners and plans to expand website content to cover more conditions.

The Board enquired about the different engagement undertaken with older women and the risk of digital exclusion at all ages. The team had strong links with the Ageing Well Network and had reached digitally excluded groups through non-digital means. There had been wide engagement with schools and youth clubs to ensure broad representation.

There was a need for adequate resources, particularly for LARC within GP practices, with the risk that current funding levels may not support continued delivery and the programme team was supportive of the importance of fair resource allocation.

The Board noted the difficulty with measuring outcomes versus outputs and the positive impact of the programme. Consideration of how to sustain the programme's achievements as the system transitioned to new cluster arrangements would be required, with the potential to consciously plan for the integration and support of successful initiatives.

Resolved: the Board noted the Women's Health Board Story.

ICBB26/024 Cluster Chair's Update

The Cluster Chair updated the Board on the context of the challenging economic environment and tight fiscal framework that there could be low expectation of additional NHS funding and a requirement for local accountability in delivering financial targets. As the organisation moved into new a new cluster model, there would be the requirement to determine which workstreams and governance arrangements would be managed at cluster level and which would be managed at place. It would be important to take the opportunity to transform how resources were used to be a platform for neighbourhood health and to support the leftward shift.

Resolved: the Board noted the Chair's update.

ICBB26/025 Cluster Chief Executive Officer's Report

The Cluster Chief Executive Officer presented his CEO's report.

Work was underway with the Local Authorities for the Special Educational Needs and Disabilities (SEND) improvement plans with coordination being undertaken across the cluster with the importance of alignment with health and local authority responsibilities and timelines recognised.

There would be upcoming delegation of direct commissioning responsibilities to the ICB in April 2027 which would including health and justice, vaccination, immunisation and screening which were currently held by NHS England. This would potentially require the establishment of a commissioning hub for the Southwest.

The Electronic Health Record (EHR) development across Dorset had received approval with a go-live target date of April 2028. This marked a significant system-wide change and would require substantial work over the coming years.

There had been a significant and unexpected delay in the Coast building at University Hospitals Dorset with completion being postponed. It was anticipated that there would be clarity on the timelines by the end of March but that this would delay beyond July. Work was underway to address the implications for the Clinical Services Review and to assess the impact on service delivery and the requirement for ongoing community communication.

The ICB was entering a period of significant organisational change with the impact of voluntary redundancies and the launch of a consultation on new structures for staff. There was now a complete Executive Team in place. It was confirmed that there were plans for stakeholder communication in relation to leavers and interim arrangements as this progressed. The Board recognised the loss of valuable colleagues and talent through the process.

The Board Assurance Statement for NHS England had been signed off by the Chair and Chief Executive on behalf of the Board, with a caveat against risks linked to the running cost reductions with clear mitigations for how changes to the ICB's functions would be delivered, as this had not been fully assured at the point of sign off. The Board ratified the submission of this statement.

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

ICBB26/026 Board Assurance Framework

The NHS Dorset Deputy Chief Executive Officer presented the Board Assurance Framework (BAF).

This had been received at the February ICB committee meetings. Previous plans to redevelop the BAF had been paused due to the organisational change, and it continued to be maintained in the current format with ongoing monthly review of the risks. The cluster arrangements would provide the opportunity to reset the BAF during transition with using best practice and learning from the three cluster organisations to develop.

Resolved: the Board approved the Board Assurance Framework.

ICBB26/027 Committee Escalation Reports

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

Finance and Planning Committee:

Additional meetings had been held for the Electronic Health Record and the Medium Term Plan submission and the usual business meetings had received the New Wareham Surgery Full Business Case (FBC) and the Community Dental Services Contract Direct Award with all relevant matters escalated to the Board.

Outcomes Committee:

The Futurecare programme had provided positive updates with effective monitoring and mitigations seen across the reporting time. Integrated Neighbourhood Teams (INTs) was at an earlier stage of development and it would be important to ensure robust outcome metrics and reporting were in place as this matured.

People Committee:

There were no significant issues for escalation to the Board at this time, however the impact of the staff wide consultation and of the Voluntary Redundancy were not yet known. Consideration would be required for where the people agenda would be sit in the future governance arrangements.

Quality and Commissioning Committee:
Discussion had included the challenge with monitoring quality and safety at the cluster level and the areas of best practice from NHS Dorset that could be considered going forward. Updates had included the national roll-out of the Dorset Hydration Project, the positive BCP Council SEND inspection, Pharmacy First and the positive work in relation to the reopening of Yeovil Maternity Services.

Resolved: the Board noted the Committee Escalation Reports.

Performance and Planning

ICBB26/028 Integrated Performance Report
The NHS Dorset Chief Operating Officer presented the Integrated Performance Report.

The Board welcomed that operational performance had not declined as the financial position had been recovered. Elective performance was strong, particularly in cancer performance across Dorset, with all cancer metrics being rated 'green'. There had been significant reductions in long waiters with the anticipation that there would be no patients waiting over 65 weeks by year end. The 18 week position had been variable during winter and had now reduced during March.

There was strong delivery of Mental Health targets and good performance in dental. Urgent and Emergency Care had been challenged during February but was seeing improvements in March. Ambulance response times had been continually improving and had achieved the under 30 minute target time. Handover delays had seen a significant improvement across the southwest with the introduction of the Trusted Handover protocol.

Although improved dental performance was welcomed, it was noted that Healthwatch was received ongoing reports of patients unable to access urgent dental appointments with the requirement for improved signposting for appointment availability and potential resource reallocation to routine dental care.

It was clarified that there was ongoing public engagement to influence appropriate use of services with campaigns including social media and the importance of reliable alternatives to emergency departments. The need for joined-up regional campaigns and community engagement was noted with the move to cluster arrangements.

Louise Bate left the meeting.

Resolved: the Board noted the Integrated Performance Report.

ICBB26/029 Medium Term Planning
The NHS Dorset Interim Chief Finance Officer introduced the report on Medium Term Planning.

This had been considered at an Extraordinary Board meeting, along with the Board Assurance Statements, prior to submission. The plan set out a £2.1b budget for 2026/27 with a break-even objective and an ICB efficiency programme to target £55.3m in savings. Capital allocations and how this would be used to support infrastructure had been

considered. The plan had been through in-depth discussion at the Finance and Planning Committee prior to Board approval. This had included the need for immediate action from month one to achieve efficiency targets with avoidance of late delivery of savings. It would be important to have rigorous financial governance and forecasting to maintain financial resilience.

It was clarified that the investment in neighbourhood health programmes with the national expectations for 1–2.5% investment would be discussed as part of the detailed budgets and external investments in the part two meeting.

Resolved: the Board noted the Medium Term Planning report.

Items for Decision

Governance Approvals

ICBB26/030 Board and Cluster Board Composition and Cluster Governance Structure

The Chair introduced the Board and Cluster Board Composition and Cluster Governance Structure. The previously circulated report set out the proposed memberships for the three individual ICB Board and Cluster Board, as well as the proposed committee governance structure for the cluster

The Cluster Board would be the cluster's main decision-making and assurance body with delegated authority from the three organisational Boards. The individual ICB boards would be retained prior to merger but would retain only those the items that could not be delegated to the Cluster Board which included the Annual Report and Accounts approval and potentially some decisions on the merger. To reflect this reduced remit, the individual ICB Boards would have a reduced membership.

The Cluster Board would meet bi-monthly and would include six executives, seven non-executives, and members from local authority partners, FT partners, primary care and the voluntary sector plus a Healthwatch participant. Development sessions would be planned.

It was clarified that the appointed chief officers and executives were joint appointments across the cluster with the 'host' employment being in their original organisation until full organisational merger.

Resolved: the Board approved the recommendations for the Board and Cluster Board Composition and Cluster Governance Structure.

ICBB26/031 Governance Arrangements – Terms of Reference and Constitution

The Head of Corporate Governance introduced the previously circulated paper seeking the Board's approval for the proposed Terms of Reference for the cluster's Joint Remuneration Committee and amendments to the ICB's constitution to reflect the new executive structure.

The Board approved the terms of reference and constitution changes, noting that further iterations were anticipated as the governance model evolved.

Resolved: the Board approved the Terms of Reference for the cluster's Joint Remuneration Committee and amendments to the ICB's constitution.

Items for Noting/Assurance/Discussion

ICBB26/032 There were no items for Noting/Assurance/Discussion.

Items for Consent

ICBB26/033 There were no items for consent.

ICBB26/034 Questions from the Public

There were no questions from the public.

ICBB26/035 Any Other Business

There was no further business discussed.

ICBB26/036 Key Messages and review of the Part 1 meeting

The Board acknowledged thanks to all staff, in particular exiting Dorset ICB staff, Board members and outgoing executives.

ICBB26/037 Date and Time of Next Meeting

The next formal meeting of the ICB Board was to be confirmed.

ICBB26/038 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: R Whiteman

Rob Whiteman, ICB Cluster Chair

Date: 11/05/2026

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: **3.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	ICB strategic ambition and Trust response
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)	N/A
Purpose of paper:	Review and Discussion
Executive summary:	The ICB cluster strategic ambitions set out a significant shift to population health, outcomes-based commissioning and Integrated Health Organisation (IHO) models. This represents a fundamental change to how care is organised and funded, including a reduction in acute-centric delivery and a move to neighbourhood-based models. The move to an IHO-style model within Dorset and BPC areas, raises questions about how to align this with other change work and the complex set of inter-relationships required to achieve improved population health outcomes. This creates important strategic implications for UHD, including: • The future role of the Trust within system delivery models • How best to respond to outcomes-based commissioning arrangements, whilst the system currently is heavily performance and compliance driven • Potential shifts in financial flows and risk, and the need to reprofile services and staffing to reflect new models of care. Time to reflect on these issues and enable discussion is important, as well as the feed through into the Trust's clinical strategy development work.
ALERT:	• The ambitions signal a deliberate reduction in acute share of activity and spend, which would result in changing how UHD delivers care.

	• The emerging model risks positioning UHD as reactive within system-led contracts. It also allows an opportunity to play a more proactive role. • Lack of clarity on IHO leadership within the Dorset system presents a strategic risk if roles aren't defined and agreed.
ASSURE:	• UHD is actively engaged in system discussions and has the opportunity to influence the development of the Dorset model, including through the provider collaborative. • There is no finalised delivery model at this stage, with further design and agreement required across the system • The Trust has strong system relationships and leadership presence, providing a platform to shape future arrangements
ADVISE:	• The ambitions form part of wider system development ahead of the planned ICB merger • Further work is required to define: - IHO models and leadership arrangements - Contracting and financial frameworks - Delivery expectations for acute providers - The fit within the ICB commissioned work on clinical strategy options • This represents core strategic planning, rather than routine assurance, and will evolve over the coming period.
Celebrating Outstanding:	N/A
RECOMMENDATION:	The Board is asked to: • Note the scale and direction of the ICB strategic ambitions • Discuss the implications for UHD, particularly in relation to IHO development and population health approaches • Support a dedicated Board development session to explore and agree the Trust's strategic position.
Implications associated with this item:	Council of Governors ☒ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☒ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☐ Strategy/Transformation ☒ System ☒
CQC Assessment Framework:	Safe ☐

	Effective	☐
	Caring	☐
	Responsive	☐
	Well-Led	☐
	Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
N/A	N/A	N/A
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

10-year health plan & our strategic ambitions

ICBs joining together across NHS Bath & North East Somerset, Swindon & Wiltshire (BSW), NHS Dorset and NHS Somerset.

We are reinventing health & care in BSW, Dorset & Somerset

- Across our Cluster of ICBs, we have already begun our journey of transformation in health and care services, with clear strategies and plans aimed at improving performance, restoring financial balance and beginning the three shifts.
- But we are in no doubt - the pressures facing our systems mean that incremental change will not deliver the outcomes our populations need. We know we must fundamentally redesign how care is organised and delivered.
- Through a co-design process with system leaders, we have agreed 7 deliberately stretching ambitions, supported by SMART goals, that are now being used to shape our full cluster and place strategies.
- By committing to these ambitions, in the next 3-5 years we will:
    - Rebuild our system around people, place, communities and prevention, abolishing the current arrangements and historical pathways
    - End hospital as the default setting for care, using acute settings only where they add greatest value.
    - Dismantle legacy pathways, behaviours and power structures that currently lock resource into low-value activity
- This is not a marginal adjustment to today's model. It is a decisive move to a system that is commissioned, funded and organised around outcomes for defined populations.
- Through delivery of these ambitions, we will measurably improve population outcomes for those in the cohorts with the highest priority health needs, change the profile of demand and shift our resources to ensure our health and care systems are high quality and sustainable for generations to come.

Co-design of these ambitions and goals

- Prior to formal clustering of our 3 x ICBs we worked with each legacy ICB system to develop and agree our respective MTPs and 5-year strategies. Partners and stakeholders helped co-design these early ambitions and commitments to significant improvements in 2026/27. These plans include:
    - Improving performance and flow
    - Restoring and maintaining financial balance.
    - Delivering decisive changes across the three national shifts: hospital to community, sickness to prevention, and analogue to digital.
- Building on these commitments, the Cluster ICB led a co-design process with system leaders across the Cluster footprint to test our appetite for change to push ourselves to go further, faster.
- This has resulted in a number of deliberately stretching ambitions – co-designed with partners and agreed as the guiding principles for the detailed work we will now undertake.
- In this document, we outline these ambitions and some supporting SMART goals that are intended to shape our work over the next 1-3yrs.
- These are not yet formal plans and require more work-up and sign-off – but make no mistake, these ambitions are not aspirational statements: they are now core to our shared purpose and will be used to flesh out our cluster-wide strategy, our underpinning needs analysis, and will now inform all our new commissioning and new delivery models.

Our Ambitions – reinventing our model of care to improve peoples' lives

Engine of reform: Strategic Commissioning & the ICB

- From the outset the Cluster ICB has been clear in its ambition and purpose – we exist to modernise NHS care by developing and delivering a 21st century approach to strategic commissioning and population health improvement: we are one of only a handful of ICBs employing a Board-voting Exec Director for Population Health Improvement and rarer still, with the role filled by a practicing GP.
- Our operating model also puts huge emphasis on place and neighbourhood delivery, with 6 x ICB Executive Place Directors organised to be coterminous with our 6 x Local Authority boundaries.
- Building on this, we and our partners are unanimous in the view that strategic commissioning is about using population health insight and intelligence to develop outcomes-based commissioning (supporting the 10-Year Plan shifts) and particularly, the move away from acute-centric and activity-led spend.
- This view is underpinned by a clear shared commitment to developing IHOs and outcomes-based contracts in our system (see following slides). As an ICB in particular, we are aiming to:
    - Strengthen commissioning capability across the Cluster ahead of full ICB merger in April 2027
    - Rebalance resources at scale, reducing the acute share of spend and deliver transformation
    - Accelerate the build and adoption of our integrated data & insights systems (*see next slide*)
    - From 2027/28, commission for defined populations, starting by focussing on CYP and people aged 65+ living with frailty/multiple long-term conditions, targeting prevention, proactive care and earlier intervention in neighbourhoods to deliver radically different models of care and support.
    - Ensure delivery is through neighbourhood care, with high-functioning Integrated Neighbourhood Teams, expanded outcomes-based/IHO contracts, and stronger VCFSE and local authority partnerships

Integrated data & intelligence – making our ambitions real

- To make our reform and reinvention ambitions real, we are embedding population health at the core of our strategic commissioning. **Our population health insight drives the strategy and ambition,** and commissioning becomes the delivery mechanism for measurable, equitable improvements in outcomes.
- **Work is now underway to establish integrated data and intelligence model** - enabling consistent insight, segmentation and risk stratification across system, place and neighbourhood. This will underpin a coherent population health strategy and a single outcomes framework.
- **A key feature of the model we are building is paired local, actionable indicators** – the national indicators enable benchmarking & ambition setting while the local paired indicators give near real-time measures that allow us to track outcomes by geography, ethnicity, deprivation and disease. **This means we can see variation quickly and act decisively.**
- We will then be embedding this directly into commissioning - using insight to inform investment, requiring disproportionate improvement for inequality groups, and continuously evaluating impact. **This is how we create the left shift** - aligning incentives and resources towards prevention, early intervention and targeted support.
- **This is underpinned by our journey to a single, cluster-wide data architecture**. We are building a secure, scalable platform that allows the three ICBs to operate as one system - while delivering early value. We are have already started on unified dashboards, including health inequalities metrics, and we are linking datasets across primary care, community, acute, ambulance and local authority.
- This enables integrated needs assessment, population segmentation and increasingly predictive insight to support commissioning decisions. The architecture is modular and standards-based, but critically tightly integrated with our population health approach - **so data, strategy and commissioning operate as one system.**
- **This is not just a data programme - it is the enabling infrastructure for strategic commissioning at scale**, allowing us to target resources more effectively and continuously improve outcomes for our population.

Building the insights model – in a nutshell...

We are establishing a single, cluster-wide data architecture to enable the three ICBs to operate as one system and support future merger.

Secure, scalable and future-ready	Building on existing MS Azure infrastructure to enable secure, scalable data sharing and best practice across the Cluster following a robust options appraisal.
Delivering early value through insight	Delivering early value through a unified dashboard including NHSE-aligned health inequalities metrics.
Enabling linked data for priority populations	Enabling linked data to support Integrated Needs Assessment priorities (initial focus: MH and CYP).
Integrating key datasets across the system	Integrating key datasets across the system (national, primary care, community, ambulance and local authority).
Low-risk, cost-effective and sustainable	A low-risk, cost-effective platform to support strategic commissioning, population health management and future flexibility, tightly integrated into population health.
Designed for transformation and future flexibility	A modular, standards-based architecture that can evolve with our needs, supporting future merger, innovation and long-term value.

HOW THIS ENABLES STRATEGIC COMMISSIONING

Better understand our population → Identify priorities and inequalities → Design targeted, evidence-informed interventions → Allocate resources to maximise value and outcomes → Monitor impact and drive timely intervention → Continuously learn and improve

We are aligning a coherent population health data model that supports strategic commissioning at scale by delivering early value, whilst assuring a well-managed transition.

Using Strategic Commissioning to remodel our system

Strategic Commissioning Ambitions

- Outcomes based commissioning for defined populations, with an initial focus on CYP and people aged 65+ by 2027/28
- Deliver high-functioning Integrated Neighbourhood Teams (INTs) in all areas by 2028
- Aligned incentives in contracts and capitated budgets to enable IHOs, MNPs, SNP
- Rapid development of our intelligence & insights data architecture to drive the changes we seek, with the beta model ready in 26/27

This means will deliver:

✅ 2 Integrated Health Organisation (IHO) contracts by the end of 2027/28

✅ More than half of all contracts will move to outcomes- based models by 2028/29

🔄 We will build a 2% transformation fund, starting 2027/28, cumulative over three years

⬆️ Increased investment (vs 2025/26 baseline) in priority inequality areas from 2026/27

👥 Commissioning for defined populations, including testing outcomes-based contracts outside allocation where legally permissible

🧭 A cluster operating model for shadow IHO working during 2026-2027

Key outcomes and outputs

👥 Neighbourhood (outcomes-based) health delivery becomes the default by the end of 2028/29

📉 Acute spend reduction from 53% to 45% (5-year outcome measure)

⭐ Same teams preventing admissions and supporting discharge

⭐ Measurable population health improvements, especially in areas of deprivation/inequality

⬇️ Reduced non-criteria to reside (NCTR)

⬇️ Fewer people admitted to hospital

🤝 Explicit, sustained investment in VCFSE partners

⭐ Systems into recurring balance by 2028/29

Engine of reform – accelerating our approach

3-year high level milestones

Today

Year 1- establishing grip and credibility

We will focus on strengthening foundations. We will build skills in population health management, outcomes-based commissioning and system leadership; enhance our use of data and analytics to identify need, variation and inequalities; expand Integrated Neighbourhood Teams; and begin embedding shared outcomes frameworks into contracts.

Year 2 – Aligning Incentives and Resources

We will focus on change in practice. We will recommission priority pathways around neighbourhood and community models, increase the use of outcome- and value-based payment mechanisms, align funding and incentives to support collaboration, and strengthen joint commissioning and pooled budgets with local authorities.

2 IHO contracts in place

2028/29

Year 3 – Embedding and Scaling

We will see a mature strategic commissioning system. We expect to routinely plan at scale while delivering locally, use outcomes and inequality measures to guide investment, support a more sustainable provider market, and clearly demonstrate improved value for money and population health outcomes.

Neighbourhood Care by default

Our ambition is to drive a real shift away from commissioning organisational services to commissioning end-to-end pathways for populations based on population needs, outcomes and value. Working with our partners, listening to our communities and understanding the lived experiences of people who use NHS services, will be core to our operating model.

Neighbourhood care is not an adjunct to this ambition - it is the primary delivery model. We will use Integrated Neighbourhood Teams (INTs) and Neighbourhood Health Centres to bring together health, social care and VCFSE to deliver proactive, coordinated care closer to home:

- **We will have ~47 INTs in place across the Cluster by 2028/29**; we will launch our first shadow INTs in 2026/27 with new MNP/SNP contract models in place by the end of 2027/28 (subject to national developments).
- **We will further develop place-based leadership and governance** to ensure stronger local accountability and local flexibility within the overall Cluster and provider architecture by the end of 2026/27.
- **We will support our providers to move through AFT applications** as a means of further enabling integration and population-based models

Our overarching shared Neighbourhood Care ambitions are to:

- Shift resources (especially people resources) out of hospital settings, initially targeting CYP and frailty services & using linked data, risk stratification and inequality analysis to identify cohorts who would benefit most from earlier, proactive and preventative support.
- Embed prevention across the whole life course, influencing commissioning decisions across all public services, not only health.
- Make high-quality digital routes the easiest way for people to access planned, proactive and ongoing care.
- Work with partners to align key CYP reform around SEND, Families First Partnership Programme, Best Start in Life hubs, identifying which of our children, young people and families would benefit most from transformed multi-agency support and prioritising them with a rapid test and learn approach during the next year

Neighbourhood Care – our ambitions

Neighbourhood Care- Ambitions

- Shift the % spend in hospital by PHM of the CYP & 65+yrs cohort and move resource into preventive support for these populations
- Make high-quality digital routes the easiest way for people to access planned, proactive and ongoing care
- Working with communities, people with lived experience and partners, we will embed a systematic approach to prevention through the life course and within all public services.

This means we will deliver:	Key outcomes and outputs
🗓️ The shift from reactive to proactive care with sustainable fewer same-day urgent care episodes by the end of 2027/28 (based on 25/26 baseline)	🛏️ Fewer hospital beds and bed days
🧓 Neighbourhood-based CYP and frailty models in place, fully utilised within 2 years	💷 Relevant budgets & decision making devolved to neighbourhood level by 2031
✅ Achievement of all 10% targets (as a minimum) that are set out in the Neighbourhood Health Framework	⭐ Reduced acute share of spend- clear shift of resources into neighbourhood care
📊 50% reduction in incidence of crisis in manageable conditions over the next 3 years	🚑 Good Emergency Department performance
🛏️ Reducing unwarranted variation for bed day use across hospital and community beds by 2028	❌ NCTR in top decile performance
	💙 Better end of life care- more people dying in their preferred place of death (based on 25/26 baseline)
	📱 Improved digital access to services resulting in reduction in unnecessary face to face health transactions that don't add value.

The asks…and an offer

Asks of the national team (1)

Delivering the scale and pace of change set out in this document will require a material shift in how financial flows, payment mechanisms and national policy levers are applied. Without this, there is a real risk that well-intentioned national arrangements continue to reinforce activity-driven behaviours and constrain our ambitions for the rapid roll-out of population-based, preventative models of care.

Space, permission and consistency from the centre

To operate effectively as strategic commissioners, we are seeking:

- Continued space from the centre to plan and deliver at scale while enabling local delivery.
- Active reduction of policy friction, where national requirements unintentionally reinforce activity-based models or slow the shift to neighbourhood and preventative care.
- Permission to move at pace where locally designed solutions are demonstrably effective, without the need for repeated national re-approval.
- Recognition of the time needed for delivery of transformation change, using national assurance and performance regimes to support multi-year delivery frameworks, with a greater focus on longer term change and move away from short term compliance

Enabling prevention through funding and incentives

If prevention is to be more than a stated ambition, national financial policy must support it in practice. Specifically:

- Longer-term funding and incentive models that reward prevention and early intervention, rather than short-term, non-recurrent allocations that inhibit sustainable redesign.
- Greater alignment between public health, NHS and local government funding to support integrated neighbourhood models over multiple years.
- Introduce explicit benefit shared mechanisms to support transformation, linked to a focus on outcomes

Asks of the national team (2)

The financial architecture must actively enable system redesign

To support pathway-based, neighbourhood and population commissioning models, we are seeking:

- Greater flexibility in payment mechanisms and financial flows, to enable outcomes-based commissioning and neighbourhood delivery models at scale, and to reduce reliance on activity-linked incentives.
- Explicit flexibility in the application of outputs from the national deconstructing block contract work, where strict application would conflict with locally agreed outcomes-based or lead-provider arrangements.
- Clear alignment between incentives and the Integrated Health Organisation (IHO) model, so that responsibility, financial risk and performance accountability sit in the same place.
- Capital and estates – real delegation of capital to enable better value decisions to be taken across revenue and capital, so that we are talking about a single NHS pound

Clarity on contracting and performance accountability

As responsibilities for performance management continue to evolve, we would welcome greater clarity on how national intervention interacts with local contractual arrangements:

- Confirmation of when and how contractual levers would be enacted in situations where performance issues arise from actions initiated by NHS England, rather than the commissioner holding the contract.

Asks of the national team (3)

Choice, markets and consistency

While we recognise there maybe limited appetite for wholesale review of choice policy, we believe the market environment has shifted materially, including the growth of virtual only independent providers. We would therefore welcome:

- Strengthened national guidance to ensure consistency and predictability in how choice is applied.
- Strengthened guidance to avoid locally commissioned services becoming a default nationally available through unintended application of choice rules.

Wider asks for enabling transformation at pace

- Aligning NHS and local government reform so that we have a single wider public sector reform programme pointing in the same direction
- Ensuring FDP supports national solutions to IG barriers
- Successful rollout of the strategic commissioning development programme
- Sharing of high impact evidence-based examples of best practice representative care models and commissioning approaches
- Recognition that the complexity of our merger we will need support for non-recurrent transition costs

...and an offer

These ambitions reflect years of innovation and commitment to improving population health across our legacy ICBs. The appetite in our system to go further, faster is clearly demonstrated and we have the energy and skills (enabled by the new policy context and commitments from the centre) to accelerate the design and implementation of radically new ways of working

We would be more than happy to work with NHSE/DHSC colleagues to develop and/or pilot new models & ways of working, as well as on new metrics to track improvements in value (incorporating the four value pillars); progress against the three shifts; and/or local paired indicators for outcomes

How we might be able to help…

- ✓ We have a Board-level Chief Officer for Population Health Improvement who is also a practicing GP
- ✓ Our Integrated Community Based Contract (with IS provider HCRG) is an innovative outcomes-based contract worth ~£160m p/y serving the whole BSW population
- ✓ Dorset is part of the National Neighbourhood Implementation programme and will be launching initial INTs during 2026/27
- ✓ Somerset has been part of the national Neighbourhood accelerator pilots and has seen demonstrable shifts in access and outcomes
- ✓ Somerset's pioneering Open Mental Health service, launched in 2019, is neighbourhood care in action
- ✓ The Dorset Insights & Intelligence Service (DiiS) and BSW's outcomes-based data platforms are major innovations, unique across ICBs – they are shaping our work to build a comprehensive integrated postcode level data insights platform
- ✓ The B&NES Community Wellbeing hub model jointly commissioned between health and social care providing a single front door to 40 VCFSE partners with physical basis in our acute and community hospitals as a foundation for neighbourhood working.
- ✓ In Dorset, the Dorset Healthcare AFT application (pending approval) will further enable integration of community, mental health and primary care services at neighbourhood level, strengthening delivery of INTs and population-based care models.
- ✓ Our CEO, and Directors of Population Health, Finance and Commissioning are part of national conversations / working groups looking at payment reform, values-based health care commissioning , new contract models & the strategic commissioning development programme.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: **3.2**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Phase 3 Move Timeline and Options
Prepared by:	Mark Mould - Chief Operating Officer, Richard Renaut -Chief Strategy & Transformation Officer
Presented by:	Mark Mould - Chief Operating Officer, 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)	See below.
Purpose of paper:	Decision/Approval
Executive summary:	The Coast programme continues to face delivery challenges, and confidence in a December 2026 completion is now low; the realistic *expected* clinically live date has slipped to April 2027. Without Coast, and alongside the seasonal pressures UHD experiences every winter, recent winter planning work tested whether Phase 3 reconfiguration could still go ahead this winter. It confirmed it could not. On this basis, the programme cannot proceed with a December 2026 Phase 3 move with sufficient confidence in safety, commissioning or operational readiness. UHD will go into winter 2026 on the current split-site arrangements. The lack of a reliable Coast build delivery date and move date has four implications: • the delay increases risk of a safe transition, unless mitigated • it is not possible to reliably confirm a move date that depends on Coast, given low confidence in contractor delivery. Therefore options to remove Coast from the critical path are needed. • alternative solutions based on a new operating model are needed. This is based on reducing patient numbers who do not

	need to be in acute hospitals. Developing this in parallel to planning for phase 3, puts these back with within UHD's own control. • it delays the Phase 4 building works, predominantly at Poole, as some works can't start until spaces are vacated. The attached paper "Delivering Phase 3" sets out how we resolve this, on a date within our control. Phase 3 delivers Bournemouth as our dedicated emergency hospital and Poole our dedicated planned care hospital. Coast's availability does not determine whether, or when, this happens, only how it happens. This plan aims to deliver a date we control, for the clear benefit of patients, by changing how the operating model manages UEC demand and flow. Coast building still matters as it gives patients and staff a modern, spacious environment, in a more efficient estate. What this plan proposes is a second, equally robust route to the same end point.
ALERT:	• A December 2026 Phase 3 move is no longer possible. • A strategic shift away from reliance on Coast as a source of bed capacity, towards a new operating model. The work to develop this is called "clinical vision of flow." • The delivery model is early stage and not yet fully proven at UHD, but is using tried and tested methodology from international best practice. It does requires further development and local validation and adoption. • If Coast is not ready, UHD would move into the existing estate as of April 2027. 4 wards would need to move into Coast when it is ready. • The delay also pushes back Phase 4 estate works, predominantly at Poole around the theatres pathways. Work to mitigate the cost of delay is underway. • The April 2027 move date is dependent on achieving the required Occupied Bed Day (OBD) trajectory and remains subject to confirmation by TMG in October 2026.
ASSURE:	• The Phase 3 move could proceed independent of Coast delivery, enabled through changes to the operating model. • A planned move window from w/c 19 April 2027 has been identified, with a potential first patient move day of Wednesday 21 April, based on operational considerations. • The same operating model, timing and monitoring apply regardless of Coast's readiness. • Occupied Bed Days (OBD) will be used as the lead indicator to track readiness and provide early warning.
ADVISE:	Work is needed to: • Review and provide views on the revised delivery approach and framing. This will be managed through the programme called "clinical vision of flow." • Support further development and testing of the operating model. • Support engagement with system partners to refine proposals, gateways and requirements to ensure system readiness for winter 2026/7 and moves in April 2027.

	• Support progression of next steps, including scheme prioritisation and integration into tracking, ahead of TMG confirmation in October 2026. • Note the 'UHD Phase 3 Den' in July 2026, where scheme owners test and confirm ownership, with a high-level plan reported back to the Chief Executive and the Board TCT committee overseeing the transformation programme.
Celebrating Outstanding:	• Clear shift to a best practice model focused on how care is delivered, rather than reliance on estate capacity. • Establishment of a single, coherent approach to Phase 3 regardless of Coast timing, improving clarity for planning and decision making. • Emphasis on system wide working, engaging partners to manage demand, flow and discharge differently.
RECOMMENDATION:	**<u>Stage 1</u>** **Note:** • the current timing of Coast delivery and that a Phase 3 move in December 2026 is no longer possible • the need to continue to track Coast building delivery, for the earliest possible, safe move into the building • the Phase 3 plan is designed so the move does not depend on Coast bed availability. **Agree**: • that for planning purposes the w/c 19th April 2027 is the earliest Phase 3 patient move week and should be the working date for the Phase 3 move. • that, as the UHD Board and with system leadership teams, we will own and drive this work to a timescale that meets the April deadline. **<u>Stage 2</u> (If stage 1 agreed)** **Agree**: • that each Care Group and Operations team reviews the ideas above, or adds their own, that are realistic to deliver within seven months • Against each of the schemes there will be responsible owners who will coordinate pulling together a 'UHD Phase 3 Den' in July • To work with partners to be fully aligned, so this is co-created and what we're doing, when, and how, against the April 2027 date, with a high-level plan and the impact of schemes shared widely.

	• Monitor and report OBD trends against the required trajectory with the same rigour applied to Coast's delivery, monitored monthly through TMG and weekly through the Capacity Planning Group. • Share and discuss with system partners our proposals and ask for support on wider plans • Identify and cost the short-term investment needed to trigger each commitment, and bring this back for sign-off alongside the OBD trajectory.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☒ Health Inequalities ☐ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☐ Strategy/Transformation ☒ System ☐
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
TMG	25/06/2026	Update provided.
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 ☐	

Consolidation of Emergency and Planned Care

Delivering Phase 3

Background

Consolidation of Emergency and Planned Care is not just about which site does what. It's about what each site stops trying to do at the same time, and what patients gain because of that. Bringing every emergency-dependent service together at Bournemouth,

emergency medicine, surgery, critical care, diagnostics and the on-call rotas behind them, stops senior cover and rotas being split across two sites, reduces the risk and delay of moving unstable patients between Bournemouth and Poole, and concentrates enough volume and expertise in one place to make care safer and staffing more resilient than two smaller, parallel set-ups ever could.

At Poole, protecting elective surgery, day case and outpatient diagnostics entirely from emergency demand means theatre lists and beds stop being cancelled or utilised by urgent pressure, patients get a calmer, more predictable environment with far fewer last-minute cancellations, and UHD can run elective care at a higher volume and efficiency than splitting it across two sites, with emergency interruption built in. This is what Phase 3 delivers: Bournemouth as our dedicated emergency hospital, Poole as our dedicated planned care hospital. This paper sets out how UHD gets there safely.

1.0 Introduction

TMG has previously supported a Phase 3 move aligned to completion of the Coast building, recognising the need for a full 6-week commissioning period before clinical use. A move date was set for July 2026, then revised to December 2026, with Coast treated as essential to the move throughout.

1.1 December 2026 Move Date

The Coast programme continues to face delivery challenges with the contractor, and confidence in a December 2026 completion is now low; the realistic *expected* clinically live date has slipped to April 2027. Without Coast, and alongside the seasonal pressures UHD experiences every winter, recent winter planning work, presented to TMG in May 2026, tested whether Phase 3 reconfiguration could still go ahead this winter. It confirmed it could not.

On this basis, the programme cannot proceed with a December 2026 Phase 3 move with sufficient confidence in safety, commissioning or operational readiness. UHD will go into winter 2026 on the current split-site arrangements.

The lack of a reliable Coast build delivery date and move date has four implications:

- the delay increases risk to a safe transition
- it is not possible to reliably confirm a move date that depends on Coast, given low confidence in contractor delivery
- alternative delivery approaches must be developed in parallel, within UHD's own control.
- it delays the Phase 4 works across both hospital sites, predominantly at Poole

Delivering Phase 3 sets out how we resolve this, on a date within our control.

2.0 Delivering Phase 3

Phase 3 delivers Bournemouth as our dedicated emergency hospital and Poole our dedicated planned care hospital. Coast's availability does not determine whether, or when, this

happens, only how it happens. This plan aims to deliver a date we control, for the clear benefit of patients, by changing how the operating model manages demand and flow so it no longer depends on holding open a fixed number of beds.

Coast building still matters it gives patients and staff a modern, spacious environment, a more efficient estate, and means UHD moves once instead of twice, so we keep pressing for its delivery. What this plan adds is a second, equally robust route to the same date, tested through scoping workshops with Care Groups, that does not wait on a capacity number from a building programme we do not control.

2.1 Proposal - Setting the Phase 3 Date

The date for Phase 3 is set independently of Coast's delivery programme. The lowest risk move window is after Easter (26-29 March), end of year performance pressures, and the school Easter holidays (returning 12 April, which affects staff availability) are clear:

> **These factors point to a Phase 3 patient move phase starting week commencing 19th April, with a potential first patient move day of Wednesday 21 April.**

This date applies whether Coast is ready by then or not. What it determines is whether UHD moves once, directly into Coast, or moves once into the existing estate and a second time into Coast later, set out below. TMG would confirm the date five to six months before the move, informed by the monitoring described in 'How We Deliver This'.

2.2 How We Deliver This

The work that makes the April 2027 move possible does not change with Coast's delivery date. It means reducing No Criteria to Reside, improving flow, strengthening discharge, and working with system partners to manage demand differently, instead of just holding more beds open. It is not a fallback plan; it is the operating model the move is built on.

This work is led through the Trust's Patient First Methodology, with Improvement and Redesign at the core, so improvement is tested, measured and embedded, not run as standalone projects. Done well, this keeps the move date in our own hands, not tied to a contractor's programme. It builds an organisation that depends on the right services for patients, not bed numbers, with a stronger and more financially sustainable position long after Phase 3 move.

To track progress, we propose monitoring Occupied Bed Days (OBD) as the lead indicator. OBD combines the effect of admissions avoided, shorter stays and NCtR resolved into one well-understood measure, instead of relying on any single scheme. Tracking actual OBD against the trajectory needed by April 2027 gives the same early warning that milestone tracking gives for Coast's construction. We propose reporting the two side by side.

2.3 What Changes Depending on Coast's Delivery Date

The plan does not change depending on Coast's timing: the operating model, the date and the monitoring stay the same. What changes is some of the operational detail below.

2.3.1 If Coast is ready in time:

Coast gives us a modern, spacious environment for care, and means UHD moves once, straight into Coast, instead of moving twice. It does not change how many beds our operating model needs, that is set by the model itself. Coast capacity could be clinically live by April 2027. Move plans and sequences are already built on this basis, and Healthcare Relocations can reschedule capacity for this date range.

2.3.2 If Coast is not ready in time:

The move still goes ahead in April 2027, on the same basis: a stronger operating model, not a fixed bed base. What changes is that UHD moves into the existing PH and RBH estate first, then into Coast later when it is ready, instead of moving once directly. That second move, not a capacity gap, is the real impact of Coast running late; the estate stays older and more constrained in the interim, a question of environment, not patient safety. The move date stays largely within UHD's control either way. Early scoping workshops with Care Groups suggest the operating model holds up, though it needs more work before we can rely on it with confidence. This also creates an advantage for whenever Coast does arrive: instead of simply adding bed capacity we have shown we do not need, UHD gets a real choice about how to use capacity across the Trust, including retiring less efficient space on the PH or RBH sites.

In the interim, the earliest Phase 3 move date (week commencing 19th April, with a potential first patient move day of Wednesday 21 April) can be held for planning purposes regardless of whether Coast is ready by then. This draft date is subject to confirmation by TMG in October 2026, informed by the OBD tracking described above.

Before confirming the Go/No-Go for the Phase 3 move, we would track the Occupied Bed Day trajectory above as closely as we track confidence in Coast's contractor delivery. If OBD is reducing as planned, the Phase 3 move date can be given with confidence regardless of Coast; if it is not, that is the signal to revisit the plan well ahead of the move itself.

3.0 Closing the Capacity Gap

The bed mitigation portfolio is already under way gives us a confirmed deficit figure and a costed set of around schemes. Alongside that, the table below sets out a wider list of ideas about how we operate, not just bed numbers, so UHD can work safely without depending on a fixed bed count, whenever Coast lands. None of this is fixed; it is a starting point to challenge, refine or add to, with each idea tested against one question: could it realistically be designed, agreed and showing real impact within around seven months, by early 2027 to deliver a different operating model.

3.1 Operating Model Changes

Theme	What this could look like	Why it matters	Partners
Front door demand re-routing	GP same day access hubs and ambulatory pathways for conditions such as cellulitis, DVT and heart failure, designed to prevent an avoidable admission rather	Stops pressure entering the bed base in the first place, rather than relying on capacity being vacated later.	ICB, GP practices, Dorset Healthcare

	than manage one once it has happened.		
SWAST Hear and Treat / See and Treat expansion / Call Before Convey	Wider use of paramedic practitioner led non-conveyance, and direct access from ambulance crews into SDEC or frailty units, bypassing ED where clinically appropriate. Conveyance to ED at peak times would require a clinician-to-clinician call.	Reduces unnecessary conveyance to a bed-based pathway at the earliest possible point, directs people into safe alternative options	SWAST / Dorset HealthCare
Urgent Community Response scale up	Maximising the two-hour crisis response service so more patients are treated and supported safely at home instead of being admitted and connected to command centre	Directly substitutes for bed-based care for a defined, well evidenced cohort.	Dorset Healthcare, SWAST, Dorset Council
Discharge process re-engineering	Criteria led discharge extended across more wards, weekend discharge parity, pharmacy led same day dispensing, and a single integrated discharge hub co locating health and social care assessors.	Shortens the tail end of every stay, independent of NCtR numbers, and is largely within UHD's own control.	Dorset Council, BCP
NCtR Reduction	Reduce the number of patients waiting on discharge pathways 1, 2 and 3 to a maximum of 110, and reduce length of stay after the ready-to-leave date is agreed.	Reduces deconditioning and increases internal capacity	Dorset Council, BCP, Dorset Healthcare
Predictive flow and a single flow command centre linked to the wider system	Expected date of discharge set and tracked from the point of admission, with a live, shared dashboard for bed state and flow across both sites.	Surfaces slippage early enough to act on it, rather than discovering it on the day a bed is needed.	Internal, EPIC and digital teams
End of life and palliative fast track	A formalised rapid pathway with Dorothy House and Macmillan so patients identified as end of life move quickly to the right setting, instead of remaining in an acute bed by default or being stepped up from home or supported accommodation.	A small, identifiable cohort with a disproportionate length of stay impact.	Dorothy House, Macmillan

Voluntary sector home from hospital support	Volunteer led settling in support, a first shop, a welfare check, help with heating or mobility aids, that gives clinicians more confidence to discharge.	Removes a common, low acuity reason for an extra night in hospital at very low cost.	British Red Cross, Age UK, Dorset Council
Enhancing Senior decision making and weekend therapy cover	Extending seven-day consultant led ward rounds and weekend allied health therapy provision to more specialties.	Removes the Friday to Monday discharge gap that quietly adds bed days every week.	Internal
Elective flow protection	Higher day case rates for high volume procedures and wider use of patient initiated follow up to reduce avoidable readmission.	Protects elective capacity from being eroded by outliers, which is itself a driver of pressure on flow.	Internal, ICB
Joint, time limited system capacity	A pooled, time limited social care capacity commitment with Dorset Council, BCP and the ICB, in the same spirit as the P1 hours conversation already under way, focused specifically on the run up to the move.	Aligns system partners around the same delivery window rather than separate timelines.	ICB, Dorset Council, BCP
Hospital at Home / virtual ward expansion	Scaling the virtual ward and Hospital at Home model to a wider range of conditions and a higher daily census, with daily medical and nursing oversight delivered at home rather than on a ward.	A genuine substitute for a physical bed, not an adjunct to one, and a distinct mechanism from NCtR reduction since it prevents bed occupancy rather than shortening it.	Dorset Healthcare, SWAST/Internal
SDEC expansion across specialties	Extending Same Day Emergency Care with extended opening hours covering evenings and weekends.	Converts admissions that would otherwise need a bed into same day attendances, reducing demand on the bed base rather than managing it once admitted.	Internal, ICB
OPAT scale up	Wider use of outpatient parenteral antibiotic therapy for patients needing intravenous antibiotics who do not need to remain in an acute bed, supported by community nursing follow up.	Shortens length of stay for a well evidenced cohort without depending on additional discharge capacity elsewhere.	Dorset Healthcare, Internal

Mental health liaison and crisis alternatives	Review with partners to improve mental health access and alternatives to attendance and admission.	Addresses a cohort with a disproportionate length of stay impact.	Dorset Healthcare

This list is a first draft. It is not exhaustive, it has not been costed or risk assessed, and several ideas will need challenge from clinical and operational colleagues before they go further. That is the point of sharing it now, not later.

Coast will genuinely improve the environment and experience of care, and we should keep pressing for its delivery. Several of the ideas above carry a cost, but that needs to be linked to the potential savings from reduced dependency on beds and supports the wider shift of care away from hospital beds in line with the 10-year plan.

4.0 Recommendations

Stage 1

Note:

- the current timing of Coast delivery and that a Phase 3 move in December 2026 is no longer possible
- the need to continue to track Coast building delivery
- the Phase 3 plan is designed so the move does not depend on Coast bed availability.

Agree:

- that for planning purposes the w/c 19th April 2027 is the earliest Phase 3 patient move week and should be the working date for the Phase 3 move.
- that, as the UHD Board and with system leadership teams, we will own and drive this work to a timescale that meets the April deadline.

Stage 2 (If stage 1 agreed)

Agree:

- that each Care Group and Operations team reviews the ideas above, or adds their own, that are realistic to deliver within seven months
- Against each of the schemes there will be responsible owners who will coordinate pulling together a ‘UHD Phase 3 Den’ in July

- To work with partners to be fully aligned, so this is co-created and what we're doing, when, and how, against the April 2027 date, with a high-level plan and the impact of schemes shared widely.
- Monitor and report OBD trends against the required trajectory with the same rigour applied to Coast's delivery, monitored monthly through TMG and weekly through the Capacity Planning Group.
- Share and discuss with system partners our proposals and ask for support on wider plans
- Identify and cost the short-term investment needed to trigger each commitment, and bring this back for sign-off alongside the OBD trajectory.

4.0 Conclusion

This plan builds an organisation that can deliver safer care and move safely in April 2027, without depending on any single building, in a way that is right for patients long after Phase 3 is done. Together, these steps give us a clear, owned route to delivering Phase 3.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

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

Agenda items discussed:	At its meeting held on **3 June 2026** the Committee received the following:
	• Internal Audit:
	  ○ Progress Report
	  ○ Follow-Up Report
	  ○ Annual Report 2025/26
	• External Audit Progress Report
	  ○ Progress Report
	  ○ Draft External Audit Opinion
	  ○ Draft Letter of Representation
	• Risk register
	• Board Assurance Framework: 2025/26 and 2026/27
	• Information Governance, including:
	  ○ Data Security and Protection Toolkit
	• Annual Report and Accounts – draft
	• Provider Licence – Draft Compliance Report
	• Code of Governance – Draft Compliance Report
	• Register of Interests and Gifts and Hospitality
	• Commercial Compliance Report
	• Review of Losses and Special Payments:
	  ○ Annual report
	  ○ >£15k (for this period)
	• Audit Committee Annual Report

ALERT	The Committee wishes to alert members of the Board that: • None
ASSURE	The Committee wishes to assure members of the Board that: • The Committee took assurance from the annual reports and presentations from each of the auditors which contained positive commentary about the way that colleagues in the Trust work with the auditors to continually improve systems and process. • The Audit Committee were assured that there were no significant areas of concern that were not already noted and where action plans were in place for improvement.
ADVISE	The Committee wishes to advise the Board that: • The Committee received a report from the Internal Auditors referring to their audit work on the Trusts overall spend on drugs. This is an area that the trust recognises

	needs improving, particularly around care group ownership and accountability for specific drugs and the reporting against care group budgets. The Audit Committee has recommended that there continues to be board oversight of this risk and has referred it to the Finance and Performance Committee for an update at the end of Q2. • There were two areas of non-compliance noted in the annual governance review report, both of which were known about and for which there were mitigating commentary.
Review of Risks	The Committee considered the Risk Register and the BAF and recognised the enormous amount of work being undertaken to improve the way the Trust thinks about, mitigates and reports on risks. The Committee will continue to work with the Trust teams to improve the alignment of key risks to the BAF and the consistency/application of tolerance levels.
Celebrating Outstanding	The Trust has ended what has been a very difficult year in a positive position which was echoed by each of the Auditors in their comment and reports. This is a testament to the leadership team who are supporting the organisation under difficult conditions to keep improving.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: **4.1.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Audit Committee Annual Review 2025-26
Prepared by:	Klaudia Zwolinska, Deputy Company Secretary
Presented by:	Tracie Langley, Committee 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:	Assurance
Executive summary:	The report describes how the Committee discharged its responsibilities during the period from 1 April 2025 to 31 March 2026 and provides assurance to the Board that the Committee has met its duties as set out in its Terms of Reference over that period.
ALERT:	N/A
ASSURE:	A review of the Committee's compliance with its Terms of Reference was undertaken in May 2026 by the Corporate Governance Team, in support of the Committee. This review involved scrutiny of the agendas and minutes of the six Committee meetings held between 1 April 2025 and 31 March 2026.
ADVISE:	The questionnaire to assess the Committee's effectiveness will be shared with Committee members and standing attendees, and the outcome will be reported to the Committee at its next meeting.
Celebrating Outstanding:	N/A
RECOMMENDATION:	The Board is asked to note the report.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐

	Public Consultation	☐
	Quality	☐
	Regulatory	☒
	Strategy/Transformation	☐
	System	☐
CQC Assessment Framework:	Safe	☐
	Effective	☐
	Caring	☐
	Responsive	☐
	Well-Led	☒
	Use of Resources	☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Audit Committee	03/06/2026	The Committee endorsed the report with recommendation to 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 ☐	

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

AUDIT COMMITTEE ANNUAL REPORT 2025/26

1 PURPOSE OF THE REPORT

1.1 The Audit Committee (the "Committee") submits this report to the Board of Directors following its review of compliance with its terms of reference. The report outlines how the Committee fulfilled its responsibilities during the period 1 April 2025 to 31 March 2026, with particular regard to providing the Board with assurance to support its responsibilities in respect of the Annual Governance Statement.

1.2 The establishment of an independent Audit Committee is a key mechanism through which the Board of Directors gains assurance that effective internal control arrangements are in place. The Committee provides independent oversight of the development and maintenance of an integrated system of governance, risk management and internal control across all of the organisation's activities, encompassing both clinical and non-clinical areas.

1.3 The Committee receives and considers reports from both internal and external auditors, counter fraud specialists and scrutinises the Trust's annual report and financial statements.

1.4 The Committee has a governance cycle detailing which papers are expected to be presented at each meeting of the Audit Committee. This is reviewed annually and updated as necessary during the year.

2 MEETINGS

2.1 Six formal meetings were held during the year, all of which were quorate:

- Friday 25 April 2025
- Wednesday 4 June 2025
- Wednesday 18 June 2025 *(joint with Finance and Performance Committee)*
- Thursday 17 July 2025
- Thursday 16 October 2025
- Thursday 15 January 2026

2.2 Meeting attendance is detailed in **Appendix 1.**

2.3 It is usual for the External and Internal Auditors, along with the Counter Fraud Specialist, to attend all formal meetings of the Committee. During the period, representatives from each were present at every meeting.

2.4 The Trust Chair is not a member of the Committee but may attend meetings at the invitation of the Audit Committee Chair.

3 MEMBERSHIP

3.1 Membership of the Committee comprises of four independent Non-Executive Directors (other than the Trust Chair), one of whom will be a qualified accountant with recent and relevant financial experience and one of whom will also be a member of the Quality Committee.

Membership of the Committee in 2025-26 comprised of:

- Tracie Langley, Non-Executive Director and chair
- John Lelliott, Non-Executive Director *(until October 2025)*
- Cliff Shearman, Non-Executive Director *(until September 2025)*
- Claire Whitaker, Non-Executive Director
- Michael Marsh, Non-Executive Director *(from September 2025)*
- Alastair Matthew, Non-Executive Director *(from November 2025)*

John Lelliott, and then Alastair Matthews, and Tracie Langley are qualified accountants. Cliff Shearman and then Michael Marsh were members of the Quality Committee during the period.

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 A review of the Committee's compliance with its Terms of Reference was undertaken in May 2026 by the Corporate Governance Team, in support of the Committee. This review involved scrutiny of the agendas and minutes of the six Committee meetings held between 1 April 2025 and 31 March 2026 and demonstrates how the Committee discharged each of its responsibilities during the period.

4.2 **Governance, risk management and internal control**

To review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical) that supports the achievement of the organisations' objectives. In particular, the Committee will review the adequacy and effectiveness of:

4.2.1 **All risk and control related disclosure statements (in particular the annual governance statement, annual report, quality accounts, annual financial statements, annual draft licence compliance, annual draft code of governance compliance, assurance process for licence condition compliance, assurance process for corporate governance statement together with any accompanying internal audit statement, external audit opinion or other appropriate independent assurances), prior to submission to the Board.**

The Committee (or joint Audit and Finance & Performance Committee) reviewed these items prior to submission to the Board:

- Annual governance statement – April 2025
- Annual report – June 2025 *(joint Audit and Finance Committee)*
- Annual financial statements, including external audit opinion – June 2025 *(joint Audit and Finance Committee)*
- Annual draft licence compliance – April 2025
- Annual draft code of governance compliance – April 2025

4.2.2 **The underlying assurance processes that indicate the degree of the achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.**

The Committee reviewed the risk register at each meeting, in addition to the Board Assurance Framework (BAF) on a quarterly basis.

Progress reports were received from internal audit in relation to audits undertaken aligned to the BAF and provided an assessment of design effectiveness, areas of strength and improvement including recommendations.

4.2.3 **The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.**

The Committee reviewed the Policy on the use of External Auditors for Non-Audit Purposes in 2024/25, and the policy remains in place.

The Committee received ongoing updates on the progress in relation to the Trust's policies.

In April 2025, the Committee reviewed the Trust's compliance with the Code of Governance for NHS Provider Trusts and the Provider Licence.

The Committee recommended approval of the annual certificates (Continuity of Services 7 and Training of Governors) in April 2025 with Board approval taking place in May 2025.

4.2.4 **The wording in the annual governance statement and other disclosures relevant to the Terms of Reference of the Committee.**

The Committee reviewed and recommended approval of the draft annual governance statement in April 2025.

4.2.5 **The clinical audit system plan to ensure that it is robust, reflecting both national and local priorities, comprehensive and embedded across all clinical teams with the outcomes used to drive improvement and enhance the overall quality of clinical care[1].**

The clinical audit plan for 2025-26 was presented to the Committee in October 2025, with Quality Committee receiving reporting in relation to Clinical Audit and Effectiveness.

4.3 **Counter Fraud**

4.3.1 **To review the adequacy and effectiveness of policies and procedures for all work related to counter-fraud, anti-bribery and corruption to ensure that these meet the NHS Counter Fraud Authority's standards and the outcomes of work in these areas, including reports and updates on the investigation of cases from the local counter fraud service;**

[1] In conjunction with the Quality Committee

The Committee received the counter fraud progress report at each meeting, including updates on investigations.

4.3.2 **To ensure that the counter fraud function has appropriate standing within the organisation.**

The annual review of the effectiveness of the Local Counter Fraud Specialist was presented to and considered by the Committee in October 2025.

The regular reports from the LCFS included updates on their activities within the Trust, including engagement with staff.

4.3.3 **To review the counter fraud programme, consider major findings of investigations (and management's response), and ensure co-ordination between the internal auditors and counter fraud.**

The Committee reviewed and approved the counter fraud programme for 2025-26 in April 2025.

The LCFS' reports to the Committee contained findings from investigations and management responses.

4.4 **Internal Audit**

To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides independent assurance to the Committee, Chief Executive and Board. This will be achieved by:

4.4.1 **Considering the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.**

The Committee received progress reports from internal audit at each meeting.

The annual review of the effectiveness of the internal audit service was presented to and considered by the Committee in October 2025.

4.4.2 **Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework.**

The Committee reviewed and approved the internal audit programme for 2025-26 in April 2025.

4.4.3 **Considering the major findings of internal audit work (and the appropriateness and implementation of management responses) and ensuring coordination between the internal and external auditors to optimise audit resources;**

The Committee reviewed the major findings and management action plans as part of the internal audit progress report presented to each meeting.

Representatives of both internal and external audit received each other's progress reports and plans as part of the Committee's meeting materials (consequently supporting coordination).

4.4.4 **Ensuring the internal audit function is adequately resourced and has appropriate standing within the Trust.**

The annual review of the effectiveness of the internal audit service was presented to and approved by the Committee in October 2025.

4.4.5 **Monitoring the effectiveness of internal audit and carrying out an annual review.**

As above.

4.5 **External Audit**

To review and monitor the external auditors' integrity, independence and objectivity and the effectiveness of the external audit process, more particularly, reviewing the work and findings of the external auditors and considering the implications and management's response to their work. This will be achieved by:

4.5.1 **Considering the appointment and performance of the external auditors, including providing information and recommendations to the Council of Governors in connection with the appointment, reappointment and removal of the external auditors in line with criteria agreed by the Council of Governors and the Committee.**

The annual review of the effectiveness of the external audit service was presented to the Committee in October 2025 and recommended for approval by the Council of Governors.

4.5.2 **Discussing and agreeing with the external auditors, before the external audit commences, the nature and scope of the audit as set out in the annual external audit plan.**

The annual external audit plan was considered at the meetings held in April 2025.

4.5.3 **Discussing with the external auditors their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.**

The Committee received external progress reports including in relation to audit risks and the audit approach, as well as technical updates.

4.5.4 **Reviewing all external audit reports, including reports to the Board and the Council of Governors, and any work undertaken outside the annual external**

audit plan together with any significant findings and the appropriateness and implementation of management responses.

The Committee reviewed external audit reports at each meeting.

4.5.5 **Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services taking into account relevant ethical guidance.**

A policy is in place on the use of external auditors for non-audit work in place which was reviewed and endorsed by the Committee in October 2024. The policy remains in place.

4.6 **Financial Reporting**

4.6.1 **To monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.**

The integrity of the financial statements is monitored through regular external audit reports.

4.6.2 **To ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided to the Board.**

As above.

In addition, the Committee received internal audit reports related to certain systems for financial reporting.

4.6.5 **To review the annual report, annual governance statement and annual financial statements before these are presented to the Board to determine their completeness, objectivity, integrity and accuracy and the letter of representation addressed to the external auditors from the Board.**

The Committee reviewed the draft annual governance statement in April 2025.

The annual report and accounts, alongside the external audit report on the financial statements are presented to the Joint Audit and Finance and Performance Committee prior to being presented to the Board for approval.

4.7 **To review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in matters of financial reporting and control, fraud, bribery and corruption, clinical quality, patient safety or other matters.**

The effectiveness of the LCFS service was reviewed in October 2025.

Please see above in relation to Freedom to Speak Up.

4.8 **To receive assurance that the Trust is complying with EPRR legal and policy requirements, including sufficient experience and qualified resource having been allocated prior to this being presented to the Board.**

The Committee received an assurance report on Emergency Preparedness, Resilience and Response in October 2025 including the workplan for 2025/26.

5 CONCLUSION

5.1 The Committee considers that it has discharged its responsibilities as noted above.

Tracie Langley
Chair, Audit Committee
June 2026

University Hospitals Dorset
NHS Foundation Trust

Appendix 1 – Attendance at Audit Committee 2025/26

Attendance at Audit Committee

Audit Committee		25 April 2025	04 June 2025	17 July 2025	16 October 2025	15 January 2026
Present	Judy Gillow					
	Tracie Langley				A	A
	John Lelliott					
	Cliff Shearman					
	Claire Whitaker					
	Michael Marsh					
	Alastair Matthews					
In attendance	Camilla Axtell					
	Vivian Alividza					
	Lucy Baxter					
	Jonathan Brown					
	Beverley Bryant					
	Terri Clark					
	Yasmin Dossabhoy					
	Tony Hall TIAA					
	Kim Hampson					
	Siobhan Harrington					
	Sarah Herbert					
	Samuel Hoey KPMG					
	Daren Jose					
	Duncan Laird					
	Helen Martin					
	Mark Mould					
	Pete Papworth					
	Sharath Ranjan					
	Richard Renaut					
	Adam Spires BDO					
	Mark Stabb BDO					
	Carrie Stone					
	Adrian Tron					
	Dr Robert Willington					
	Dr Peter Wilson					
	Klaudia Zwolinska					
Was the meeting quorate?		Y	Y	Y	Y	Y

Key

	In attendance
	N/A
A	Apologies
D	Delegate Sent

Appendix 2 – Audit Committee Governance Cycle

	Jan	Mar	May	JA&FPC	July	Oct	Goes to
Standing Reports							
Audit Committee Minutes	X	X	X	X	X	X	N/A
Matters Arising - Action List	X	X	X	X	X	X	N/A
Risk Register	X	X	X	X	X	X	N/A
External Audit Progress Report	X	X	X	X	X	X	N/A
Internal Audit Progress Report	X	X	X	X	X	X	N/A
Counter Fraud Report	X	X	X	X	X	X	N/A
Commercial Compliance Report	X	X	X	X	X	X	N/A
Review of Losses and Special Payments by Exception >£15k	X	X	X	X	X	X	N/A
Quarterly Reports							
Board Assurance Framework	X		X		X	X	N/A
Deep Dives *(tbc)*	X		X		X	X	N/A
Information Governance	X		X		X	X	N/A
Annual Reports							
External Audit Annual Plan		X					CoG Part 2
Internal Audit Annual Plan		X					
Counter Fraud Annual Plan		X					
Internal Audit Annual Report			X				
Counter Fraud Annual Report			X				
Review Fit and Proper Persons Test					X		
Review of External Auditors' Performance						X	CoG Part 1
Review of Internal Auditors' Performance						X	
Review of Counter Fraud Service's Performance						X	
Audit of Non-Clinical Policies	X						
Clinical Audit - report from Quality Committee					X		
Draft Board Assurance Framework - Coming Year			X				BoD Part 1
Quality Governance Framework			X				
Quality Impact Assessment Process			X				
Annual Review of Losses & Special Payments			X				
Freedom to Speak Up						X	
Register of Interests and Gifts & Hospitality			X				BoD Part 1
Emergency Preparedness, Resilience & Response						X	
Timeline for Annual Report & Accounts	X						
Terms of Licence - Draft Compliance Report		X					BoD Part 1
Code of Governance - Draft Compliance Report		X					BoD Part 1
Annual Certificates (CoS7, Training of Governors)		X					BoD Part 1
Going Concern		X					BoD Part 1
Draft Annual Governance Statement		X					BoD Part 2
Draft Remuneration Report		X					
Draft Annual Accounts			X				BoD Part 2
Report on the Financial Statements				X			BoD Part 2
Final Draft Annual Report & Accounts				X			BoD Part 2
Quality Account				X			BoD Part 2
Letter of Representation				X			BoD Part 2
Scheme of Delegation Review						X	BoD Part 1
Standing Financial Instructions Review						X	BoD Part 1
Anti-Fraud, Bribery & Corruption Policy and Statement			X				BoD Part 1
Policy on the use of External Auditors for Non-Audit Work (triennially - *next due in 2027*)						X	BoD Part 1
Review of Risk Management System	X						
Audit Committee Governance Cycle		X					N/A
Audit Committee Terms of Reference					X		BoD Part 1
Audit Committee Annual Report			X				BoD Part 1

Ad-hoc/Exception reports:
Well Led - action plans
Compliance - Constitution and Standing Financial Instructions
Receive other sources of assurance
Business of other Committees and Inter-relationships

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: 4.1.2

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Board Assurance Framework – Q1 2026/27
Prepared by:	Jo Sims – Associate Director Quality Governance and Risk
Presented by:	Sarah Herbert, Chief Nursing Officer
Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☐ Patient Experience ☐ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	NA
Purpose of paper:	Assurance
Executive summary:	The report provides details of BAF at the end of Q1 2026/27.
ALERT:	There are no matters to Alert
ASSURE:	The Board Assurance Framework (BAF) supports the Board's strategic focus and strengthens risk management. It enables the organisation to identify, report and monitor key risks to strategic objectives, track corrective actions and provide progress updates to the Board. The BAF also provides assurance on delivery of objectives and highlights areas of concern.
ADVISE:	The UHD Board Assurance Framework for 2026/27 was redesigned in April 2026 to provide greater depth and clearer visibility of controls, assurances, planned actions and resulting risk levels linked to the Trust's strategic objectives. Risk descriptions and supporting detail are aligned to relevant breakthrough objectives, corporate projects and corporate risks rated 15–25 on the risk register, with links also made to the 2026/27 Internal Audit Plan. 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 months. Board subcommittees will receive a quarterly report on current BAF risks linked to any relevant strategic objectives for the committee. To align BAF updates with risk register reporting, leads are responsible for updating the BAF at the end of each quarter. A

	central repository has been established to support document and version control. This report provides the position of the BAF at the end of Q1 (April-June 26).
Celebrating Outstanding:	**N/A**
RECOMMENDATION:	That the Board notes the contents of the report.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☐
CQC Assessment Framework:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well-Led ☒ Use of Resources ☒

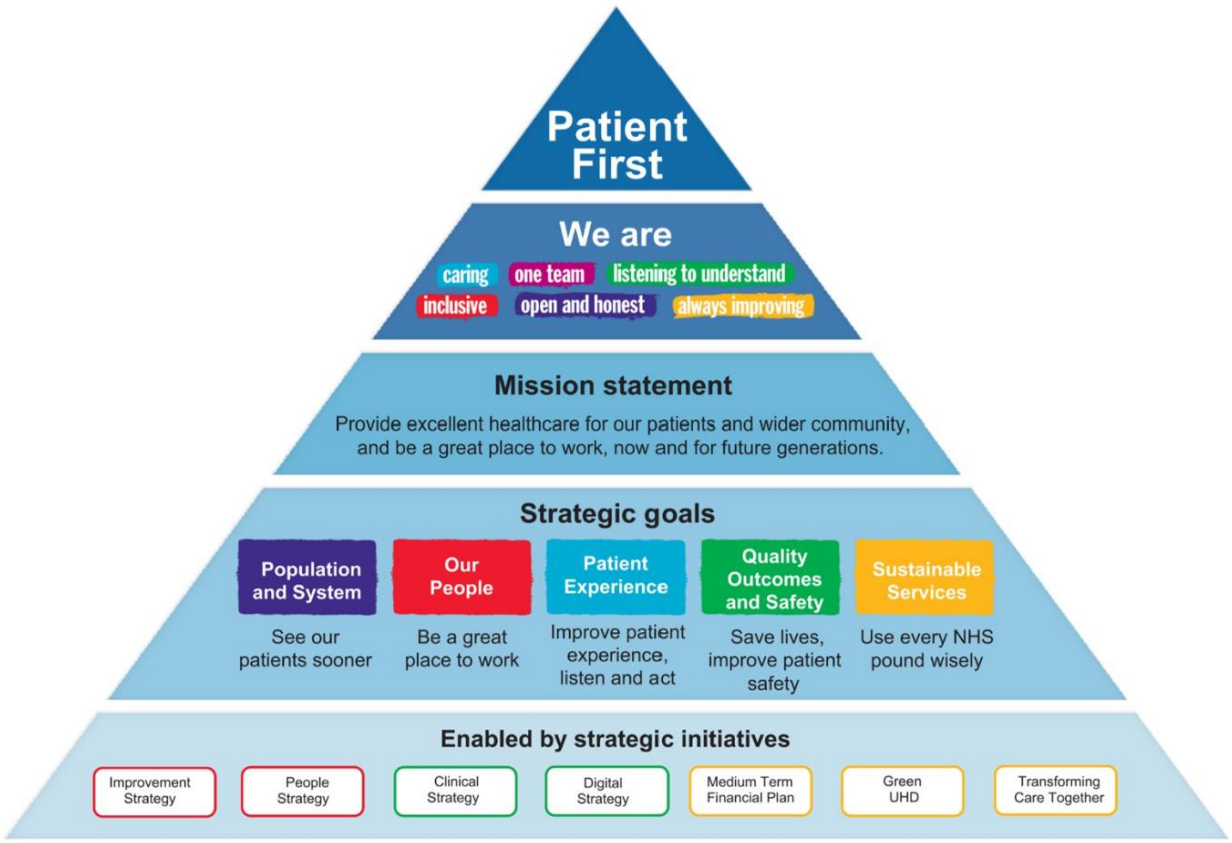
Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**

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

-

Board Assurance Framework

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



5 strategic themes

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

Corporate Projects 2026/27

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

Strategic risk description	
There is a risk that the Trust cannot achieve its strategic priority to focus on patient experience due to: • Increased demand due to the impact of deprivation, multi- morbidity and an ageing population, and seasonal variation • Increased demand – unplanned care, emergency department attendances, on patient flow across the system. • Significant growth in the number of patients waiting for elective treatment. • Ageing estate and building/digital infrastructure leading to poor patient experience. • Insufficient workforce due to availability • Lack of system capacity resulting in increased number of patients with NCtR awaiting discharge, increased length of stay, and increased risk of deconditioning. • Insufficient system and Trust provision for patients with a mental health disorder • Inconsistent compliance with fundamentals of care Resulting in potential harm to patients, impact on outcomes, experience and quality of care, impact on external relations, and regulatory breach (CQC).	**Lead Executive Director(s): CNO** **Date last reviewed: 30/06/26** **Strategic objective** All patients at UHD receive quality care which results in a positive experience or them, their families and carers. Every team is empowered to make continuous improvement by engaging with patients in a meaningful way, using their feedback to make change. **Breakthrough Objectives** 90% of complaints closed within 35 days 95% of Friends and Family Test responses rated good or very good **Linked Corporate Projects** Fundamentals of Care **Links to Internal Audit Plan 26/27** Mental Health Act Consent IPC MIS

Current and Target Risk Ratings

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

Risk category and risk appetite statement

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

Key Controls (to manage risks related to goal)	**Key assurances** (effectiveness of controls)
Prevention Controls (parts of a system of internal controls designed to prevent a risk from occurring) • Patient Experience and Engagement Strategy • People and Culture Strategy – Behaviour Charter • Trust Policies and Procedures • Fundamentals of care programme **Detection controls** (those that provide an early warning of control failure) • Quality Committee oversight of risks related to patient safety, quality and experience: risk framework (risk categories/risk appetite) • Quality Committee oversight of patient experience metrics • Patient Experience Group monitoring KPI and breakthrough objectives • Finance and Performance Committee oversight of delivery against constitutional standards including in year deep dives. • CQC engagement process • Patient Champions, Patient Safety Partners **Contingency controls** (those that help prepare for an effective reaction in response to a control failure or overwhelming event. Designed to maintain resilience) • CQC action plans • Actions from complaints, claims, LERNS, Inquests • Trust Escalation process	Internal: • National Inpatient and outpatient survey • National Staff survey • PLACE Audit • Complaints report to Board • Annual Safeguarding Report • Quality Account • Patient feedback – FFT, patient surveys, focus groups, user/stakeholder engagement. • Matron's walkabouts • Clinical Accreditation Scheme (report to QC) • Quality Assurance Tool (report to CGG and QC) • Internal audit programme • 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. • Care Group SDR Reports – patient experience. • Trust annual governance statement • Learning from death reviews • TMG corporate projects and corporate SDR External: • CQC Adult Inpatient Survey • CQC inspection report(s) CQC Regulation 10 – dignity and respect CQC Regulation 12 - safe care and treatment
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)*	
June 26	No current 15+ risks

Date	**Updates (Improvement, Identified gaps in controls and/or assurances)** *(to be updated at least quarterly)*	**Actions to be taken next quarter** *(to be updated at least quarterly)*
Q1	Complaints policy and procedure aligned to PHSO/NHS complaints standards – clear SOPs. Friends and Family Test migrated from Formic to Microsoft Form – cost reduction Weekly review of complaints with Care Groups	Undertake a full audit of the complaints backlog; triage by date, complexity and risk; and implement a 6-week recovery trajectory Review PALS and Complaints staffing/capacity and triage process to reduce backlog and support earlier informal resolution

	Review of backlog and established 6-week improvement plan to address complaints backlog Patient Experience Group Agenda revised in collaboration with Care Group representatives to reflect Care Group reporting of improvements (AAA report)	Increase the number of Early resolution of complaints at a local/ward/department level Increase FFT return rates through (QR codes) across areas with low returns Review and refresh complaints handling training for care group teams, particularly early resolution at ward level, thus decrease the number of formal complaints and reduce reliance on central team Triangulate complaints, PALS, and FFT themes quarterly to identify systemic issues and inform quality improvement priorities, and ultimately increase the FFT satisfaction rate

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

Strategic risk description	
There is a risk that UHD cannot achieve its strategic priority to be a great place to work because of: • Insufficient workforce supply attributable to national and local workforce shortages. • Insufficient attention to the positive impact of an attractive 'employee value proposition (EVP) helping to attract and retain across all staff groups. • Pressures on leaders' and managers' capacity and capability, in their task to create a positive environment for all colleagues and to implement, deliver and sustain change. • Insufficient opportunities for training and development because of operational pressures, leading to diminution of skills and failure to attract and retain talent. • Employee turnover, attributable to sustained operational pressures, leading to the potential for burnout and fatigue. • Reduced workforce availability attributable to sickness absence (primary drivers are musculoskeletal problems and stress, anxiety and depression). • Scale of digital change and the requirement for workforce digital literacy. • Ageing estate / extensive new estates footprint leading to poor staff experience during the change process. • Financial and workforce controls, in line with national planning guidance, require workforce reduction targets. • Insufficient support from the People Directorate given the breadth and volume of demand from the people agenda, including support for change programmes. • Impact of Industrial action.	**Lead Executive Director(s)**: CPO **Date last reviewed:** 30/06/26 **Strategic objective:** To be a great place to work, attract and retain the best talent. **Breakthrough objectives:** • Increased response rate and improved staff survey results • Increased substantive staff availability measured by a reduction in temporary staffing spend • 15% reduction in premium bank spend (compared to 2025/26) • 30% reduction in agency spend. **Linked Corporate Projects** All workforce programmes including Workforce operational efficiency and reduction plan (WOERP) **Links to Internal Audit Plan 26/27** • Rostering • Optimising and valuing admin

Current and Target Risk Ratings

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

Risk category and risk appetite statement

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

Key Controls (to manage risks related to goal) OBJ	**Key assurances** (effectiveness of controls)

Prevention Controls (parts of a system of internal controls designed to prevent a risk from occurring)
• People and Culture Strategy, incorporating:
  • Strategic Workforce Plans (with monthly Provider Workforce Return (PWR)
  • Health and Well Being Plans - THRIVE
  • Equality, Diversity & Inclusion plan
  • Learning, Education and Training plan
• Behaviour Charter
• HR Policies and Procedures
• Digital Strategy
• Estates Strategy and People Ready strand of Transforming Care Together programme
• Staff vaccination programme and support
• Freedom to speak up policy.
• Accountability Framework
• Workforce Operational Efficiency and Reduction 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 Group.
	• People and Culture Committee and annual report
	• Chief People Officers Report
	• Transforming Care Together – People Ready Assurance Report
	• Safer Staffing Reports
	• Guardian of Safe Working Hours Report
	• WRES/WDES/ gender pay annual reports
	• Freedom to Speak up Report.
	• Integrated Performance Report
	• Patient First Report
	• Risk Register Report
	• Care Group and Corporate SDR Reports
	• Staff Partnership Forum Reports
	• Workforce Operational report
	• Workforce Operational Efficiency & Reduction Programme reports
	• Employee Relations Triage Reports and Annual Report
	• People Promise charters and reports

Detection controls (those that provide an early warning of control failure) • Risk escalation process from SDRs to People and Culture Group • People and Culture Committee oversight of risks related to workforce, staff safety, and health and wellbeing • People and Culture SDR meeting	
Contingency controls (that help prepare for an effective reaction in response to a control failure or overwhelming event. Designed to maintain resilience) • Bi-monthly people and culture group review of workforce programmes to deliver operational and strategic priorities • Strategic Deployment Review meetings • People Ready meetings	

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
30 June 26	1397 Provision of 24/7 Haematology/ Transfusion Laboratory Service
	2229 Obstetric Ultrasound Scanning Service
	1855 Lack of Breast Radiologists

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)*
5 July 2026	Assurance/ Improvements: recruitment of project managers to lead the WOERP; recruitment of interim Director of Organisational Development; reduced time to hire; development of KPIs for	• Review and refresh People Strategy. • Gap assessment to ensure that all workforce risks are addressed in the 2026/27 Delivery Plan.

	priority service areas (resourcing and Occupational Health); reviewed workforce risks and provided training to staff; designed Thrive Live 2026.
	
	Identified gaps: People Strategy requires review and refresh to reflect new legislation.
		• Priorities for Q2 include:
		  ○ Preparation for 2026 Staff Survey.
		  ○ Thrive Live 2026
		  ○ People ready changes.
		  ○ Review temporary staffing function.
		  ○ Delivery of WOERP Plans.
		  ○ Registered nursing profiles.
		  ○ Develop Organisational Development priorities/ plan.
		  ○ Support Healthset Resourcing
		  ○ Support development of the Digital Target Operating Model across Dorset Trusts.
		  ○ Support the Southern Counties Pathology reconfiguration.
		  ○ Succession Planning and Talent Management.

Trust strategic priority: Population and System - See patients sooner

Strategic risk description

There is a risk that the Trust cannot achieve its strategic priority to see patients sooner due to:

- Delay in Phase 3 Transformation programme resulting in sub optimal pathways and processes for planned and emergency care.
- Emergency department capacity and workflow pressures resulting in increased waiting times and increased corridor care.
- Lack of system resilience due to workforce and funding pressures in community/primary/social care
- Lack of system capacity resulting in increased number of patients with No Criteria to Reside (NCtR) awaiting discharge
- Higher demand due to local patient population profiles, with high level of frailty adding to the demand for ongoing support out of hospital (linking to above bullet).
- Sustained operational pressures due to capacity and demand and potential for industrial action.
- Increased demand in specific specialties, due to local and national health promotion campaigns and initiatives.
- Insufficient workforce supply due to national and local workforce shortages in specific areas.
- Lack of sufficient capacity and resources in diagnostic services pending full completion of CDC development programme.
- Ageing estate and building.
- Inadequate digital infrastructure.
- Capacity (workforce and physical estate) constraints creating a reliance on high-cost outsourcing / insourcing to deliver elective activity within a restricted financial allocation.
- Limits on ISP elective activity contracts due to System financial plan resulting in potential further increases in demand and reduced capacity system wide.
- Inefficiencies and variation in systems and processes impacting the productivity of teams to deliver elective and non-elective pathways.
- Lack of unified organisational culture and ownership of the objective.

Resulting in possible harm to patients due to treatment delays, poor experience, impact on external relations, failure to deliver the trust /System transformation programme and failure to meet NHS constitutional performance standards. Long-term threat to service sustainability and regulatory breach (CQC).

Lead Executive Director(s):
Chief Operating Officer

Date last reviewed: 01/07/26

Strategic Objective
Consistently delivering timely, appropriate, accessible care as part of a wider integrated care system for our patients.

Breakthrough Objective:
82% of patients admitted, transferred or discharged from ED within 4 hours

7% improvement in patients waiting 18 weeks or less for elective care (RTT standard)

80% of cancer patients treated within 62 days of referral

Linked Corporate Projects
Operational Flow
Outpatients

Links to Internal Audit Plan 26/27
Optimising and valuing admin
Booking systems

Current and Target Risk Ratings

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

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

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

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

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
June 26	1053 Inability to Reduce Medically Ready for Discharge (MRFD) Bed Occupancy to Safe Reconfiguration Threshold (Currently in holding pending refresh)
	1395 Lack of Capacity in Cellular Pathology Causing a Delay in Processing and Reporting.
	1460 Inability to meet UEC 4-hour safety standard leading to an adverse impact on patient safety and quality
	1665 School age Neurodevelopmental service
	1697 Increased waiting list for SACT treatment/ Capacity on Day units

Date	**Update (Improvements, identified gaps in controls and/or assurances)** *(to be updated at least quarterly)*	**Actions to be taken next quarter** *(to be updated at least quarterly)*
Q1 & moving to Q2	**Cancer 28/ 62-day standard** – Delivery of specific actions at pathway level to deliver Cancer trajectory 28day end of Q2 and 62day by Q3/Q4	(1) Implementing pathway level national benchmarking v Pathway UHD delivery in 3 of the cancer sites (2) Delivery of the cancer recover actions to support pathway improvement focusing initially on clearing FDS waiting time backlog. (3) UHD cancer Group developing delivery role in leading Trust strategic cancer (4) Wessex cancer continues to support through their improvement team
	4 hour Organisational Standard deliver through the Excessive Hospital Patient Stays work (Three Horizons) 1. Hold Horizon 1 Ways of Working agreed through the Future Care Programme (now within CVF) 2. Implement the Admitted Flow Programme (Clinical Vision of Flow) 3. Work with system partners on System Re-Design and Re-Commissioning	(1) Embed Horizon 1 into the Clinical Vision of Flow (CVF) programme. (2) Establish and progress the governance and work programme of the CVF (3) Work with commissioners to Close commissioning gaps
	(1) **Elective RTT** – Operational planning trajectories for RTT 18 week performance and 52ww as a percentage of the total waiting list, have been met in M02, whilst total waiting list and DMO1 is forecasted to be off plan for Q1 and requires specific actions at modality level to be documented and timescales for recovery	(1) Documentation of actions and timescales for DMO1 recovery at modality level to achieve operational plan trajectory. Sign off to be agreed at Planned Care Improvement Group. (2) Deliver action plan to reduce the total waiting list in line with the operational plan, including validation. (3) Bring forward ERF funding to increase capacity

	agreed. (2) Visibility of the elective priorities and plan for the Trust in 2026/27 has been shared with TMG in May. (3) Delay in CDC Endoscopy build will impact on DMO1 recovery plan for Endoscopy	to meet the waiting list and DMO1 recovery actions (4) Revised timeline to deliver new Endoscopy Unit to be agreed by Move Ready Group and Planned Care Hospital Oversight Group. Implement mitigation plan in intervening period.

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

Strategic risk description

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

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

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

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

Date last reviewed: 22/06/26

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

Breakthrough objectives:

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

Linked Corporate Projects
Healthset

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

Current and Target Risk Ratings

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

Risk category and risk appetite statement

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

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

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
1 April 26	2303 Noncompliance with NICE TAs in Cancer services due to capacity and resource impact 2310 Emergency Theatre staffing supporting a second theatre out of hours 2262 Insufficient capacity and lack of specialist staffing and environment for respiratory high care patients and safety impact 1970 Lack of sufficient provision of glaucoma service 1974 Significant time delays for macular injection treatment 2052 Care of patients in non-clinical/corridor areas in the Emergency Department
30 June 26	2310 Emergency Theatre staffing supporting a second theatre out of hours 2262 Insufficient capacity and lack of specialist staffing and environment for respiratory high care

	patients and safety impact 1974 Significant time delays for macular injection treatment 2052 Care of patients in non-clinical/corridor areas in the Emergency Department 2229 Obstetric ultrasound scanning service 1855 Breast radiologist provision 2302 Accuracy of clinical coding 1460 UEC 4 hour standard 1397 Provision of 24/7 Haematology/ Transfusion Laboratory Service

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)*
1/4/26	Progress against 25/26 priorities and PSIRF plan included in Quality Account report 25/26	New PSIRF priorities to be set out in PSIRF \plan. Establish new Pressure Ulcer steering group and QI programme Review PSII VTE Thematic review report and agree action plan Continue to implement WHO checklist project Report on review of LfD policy (audit and BDO reports) at MSG
29/6/26	New PSIRF Plan approved VTE Thematic review presented to PSIRF Oversight and action plan agreed New Audit Management System (AMaT) is now in place, Annual Audit plan approved, Audit report 25/25 approved. Harm review tool for ED waits in pilot Review of eDischarge summary breaches – project group in place and thematic review in progress. Gaps being addressed by Care Groups. Annual Safeguarding Report, Annual IPC Report and Annual Patient Experience Report completed New ToR agree for PSIRF Oversight to enhance monitoring of PSIRF principles	Develop wider Harm Review SOP Clear eDS backlog and implement new SOP Develop SOP for ED waits and Corridor care breaches Implement actions from Learning from Deaths Audit. Implement new Oversight model from 1 July 26

Trust strategic priority: Sustainable Services - Use every pound wisely

Strategic risk description

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

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

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

Lead Executive Director(s):
Chief Finance Officer

Date last reviewed: 26/06/26

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

Breakthrough objectives:

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

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

Current and Target Risk Ratings

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

Risk category and risk appetite statement

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

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

Links to Corporate Risks rated 15-25 (*This section should be cross referenced against the risk register and updated at least quarterly with any changes in risk profile noted)*	
April 26	1595: Medium Term Financial Sustainability 2302: Accuracy of Clinical Coding
29 June 26	1950: The Trust Electronic Patient Record (EPR) will be unsupported from April 2027 and is not fit for purpose 1595: Medium Term Financial Sustainability 2302: Accuracy of Clinical Coding

Date	**Update (Improvement, Identified gaps in controls and/or assurances)** *(to be updated at least quarterly)*	**Actions to be taken next quarter** *(to be updated at least quarterly)*
Q1	Internal audit has identified the need for	High cost drugs. Enhanced spend reporting by

	improved internal reporting of drugs spend and a strengthened budgetary mechanism Workforce controls scoping work completed across multiple dimensions, including for enhanced VRP (Vacancy Recruitment Panel) approach, consistency across the Trust for Recruitment and Retention premia, and overtime / additional hours payments Medical Staffing Patient First project underway – medical job planning achieved in 100% of specialties, with over 6000 additional clinic slots identified Delivered 2025/26 full year position in line with forecast revenue and capital positions including actions agreed within the H2 recovery trajectory	specialty distributed by chief pharmacist to be in place by M3, enhanced budget approach to be embedded by Q2 Enhanced VRP approach for 26/27 agreed and implemented Consistent approach agreed across the Trust for Recruitment and Retention premia, and overtime / additional hours utilization, reducing spend where appropriate Job planning monitoring through MSTEG to ensure ongoing compliance with >95% job plans in place, clinic standardization reports into MSTEG and GIRFT groups 2026/27 revenue forecasting process to be undertaken alongside M2 reporting checkpoint, identification of risks and mitigations to delivery of the revenue position

Trust strategic priority/initiative: Transforming Care Together

Strategic risk description	
There is a risk that delays and interdependencies across the Transforming Care Together (TCT) programme (Build Ready, Reconfiguration/Service Ready and People Ready) result in a prolonged partial reconfiguration and impact delivery of Phase 3 of the planned and emergency care model. Delays compound operational pressures, patient flow, performance and safety. Delays impact of the delivery of programme benefits, increase costs and delay the overall reconfiguration benefits. Delays also create suboptimal clinical pathways and processes, increase pressure on staff and impact on morale, wellbeing and staff retention.	**Lead Executive Director(s):** Chief Strategy and Transformation Officer **Date last reviewed: 25/06/26** **Strategic Objective:** Separation of planned and emergency care - seamless, safe moves of services and patients into new configurations Workforce retained and service staff integrated to safely deliver services NHP and BEACH buildings delivered and space effectively utilized Benefits delivered (financial, clinical) **Breakthrough objectives:** To achieve Phase 3 separation of planned and emergency services. Measures to track this: • Number of critical path actions completed and off track • Number Service Reviews completed and rating including Go/No-Go list criteria • Number of workforce plans & consultations completed • Number of Gateway reviews completed and rating • Quality & Financial benefits as per FBCs • Delivery of build programmes on time and to budget • Number of completed service moves **Links to Internal Audit Plan 26/27** N/A

Current and Target Risk Ratings						
Severity (impact)	**Likelihood**	**Current Risk Rating**	**Target Risk Rating**			
			Q1	**Q2**	**Q3**	**Q4**
4	**5**	**20**	**20**	**16**	**16**	**12**

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

Key Controls (to manage risks related to goal)

Prevention Controls (parts of a system of internal controls designed to prevent a risk from occurring)

- Regular oversight through Build Ready, Reconfiguration Ready and People Ready Groups, with escalation to Programme Board and Risk Oversight Committee
- Monthly portfolio risk and issue log review with alignment to the corporate risk register and BAF
- Service Reviews and Gateway Reviews to assess readiness for moves with actions followed up by Care Groups
- Robust critical path timeline and on-going monitoring, that clearly articulates deliverables and interdependencies between specific deliverables
- Good and effective management of individual programmes (Beach, NHP, Decants, Clinical Integration, Space)
- Close working with Capital and external partners (e.g. Darwin) to improve tracking, reporting and recovery planning as well as monitoring of Building Safety Act compliance
- Ongoing workforce planning, triangulation and consultation activity through People Ready programme and active management of workforce risks
- Focus on Critical Path actions
- Monitoring of operational pressures (e.g. ED flow, capacity and demand) with escalation through oversight groups
- Alignment with system demand and capacity planning (e.g. CSR workshops, winter planning, system actions)

Detection controls (those that provide an early warning of control failure)

- Monthly highlight reporting
- Weekly Programme Review meetings with Contractors
- Gateway Review Meetings
- Care Groups Strategic Deployment Review meetings

Contingency controls (those that help prepare for an effective reaction in response to a control failure or overwhelming event. Designed to maintain resilience)

- Strengthened gateway review processes.
- Enhanced reporting to ensure all critical path actions align

Key assurances (effectiveness of controls)

- Monthly Meetings (RRG/BRG/PRG/MRG) that reviews and escalates any barrier and delays
- Risks are on the agenda and reviewed on a quarterly basis
- Gateway Reviews (inc. Go/No go process) and Service Reviews to ensure readiness
- Detailed programme timeline is updated and any variance or off track issues are highlighted to BRG/RRG
- Ongoing Internal Audit Reviews of Reconfiguration Programme
- NHP National Team Readiness Assessment and Oversight

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)*

April 26	2195, Delay to completion of NHP and Trust Capital Build Scheme
29 June 2026	Following Risk Oversight Group in May it was agreed to move to 1 overarching TCT risk on the risk register, cross referenced to other relevant corporate risks (1595,1460.1053 and 1950). New TCT risk to be approved by the June Risk Oversight Committee. All other sub programme risks have been removed from the risk register and will be managed within the relevant programme group meetings.

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)*
May 26	COAST build confidence rebuilding programme (micros milestone tracker and KPIs	NHP and delivery assurance review to complete.
	Impact on Poole / Phase 4 programme	QS costings and options to mitigate to TCT
	UEC readiness for Moves over winter months	System undertaking winter plan 26/7 readiness assessment and workshop early July with move option.
	"Tricky issues" list being progressed	Reconfiguration Group oversight and tracking
June 2026	Build Ready: the COAST delay has been confirmed, meaning Phase 3 moves will not take place in December. Darwin is being engaged to confirm confidence in the handover timeline. Alternative non-COAST move options are being explored, with the earliest planned move date now April 2027.	Ongoing scrutiny of COAST programme plan
	Service ready - the non-coast option is being developed with Care Groups, and the mock move week planning continues to test logistical aspects of the move (transfer routes, conveyances, teams and roles involved in the physical move). Unresolved issues still being tracked through relevant group	New clinical model (without COAST) option agreed at TMG on 25/6/26 - Clinical Vision of Flow to progress to support this as well as Care Groups Mock Move Week to be completed to understand impact on sequencing 3 unresolved issues continue to be progressed
	People Ready - good progress has been made on the workforce plans and consultations. Completion of the roster remains at risk, and the Workforce Systems Team is currently working through mitigations for this.	Finalise o/s workforce plans and maintain momentum with consultations.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: 4.1.3

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Risk Report – June 2026
Prepared by:	Jo Sims – Associate Director Quality Governance and Risk
Presented by:	Sarah Herbert, Chief Nursing Officer
Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☐ Patient Experience ☐ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	This report.
Purpose of paper:	Assurance
Executive summary:	The report is provided in accordance with the UHD Risk Management Strategy. To provide details of the risks rated 15 and above on the UHD NHS Foundation Trust risk register.
ALERT:	No new corporate risks (risks rated 5-25) to Alert.
ASSURE:	Two risks previously rated 15 has been reduced following mitigation: 2303 Non-compliance with NICE TAs in Cancer services due to capacity and resource impact: risk rating reduced from 15 to 12 following completion of the most urgent TA. Implementation of four further specialised TAs remains outstanding. Work with Cancer Services is ongoing, with limited capacity closely monitored across the Trust. 1378 Lack of an electronic results acknowledgement system: risk rating reduced from 15 to 9. The risk was placed in holding last month pending review. The review concluded that the risk description should be amended to reflect that ICE has now been implemented, with the final phase of rollout planned for August 2026. SOPs are in place, standards for ICE use have been established, and training materials and user guides are available.
ADVISE:	There are 201 approved risks on UHDs Risk register, of which 14 are rated as 15 and above.
Celebrating Outstanding:	N/A

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

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**

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

Risk Register Report

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 01/07/2026

Risk Register Report

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 201 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 – Our People **Risk Category – Knowledge and Skills** **Appetite = Cautious** **Tolerance = 9-15**	
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 Finance Officer (currently covering CPO risks)
Controls in place	• Cross-site training of additional staff is ongoing to improve workforce flexibility and resilience where rota gaps cannot be filled. • Approval is being sought for additional locum support at Poole. • Plans in place to redistribute staffing more evenly across rotas following completion of cross-site consultation. • Recruitment activity remains proactive to strengthen the substantive workforce. • Band 7 staff are providing operational backfill for vacant shifts where possible. • Not all Band 7 staff can provide cross-disciplinary cover due to lapsed competencies. • Use of senior staff for operational cover reduces capacity for supervision, training, quality management, and service development. • Staff wellbeing, retention measures, and absence management processes remain in place. • Service continues to meet JACIE, MHRA, and UKAS accreditation requirements. • Standard operating procedures are in place across both sites to support safe service delivery. • Includes clear out-of-hours laboratory closure procedures. • SOPs and flowcharts support access to Flying Squad blood when required.

Gaps in controls	• Lack of establishment to support robust and sustainable model to ensure patient safety
Action plan(s)	**Action** / **Due date** Establishment of Robust Out of Hours Service / 13/07/2026
Tolerance breach?	No
Target risk rating	1
Progress update	Recruitment to four vacant Band 6 posts remains ongoing; however, these vacancies continue to significantly impact roster resilience and increase reliance on overtime and temporary staffing. Two locum Biomedical Scientists are currently being onboarded at Poole and are expected to provide additional overnight rota resilience shortly. Confirmation that the COAST building will not complete until at least March/April 2027 means overnight Haematology and Blood Transfusion services at Poole must be maintained for a longer period than originally anticipated, extending the workforce pressures associated with the current service model.

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

	• Plans in place to upskill staff already in post will add limited capacity over next three months; quote requested from external insourcing company to see if the staffing issues could be addressed using them in the short term. • Prioritisation of those areas measured for MIS audit may reduce risk of losing this funding but will not necessarily help most urgent patients and so will not mitigate risk of loss of reputation
Action plan(s)	**Action** / **Due date** Upskilling of substantive staff — 01/09/2026 Sonographer enhanced practice. — 01/09/2026
Tolerance breach?	No
Target risk rating	6
Progress update	Risk remains the same; insourcing continues. Sonographer interviews held on 19/06/2026; no suitable candidates. General Ultrasound Manager interviews being held on 22/06/2026. Screening Support Sonographer interviews being held on 30/06/2026. 2 x B6's have completed their preceptorships and will progress to B7 independent scanning. Delay with sonographer completing their obstetric assessment; extended to end of July. Further resignation of B7 Sonographer 0.76 WTE.2 x Sonographers on maternity leave not returning until September 2026 and reducing hours. Bank shifts have been offered to substantive staff.

Risk type – Our People **Risk Category – Workforce Capacity** **Appetite = Cautious** **Tolerance = 9-15**	
Risk ID	1855
Risk Title	Lack of Breast Radiologists and Mammographers
Date risk raised on the risk register	23/02/2023
Date risk approved as 15+ risk	21/11/2024
Risk Rating	20 ⟷
Risk Description	If we do not increase the number of breast radiologists, we will be unable to sustain the demands of the service.
Executive sponsor	Chief Finance Officer (currently covering CPO risks)
Controls in place	• Review of Incidents and complaints reported • Weekly planning meeting to discuss previous week and week going forward • Meticulous rota planning • Robust and ongoing Recruitment/retention processes • Creation of new post to support consultant radiographers and promote succession planning • Review of pressures in both clinic pathways to ensure priorities are addressed • Weekend working and extra clinic in RBH • Waiting list to record backlog • Staff in post spreadsheet to document staff in post.

	• Staff supporting HSU training in own time to maximise future opportunities for joint working and new staff joining the service • Staff working as single practitioner in clinics where two are required
Gaps in controls	• Lack of radiology capacity to sustain service. • Lack of suitable applicant for both substantive and locum positions - 2 WTE breast radiologists for which service is funded have not been filled, nor has the WTE consultant radiographer post. • Reliance on staff who are already working extra shifts • Radiologist on call rota and time off in lieu reduces available staff for sessions • Inability to provide legislative axilla scanning of Melanoma patients
Action plan(s)	**Action** / **Due date** Review SBARN — 30/07/2026 Implement a monthly Quality and Safety Meeting — 30/07/2026 Monthly Review of Mitigating Actions – see progress update — 30/07/2026
Tolerance breach?	Yes
Target risk rating	2
Progress update	Discussion 29th with Clinical Director related to the risk register entry and current status. In addition to entry below on 25th . Band 6 successful applicant hoped to commence end of July. B7 advert for mammographer now gone out to recruitment. Whilst Mammographers have returned in post a number still not working full hours. Currently 17 staff on a formal sickness management pathway. Clinical Specialist due to qualify in Sept which will improve clinic cover at mammography level. Radiologist ST5 currently on last placement and keen to work in the unit will be available early next year Consultant post will be advertised early Jan 2027. Complaint and FOI request received about inability to meeting NICE 2022 guidance into screening for patients on Melanoma pathway. In terms of risk entry discussion regarding reviewing the risk title and description as whilst staffing is significant risk in service provision it is not the only factor, A service risk rather than a specific staffing related risk based on a set of criteria may also assist ongoing monitoring of . Discussion already undertaken with Radiology superintendent about potential criteria (Assessment and Symptomatic service , Screening service , round length, Mammographer staffing , Radiologist Staffing and service provision in terms of national guidance) and shared with Clinical Director for DBSU . To follow up at Care Group level .

Risk Type - Population & System **Risk Category - Flow and Capacity**	**Appetite = Cautious** **Tolerance = 9-15**
Risk ID	1460
Risk Title	Inability to meet UEC 4-hour safety standard leading to an adverse impact on patient safety and quality
Date risk raised on the risk register	05/02/2021
Date risk approved as 15+ risk	22/02/2021
Risk Rating	16 

<table>
<tr><td>Risk Description</td><td>There is a potential risk of harm and impact on quality of care to patients waiting in excess of 4 hours in ED and being cared for in an inappropriate setting.</td></tr>
<tr><td>Executive sponsor</td><td>Chief Operating Officer</td></tr>
<tr><td>Controls in place</td><td>Compliance with National 4 hr performance Standard

• Performance review against metrics
• Daily breach validation
• Efficient patient pathways and streaming process to SDEC's and UTC
• Patient safety checklist in place
• TAD Process
• Trust and ED Escalation plans/SOPs
• Avoidable lost time and patient delay
• IPS optimisation
• All elements of initial assessment: TTT, TT first clinician and TT decision are all within 3 hrs of arrival
• Diagnostic reporting standards (blood tests/x-ray and CT)
• ‘Surge Management’ criteria and plan
• External transfers procedures compliant with patient category
• Implementation of 4 and 12 hour escalation process and UHD ambulance divert policy.
• 4 hour performance metrics linked to ED escalation
• Corridor SOP
• Escalation email/text process along with ED shift report template improvement</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.
• UEC growth, MRTL numbers and industrial action could expose the Trust to reduced patient flow and performance
• Type 3 data from MIU and UTC remains a manual process needs to be automated for new standards
• Executive Enhanced support meeting has been put in place for the emergency department (Chief Medical Officer/Chief Nursing Officer & Chief Operating Officer).
• ED Action plan to be reviewed and recast to reduce to a smaller number of actions over 30/60/90 days.
• Clinical Engagement on supporting the Trust 4hour safety standard and further work on ensuring the Interprofessional standards are being followed.
• Revised structure, focus and workplan for the Improving Hospital Flow Group developed for TMG review on 12th September.
• IT ED System: Review of the operational configuration to ensure it supports the operational flow.
• Staff compliance with ongoing observations and completion of SHINE assessments due to capacity constraints within the department</td></tr>
<tr><td>Action plan(s)</td><td>
<table>
<tr><th>Action</th><th>Due date</th></tr>
<tr><td>Establish Corridor Care National reporting – in progress</td><td>26/06/2026</td></tr>
<tr><td>Flow Program launch – in progress</td><td>26/06/2026</td></tr>
<tr><td>ED Recovery and Improvement Plan– in progress</td><td>30/06/2026</td></tr>
<tr><td>Create a process for 24 hour RCA and thematic governance– in progress</td><td>30/06/2026</td></tr>
</table>
</td></tr>
</table>

Tolerance breach?	Yes
Target Risk Rating	6
Progress update	Risk reviewed, scoring remains unchanged. Action plan was updated by LA. Controls updated. Missed month 1 trajectory, 68.5% against a 70% trajectory.

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

Action	Due date
Department to accelerate BMS cut up training programmes	30/07/2026
Department to accelerate BMS reporting training programmes	30/07/2026
Department to implement order comms	30/07/2026
Department to implement digital pathology	30/07/2026
Trust to initiate cultural review with a view to optimising productivity in consultant body	30/09/2026
Address demand and capacity staffing issues in Cellular Pathology	30/09/2026

	Implementation of Automation project	03/10/2026
	Address demand and capacity staffing issues in Cellular Pathology	30/12/2026
Tolerance breach?	Yes	
Target Risk Rating	4	
Progress update	Automation: AS-410 from [redacted] delivered 08/06/2026 [redacted] kit due to be delivered 30/06/2026 in accordance with implementation plan. Ventilation review complete and highlighted a number of recommendations. Senior team working with estates to resolve on-going leaks in ceiling. Validation teams identified . Staffing; all fixed term posts and locum to backfill and support validation in placed and competency accessed. Digital Project: CCIO has submitted a network business case for the next 4 years of funding. Funding considerably less as spit over other specialities in the trust. Plan of additional reporting licences in flight. deployment of 7 digital home workstation complete. whilst 2025 showed 20% improvement in TAT in 10 days, recent slippage contributed to implementation of new reporting tool. Metrics to be embedded . Weekly cancer improvement group established, to monitor across all services. Action to create teams channel to forecast demand and activity for Histopathology .	

Risk Type - Population & System **Risk Category - Flow and Capacity**	**Appetite = Cautious** **Tolerance = 9-15**
Risk ID	1665
Risk Title	School age Neurodevelopmental service
Date risk raised on the risk register	03/09/2021
Date risk approved as 15+ risk	15/08/2023
Risk Rating	15 ⟷
Risk Description	The school age neuro-developmental service does not have enough capacity to meet demand for children aged 5-16 yr olds who are: - medicated and monitored to manage neurodevelopment issues - referred to the school age Neurodevelopmental service for advice, guidance and treatment
Executive sponsor	Chief Operating Officer
Controls in place	• Regular oversight within UHD with Exec team support alongside the bi-weekly ND Operational group chaired by the ICB. Action log in draft for some short-term improvements related to referral triage and increased exclusion criteria. • National targets in place-RTT zero tolerance 78 week waits, 65-week target from March 2024 • Local contractual expectation (provision of service and rejection of referrals) in place • Monitor of patient satisfaction via Complaints and claims • Escalation process in place and compliance monitored • Dorset Pathway in place and compliance monitored • Workforce template agreed • Monitoring of staff wellbeing through Absence, sickness & turnover • Triage of referrals being received to ensure visibility of activity on eCamis & effective management of the waiting list.
Gaps in controls	• National target achievement • Local contractual expectation (provision of service and rejection of referrals)

	• Poor patient satisfaction • Poor staff wellbeing • Lack of capacity to triage referrals in a timely fashion.
Action plan(s)	**Action** / **Due date** Monitor backlogs of referrals – in progress / 30/07/2026 Improve communications with families RE waiting times – in progress / 31/07/2026 IPT of patients to Haven Medical Ltd / 31/08/2026
Tolerance breach?	No
Target risk rating	3
Progress update	Significant improvement in untriaged referral backlog - now up to date following period of clinical catch up work. Backlog of admin letters persists with plan to clear by mid-July. Capacity vs demand shortfall persists Ongoing bi-weekly internal Care Group led meetings with live action tracker. Current focus is admin backlog clearance.

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

	• Despite controls in place, increasing numbers of patients receiving SACT and increasing NICE TAs meaning more patients coming through system • Awaiting agreement on policies and procedures to move SACT into the community. Community capacity is a limiting factor with a very small team only providing haematology treatments for patients at home. CFA being discussed to bring additional nurse in for oncology treatments at home.
Action plan(s)	

Action	Due date
Review 'bought in' chemo	19/06/2026
Staffing	31/07/2026
Training	02/11/2026
Regular review to ensure waiting list reduced	01/12/2026
Weekly operational meetings	03/05/2027

Tolerance breach?	No
Target risk rating	4
Progress update	Current waits are between 5 and 7 weeks depending on the length of regime (8 hour regime will have a longer wait). Cap increased by 1 last week.

Risk Type – Quality and Safety **Risk Category – Patient Outcome (Clinical effectiveness) Appetite = Minimal Tolerance = 6-10**	
Risk ID	2310
Risk Title	Theatre staffing - ability to support a second CEPOD theatre out of hours
Date risk raised on the risk register	29/01/2026
Date risk approved as 15+ risk	31/03/2026
Risk Rating	16
Risk Description	Current out-of-hours staffing levels in emergency theatres do not allow UHD to open a second emergency theatre when a simultaneous 'life or limb' case arises. The inability to open a second emergency theatre due to current staffing levels creates a significant life threatening clinical patient safety risk.
Executive sponsor	Chief Medical Officer
Controls in place	• From the beginning of February, additional staff on shift overnight and across the weekend. 1 x AP, 2 x Scrub - 1 with core obstetric skills • Emergency theatres (EMT) policy now in place • EMT booking processes (Golden patient, bookings) reviewed and documented - communicated to teams
Gaps in controls	• Requires Bank/overtime cover • Not within theatres funded establishment • WFP is underway and is part of our proposal and transformation • Core emergency team
Action plan(s)	

Action	Due date
To create a core Emergency theatre team	11/12/2026

Tolerance breach?	Yes
Target Risk Rating	6
Progress update	Recruitment ongoing

Risk Type – Quality and Safety **Risk Category – Patient Outcome (Clinical effectiveness) Appetite = Minimal Tolerance = 6-10**	
Risk ID	2262
Risk Title	Insufficient capacity and lack of specialist staffing and environment for respiratory high care patients and safety impact
Date risk raised on the risk register	18/11/2025
Date risk approved as 15+ risk	31/03/2026
Risk Rating	15
Risk Description	If we do not address the insufficient capacity and lack of specialist staffing for acute NIV, then patient safety will be compromised through increased risk of harm or death, staff wellbeing will be impacted by unsustainable workload pressures, and critical care services will remain overburdened, leading to failure to meet national clinical standards and poorer patient outcomes. The requirement for ward nursing staff to provide Level 2 respiratory care significantly reduces the capacity available for the remaining patients on the ward. While nurses are delivering high-intensity monitoring, interventions, and escalation management for Level 2 patients, the rest of the ward is at risk of delayed assessments, reduced observation frequency, slower response to deterioration, and delays in routine care activities such as medications, hygiene needs, and mobilisation. This reduction in available nursing time increases the likelihood of avoidable harm occurring in the wider patient cohort, including missed or late medications, increased risk of falls or pressure damage, delayed recognition of clinical deterioration, prolonged length of stay, and reduced patient experience.
Executive sponsor	Chief Medical Officer
Controls in place	• If there is insufficient capacity on the respiratory ward, the patient is managed in Critical Care. • Continued review of staffing and skill mix to ensure safety of all patients on the wards and ratio of 2:1 for level 2 patients. • Reporting of concerns via the LERN process.
Gaps in controls	• Additional burden placed on ITU. • Dependent on available critical care capacity and staffing. • Inability to ensure safe staffing numbers to provide care to all patients. • Ensuring required skill mix of staff may not always possible due to ward acuity, level 2 requirements etc. • Inability to provide appropriate therapy support services.
Action plan(s)	

Action	Due date
SOP to be created	31/08/2026
Review of staffing ratios and skill mix	31/08/2026
Respiratory High care unit	31/12/2026

Tolerance breach?	Yes
Target Risk Rating	3
Progress update	Staffing for 9 bed ALU - 6 level 2 and 3 step down beds have been submitted that meet BTS recommendations. CG supportive of the 9 beds.

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

	• Recruitment for replacement consultant needs to be undertaken (finance agreed)
Action plan(s)	

Action	Due date
Increase number of patients in macular One Stop clinics	26/06/2026
POD virtual review clinic model	31/07/2026
Identify additional space to provide macular assessments and treatments	03/08//2026
Ophthalmology Practitioner Training (OPT) - macular module, for all Macular Nurse Specialists	03/08//2026
Absence Management	17/08/2026
support recruitment and retention	31/08/2026
Monitor number of patients waiting for appointment	31/12/2026

Tolerance breach?	Yes
Target risk rating	9
Progress update	Awaiting space allocation for Macular. Agency Nurse has resigned, awaiting communication for replacement.

Risk Type – Quality (Outcome and Safety) **Risk Category – Patient Safety Appetite = Cautious Tolerance = 4-6**	
Risk ID	2052
Risk Title	Care of patients in non-clinical areas in the Emergency Department
Date risk raised on the risk register	10/04/2024
Date risk approved as 15+ risk	24/11/2025
Risk Rating	15 ⟷
Risk Description	A lack of capacity in the hospital and a requirement to release ambulance crews in a timely manner has led to an increase in the use of non-clinical areas, particularly corridors for patients awaiting a trolley/chair space in both Emergency Departments. This creates a risk of harm to patients, a compromise to privacy and dignity and an increased risk of obstruction of thoroughfares and escape routes.
Executive sponsor	Chief Nursing Officer
Controls in place	• SOP on corridor use • Ambulance handover SOP • Divert procedures including dynamic conveyancing • Escalation process • Privacy screens in place to protect privacy and dignity at RBH
Gaps in controls	• Staffing is reliant on bank and agency and therefore levels not always met. • Non-compliance with corridor SOP requirements e.g. dementia patients, falls risks, mental health presentation should not be in the corridor • Lack of oxygen supply - use of oxygen cylinders • Observations not being completed, patients not being reviewed within a recommended timeframe, NEWS escalations not being addressed

	• Lack of call bells at RBH and non-compliance with responding to them at PH. • Increase in complaints and LERNs related to unsafe care or poor experience.
Action plan(s)	**Action** / **Due date** Improve the facilities for patient privacy and dignity in Bournemouth corridor — 31/12/2025 Decompress the Emergency Department to prevent crowding — 31/08/2026
Tolerance breach?	Yes
Target risk rating	3
Progress update	Risk reviewed and remains unchanged. Controls and gaps in controls updated.

Risk Type - Sustainable Services Risk **Risk Category - Financial Management Risk Appetite = Cautious Tolerance = 9-15**	
Risk ID	1595
Risk Title	Medium Term Financial Sustainability
Date risk raised on the risk register	27/05/2021
Date risk approved as 15+ risk	28/06/2021
Risk Rating	15
Risk Description	There is a risk that the Trust cannot achieve its strategic priority to return to a financial surplus by 2028/29 Failing to deliver a financial break-even position would result in regulatory intervention, an unplanned reduction in cash and the inability to afford the medium term capital programme.
Executive sponsor	Chief Finance Officer
Controls in place	• Budgets developed with directorate teams, formally accepted at Care Group level and fully devolved to named budget holders. • Dedicated financial support in place including additional variance analysis and reporting. • Scheme of delegation, Standing Financial Instructions, and other finance policies and procedures in place. • Monthly reporting to Trust Management Group, Finance and Performance Committee and Board highlighting risks and mitigating actions. • Patient First 'driver' and 'watch' metrics agreed and monitored monthly. • Alignment of approved nursing templates, e-roster templates, and budgeted establishment. • Enhanced vacancy and non pay controls implemented to support financial recovery. • Financial planning with system partners • Efficiency Improvement Programme in place with oversight by Finance and Performance Committee. • QIA policy and process in place
Gaps in controls	• Internal audit has identified the need for improved internal reporting of drugs spend and a strengthened budgetary mechanism. • Workforce controls scoping work completed across multiple dimensions, including for enhanced VRP (Vacancy Recruitment Panel) approach, consistency across the Trust for Recruitment and Retention premia, and overtime / additional hours payments.

	• Medical Staffing Patient First project underway – medical job planning achieved in 100% of specialties, with over 6000 additional clinic slots identified. • Delivered 2025/26 full year position in line with forecast revenue and capital positions including actions agreed within the H2 recovery trajectory.
Action plan(s)	**Action** / **Due date** Medium Term Financial Sustainability / 31/03/2027
Tolerance breach?	No
Target Risk Rating	8
Progress update	The Risk was reviewed by FPC as part the financial report, no changes to the risk grading were noted. (May - The risk has been reviewed and updated to reflect the current medium term risk).

Risk Type - Sustainable Services Risk **Risk Category - Financial Management Risk** **Appetite = Cautious** **Tolerance = 9-15**	
Risk ID	2302
Risk Title	Accuracy of Clinical Coding
Date risk raised on the risk register	05/01/2026
Date risk approved as 15+ risk	26/01/2026
Risk Rating	16
Risk Description	There is a risk that clinical coding especially fails to adhere to national coding standards and contains significant data analysis errors. Inadequate coding may impact on the Trust HSMR data. Poor standards of coding may also impact on financial income, other patient safety and quality metrics, and the wider national NHS benchmarking and league tables, all of which also rely heavily on coded data.
Executive sponsor	Chief Finance Officer
Controls in place	• Oversight by Mortality Surveillance Group • HR processes • Local Policies and SOP's • Internal Qualified Auditor • [redacted] Coding software • HED • National Clinical Coding Qualification (NCCQ) • NHSE - National Clinical Coding Standards
Gaps in controls	• Lack of completion of e-Discharge forms • Agreed SOP for palliative care coding is not being followed • Weak leadership structure within the service • Predominately remote workforce • Majority of the team do not hold the NCCQ

	• Consistent breach of clinical coding standards during the coding process • Overly stretched clinical coding auditor
Action plan(s)	

Action	Due date
External Audit of Clinical Coding– in progress	27/02/2026
Palliative Care Coding SOP	31/08/2026
Competency framework for coders	30/09/2026
Clinical Coding Consultation - Service Transformation	30/09/2026
Implementation of new Clinical Validation Plan	30/11/2026

Tolerance breach?	Yes
Target risk rating	4
Progress update	Implementation planning for the new Clinical Coding operating model continues. A multi-professional review of all flexible working requests and reasonable adjustment requests has been completed, with Executive and HR involvement throughout the process to ensure individual circumstances have been fully considered alongside the requirement to deliver a safe, compliant and accurate Clinical Coding service. Outcome letters are currently being finalised and issued to staff. Subject to office accommodation availability, phased implementation of the new operating model remains scheduled to commence in July 2026. Further work has been undertaken to strengthen assurance around workforce capability and coding quality. Individual baseline coding audits are currently being finalised and a formal practical coding competency assessment has been developed. All coding staff will be required to undertake the assessment by the end of June / beginning of July, providing for the first time an objective baseline of coding capability across the workforce. Results from both the baseline audits and competency assessments will be reviewed with individuals by their line manager and the Clinical Coding Auditor – Quality and Capability Assurance, with individual development and improvement plans being established where required. Progress has also been made in implementing the Clinical Validation Plan. Clinical engagement has commenced across a number of specialties including General Surgery, Trauma & Orthopaedics, Women, Children's and Cancer Services (WMCCS), Dermatology and Breast Services. Arrangements are being established for ongoing Clinical Coding attendance at specialty governance forums to support documentation improvement, coding validation and clinical engagement. In parallel, a Trauma & Orthopaedics Coding Optimisation and Clinical Documentation Improvement Pilot has been established, incorporating significant clinical validation and clinician engagement. The pilot will be used to refine and develop the wider clinical validation approach prior to phased implementation across other specialties within the Trust. The Head of Clinical Coding and senior members of the coding leadership team have also completed enhanced HED training to strengthen proactive monitoring of HSMR intelligence, mortality indicators and clinical validation processes. Recruitment to the revised structure has been delayed pending completion of the Trust's consistency matching process for revised job descriptions. As a result, vacancies have not yet been advertised, extending reliance on temporary resource and delaying implementation of the substantive workforce model. Workforce pressures have continued to increase during the reporting period. By 5 June 2026, the service will have experienced the loss of 6.1 WTE staff (7 individuals) since commencement of the transformation programme, with a further 1.0 WTE resignation currently being processed. The service is also managing 5.22 WTE of long-term sickness absence. These workforce pressures continue to impact service resilience and contribute to a growing backlog of uncoded activity. Whilst the Managed Service Provider (MSP) continues to provide important mitigation through additional capacity and specialist expertise, there remains a recognised risk that increasing operational pressure to recover backlog positions may result in greater focus on coding throughput and timeliness, reducing the opportunity for detailed review of the full medical record. This may adversely impact coding accuracy, completeness and compliance with national coding standards if not carefully managed through audit, assurance and competency improvement activities. To further mitigate this risk, an additional interim expansion of the MSP provision is currently being pursued to provide further resilience, support backlog recovery, and reduce operational pressures on the substantive workforce whilst recruitment to vacant posts and implementation of the new operating model progresses. Overall, a number of key improvement actions are now moving from planning into implementation. However, the benefits of these interventions have not

	yet been fully realised or evidenced. Continued workforce instability, recruitment delays and backlog pressures present an ongoing risk to coding quality, compliance with national standards, HSMR accuracy and financial assurance. Whilst further MSP expansion is being pursued as a mitigating action, the risk remains significant pending implementation of the new operating model, completion of competency assessments, recruitment to vacant posts and demonstrable improvement in coding quality and audit outcomes.

Risk type - Sustainable Services **Risk Category - Information Technology Appetite = Open Tolerance = 12-20**	
Risk ID	1950
Risk Title	The Trust Electronic Patient Record (EPR) replacement
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 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 being replaced. Implementation plans in progress. 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 consistently in place
Action plan(s)	**Action** / **Due date** EPIC / 2028
Tolerance breach?	No
Target risk rating	6
Progress update	An SBAR will be created for the Digital Team and to go to Digital Governance for approval to reduce the risk score for this so this can be actioned at the next update.

Risk Heat Map

Consequence						
Current Risk Grading		No Harm (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Likelihood	Almost Certain (5)	1	8	4	0	0
	Likely (4)	2	20	20	5	1
	Possible (3)	2	27	43	9	4
	Unlikely (2)	0	10	31	7	3
	Rare (1)	0	2	1	1	0

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

Current Risk Score	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26
Very Low (1-3)	**5**	**5**	**5**	**5**	**4**	**5**	**6**	**6**	**6**	**7**	**7**	**5**
Low (4-6)	**71**	**79**	**79**	**75**	**72**	**70**	**64**	**68**	**69**	**71**	**73**	**72**
Moderate (8-10)	**92**	**93**	**95**	**96**	**90**	**86**	**86**	**84**	**81**	**75**	**78**	**81**
Moderate (12)	**44**	**43**	**36**	**32**	**33**	**31**	**34**	**39**	**36**	**34**	**35**	**29**
High (15 -25)	**14**	**14**	**15**	**14**	**15**	**15**	**16**	**16**	**19**	**19**	**16**	**14**
Total number of risks under review	**226**	**234**	**230**	**222**	**214**	**207**	**206**	**213**	**211**	**206**	**209**	**201**

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

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

Risk Appetite Scales

Risk type and category definitions

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

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

Appendix B: Matrix and descriptors for Risk Register Assessment

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

25	5	5	An issue which impacts on a large number of patients, increased probability of death or irreversible health effects occurring and evidenced daily

Table 1 Consequence scores

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

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

Table 2 Likelihood score (L)

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

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

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: **4.1.4**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Compliance with Provider Licence and Code of governance for NHS provider trusts
Prepared by:	Leonora May, Director of Corporate Governance Executive directors
Presented by:	Leonora May, Director of Corporate Governance
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	NA
Purpose of paper:	Assurance
Executive summary:	<u>Provider Licence</u> The NHS provider licence forms part of the oversight arrangements for the NHS. All NHS foundation trusts are required to hold a licence. The provider licence sets the conditions that providers must meet. Breach or suspected breach of those conditions may provide the basis for formal regulatory intervention. The Trust's internal control environment is designed to support and ensure compliance with the conditions of the provider licence. The Trust describes how it meets the requirements of the governance arrangements conditions within its Annual governance statement. Compliance against the conditions of the provider licence is reported to the Audit committee annually. The Director of Corporate Governance and executive directors have undertaken a detailed review of each condition against the Trust's arrangements. There are no areas of non-compliance to report. The full review was presented to the Audit committee at its meeting in June 2026 and is available with the reading room papers for this meeting.

Code of governance

Trusts should comply with the provisions within the Code of governance for NHS provider trusts or explain in each case why the Trust has departed from the code. For some provisions of the code, the Board is required to provide disclosures in the Annual report to demonstrate compliance. These disclosures are included in the Annual report 2025/26 within the Accountability report.

The Director of Corporate Governance has undertaken a detailed review of each provision of the Code against the Trust's governance arrangements. The full review was presented to the Audit committee at its meeting in June 2026 and is available with the reading room papers for this meeting. Areas of non-compliance where explanations have been provided are set out below.

Areas of non-compliance where explanations have been provided

B.2.7
This provision requires that at least half of the Board, excluding the Chair, should be Non-executive directors. During 2025/26 and to date, the Trust has eight executive directors and seven Non-executive directors (excluding the Chair) in post. This is because from May 2025, one of the Non-executive directors took up the role of interim Chair and that role was not backfilled. The postholder's substantive role is as a Non-executive director. This position was supported by the Board, Council of Governors and NHSE regional team to provide continuity and stability to the Board during a period of significant transformation and change. During the period, the Trust's Constitution was updated to include a casting vote for the Chair.

E.2.2
This provision requires that the levels of remuneration for the Chair and other Non-executive directors reflect the national Chair and Non-executive director remuneration structure. The level of remuneration for the interim Chair is in keeping with the national structure. The Non-executive directors are paid slightly more than the amount recommended by the structure. It should be noted that the structure has not been updated since 2019 and that foundation trusts retain discretion to depart from the structure with reason. The size of the merged Trust was taken into account as a factor when establishing remuneration for the Non-executive directors as well as the significant transformation and change. It should also be noted that the predecessor trusts paid Non-executive directors at a higher level than recommended.

Last year, non-compliance was reported in relation to:

- A Board member notice period

	• The Senior independent director was also the Chair of the Audit committee which is not recommended. This has not been the case during 2025/26 • Non-executive director remuneration (consistent with this year)
ALERT:	Non-compliance with the Code of governance for NHS provider trusts has been reported for two provisions of the Code as set out above. Explanations have been provided.
ASSURE:	There are no areas of non-compliance to report in relation to the Provider Licence. The Trust's internal control environment is designed to support and ensure compliance with the conditions of the provider licence. Overall, compliance with the code of governance for NHS provider trusts is good. There were two issues reported last year which have been resolved (notice period and the Senior independent director also being the Chair of the Audit committee). Benchmarking with similar sized organisations demonstrates that the Trust is not an outlier in relation to Non-executive director remuneration.
ADVISE:	The required disclosures are included within the Annual 2025/26 which was approved by the Board at its meeting on 17 June 2026.
Celebrating Outstanding:	There are no areas of non-compliance to report in relation to the Provider Licence. Overall, compliance with the code of governance for NHS provider trusts is good.
RECOMMENDATION:	To note the compliance report.
Implications associated with this item:	Council of Governors ☒ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☒ Health Inequalities ☐ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☐ System ☒
CQC Assessment Framework:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well-Led ☒

	Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Audit Committee	03/06/2026	The Committee noted the report.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 2 MEETING

Meeting Date: 15 July 2026

Agenda item: **4.1.5**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Data Security and Protection Toolkit report
Prepared by:	Camilla Axtell, Information Governance Manager & DPO
Presented by:	Beverley Bryant, Chief Digital 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)	NA
Purpose of paper:	Assurance
Executive summary:	A summary of the Trust's Data Security and Protection Toolkit compliance levels for 2025/26.
ALERT:	None
ASSURE:	High level of assurance provided by BDO in relation to DSPT audit.
ADVISE:	DSPT not fully compliant at 30th June 2026 deadline – action plan agreed in principle and has been submitted to NHSE. Support for completion/prioritisation of Information Assurance work and IG training compliance required Trust-wide.
Celebrating Outstanding:	NA
RECOMMENDATION:	None
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☒

	Regulatory Strategy/Transformation System Explain the impact on each selected area; positive outcomes, risks and mitigations, and any oversight needed.	☒ ☐ ☐
CQC Assessment Framework:	Safe Effective Caring Responsive Well-Led Use of Resources	☒ ☐ ☐ ☐ ☒ ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Audit Committee	03/06/2026	Approved
Information Governance Steering Group	18/06/2026	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	☐ ☐ ☐ ☒

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS – PART 1

Meeting Date: July 2026

INFORMATION GOVERNANCE: DATA SECURITY AND PROTECTION TOOLKIT REPORT

The Trust submitted its Data Security and Protection Toolkit (DSPT) return for 2025/26 to NHS England on 30th June. The scope of this has been updated this year so the Trust is now required to provide assurance in relation to all its information assets which contain personal data, as opposed to a smaller set of systems which directly support the Trust's Essential Functions. This has increased the IT systems in scope of the review from 66 in 2024/25 to 340 in 2025/26.

Within the DSPT, there are 240 evidence statements across 47 objectives with which organisations must be able to evidence compliance. The structure of the DSPT is such that if an organisation is unable to evidence one statement within an objective, the entire objective is marked as "Not Achieved" irrespective of compliance with the other statements.

The submission will reveal a lot of positive work that has been undertaken this year, including the provision of assurance regarding the protection of data in transit, IG policy, process and procedure development, management of data subjects' rights and appropriate resilience preparation. These areas have been independently audited by BDO, with a "High" level of confidence in the submission. This audit reviewed a subset of 12 out of 47 outcomes, and therefore the assurance provided is based upon this cross-section.

There are several areas which were deemed to not be achieving the required standard at this time, including areas which rely on Information Asset Assurance to be obtained through the annual assurance-gathering exercise, IG training compliance levels, and the annual Clinical Coding audit. These actions have been added to a formal Improvement Plan, which has been agreed in principle and submitted to NHS England for approval. Upon receipt of that formal approval, the Trust's DSPT status will be marked as "Approaching Standards".

Camilla Axtell - Information Governance Manager and Data Protection Officer

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Finance and Performance Committee – Chair's Report
Presented by:	Alastair Matthews, Chair of the Finance and Performance Committee.
Agenda items discussed:	At its meeting held on **1 June 2026**, the Committee received reports on the following: • Fire Safety update • 2026/27 Financial Performance Month 1 • Efficiency Improvement Programme • National costs submission assurance • New Hospitals Programme: Cashflow and Contract • 2026/27 Operational Performance Month 1, including complex discharge report • HealthSet Programme update and IT essential systems • Green Plan - strategic initiatives • Private Patients Strategy - update • Risk Register: review of significant risks; new risks rated 12 and above (Finance and Performance) • Pathology South Six - letter of intent The Committee Approved: • Karl Storz Theatre Equipment Service and maintenance
ALERT	1. The Trust delivered a deficit of £3.6m in April, £1.0m adverse to Plan, half of which related to the direct costs of industrial action in the month. A formal forecast is expected to be provided to the July Committee meeting. Progress is being made both in reducing the unidentified gap in savings required to deliver the Plan (currently £18.5m) and to improve the level of risk adjusted savings identified (currently £27.5m of a total requirement of £68.5m) - at the current rate of improvement and with 2 months of the year already elapsed the challenge is significant. The Committee reviewed the substantial actions being undertaken and noted there is potential to significantly mitigate the risk, however, this remains a concern until substantial improvements in the above metrics are firmly identified and validated. (Further assurance required) 2. The level of Non-Criteria to reside patients continues to be well in excess of 200, significantly above plan and impacting patients and operational performance. The Trust continues to work on the elements contributing to

	this within its control and is escalating significant wider system related factors related to capacity across pathways with partners. The Committee agreed the key measures to be reported to the Board in future to monitor progress. The interaction of this with delays in the completion of the COAST building is of particular concern as part of the Trust's winter planning process. The Trust Board has a specific focus on this area and it is clear this needs to continue pending clear improvements being evidenced. (Further assurance required) 3. There are ongoing delays to the COAST building programme with the likelihood that the building will not be available until March/April 2027. The Committee noted the actions being taken by the Trust with the Main contractor and NHSE to increase confidence in delivery timescales but at this stage is not assured on a completion date upon which firm operational planning for Phase 3 moves and inter-related capital works can be based. (Further assurance required) 4. Emergency Department 4 Hour wait performance continues to be challenged. There are signs of improvement - the Flow programme is commencing with good clinical engagement which alongside other changes has the potential to positively impact performance. Evidence of positive improvement will need to be seen before assurance can be provided to the Board. (Partially Assured)
ASSURE	1. Whilst recognising significant demand pressures particularly impacting urgent care pathways the Committee noted that the Referral to Treatment Position overall, as well as long waits position, continued to improve in April. Managing the balance between activity and financial pressures throughout the year in order to deliver the overall Operational Plan for 2026/27 will require constant attention. 2. The Committee noted that whilst the level of activity on the HealthSet programme was increasing significantly, the reporting being provided did not cover overall programme timelines, progress, costs etc. The Committee was informed a formal proposal for Governance was due to be presented to the July Trust Board.
ADVISE	1. The Trust failed to meet the 28 day faster diagnosis target and despite significant improvement since January also failed to meet the 62 day referral to treatment target. The Trust has recovery plans in place and close monitoring will be necessary to ensure these plans deliver the necessary Improvements. 2. The Committee noted the letter of intent signed by the Chief Executives of all organisations in the Pathology South Six programme, albeit there has been some delay in progressing compared to the expectation in the business case.

Review of Risks	1. The Committee reviewed, discussed and noted the risks allocated to the F&PC. There was discussion on how some risks that appear to fall into both quality/safety and performance/finance domains are categorised which will be reviewed at the risk oversight committee.
Celebrating Outstanding	1. The Trust continues to make good progress on sustainability, with delivery of many improvements including additional solar energy. The Trust is in the process of commissioning joint work on climate adaption and starting a project to look strategically at decarbonisation which will provide important inputs to the ongoing development of the next Green Plan.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Finance and Performance Committee – Chair's Report
Presented by:	Alastair Matthews, Chair of the Finance and Performance Committee.
Agenda items discussed:	At its meeting held on **6 July 2026**, the Committee received reports on the following: • 2026/27 Financial Performance Month 2 • Financial Risks and Mitigations – Month 2 Forecast Outturn Scenarios • Efficiency Improvement Programme • New Hospitals Programme: Cashflow and Contract • 2026/27 Operational Performance Month 2 • Our Dorset Digital Strategy Implementation Report • HealthSet Programme update and IT essential systems • Premises Assurance Model (PAM) • Estates Compliance Report • Private Patients update • Risk Register: review of significant risks; new risks rated 12 and above (Finance and Performance) The Committee recommended to board to approve: • Private Patient Oncology Concession preferred supplier • IV Fluids Service Contract The Committee approved: • Supply Of Fire Door Surveying and Remedial Work Across UHD • Treasury Cash Management Policy
ALERT	1. The Committee reviewed the financial performance to May 2026 with the Trust delivering a deficit of £6.2m which is £1.2m adverse to Plan, compared to £1.0m adverse the prior month. The initial forecast for the full year indicates the range of full year outturn is substantial this early in the financial year – primarily driven by the level of unidentified EIP (Efficiency Improvement Programme) and the risk adjusted value of the identified schemes. A significant level of mitigations will be required to enable the Trust to deliver its breakeven plan. The Committee reviewed the mitigations and further risks/opportunities and noted the actions being taken (Partially assured) 2. The level of recurrent EIP – there is a substantial shortfall in recurrent EIP delivery forecast in the latest EIP

	reporting. It was clear that there is focus on improving this. The Board is asked to note that the current underlying financial position into 2027/8 will be extremely challenged if the level of recurrent savings is not significantly improved (Further assurance required) 3. The Trust is currently falling short against Plan trajectory on Cancer performance – the Committee reviewed the recovery actions for each performance target by tumour site. In doing so it became clear that the actions will, in many instances, take some to impact on the reported performance and can depend on recruiting the required staff, which means performance is not anticipated to fully return to trajectory until Q3 (62 days). Some additional governance arrangements are also being established to increase oversight (Partially assured) 4. The level of Non-Criteria to reside patients continues to be above 200, significantly above Plan. Whilst the Trust progresses actions to address aspects that are within its control there are many factors that impact across the Health and Care system and the level of system working to address this with shared understanding supported by shared evidence and targeting of resourcing needs to develop further (Further assurance required) 5. The COAST building continues to be delayed with confidence as to a completion date low. The Trust is considering strategies to enable the significant planned moves to be delivered in April 2027. The Committee will review the likely operational and financial impacts on the capital programme once the plans are firmed up (Further assurance required)
ASSURE	1. Whilst there are aspects of non-cancer waits that require attention (eg Community Health Neurodevelopmental services) overall performance has been on trajectory for the first 2 months, as has ED 4 hour performance 2. Whilst there remain ongoing risks highlighted in the Estates Compliance Report the actions identified to manage and address these were clear
ADVISE	1. Progress on the Healthset Programme continues with no significant concerns being raised at this stage. The Committee noted that the proposed future governance process for the overall pan-provider programme will be coming to the July Board 2. The Trust will need to submit its finalised Premises Assurance Model return in September. The Committeee reviewed progress and due to submission deadlines and timing of Board meetings requests that approval of the final return be delegated to F&PC, with a copy of the final return going to Board for information and noting 3. The Committee reviewed and commented on an initial Digital Strategy Implementation report which is expected to come back to the Committee and then Board for approval in September
Review of Risks	1. The Committee noted the risk report and related actions

Celebrating Outstanding	1. The draft of the Digital Implementation Report was well developed and clearly demonstrated how the Dorset Digital Strategy is planned to be realised

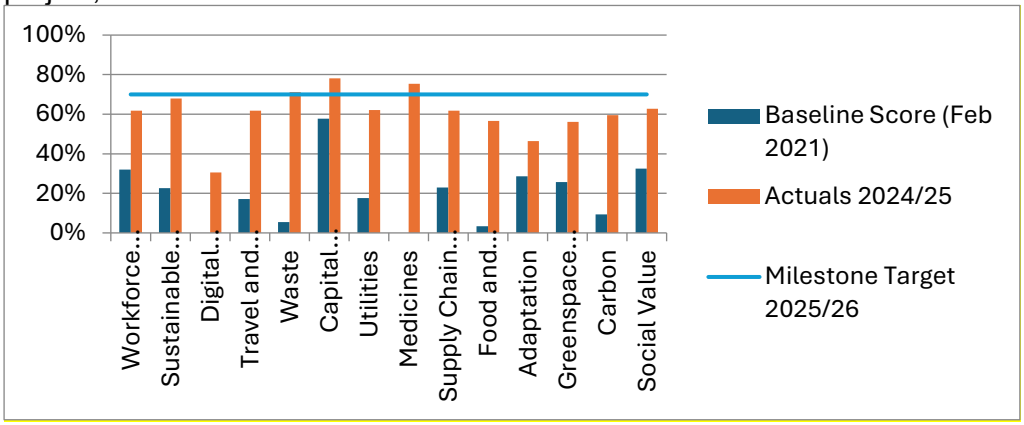
University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: **4.2.3**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Green Plan progress
Prepared by:	Stuart Lane, Sustainability Energy Officer George Atkinson, Associate Director of Estates
Presented by:	Richard Renaut, Chief Strategy and Transformation Officer
Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☒ Patient Experience ☐ Quality Outcomes & Safety ☐ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	None
Purpose of paper:	Assurance
Executive summary:	The Trust has progressed well against the Green Plan cornerstone targets including infrastructure improvements and new building systems that have delivered significant energy consumption reductions and a 1200 tonne carbon reduction over 2025/26. The Trust has engaged the Carbon and Energy Fund CEF to assist in heat decarbonisation of the main hospital sites with a clear steer to explore geothermal options. Following tender a preferred provider will be identified by the summer. The annual report has captured progress and reported on against the Task Force for Climate Disclosure TFCD framework, highlighting where the recently launched Climate Adaptation Project will address compliance.
ALERT:	**PV project** The renewable energy project has experienced delays due to technical clarifications and weather-related impacts, recent supply chain issues regarding the production and delivery of the steel supports and frames have compounded project delays. Progress is now being made to finalise the remaining elements with the MSCP at Bournemouth being the last phase. The draw down of the central funding has been completed ahead of the completion. The capital finance team are assisting in the final phases to ensure the funds are fully utilising MOU funding. A revised implementation schedule is being finalised.
ASSURE:	**Climate Adaptation Project**

	A Climate Adaptation Project approved by Board in 2025 has now been commissioned. The project the scope and draft program is provided as **attachment 1 (reading room).** Stakeholders have been identified and contacted across UHD and the Dorset system. The first stakeholder meeting is being scheduled for June 2026. **Green UHD Steering Group** The new format group held its first meeting on 10th April 2026. The meeting is now scheduled to be quarterly instead of monthly which liberates time for activity area working groups to complete their identified tasks. The SMART targets focussing on priorities for 2026/27 have been captured within the AAA reports of each activity area. These are summarised in **attachment 2 (reading room).** **SDAT** The chart below shows the progress by the activity area groups have towards Trust Sustainable Development Assessment Tool 2025/26 stretch target of 70%. Total average score is now 61%, which is progress, but will require ongoing effort to move to the 70% goal. Digital is set to improve with closer alignment with the Dorset wide digital services. Adaptation should improve project, referenced above.  Annexes are in the reading room.
ADVISE:	**Green UHD steering group**: Whilst most of the new group focused format is working to plan it is noted that four of the working groups have yet to meet and report for the first quarter under the new governance process. ➢ Digital Transformation* ➢ Sustainable Care Working Group * ➢ Workforce and Leadership Working Group * ➢ Medicines * Sustainability and Carbon Manager has drafted SMART targets for these groups and shared with Activity Area Leads (where they have been identified). **CQC Recommendation Report** Sustainability has been included under CQC well led inspections. The 2025 CQC report was positive about the UHD Green Plan progress, however it made 8 recommendations as **summarised in attachment 4 (reading room)** along with reference to the SMART targets to deliver the recommended actions. These targets are captured in the draft Sustainable Care Working Group Triple A template and Workforce and Leadership Working Group template – **attachment 5 and 6 (reading room).**

Decarbonisation
The Trust has engaged the Carbon Energy Fund CEF to assist in the procurement of decarbonisation of the main hospital sites at Poole and Bournemouth. Following the project launch event the team from the CEF are working through the pre-procurement reviews with the two interested companies for the decarbonisation of the Bournemouth and Poole sites in line with NHS 2040 Net Zero target, this includes potential for a wider heat network to third parties.

There are two elements to this project with a clear steer to explore geothermal options and building improvements with the option to extend a heat network beyond the campus sites as set out in a previous recommendation paper, Decarbonisation options for the UHD hospital estate, August 2025. Attachment 3 (reading room).

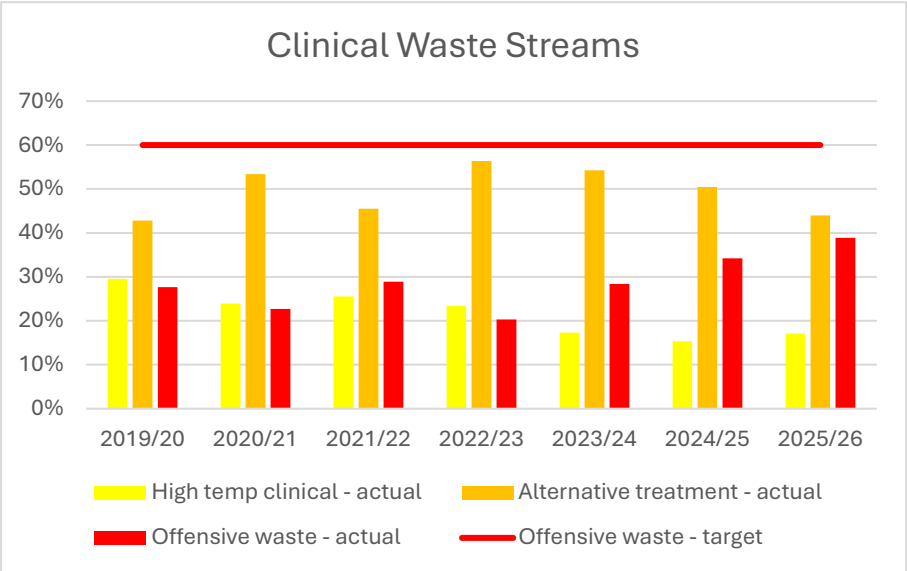
A review of a possible CHP scheme for the Bournemouth energy centre is included as part of the project delivery to create possible revenue savings to enhance the overall NPV of the project.

It should be noted that the procurement for the deep geothermal solution at the Bournemouth hospital site will be synchronised to run alongside the fabric and network tender to allow the trust to produce a coordinated business case targeted for review and approval through September.

Green Plan
The 5-year sustainability strategy ”Our UHD Green plan 2021-2026“is entering the final year for review. The new UHD Green Plan is to be prepared ready for 2027, this will build upon the successes from the existing plan and will also be informed by the CEF decarbonisation project work and the output from the climate adaptation review being carried out this year.

Celebrating Outstanding:

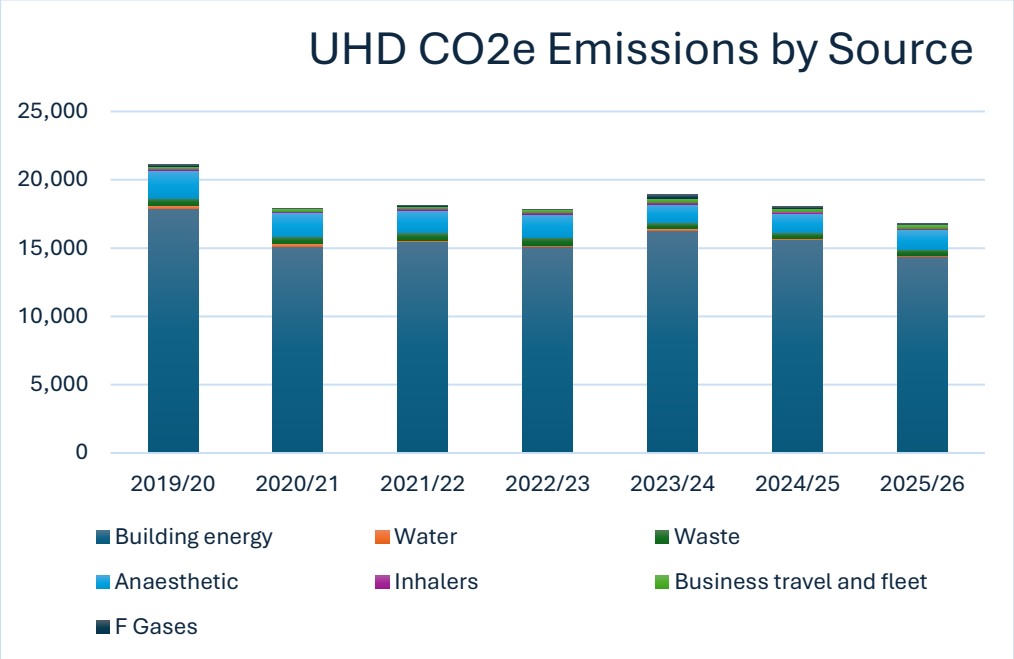
Waste Segregation
The full roll out of the offensive waste stream in line with NHS requirements is complete. Segregation data shows good progress towards the Trust 60% offensive waste target. (red) with the corresponding reduction in AT waste, (orange). The national target is to get offensive at 60% with AT and Incineration only at 20% each.



Grant funding
During 2025-26 bids were successful for PV schemes across the UHD sites MOUs fully drawn down for £3.1m of solar funding. Project is currently ongoing – funding secured.

Travel
Inter-site Bus – this has been well received by staff over the year and has provided an excellent base of data to inform the tender specification as we go to market for a 3 + 2 year contract. The new contract may extend the service to members of the public during non-peak times ensuring that we prioritise staff travel and also bring in revenue to offset the cost of the service.

Carbon & Energy Reductions



The full year end carbon calculations show an in-year carbon reduction of over 1200 tCO2e. This is in line with our green plan objective. Emissions reductions have made from Waste, Business travel, Refrigeration or F Gases, however by far the largest reduction are from building energy.

Implications associated with this item:

Council of Governors	☐
Environmental Sustainability	☒
Equality, Equity, Diversity & Inclusion	☐
Financial	☒
Health Inequalities	☐
Operational Performance	☒
People (inc Staff, Patients)	☐
Public Consultation	☐
Quality	☒
Regulatory	☒
Strategy/Transformation	☒
System	☒

The UHD sustainability strategy or Green Plan links into the wider Dorset plan and supports the system operationally. The project this year to understand the Climate Adaptation challenges in collaboration with DCH and DHC will inform the 2027 Green Plan for UHD and the wider system across Dorset

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

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
FPC	01/06/2026	The Committee noted the report
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: **4.2.4**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Premises Assurance Model (PAM) update
Prepared by:	Martin Nash, Compliance Manager, Estates
Presented by:	Richard Renaut, Chief Strategy and Transformation Officer
Strategic themes that this item supports/impacts:	Population & System ☐ Our People ☐ Patient Experience ☐ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	Estates Backlog risks
Purpose of paper:	Decision/Approval
Executive summary:	The NHSE Premises Assurance Model (PAM) has undergone a considerable change this year; ratings against the Self-Assessment Questions (SAQs) have moved from an assurance 1-5 rating scale to a compliance base ”yes or no.” The SAQs were released on 15 April 2026 and the submission window closes 8 September 2026. Board approval is required each year. Delegated authority will be sought for submission (see recommendation). Due to the scale of the change and timeframes involved, the Quality & Compliance team have increased support to the various areas around the Trust that submit to the PAM: • All areas are being asked to provide evidence for their ‘yes/no’ ratings. • All ‘no’ ratings result in a corresponding action plan. • Relevant sections and their action plans have been sent to the corresponding Safety Groups for review and up-date. • Internal Audit will be reviewing the process, to provide assurance and recomendations, for this, the first year of the new process. Work is progressing well against using the PAM Action Plan with more completed actions and a reduction in actions yet to commence. Work continues to move towards full compliance or

<table>
<tr><td></td><td>justified non-compliance, and the majority of actions should be completed by final PAM submission.</td></tr>
<tr><td>ALERT:</td><td>The PAM is likely to identify a number of areas with a “no” to compliance, and a workplan that has considerable cost involved (revenue and capital). In some areas the costed action plan won’t be detailed, as survey work is required. Best estimates will be used.

UHD is “in the pack” for the level of estates backlog, and ERIC benchmarking. For UHD this is an estimated £200m capital backlog. Thus like many Trusts, a “no” to compliance will not be unexpected. Work on mitigations, and risk tolerance, and an upto date and actively managed risk register will be essential.

Equally where a “yes” is recorded, this needs to be objectively arrived at, based on good evidence to provide assurance. The use of the Internal Audit team at BDO will be timed to inform the process and return, and then the ongoing management of the risk. As this is year one of the Yes/No approach, calibration of how other Trusts answer will inform the approach for future years.</td></tr>
<tr><td>ASSURE:</td><td>Overall NHSE PAM Compliance Position in June is
Hard FM compliance: 68.79%
Soft FM compliance: 79.57%
Estates competency: 84.34%
Patient experience: 100%
Headline position
Positive momentum demonstrated across multiple Estates & Facilities disciplines and reflects the continued focus on strengthening governance, assurance documentation and evidence collection in preparation for the NHSE PAM submission in September.

NHSE PAM Action Log Status<table><tr><th>Status</th><th>May 2026</th><th>June 2026</th><th>Movement</th></tr><tr><td>Completed</td><td>1</td><td>16</td><td>+15</td></tr><tr><td>Not Started</td><td>63</td><td>47</td><td>-16</td></tr><tr><td>In Progress</td><td>13</td><td>18</td><td>+5</td></tr></table>Risks
Current risks affecting delivery include:
Availability of specialist resource and subject matter expertise.
Dependencies on cross-departmental collaboration and external stakeholders.
Ongoing evidence gathering and document standardisation required to demonstrate PAM compliance.</td></tr>
</table>

	Despite these challenges, progress remains positive and there are no significant concerns regarding the overall direction of travel. Next Steps The next phase of work will focus on: • Getting accurate updates on outstanding "Not Started" actions. • Assessing risk levels of actions not likely to be completed before PAM submission. • Embedding consistent document management and evidence retention arrangements across Estates disciplines. • Continuing engagement with Authorised Persons (APs) and operational leads to ensure evidence remains accurate, current and readily accessible. • Further strengthening of governance reporting with Safety Groups involvement, and sign off of the final submissions (e.g. Ventilation Group sign off) The BDO internal audit scope is being agreed. Any recommendations on the "in flight" process will be used to improve this years process, and help in the design of next years.
ADVISE:	UHD estates team are developing a "future proofed hospitals" project to look at a masterplan view of removing backlog, and future proofing the estate. This includes being more digital and climate resilient. Initial work with Hoare Lea as specialists in this field in helping shape the thinking. This project will then inform the estates masterplan, as well as current and future capital projects. Examples include NHP funded works at Poole Hospital, and the carbon reduction tender underway.
Celebrating Outstanding:	Early engagement of teams means we believe we are ahead of many other Trusts in preparing for our submission.
RECOMMENDATION:	The Board is asked to note the progress made in the development of the Premises Assurance Model (PAM) and to agree that, in light of the submission deadline of 8 September 2026 falling ahead of the next scheduled Board meeting, delegated authority be granted at the July Board meeting to the Finance and Performance Committee for final approval of the PAM submission. The Board will receive the final version in September 2026 and will have the opportunity to review and provide comments in advance of consideration by the Finance and Performance Committee.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☒ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☐ Operational Performance ☒ People (inc Staff, Patients) ☒

	Public Consultation Quality Regulatory Strategy/Transformation System	☐ ☒ ☒ ☐ ☐
CQC Assessment Framework:	Safe Effective Caring Responsive Well-Led Use of Resources	☒ ☒ ☒ ☒ ☒ ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Finance and Performance Committee	06/07/2026	The Committee noted the report.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality Patient confidentiality Staff confidentiality Other exceptional reason	☐ ☐ ☐ ☐

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Quality Committee – Chair's Report
Presented by:	Michael Marsh, Chair of the Quality Committee
Agenda items discussed:	At its meeting held on **16 June 2026**, the Committee received the following: • Risk Register: risks rated 12 – 25 (Quality & Safety) • Integrated Performance Report • Annual Claims Litigation Report • Maternity and Neonatal Safety Champions Report • Safeguarding Report • Medicine Optimisation Group Report • Dementia Report • Patient Experience Report • Annual Complaints Report • Draft Quality Account • Report from Clinical Governance Group
ALERT	The Committee wishes to alert members of the Board that: • Late notice of the Resident Doctors Industrial Action was called only allowed some clinical activity to be reinstated. • The potential of technology to support improvement as highlighted in the themes identified in the Annual Claims Report, this includes the implementation of Electronic Patient Record and tools such as Ambient Voice Technology to record consultations and discussions.
ASSURE	The Committee wishes to assure members of the Board that: • The Integrated Performance Report shows stabilisation of 4-hour Emergency Access with some reduction in care in non-clinical areas. Work led by Dr Ian Sturgess has been completed, though no measurable improvement has been seen yet it is anticipated it will over the next 3-4 months. NCTR remains at about 230. Within cancer it is recognised that colorectal, urology, and gynaecology need to improve performance. A new Cancer Board will commence next week to drive improvement of the next 3-4 months. There has been a MRSA bacteraemia case. Work continues to drive improvement of VTE prophylaxis uptake. The Committee was **Assured**.

	• The Annual Claims Report shows that poor documentation is a clear theme. The implementation of the electronic patient record should drive improvement with use of mandatory fields. The CMO will communicate key themes to Consultants and Resident Doctors. Other themes will be used in discussions with care groups. The Committee was **Assured.** • **T**he Maternity and Neonatal Safety Report shows neonatal nurse sickness rate of 11.2%and learning from maternity sickness rates is being used. An improvement approach continues in relation to Post Partum Haemorrhages (PPH) greater than 1.5 litres. Most quality indicators are positive. The Committee was **Assured**. • The quarterly Safeguarding Report shows no change in themes. Level 3 children safeguarding training remains a challenge **(69.2%)** and work is progressing to understand cancellations of training sessions. Oliver McGowan training stands at **25% below the ICB 30% target**, work to increase awareness of training is ongoing. The Committee was **Assured**. • The Medicines Optimisation Group Report shows progress on implementation of NICE Cancer TAs and VTE performance. There is focused work on Patient Group Directives to address both a backlog and process issues. The Committee was **Assured**. • The Dementia Report shows key developments, and the new national dementia audit has been completed, and results will be reviewed at a future meeting. Limitations of the audit were noted and the CNO confirmed the desire for UHD to become an exemplar of dementia care. The Committee was **Assured**. • The Patient Experience report shows a decrease in PALS accompanied by increase in formal complaints. The CNO emphasised the importance of a more proactive response with adoption of real-time feedback. The Committee was **Assured**. • The Annual Complaint Report shows about 800 per year and confirms the focus on improving compliance with the 30-day response target. Further analysis of themes and underlying causes will be undertaken to support assurance. The Committee was **Assured**.
ADVISE	The Committee wishes to advise the Board that: • The Clinical Governance Committee has been working on improving governance and reporting through the organisational structures because of the issue of discharge summaries not being sent to General Practice. • The draft Quality Account was reviewed and suggested some wording change for clarity and avoid misrepresentation.
Review of Risks	

	• The Risk Register was reviewed and noted that several key risks had been reviewed by the Risk Oversight Group and the scoring reduced.
Celebrating Outstanding	• Significant work to develop Quality Account including wide engagement.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	Quality Committee – Chair's Report
Presented by:	Michael Marsh, Chair of the Quality Committee
Agenda items discussed:	At its meeting held on **7 July 2026**, the Committee received the following: • Risk Register: risks rated 12 – 25 (Quality & Safety) • Integrated Performance Report • Quality Impact Assessment Report • Maternity Safety Champions Report • Annual Safeguarding Report and Statement • Annual Looked After Children Report • Annual Infection Prevention & Control Report and Statement • Electronic Results Acknowledgement Process • Mixed Sex Accommodation Declaration • National Standards for Healthcare Food & Drink • Report from Clinical Governance Group • Committee Effectiveness Review – Survey Outcome
ALERT	The Committee wishes to alert members of the Board that: • There have been 2 MRSA bacteraemia cases since April 2026 and is an area of focus for the Infection Prevention and Control Team. • Issues of prescribing aspirin, folate and antibiotics to pregnant women has been an issue and work continues to find work arounds. • There is an Eliminating Mixed Sex Accommodation Annual Statement to be presented at the public Board and published on the Trust website.
ASSURE	The Committee wishes to assure members of the Board that: • Further review of the Medical Devices Corporate Project has confirmed completion of all 30 Isherwood recommendations, clarified the governance model to ensure efficient clinical and managerial input to make best use of investment, maintain patient safety and regulatory compliance. The committee was **Assured.** • The Electronic Results Acknowledgement Process continues its successful role out. A pilot for laboratories rejecting paper requests has started in orthopaedic ward E3. It's anticipated to run for 4 weeks and then rolled out

	Trust wide incorporating lessons learned in the pilot. The committee was **Assured.** • Ongoing work on mortality review processes has identified several weaknesses and steps are being taken to ensure adequate numbers of case reviews and appropriate case selection along with involvement of critical care consultants when required. In addition, involvement of speciality consultants in deaths occurring within ED when required. The committee was **Assured**. • Performance improvements were noted in some elements of access and focus given to areas with poorer performance. NCTR remains over 200 and not all cancer access targets have been achieved. The work on Clinical Vision of Flow and the establishment of the Cancer Board will focus on these issues. The committee was **Assured**. • There is clear evidence that the Equality and Quality Impact Assessment (EQIA) policy and processes are working effectively and identify projects that should not proceed (endoscopy and maternity staffing). Improvements and refinements to the approach are being implemented. The committee was **Assured**. • The maternity Safety report shows that the neonatal nursing sickness remains elevated though has fallen from 11.9% to 8%. The review of APGAR scores of less than 7 at 5 minutes has identified areas of improvement for the MDT to address. The shortage of middle grade obstetric staff has resulted in two diverts of labouring women. The national report combining the work of Broness Amos and Dame Ockenden has a 10-Point Plan that will be brought to the next Board. The committee was **Assured.** • The Annual Safeguarding Report was reviewed and increase complexity of partnership working was highlighted along with the expectation of less Deprivation of Liberty Safeguards (DOLS) following changes in policy nationally. The two Learning Disability and Autism experts that commenced in October 2025 have resulted in improvements. The committee was **Assured**. • The Annual Infection Prevention & Control Report provides confirmation that all mandatory reportable infections have notified. There is a strong focus on hand hygiene and other actions in view of the MRSA cases, noting a 54% reduction in cases on the previous year. C. difficile cases are above the NHSE target which is a national issue and a Quality Improvement project is underway focusing on environment and cleaning as well as antibiotic stewardship. The committee was **Assured**. • The National Standards for Healthcare Food and Drink were reviewed. There is a need for remedial work at the Poole site kitchens. The committee was **Assured**. • The Clinical Governance Committee demonstrates a wide range of work and fulfils its functions effectively. The Committee was **Assured**.

ADVISE	The Committee wishes to advise the Board that: • There is a lack of confidence in the 'Baby Tagging System' that requires careful consideration of continued reliance on the system. • There is a Board of Directors' Statement of Commitment to Infection Prevention and Control to be endorsed and adopted by the Board (attached as appendix).
Review of Risks	• Due to the delays in the COAST building, there is a need to maintain overnight haematology and transfusion services at Poole for a longer period than anticipated (Risk ID 1397). This requires ongoing mitigation.
Celebrating Outstanding	• The OASIS Team have received national recognition at the Royal College of Midwives Research Awards for the work they do in supporting vulnerable women.

University Hospitals Dorset
NHS Foundation Trust

Board of Directors' Statement of Commitment to

Infection Prevention and Control (2026–2027)

The Board of Directors of University Hospitals Dorset NHS Foundation Trust reaffirms its commitment to achieving and maintaining the highest standards of Infection Prevention and Control (IPC) in accordance with the **Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (updated July 2022)**. The Board recognises that effective infection prevention and control is fundamental to patient safety, quality of care, staff wellbeing, and public confidence in the services provided by the Trust.

The Board accepts collective responsibility for ensuring that robust systems, processes and governance arrangements are in place to minimise the risk of healthcare-associated infections (HCAIs), antimicrobial resistance, and communicable diseases across all Trust services. Through effective leadership, oversight and assurance, the Trust remains committed to delivering safe, high-quality care within a clean and well-maintained healthcare environment.

To fulfil these responsibilities, the Trust is committed to:

Governance, Leadership and Assurance

- Maintaining effective leadership, governance and accountability arrangements for infection prevention and control.
- Delivering and monitoring a robust annual IPC work programme aligned to national guidance, local priorities and organisational risks.
- Ensuring risks relating to infection prevention and control are identified, assessed, monitored and mitigated through established governance frameworks.
- Supporting a culture of continuous learning, improvement and shared responsibility for IPC across all services.

Protecting Patients, Staff and Visitors

- Protecting patients, staff, volunteers and visitors from avoidable infection and reducing the incidence of healthcare-associated infections.
- Implementing evidence-based infection prevention and control practices across all clinical and non-clinical settings.
- Providing appropriate facilities, equipment and resources to prevent and minimise the transmission of infection.
- Working collaboratively with partners across the healthcare system to support safe patient care and public health objectives.

Safe Environments and Clinical Practice

- Providing and maintaining clean, safe and appropriate care environments that meet national standards.
- Ensuring evidence-based IPC policies, procedures and standard operating procedures are in place, regularly reviewed and monitored for compliance.

- Supporting effective microbiology and laboratory services to facilitate timely diagnosis, surveillance and management of infection.
- Promoting antimicrobial stewardship practices that support the responsible use of antimicrobials and contribute to the reduction of antimicrobial resistance.

Information, Communication and Partnership Working

- Providing accessible and timely information to patients, carers and the public regarding infection prevention and control.
- Ensuring relevant infection-related information is shared appropriately when patients transfer between healthcare organisations.
- Working collaboratively with healthcare providers, commissioners, regulators and public health partners to support effective infection prevention and control across the wider health and care system.

Workforce and Occupational Health

- Ensuring staff receive appropriate education, training and support to fulfil their infection prevention and control responsibilities.
- Providing access to suitable personal protective equipment (PPE) and training in its safe and effective use.
- Supporting staff through access to occupational health services and measures designed to protect them from communicable infections.
- Promoting a culture in which all staff understand their role in preventing and controlling infection and are empowered to raise concerns and contribute to improvement.

The Board receives assurance regarding compliance with these commitments through the Infection Prevention and Control Group (IPCG), chaired by the Director of Infection Prevention and Control (DIPC), together with regular reporting through the Trust's governance framework, including the Quality Committee, Integrated Performance Reports and the annual DIPC report.

The Director of Infection Prevention and Control is appointed by and accountable to the Board and Chief Executive for providing professional leadership and assurance in relation to infection prevention and control. The DIPC is supported by the Deputy Director of Infection Prevention and Control, Infection Prevention and Control Nurse Consultant, Infection Prevention and Control Doctor and the wider Infection Prevention and Control Team in delivering the Trust's IPC objectives and statutory responsibilities.

Through this statement, the Board of Directors formally reaffirms its commitment to maintaining effective infection prevention and control arrangements, continually improving standards of care, and ensuring the safety of patients, staff and visitors throughout 2026–2027.

Endorsed and adopted by the Board of Directors
Review date: January 2027

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: **4.3.2**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Equality and Quality Impact Assessment (EQIA) Report
Prepared by:	Sarah Herbert Chief Nursing Officer, Judith May, Director of Performance and Oversight, Trudi Ellis, Transformation Lead Nurse
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)	Relevant to all elements of the BAF
Purpose of paper:	Assurance
Executive summary:	A standard EQIA form has been produced for use in UHD and should be completed for: • Efficiency Improvement Projects • Workforce plans • Service change and service development proposals. The UHD EQIA Policy provides a framework for the Quality Impact Assessment (EQIA) process within UHD for the 3 workstreams above. This report provides a summary of Equality & Quality Impact Assessments (EQIAs) completed and reviewed across both Productivity & Efficiency schemes and Transformation programmes during panel reviews in May and June 2026. Three new transformation EQIAs have been completed since April 2026 and approved through Care Group Senior Leadership Teams, with further EQIAs progressing across a number of clinical services. The Panel noted that the EQIA process is not delaying implementation of transformation schemes, as projects are phased and tracked alongside governance requirements.

	The need to strengthen assurance around local governance arrangements for EQIA approval across Care Groups was identified. Assurance will be sought to ensure that all Care Groups have consistent appropriate sign-off processes in place and that EQIAs are being reviewed through Care Group Boards where required prior to submission to panel. EQIA's reviewed were Endoscopy Reconfiguration, maternity staffing and therapy staffing with risk identified above 8.
ALERT:	Endoscopy reconfiguration - the Panel was not assured that the proposed temporary Endoscopy reconfiguration provides a safe and sustainable solution. Concerns remain regarding clinical governance, patient safety, operational resilience and the potential impact on JAG accreditation if recovery facilities are shared with Dermatology. The EQIA for maternity staffing highlighted significant risk despite potential mitigations. Given the services recent CQC inspection and the current national context, with likely recommendations from both the Ockendon and Amos reports in the coming months, the decision was made not to support the staffing changes. The decision will remain under review once a birth rate plus review has occurred and there is greater understanding of the impact of the national reviews. Therapies Staffing is continuing to flag risk above 8 so presented for review at the EQIA meeting. · Clinical outcomes could be impacted and are listed as a risk of 8 based on length of stay targets. This is mitigated to a risk of 6. · Associated risk on risk register (1303) – In patient therapy demand is unmitigated pending approval of business case. Decision to review EQIA in 3 months made when outcome of business case known. Variability in Care Group EQIA governance arrangements was identified, with further assurance required that all EQIAs are being appropriately reviewed and approved through local governance processes.
ASSURE:	442 EQIAs are currently completed for 2026/27, an additional 7 EQIAs since May 2026. None of these 7 EQIAs have raised a risk score of above an 8. 35 of these schemes are covered with other assurance provided by Procurement and Pharmacy. There is not a EQIA for these schemes. Updates were received on Productivity & Efficiency and Strategy & Transformation programmes, with three new transformation EQIAs completed and approved and further assessments progressing across several clinical services. The Panel was assured that the EQIA process is not delaying delivery of transformation schemes, with implementation managed alongside the programme governance and phased delivery arrangements.

ADVISE:	97 productivity and efficiency scheme EQIAs remain in draft and 63 EQIAs haven't been started. Those with EQIAs outstanding will be completed by the mid-June deadline. As a result of the ongoing delays to phase 3 moves and review of inpatient options there have been no new EQIAs completed for June 2026. The Endoscopy reconfiguration should continue to be escalated through Care Group and reconfiguration governance structures until an agreed, compliant solution is identified. The team continue to review an interim plan for inpatient endoscopy procedures pending phase 3 moves and will provide an updated EQIA once appropriate mitigation has been agreed. Care Groups should ensure robust governance arrangements are in place for EQIA review and approval, with oversight through Care Group Boards where appropriate.
Celebrating Outstanding:	Strong EQIA Delivery for 2025/26 • 442 EQIAs completed for productivity and efficiency alone, demonstrating a well-embedded and functioning process • Continued progress since April, including a reduction in draft EQIAs
RECOMMENDATION:	The Board is asked to: • Note the current EQIA position and key risks • To note the required accelerated completion of EQIAs for 2026/27 schemes • Endorse strengthened requirements for care group oversight and sign off through structured governance processes • To ensure continued assurance provided on identified high risk EQIA to ensure that progress is made and ongoing mitigations are reviewed and monitored • Maintain oversight of: ○ Transformation delays and EQIA alignment • To note the decision regarding the maternity staffing EQIA
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☐ Strategy/Transformation ☒

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

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Equality and Quality Impact Assessment Panel	26/06/2026	AAA escalation to Quality Committee on current EQIA position across Trust
Quality Committee	07/07/2026	The Committee noted the report.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: **4.3.3**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Annual Complaints Report
Prepared by:	Deputy Head of Patient Experience
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)	Trust Strategic Priority: Patient Experience – *Improve patient experience, listen and act.* 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 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
Purpose of paper:	Assurance
Executive summary:	In accordance with Regulation 18 of the NHS Complaints Regulations (2009), this report sets out a detailed analysis of the number and nature of complaints received by University Hospitals Dorset NHS Foundation Trust (UHD) in 2025/26.

ALERT:	881 complaints were received by the Trust in the year 2025/2026, averaging 73 per month. Of these 881 complaints, 473 were managed via the formal investigation process and 408 were managed via the Early Resolution process. Overall, this represents an increase of 9.71% when compared with the 803 complaints received in 2024/2025
ASSURE:	The Trust had 13 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO), compared with the 14 cases referred the previous year. During the period 2025/2026 the Trust had 16 cases closed by the PHSO, three cases that were upheld / partially upheld by the PHSO and 13 cases were closed with “no further action” meaning that the PHSO did not consider a full investigation necessary.
ADVISE:	53.05% of all complaints investigated were responded to within the Trust internal target of 35 working days. The average response time for all complaints in 2025/2026 was 37.57 working days.
RECOMMENDATION:	Note the contents of the Annual Complaints Report for 2025/26.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☒ Regulatory ☐ Strategy/Transformation ☐ System ☐
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-Led ☒ Use of Resources ☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Quality Committee	02/06/2026	The Committee noted the report.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

University Hospitals Dorset
NHS Foundation Trust

2025/2026

ANNUAL COMPLAINTS REPORT

Table of Contents

EXECUTIVE SUMMARY

The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009), requires that all Trusts provide an annual report on the handling and consideration of complaints. The required inclusions to meet this statutory requirement are detailed in this report.

In Summary:

- 881 complaints were received by the Trust in the year 2025/2026, averaging 73 per month. Of these 881 complaints, 473 were managed via the formal investigation process and 408 were managed via the Early Resolution process. Overall, this represents an increase of 9.71% when compared with the 803 complaints received in 2024/2025

- 7041 PALS concern were received by the Trust in 2025/2026, averaging 586 per month. This represents an increase of 6.3% when compared with the 6624 PALS concerns received in 2024/2025.

- The Trust had 13 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO), compared with the 14 cases referred the previous year. During the period 2025/2026 the Trust had 16 cases closed by the PHSO, three cases that were upheld / partially upheld by the PHSO and 13 cases were closed with “no further action” meaning that the PHSO did not consider a full investigation necessary.

- 53.05% of all complaints investigated were responded to within the Trust internal target of 35 working days. The average response time for all complaints in 2025/2026 was 37.57 working days.

- At the end of the reporting year, 4.88% of complainants were dissatisfied with the formal response that they received. This represents a total of 43 of the 881 of the responses sent. In 2024/2025 this was a total of 5.11% (41 of the 803 complaints)

1.0 INTRODUCTION

1.1 This report describes how complaints have been managed at University Hospitals Dorset NHS Foundation Trust (UHD). The report details the number and nature of complaints received during the year and demonstrates the Trust's commitment to learning and improvement.

1.2 The Chief Executive is responsible for ensuring compliance with the arrangements made under these regulations. The responsibility for the handling and considering of complaints in accordance with these regulations is delegated, via the Chief Nurse, to the Head of Patient Experience.

2.0 THE PROCESS FOR MANAGING CONCERNS AND COMPLAINTS

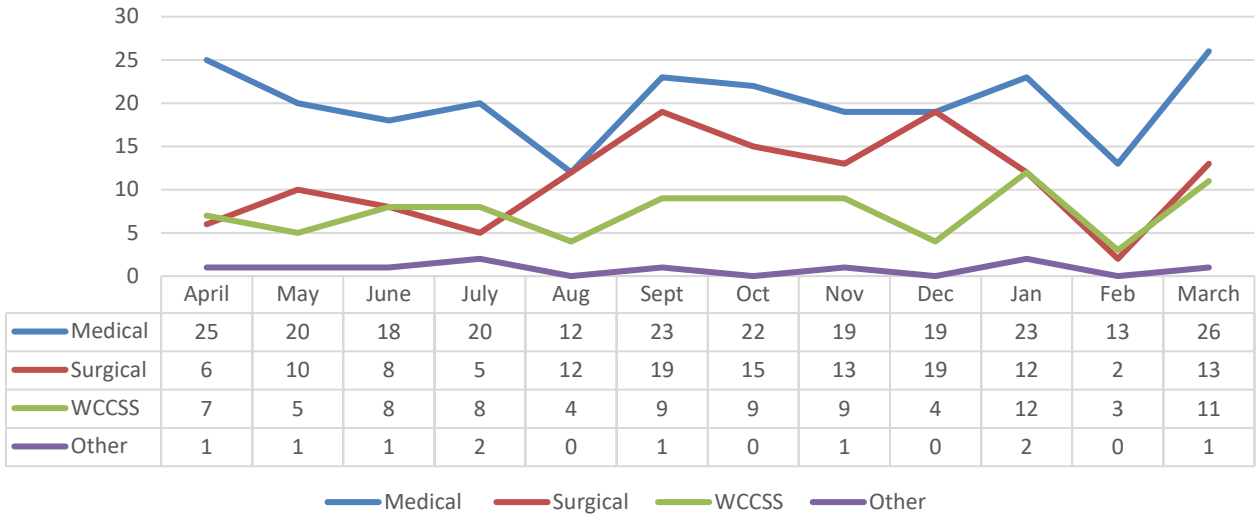
2.1 The Trust follows a corporate model for managing concerns and complaints. The Patient Advice and Liaison Service (PALS) team manage any concerns received within the Trust and act as liaisons for those raising the concerns between the relevant departments within the Trust. There is also a centralised complaints team managing the administration of the formal complaints (including early resolution), coordination of the complaint investigation and the complaint responses.

3.0 COMPLAINTS RECEIVED

3.1 The Trust received a total of 881 complaints in 2025/2026, this includes the Early Resolution complaints (ERC) that form part of the complaint process.

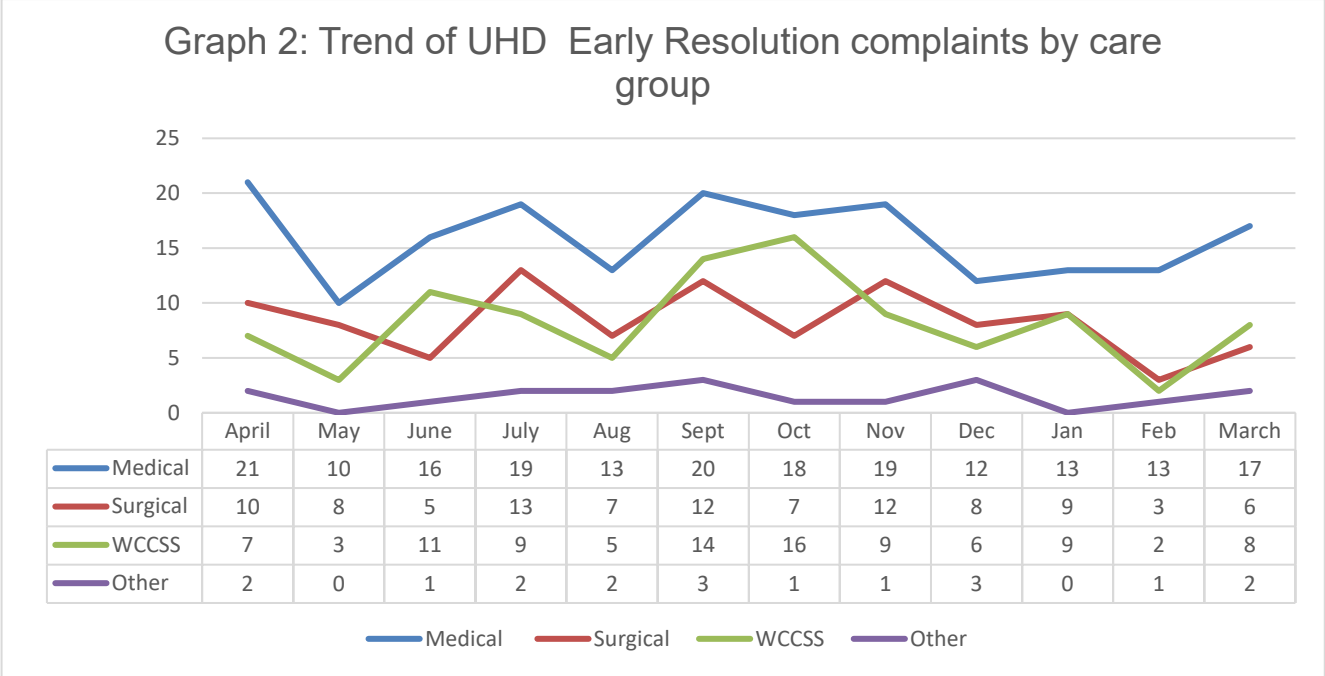
The Trust managed 473 formal complaints. This is presented as a monthly trend, by care group, in Graph 1.

Graph 1: Trend of UHD formal complaints by care group



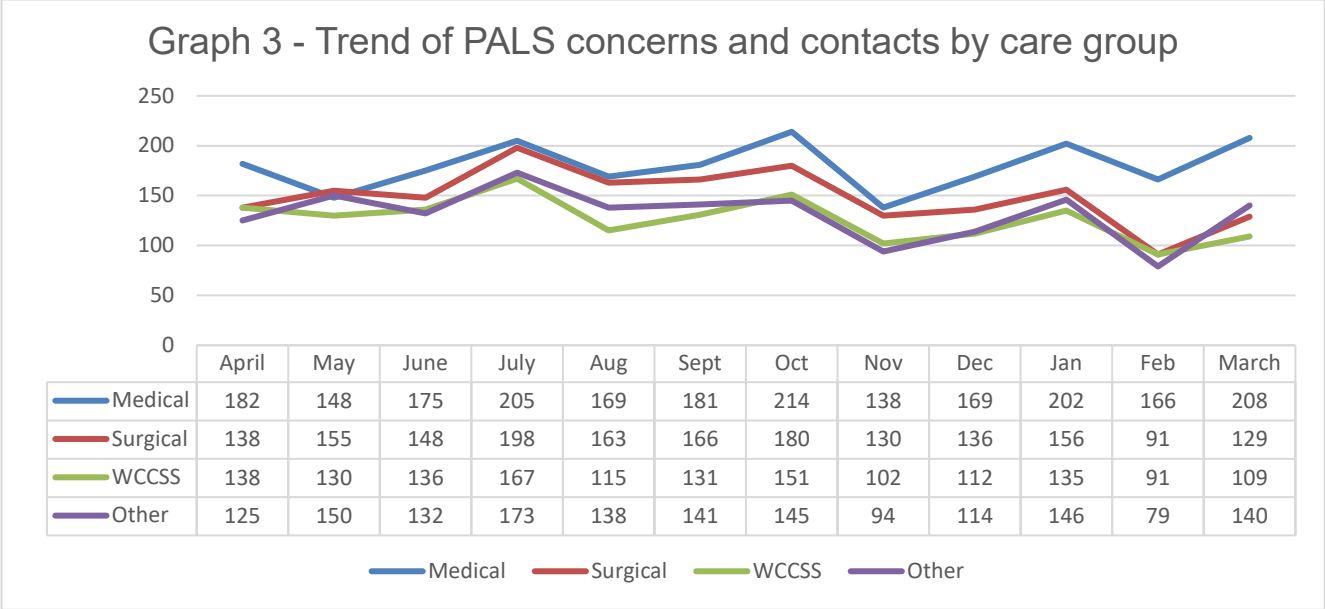
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Medical	25	20	18	20	12	23	22	19	19	23	13	26
Surgical	6	10	8	5	12	19	15	13	19	12	2	13
WCCSS	7	5	8	8	4	9	9	9	4	12	3	11
Other	1	1	1	2	0	1	0	1	0	2	0	1

3.2 In addition to the 473 formal complaints, the Trust also handled 408 early resolution complaints. This has been broken down to the care groups and is shown in Graph 2.



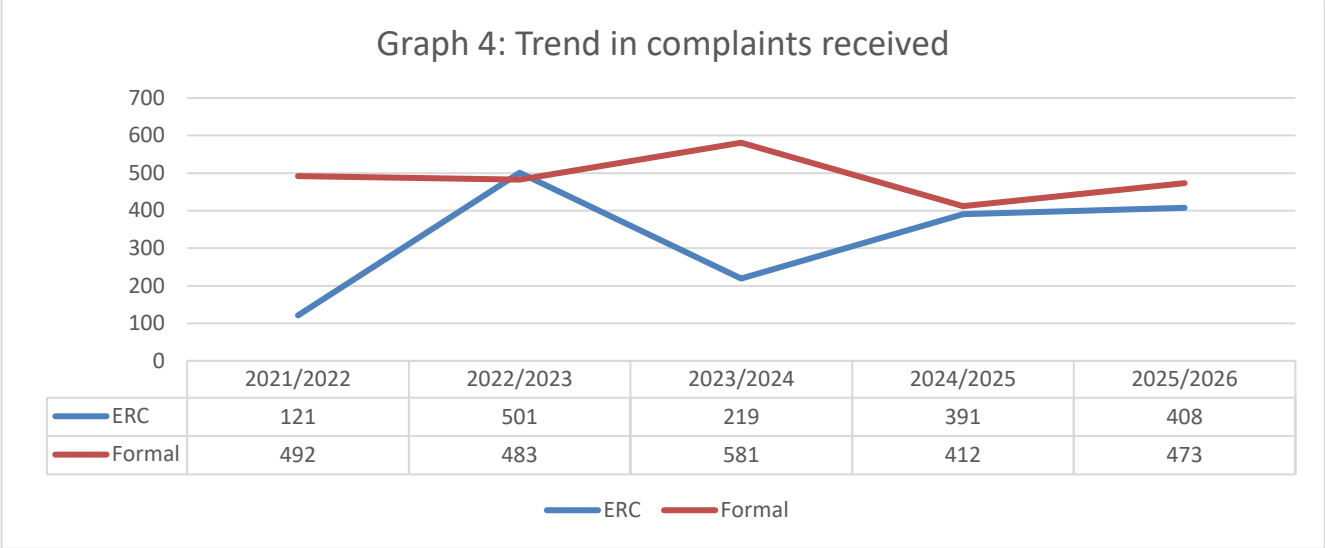
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Medical	21	10	16	19	13	20	18	19	12	13	13	17
Surgical	10	8	5	13	7	12	7	12	8	9	3	6
WCCSS	7	3	11	9	5	14	16	9	6	9	2	8
Other	2	0	1	2	2	3	1	1	3	0	1	2

3.3 A total of 7041 (2024/2025 = 6624) PALS concerns, and contacts were processed and responded to in this year, via the PALS team. This is broken down to the care groups and shown in Graph 3.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Medical	182	148	175	205	169	181	214	138	169	202	166	208
Surgical	138	155	148	198	163	166	180	130	136	156	91	129
WCCSS	138	130	136	167	115	131	151	102	112	135	91	109
Other	125	150	132	173	138	141	145	94	114	146	79	140

3.4 The trend in complaints received can be seen in Graph 4. The graph shows an increase in ERC's over the past year and a slight increase in formal complaints. However, to note the PALS team have been managing and resolving more of what could become early resolution complaints and that is shown in the increase in cases in that team.



3.5 Table 1 shows the breakdown of persons making a complaint and their method of communication.

Table 1: Complainant profile and mode of communication, 2025/2026			
Person making the complaint		**Mode of communication**	
Patient	**60.16% (530 of 881)**	Phone	3.29% (29 of 881)
Spouse	**7.49% (66 of 881)**	Email	88.76% (782 of 881)
Parent	**10.78% (95 of 881)**	In person	3.06% (27 of 881)
Relative / Carer	**19.3% (170 of 881)**	Letter	4.88% (43 of 881)
Other	**2.27% (20 of 881)**		

4.0 RESPONSIVENSS AND PERFORMANCE

4.1 Trust performance is monitored locally (recorded on an electronic database - Datix) and via national KO41a data submission. The data is reported by NHS Digital who through development and operation of national IT and data services help patients get the best care and use data to improve treatment. The information obtained via this collection monitors written complaints received by the NHS regarding Hospital and Community Health Services. This data is published and enables comparison with other Trusts.

4.2 Key performance indicator (KPI) targets are detailed, in tables 4 and 5 below

Table 4: complaint handling performance	Q1	Q2	Q3	Q4	Yr end
Number of complaints received	204	234	242	201	881
% complaints acknowledged within 3 working days (KPI 100%)	97%	100%	100%	99.5%	99.21%
% response within 35 day internal target (KPI 100%)	41.6%	48.1%	48.32%	29.7%	53.05%
Average response times in days	35.83	35.01	34.45	44.99	37.57
Number re-opened complaint investigations (KPI <10%)	13	13	6	11	43
Complaints opened for investigation by the PHSO	5	4	4	0	13
PHSO investigations closed (& upheld/partially upheld)	1	2	0	0	2

4.3 The outcome of all closed complaints, by quarter, is shown in Table 5, the numbers will be lower than the information in the previous table as there are complaints received that remain under investigation. The data shows UHD upholds less complaints when compared to the national average.

4.4 Where a complainant is unhappy with their complaint response and feels that local resolution of their complaint has not been satisfactory, they have the option of asking the Parliamentary and Health Service Ombudsman (PHSO) to carry out an independent review of their complaint. In 2025/2026 13 complaints were opened for investigation by the PHSO and 2 upheld or partially upheld. The remaining cases are either still under investigation or were closed without investigation progressing once the complaint casefile and records were supplied.

Quarter		Table 5: Outcome of complaints investigated and resolved					
	Closed	**Upheld**	***National average***	**Partially Upheld**	***National average***	**Not upheld**	***National average***
Q1	190	39 (20.53%)	*25%*	60 (31.58%)	*40.5%*	91 (47.89%)	*34.4%*
Q2	212	50 (23.58%)	*25%*	56 (26.42%)	*40.5%*	106 (50%)	*34.4%*
Q3	238	49 (20.59%)	*25%*	75 (31.51%)	*40.5%*	114 (47.9%)	*34.4%*
Q4	165	34 (20.61%)	*25%*	45 (27.27%)	*40.5%*	86 (52.12%)	*34.4%*

4.5 The number of reopened investigations and upheld/partially upheld PHSO investigations are measures of the quality of complaint handling. During 2025/2026, the number of reopened investigations fell well below the internal target of <10%.

5.0 THEMES AND LEARNING FROM COMPLAINTS

5.1 Learning from the detail of individual upheld complaints is monitored on Datix and is reported via the Patient Experience Group PEG), patient experience report to the Clinical Governance Group quarterly and Quality Committee. The evaluation of learning and monitoring of improvements are reported in care group governance reports to the Clinical Governance Group.

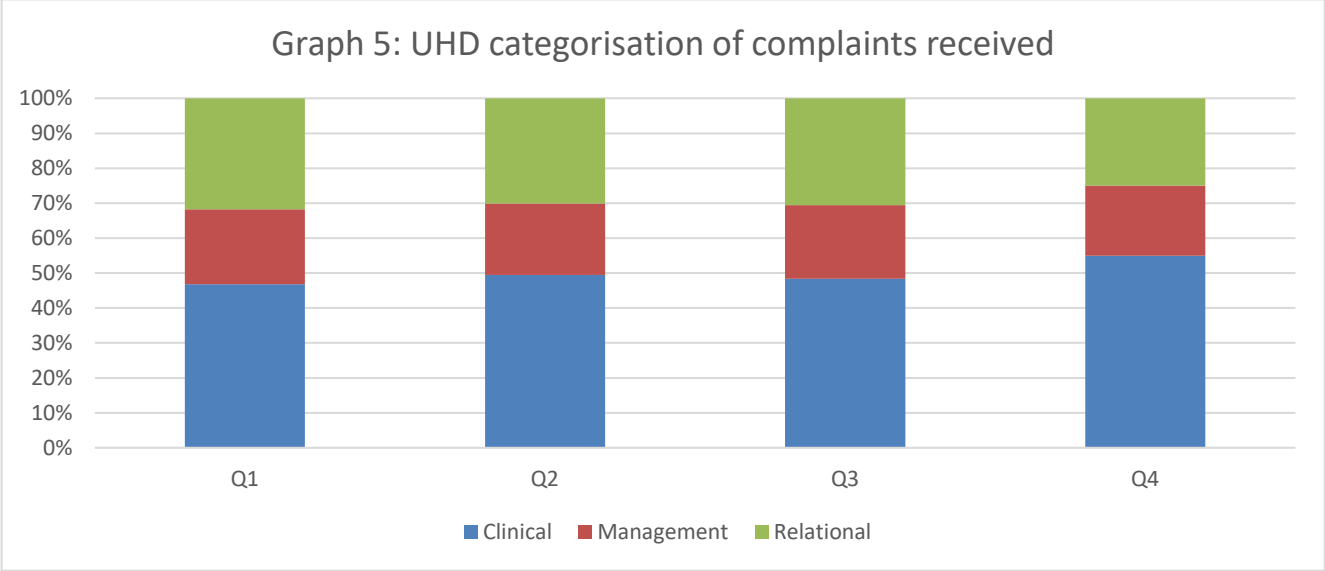
5.2 A high level summary of examples of learning can be found at Appendix A and are shared on the public website alongside the annual reports.

5.3 The data collected from complaints is analysed to help identify themes and emerging trends. The themes are extracted from the complaint narrative, taken from the perspective of the patient or their representative.

5.4 The tool used for theming complaints at UHD is based on the Healthcare Complaints Analysis Tool (HCAT); UHD has 3 over-arching categories, 9 themes and over 50 sub-themes. A summary of the 9 themes can be seen below.

CLINICAL	MANAGEMENT	RELATIONAL
•Quality •Safety •Effectiveness	•Environment •Systems & processes •Well led	•Communication/listening •Attitude •Dignity & respect

5.5 As can be seen in graph 5, the highest proportion of UHD complaints consistently fall into the clinical category; this is similar to the national data. It should be noted that there are caveats regarding reliability of this comparison: it is collated from the KO41a data collection (community services and NHS hospitals); and secondly.



5.6 The data, by complaint category is shown by quarter in Graph 5, above. The top 3 complaint themes, by category, by quarter are shown in Table 6 overleaf. It is recognised that reporting themes and sub-themes by directorate or specialty will generate more relevant and useable data for tends, learning and improving.

Table 6: 2025/2026 TOP COMPLAINT THEMES, BY QUARTER

Complaint category	Quarter	
CLINICAL **Quality** e.g. Clinical standards **Safety** e.g. incidents, staff competencies **Effectiveness** e.g. procedural outcomes	Q1	• Inadequate examination and monitoring • Clinical skills and conduct • Error - diagnosis
	Q2	• Inadequate examination and monitoring • Error – diagnosis • Failure to respond to changes in clinical presentation
	Q3	• Inadequate examination and monitoring • Clinical skills and conduct • Error- diagnosis
	Q4	• Inadequate examination and monitoring • Clinical skills and conduct • Outcomes and side effects
MANAGEMENT **Environment** e.g. facilities, equipment, staffing levels	Q1	• Trust administration and bureaucracy • Discharge • Documentation / records
	Q2	• Delay – access (outpatient) • Documentation • Delay – procedure or referral

Table 6: 2025/2026 TOP COMPLAINT THEMES, BY QUARTER		
Complaint category	**Quarter**	
Systems & processes e.g. bureaucracy, waiting times, accessing services **Well led:** eg leadership and decision	Q3	• Delay – access (outpatient) • Delay – procedure or referral • Discharge
	Q4	• Delay – access (outpatient) • Delay - procedure or referral • Delays – accessing emergency / urgent care
RELATIONAL **Communication & listening** eg not acknowledging information given **Attitude** eg behaviour **Dignity& respect** eg caring and patient rights	Q1	• Communication breakdown • Communication absent • Caring and compassion
	Q2	• Communication breakdown • Communication absent • Dismissing patient or family
	Q3	• Communication breakdown • Caring and compassion • Communication absent
	Q4	• Communication breakdown • Caring and compassion • Dismissing patient or family

6.0 CONCLUSIONS & RECOMMENDATIONS

6.1 The Trust has received 473 (2024/2025 = 412) formal complaints, 40 (2024/2025 = 391) early resolution complaints and 7041 (2024/2025 = 6624) PALS enquiries and concerns during 2025/2026. This is an increase in the number of complaints received from 2024/2025. There also continues to be significant increase in the cases managed in the PALS service.

6.2 A national comparison of complaints received (NHS Digital) shows that UHD is not an outlier with regards to the number of complaints. The Trust has increased the number of early resolution complaints and PALS cases managed throughout 2025/2026.

6.3 The Trust previously underperformed with the final response timescale of 55 working days. This in part can be attributed to the high clinical demand on our staff that were needed to have input into the responses.

6.4 Complaints team continue to focus on the 35-day timeline for answering complaints as a trust standard which was introduced in 2024/2025. The complaints team continues to work in partnership with the care groups and corporate teams.

6.5 The PALS and complaints team continue to encourage patients and staff to raise and resolve concerns as they are happening to avoid the need for formal complaints

6.6 Complaints team will continue to improve communication with complainants to explain about the processes and any potential delays

Appendix A: 2025/2026 examples of learning from upheld complaints

You Said: Concerns raised about lack of lighting in patient and visitors car park.
We Did: This was due to the lights not working and out maintenance team have rectified this. The team will also be auditing the lighting provision during the darker months to ensure that there are safe, well-lit paths to and from the car parks

You said: It was fed back that signage for one of our older person's wards did not effectively demonstrate what type of ward it was
We did: Additional signage was arranged

You said: Concerns were raised by a patient's family that their relative was not being assisted out of bed as frequently as they would like.
We did: A tally chart has been introduced to encourage patients to sit out of bed and to mobilise on the ward

You Said: Concerns raised that there was a delay in patient receiving therapy input over the weekend
We Did: Therapy department have completed an audit to analyse frequency and quality of therapy input for this particular patient group which has informed workforce planning and further recommendations to improve care. Recruitment continued to be prioritised with new members of staff have started within the team.

You Said: Concerns raised about queues to get into the visitors car park, causing anxiety around getting to appointments in time
We Did: A new automatic number plate recognition system has since been introduced, reducing the time vehicles spend queuing at the car park entrance. . We have also added blue badge scanners at all our payment terminals and exit barriers. This allows blue badge holders to validate their parking session without needing to visit our parking kiosk.

You Said: Concerns regarding storage of medicines in the locked storage in patient's rooms
We Did: New practices have been introduced including the change of codes every 29 days or immediately following any potential security breach. Compliance will be audited annually and shared via our e-learning medication management package as well as Trust wide via senior leadership teams.

You Said: Concerns raised regarding congestion in the car park and feedback regarding the speed humps on the Bournemouth site
We Did: Our external car park company have increased staffing at the exit barriers during peak periods. The speed bumps have been reviewed and will be replaced with ones at a lower height.

You Said: Patient did not receive information regarding stopping certain medications prior to surgery in writing.
We Did: Processes changed so that this information can be provided via email to patients.

Prepared and written by Christina Harding
Deputy Head of Patient Experience
May 2026

University Hospitals Dorset
NHS Foundation Trust

QUALITY COMMITTEE

Meeting Date: 07 July 2026

Agenda item: 5.6

Subject:	Eliminating Mixed Sex Accommodation Annual Statement 2026/27
Prepared by:	Vivian Alividza, Deputy Chief Nurse
Presented by:	Sarah Herbert, Chief Nursing Officer

Strategic themes that this item supports/impacts:	Population & System Our People Patient Experience Quality Outcomes & Safety Sustainable Services	☐ ☐ ☒ ☒ ☐
BAF/Corporate Risk Register: (if applicable)	None	
Purpose of paper:	Decision/Approval	
Executive Summary:	The Board of Directors are required to publish an annual statement which reaffirms its commitment to eliminating Mixed Sex Accommodation which is attached and seek Quality Committee approval. This statement will then be presented at the public board meeting and published on the trust website.	
Background:	University Hospitals Dorset NHS Foundation Trust remains committed to complying with the Government's requirement to eliminate mixed-sex accommodation, except when it is in the patient's overall best interest, for example in critical care settings such as intensive care and other specialist care areas. The trust implements this commitment in practice through the Same Sex Accommodation policy and other associated policies.	
Key Recommendations:	Once approved, the statement will be published on the Trust's website to reaffirm to the public the Board's commitment	
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	07/07/2026	Agreed to recommend 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	☐

University Hospitals Dorset
NHS Foundation Trust

Eliminating Mixed Sex Accommodation Annual Statement 2026/27

University Hospitals Dorset NHS Foundation Trust (UHD) remains committed to complying with the Government's requirement to eliminate mixed-sex accommodation.

We have the necessary facilities, resources and culture to ensure that patients who are admitted to our hospitals share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms close to their bed area.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in Intensive Care (ICU), Coronary Care (CCU), or when patients actively choose to share (for instance Chemotherapy Day Unit).

The trust implements this commitment in practice through the Same Sex Accommodation and Privacy and Dignity Policies. Evidence of compliance includes reports of all breaches via the organisation's incident reporting system including the completion of Duty of Candour. If our care should fall short of the required standard, we will identify this through our internal reporting process, review the reasons, and report internally and externally.

Our mixed sex accommodation data is regularly reviewed by our Quality Committee and reported to the Board, through the Integrated Performance Report. UHD remains compliant with the requirements of national reporting. This is part of our ongoing commitment to delivery of our declaration of compliance and learning where concordance is not achieved.

Following the recent Supreme Court ruling and once national guidance is published, UHD will review it's policies and procedures to ensure regulatory compliance.

July 2026

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

ESCALATION and ASSURANCE REPORT – Alert, Assure, Advise	
Report from:	People and Culture Committee – Chair's Report
Presented by:	Sharath Ranjan, Chair of the People and Culture Committee

Agenda items discussed:	At its meeting on **6 July 2026**, The Committee received the following:
	• Staff Story: Simulation Technicians
	• Chief People Officer's Report, including:
	• People and Culture risk register
	• Integrated Performance Report – Our People
	• Communications: a well-informed workforce
	• Workforce Operational Efficiency and Reduction Plan (WORP)
	• Status report on the progress against the action plans from:
	  ○ WRED/WDES
	  ○ Gender pay gap
	• Medical Revalidation
	• Safe Staffing: Nursing
	• Annual Security Report
	• Guardian of Safe Working Hours Annual Report
	• HR policies
	• Healthcare Science Forums – feedback on recruitment
	• Mandatory Learning Oversight Group Escalation Report

ALERT	**Senior Leadership changes and capacity to deliver transformation / National Changes** With the Chief People Officer's current secondment to the region and the departures of key personnel within the CPO directorate, there is an impact on our people who find it unsettling. The leadership capacity required to deliver the scale of changes across the trust will also be stretched. Mitigations are in place with interim appointments to those key roles and capacity is being monitored. Pete's oversight and early conversations with the directorate has brought a sense of stability. **Values based appraisal completion rates and Quality Assessment** Values based appraisal rates continues to remain below the 90% target for May (74.5%). The committee had previously

	noted an improvement heading towards the March completion deadline. In discussions, the committee was not sufficiently assured of the quality of appraisals and the current mechanisms to assess it. The committee has sought further assurance through an audit/assessment of the quality of appraisals. There is an A3 plan in place to drive improvements.
ADVISE	**Annual Security Report – Incidents of Violence and Aggression towards staff** Although there was a small reduction in the number of incidents related to Violence and Aggression compared to the previous year, the number is still high (900+). The committee noted the report and raised questions around how we could learn from other organisations (in the absence of national benchmarking). Despite our Anti Racism commitment and stated non-tolerance, there is no current data (or reporting requirement) for incidents related to race or any other form of discrimination suffered during these incidents. **Mid-point In patient Establishment Review** The committee received the report and noted the alert related to staff ratios (Registered Vs Unregistered Nurse) below the recommended level – 60:40. The committee was reassured that no wards had ratios below the recommended level which would be deemed inappropriate having considered a range of indicators, reviews and validation. As this is a midpoint review, there are no changes to establishment templates.
ASSURE	**Medical Revalidation and Appraisal** The report is due at the Board for Sign-off. The committee noted the capacity issues related to the appraisers and the plans to address them in 2026-27. Whilst there were appraisals which missed the deadline during the last year, the majority were completed (within 6 months of deadline) and the committee was assured about UHD's current position and reassured about the plan for 2026/27.
Review of Risks	The committee noted the progress in reviewing the current process and the refreshed approach to monitoring and reassessing risks. Most risks presented to the committee relate to shortages in workforce. The committee has asked for pace of completion of the review (summits held in Nov 25 and Mar 26).
Celebrating Outstanding	Staff Story – The committee heard from our Simulation Technicians who had developed a range of digital solutions to support the organisation with simulations beyond conventional applications. They reminded the committee about the vast

	amount of talent across the organisation who are keen to explore innovative solutions through curiosity, drive and exploitation of our existing digital licenses.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: **4.4.2**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap action plan update
Prepared by:	Bridie Moore, Head of Organisational Development
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)	Our People: Be a great place to work
Purpose of paper:	Assurance
Executive summary:	This paper provides an update on delivery of the Trust's Equality, Diversity and Inclusion (EDI) priorities, bringing together the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap into a single, integrated action plan. Progress has been made across key areas, including strengthened Board-level accountability, development of inclusive recruitment practices, increased focus on wellbeing, and growing maturity of staff networks. However, the data continues to demonstrate inequalities in recruitment outcomes, career progression, and staff experience for ethnically diverse and disabled colleagues. The scale of the issues identified mean that achieving sustainable change will require a long-term approach whilst maintaining a clear sense of urgency and avoiding complacency. A suggested focus for the next 6-18 month is outlined with a shift from activity to measurable outcomes over the next 6–18 months. Key priorities include improving recruitment equity (particularly at senior levels), strengthening progression pathways, embedding inclusive leadership behaviours,

	enhancing staff voice, and improving data transparency and monitoring.
ALERT:	Inequalities remain across recruitment, progression and staff experience, particularly for ethnically diverse and disabled colleagues, with limited improvement in some areas of bullying, harassment and discrimination indicators. Without an increased focus on this agenda, there is an increased a risk of an impact to staff, patients and our UHD reputation.
ASSURE:	The Trust has met its regulatory reporting requirements for WRES, WDES and Gender Pay Gap (data submitted May 2026) and will further strengthen its approach through development of a single, integrated EDI action plan which will be brought to the committee for approval before October. There is clear evidence of progress, including: • Embedding EDI objectives within Board appraisal processes • Delivery of inclusive recruitment initiatives and training • Increased executive engagement with staff networks • Enhanced focus on wellbeing and flexible working • Continued rollout of inclusive leadership and behavioural expectations These actions provide a stronger foundation for improving workforce equity and staff experience.
ADVISE:	The proposed focus for the next 6- 18 months strengthens the Trust's approach by: • Introducing improved monitoring of recruitment and progression data • Developing targeted interventions for under-represented groups • Aligning delivery to the People Promise and the proposed People strategy
Celebrating Outstanding:	Staff networks continue to demonstrate increasing maturity and influence, playing a key role in shaping organisational improvement and supporting colleague voice There has also been strong executive and Board engagement in EDI development, including targeted leadership sessions and increased visibility at staff network events.
RECOMMENDATION:	The Board is asked to: 1. **Note** progress against the integrated EDI action plan 2. **Discuss** the proposed priorities and focus 3. **Provide oversight and scrutiny** to ensure delivery against statutory requirements and improvement trajectories
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☐ Health Inequalities ☐ Operational Performance ☐

	People (inc Staff, Patients)	☐
	Public Consultation	☐
	Quality	☐
	Regulatory	☐
	Strategy/Transformation	☐
	System	☐
CQC Assessment Framework:	Safe	☐
	Effective	☐
	Caring	☐
	Responsive	☐
	Well-Led	☒
	Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
People and Culture Committee	06/07/2026	The Committee noted the report.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality	☐
	Patient confidentiality	☐
	Staff confidentiality	☐
	Other exceptional reason	☐

Integrated WDES, WRES and Gender Pay Gap Action Plan – Progress update

1. Purpose (Advise / Assure)

To provide an update on progress in delivering the Trust's equality, diversity and inclusion (EDI) action plans, bringing together the requirements of the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap.

The paper also sets out the proposed focus for a refreshed, integrated action plan for the next 6–18 months, with a strengthened emphasis on impact and measurable outcomes.

2. Context and Background

The People and culture committee has previously reviewed the following papers:

- WRES report (published October 2025) and updated action plan reviewed 5th January 2026.
- WDES report (published October 2025) and updated action plan reviewed 5th January 2026.
- Gender Pay Gap report (published 31st March 2026) reviews 2nd March 2026.

These reports identified persistent inequalities across:

- Recruitment and appointment outcomes
- Career progression and access to opportunity
- Staff experience, including discrimination and feeling valued.

In response, the Trust has moved to an integrated EDI improvement approach, combining WRES, WDES and Gender Pay Gap actions into a single coherent plan aligned to the People Promise.

3. Legislative and Regulatory Framework

The plan supports the Trust in meeting its statutory and regulatory obligations across a range of equality, workforce and cultural requirements. This includes compliance with the Equality Act 2010, specifically the Public Sector Equality Duty (PSED), which requires the Trust to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between diverse groups. It also addresses the Equality Act 2010 (Specific Duties) (England) Regulations, which mandate the annual publication of equality information and the setting of equality objectives every four years.

Additionally, the plan meets requirements under the Gender Pay Gap Regulations through the annual publication of pay gap data. It aligns with NHS contractual and national policy requirements, including the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), which require not only reporting but demonstrable improvement trajectories supported by robust action plans.
Finally, it reflects the expectations of the Care Quality Commission (CQC) and NHS Oversight Framework, which place strong emphasis on inclusive organisational culture, positive workforce experience, and the creation of safe, supportive working environments.

Suggested focus and action plan

The suggested focus for the next 6-18 months has been developed by building on existing actions from the current plans. It places a stronger emphasis on delivering measurable outcomes rather than activity, with particular focus on improving equity in recruitment, supporting career progression, and enhancing the day-to-day experience of staff. The suggested focus has been further informed by the 2025 Staff Survey results, which was reviewed by the People and Culture Committee (PCC) in May 2026.

Theme	Consolidated Action	Progress since October 25	Suggested focus for next 6 -18 months
Leadership & Accountability	Embed EDI objectives in Board appraisals and deliver Board development	All Board members undergoing appraisals with EDI objectives. Board Dev session in scoping stage with Excellence in Action Exec sponsors for staff network groups and increased attendance at network meetings Focused DEN Listening events	Board members to review and report on progress against EDI objectives. Role modelling importance of agenda through Exec led Staff Voice listening conversations being launched in June.
Inclusive Recruitment	Review and strengthen inclusive recruitment practice (training, positive action, tracking senior roles)	First group of recruitment allies trained to support EDI lead and network leads in supporting more inclusive interview panels. Ongoing Conscious Inclusion training modules New recruitment policy in draft	Introduce additional scrutiny of shortlisting and offers for B8a + roles. Increase number of “inclusive panels” by developing accreditation of recruiting managers and associated infrastructure including training.
Career Progression & Pay Equity	Improve equitable access to career development and progression through inclusive learning, supported by robust monitoring of promotion and progression outcomes across protected characteristics.	49.95% BME respondents in the 2025 Staff survey believed the organisation provided equal opportunities for career progression or promotion compared to 59.11 for White staff. 52.76% staff with a LTC, or illness compared to 57.98% for staff without.	Undertake detailed data analysis of progression barriers and triangulated with staff feedback. Create dashboard to present data and use this data to target interventions. Develop multi-year evidence based, targeted progression

			pathways for disabled and BME staff with input from network and professional leads.
Workforce Health & Wellbeing	Write, implement and embed reasonable adjustments process	Reasonable adjustments policy in process of approval and due to be published shortly.	Identification of budget and development of SOP to effectively implement and embed policy. Communicate policy to managers and focus on consistency of delivery.
	Strengthen wellbeing / Thrive / manager capability	Increased focus on wellbeing issues through Thrive events.	Target manager capability through new management framework Thive Live extended to 3 weeks for 2026 working collaboratively to ensure that EDI is included in the campaign.
	Improve flexible working and work–life balance	Timewise conducted a review of flexible working at UHD and working with Exec to plan next steps.	Scope, design and implement Flexible working improvement project to strengthen flexible working practices and improve workforce availability.
Staff Experience & Voice	Deliver listening events and co-design with staff networks	Monthly network events and speakers for network events.	Shift from listening into action track themes and outcomes
	Strengthen impact of staff networks	Networks mature and influencing change (ongoing strength)	Formalise role of networks in influencing policy and progression pathways
	Improve engagement and feeling valued	Staff Engagement score and questions about feeling valued have decreased marginally in 2025 but remain consistent and above comparator average.	Ongoing monitoring of engagement and value questions through quarterly Pulse and Staff Survey and triangulated with

			direct staff engagement and listening campaign. Target manager capability through new management framework
Bullying, Harassment & Culture	Reinforce zero tolerance and anti-discrimination approach	Board and governors' development sessions with excellence in action. Piloting in-house trained Reverse Mentors to support Florence Nightingale leadership programme delegates.	Development of behavioural interventions to further embed the behavioural framework, recognising and responding to the complex, multi-faceted nature of the issues.
	Implement Behavioural Charter and inclusive leadership training	Phase 1 of Behaviour charter launched. Ongoing delivery of Conscious Inclusion as a core new manager's module and to all staff	Development of behavioural interventions to further embed the behavioural framework, recognising and responding to the complex, multi-faceted nature of the issues.
	Reduce bullying, harassment and discrimination disparities	WRES questions in 2025 Staff Survey, BME staff experiencing harassment, bullying or abuse in the last 12 months remained static. There is small but positive improvement in the staff questions that inform WDES indicators.	Introduce measurable reduction targets
International Workforce	Ensure PDP coverage and support for internationally recruited staff	Established support from Practice Educator team and others New LMS (Totara) will improve access to data during roll out in 2026/27.	Maintain support and monitor PDP.
Data, Transparency & Monitoring	Integrate WRES, WDES and Pay Gap reporting	In progress	Develop and introduce integrated EDI dashboard.

			Develop 3-year action plans at care group levels.
	Improve data quality (particularly disability declaration) and establish in-year monitoring and performance tracking to inform targeted interventions.	Review of digital improvement opportunities across People work streams. Improved reporting into PCC	Continue targeted campaigns to improve completeness. Establish more frequent review cycle

Summary

The Trust has met its regulatory requirements to submit the latest WRES, WDES and Gender Pay Gap data, reflecting the position as at 31st March 2026, via the appropriate portals by the required deadlines. The formal WRES and WDES reports, alongside a refreshed and consolidated action plan, will be developed for review and approval by the Board later in 2026.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: 4.4.3

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Medical Appraisal and Revalidation Annual Report 2025-26
Prepared by:	Dr Georgina Page, Appraisal Lead John Ward, Head of Medical Staffing Rachel Ivamy, Appraisal and Revalidation Officer
Presented by:	Dr Peter Wilson, Chief Medical Officer and Responsible 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)	Not applicable
Purpose of paper:	Decision/Approval
Executive summary:	This paper presents the Medical Appraisal and Revalidation Annual Report for the period 1 April 2025 to 31 March 2026. The report provides assurance that the Trust has appropriate systems and processes in place to support medical appraisal, revalidation, and clinical governance in line with statutory requirements. Positive progress has been made with regard to policy ratification, oversight of medical appraisal and revalidation from a governance perspective and developing relationships and collaborating with system partners in the context of approach to Appraisal and Revalidation of Doctors. There is also recognition that there are ongoing workforce related challenges, particularly with regard to insufficient appraiser capacity, which continue to impact appraisal timeliness. A clear plan is in place to seek to address these issues during 2026/27. The Board is asked to take assurance that the Trust remains compliant with the Medical Profession (Responsible Officers) Regulations, approve the report, and complete the Statement of Compliance (page 23 of the main report).

ALERT:	• Insufficient appraiser capacity remains of significant challenge, with current numbers not meeting organisational demand. There are plans underway to consider introducing a panel approach to appraisals for Locally Employed Doctors (LEDs), which will reduce the overall need for appraisers on a 1:1 basis and continued focus on attracting more appraisers at Consultant and Speciality, Associate, & Specialist (SAS) doctors. • Data limitations: inability to report median duration of HR cases, due to current system/process capability highlights system/reporting gaps. More broadly, consideration is being given to the appetite to procure a bespoke HR Case Management system, which will support addressing the risk around not currently holding the required data.
ASSURE:	• The Responsible Officer is in place. • The Appraisal and Revalidation Policy is approved and current (ratified May 2026). • Robust governance processes are established, including oversight via the Responsible Officer Advisory Group. • All GMC revalidation recommendations were submitted on time for the reporting period. • Clinical governance systems effectively manage performance, concerns, and professional standards. • Effective employment checks, EDI safeguards, and fair processes are in place.
ADVISE:	• Development of a panel appraisal model for locally employed doctors is underway. • A Dorset-wide appraiser development programme is in progress. • Work remains ongoing to finalise appraiser assurance framework. • Engagement in regional and national appraisal/revalidation networks continues.
Celebrating Outstanding:	• Successful policy ratification and governance processes strengthened.
RECOMMENDATION:	The Board is asked to: • Approve the Medical Appraisal and Revalidation Annual Report 2025/26 • Approve the Statement of Compliance declaration (page 23)
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☒

	Public Consultation	☐
	Quality	☐
	Regulatory	☒
	Strategy/Transformation	☐
	System	☐
CQC Assessment Framework:	Safe	☐
	Effective	☒
	Caring	☐
	Responsive	☐
	Well-Led	☒
	Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Quality committee	07/07/2026	Agreed to recommend to Board to approve.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The Board of: University Hospitals Dorset NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	N/a
Comments:	Dr Peter Wilson, Chief Medical Officer is formally appointed to the Responsible Officer role.
Action for next year:	N/a

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Challenges remain regarding the number of appraisers, and as such the requirement for additional appraisers remains an absolute need and priority.
Comments:	Appraiser numbers remain challenged. The process for the resident doctors, with a view to cover the appraisal via a panel process, is under review. This should help with demand on appraisers and appraisees from an efficiency perspective. Also need to highlight to Care Groups where more support is needed.
Action for next year:	Work with Locally Employed Doctor (LED) leads to develop a panel review process. Report appraiser numbers to Care Groups.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	Undertake periodic spot-checks to ensure the prescribed connections remain accurate.
Comments:	Spot checks have been completed which has identified some discrepancies, which have been addressed.
Action for next year:	Continue periodic spot-checks

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Review the Appraisal and Revalidation Policy, negotiate with the LNC and seek ratification through the Trust's Governance structure.

Comments:	Policy agreed with LNC and ratified by the People and Culture Committee (PCC) in May 2026, with a review date of May 2029.
Action for next year:	N/a

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	No
Action from last year:	Continue to work with peer organisation on an ongoing basis and share learning.
Comments:	There has been no formal peer review since HLRO visit in 2024. Work is underway with other Dorset Trusts (Dorset County Hospital Foundation Trust, DCH and Dorset Healthcare University Foundation Trust, DHUFT) to provide a support and development programme for appraisers. Also working collaboratively with LED panel appraisal process.
Action for next year:	Continue to develop relationships with other Dorset Trusts, to support and develop the appraisal process.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last	To continue to ensure there is assurance around the

year:	prescribed connections and appropriate support is provided to doctors working under such circumstances.
Comments:	Developed communication streams with the Temporary Staffing team to enable monitoring of short-term/locum doctors.
Action for next year	To continue the collaborative working with Temporary Staffing and ensure engagement of applicable key stakeholders.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	To continue to work to a position of working proactively to ensure appropriate action is taken before the appraisal activity is due.
Comments:	Doctors' appraisal continues to be monitored through the monthly Responsible Officer Advisory Group (RAOG).
Action for next year:	Continue monitoring through ROAG and proactive working to ensure appraisals are completed in a timely manner.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	To focus on taking appropriate steps earlier in the process, as opposed to potentially up to 6 months after the appraisal being due.
Comments:	Introduction of the appropriate escalation process and monitoring through ROAG to continue.
Action for next year:	Continue to work proactively to reduce delayed appraisals. Ensure appropriate communication regarding appraisal requirements with appraisees.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	To agree and formally ratify Appraisal and Revalidation Policy by March 2026.
Comments:	Policy agreed with LNC and ratified in May 2026 with a review date of May 2029.
Action for next year:	N/a

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	No

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action from last year:	Continue review of current appraisers with Senior Medical Leadership working with the Appraisal Team to change the culture issues surrounding appraisal. Additionally, articulate the positives of being an appraiser, promote the role and recruit widely from the medical workforce future appraisers. Ensure appraisers are treated fairly, trusted, valued and recompensed appropriately.
Comments:	Following the Trust job-planning review process the number of appraisers has remained broadly static, whilst we have seen some new interest, with training facilitated periodically. Unfortunately, despite significant work to increase appraiser numbers of current levels do not meet the requirements. The most significant requirement for additional appraisers falls within one of the Trusts Care Groups (Medical). The challenge with recruitment is offset by the need to ensure appropriate numbers of Supervisors are maintained within the limitations of the PAs available.
Action for next year:	Review levels of appraisers within Care Groups to understand the need for additional appraisers, to feature as part of service level Job planning.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Continue review of Appraiser Training and ensure adequate training is continually provided to all appraisers on a formal schedule, regularly and as well as on a as needed basis. Suggestion to include involvement of the RO, Deputy Chief Medical Officer and Medical Directors in this to help assist with the current cultural issues.

Comments:	Dorset-wide appraiser support and development programme underway in collaboration with DCH and DHUFT. Appraiser assurance process under review.
Action for next year:	Finalise the appraiser assurance process. Continue Dorset-wide collaboration appraiser support and development process.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	N/a
Comments:	Forms part of the Trust constitution.
Action for next year:	N/a

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	N/A
Comments:	Standard process, no concerns
Action for next year:	N/a

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	To ensure all recommendations to the GMC are made in advance of the respective revalidation due dates.
Comments:	Standard practice to communicate appropriately with doctors.
Action for next year:	Develop revalidation review with timely communication to doctors regarding requirements ahead of revalidation.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	Continue with current practice and review as necessary.
Comments:	N/a
Action for next year:	N/a

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	Continue to review as and when new systems introduced.
Comments:	Appraisal input guidance notes have recently been reviewed and updated. Output guidance notes have also been developed.
Action for next year:	Continue to review and adjust guidance notes as needed.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	Continue to review as and when new systems introduced.
Comments:	Doctors are able to access the relevant information either on request or through IT systems in place.
Action for next year:	N/a

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes

Action from last year:	Continue to review as necessary.
Comments:	As part of the Trusts procedure for handling concerns regarding medical and dental employees, there is a professional advisor panel which would consider concerns regarding a practitioner's fitness to practice. The PAP panel includes the CMO (Chair), other senior clinicians from a broad range of specialties and HR input to ensure due consideration is given to the concern(s) being raised regarding the practitioner.
Action for next year:	N/a

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	Continue with current practice and review as necessary. This information should include consideration of any protected characteristics and a timeframe for conclusion of investigations.
Comments:	N/a
Action for next year:	N/a

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	To continue with the current established processes.
Comments:	The current established process remains in place.
Action for next year:	N/a

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes
Action from last year:	Continue to review where required.
Comments:	Forms part of established HR processes and procedures
Action for next year:	N/a

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	Continue to work closely with neighbouring Trusts on the continued development of appraisal and revalidation processes.
Comments:	The Appraisal and Revalidation Lead has attended the regional RO/appraisal updates.
Action for next year:	Ensure Trust representation at appropriate meetings.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	N/a
Comments:	There is a standardised appraisal framework that all medical staff are subject to, which is in line with the GMC Good Medical Practice principles. The Trust has a behaviour charter which outlines expectations for all staff to follow.
Action for next year:	N/a

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	N/a
Comments:	All NHS appointments are subject to rigorous employment checks in line with the NHS Employment Check standards.
Action for next year:	N/a

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	N/a
Comments:	There are various internal support mechanisms available, e.g. EDI, HR, Medical Staffing, FTSU, chaplain service, occupational health, line management, or Executive level colleagues, should support or escalation be required.
Action for next year:	N/a

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	N/a
Comments:	There are various internal support mechanisms available, e.g. EDI, HR, Medical Staffing, FTSU, chaplain service, occupational health, line management, or Executive level colleagues, should support or escalation be required.
Action for next year:	N/a

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	N/a
Comments:	Learning and Development, specifically EDI and the FTSU team actively monitor and support as appropriate. Additionally, there are training materials regarding the Trust values and behaviours charter. It is part of everyone's responsibility to work in line with these requirements.
Action for next year:	N/a

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaint procedure).

Y/N	Yes
Action from last year:	N/a
Comments:	There are multiple routes available to doctors both internally and externally to support this requirement.
Action for next year:	N/a

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	N/a
Comments:	The Trust monitors all MHPS / HR related demographics, which is reported through the Joint LNC.
Action for next year:	Continue to develop dashboard to ensure appropriate visibility of the data in an efficient manner.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	Continue to review processes and procedures as and when required.
Comments:	Network meetings attended by the appraisal/revalidation team. Collaboration with other Trusts has taken place as required.
Action for next year:	Continued to engage with network meetings and neighbouring Trusts.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	962
Total number of appraisals completed	788
Total number of appraisals approved missed	156
Total number of unapproved missed	5
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	102
Total number of late recommendations	0
Total number of positive recommendations	92
Total number of deferrals made	10

Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	16
Total number of trained case managers	8
Total number of concerns received by the Responsible Officer[2]	10
Total number of concerns processes completed	8
Longest duration of concerns process of those open on 31 March (working days)	12+ Months
Median duration of concerns processes closed (working days)[3]	The Trust does not hold data in this format
Total number of doctors excluded/suspended during the period	1
Total number of doctors referred to GMC	2
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	82
Total number of new employment checks completed before commencement of employment	82
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Actions identified in the previous reporting period have largely been progressed. This includes, the ratification of the Medial Appraisal and Revalidation Policy (May 2026), continuation of monitoring processes through the ROAG, and implementation of updated appraisal guidance. Spot checking of prescribed connections has been undertaken and discrepancies have been addressed. Collaborative working with Dorset system partners has developed, in relation to appraiser development and appraisal processes. Finally improved links with the temporary staffing team have supported oversight of locum doctors, and doctors engaged on short term agreements.
Actions still outstanding
Key actions which remain ongoing, include the following: increasing the number of trained appraisers, particularly within specific Care Groups (Medical), development of a panel appraisal process for locally employed doctors, and further development of peer review arrangements. Additionally, working to finalise the appraiser assurance process and enhance visibility of workforce demographic data via dashboards is also outstanding.
Current issues
The primary issue remains insufficient appraiser capacity, with current levels not meeting organisational requirements. This is compounded by workforce constraints linked to job planning and supervision requirements. The appraisal completion rates indicate 156 approved missed and 5 unapproved missed appraisals, reflecting ongoing pressure within the system – in part linking back to the insufficient appraiser capacity. With regard to the concerns regarding medical staff, a small number of concerns have been raised (10), with some processes extending beyond 12 months. The Trust does not currently hold median duration data for concerns processes, which links to the current systems and processes not being sufficient to record such details – this concern, is currently being considered as part of the wider People directorate, around considering the appetite for procuring a bespoke system to support with requirements.

Actions for next year (replicate list of ‘Actions for next year’ identified in Section 1):
• Develop and implement a panel appraisal process with Locally Employed Doctor leads • Report appraiser numbers to Care Groups and review appraiser capacity within job planning • Continue periodic spot-checks of prescribed connections • Continue collaboration with Dorset Trusts on appraisal development and peer support • Maintain and strengthen working arrangements with Temporary Staffing • Continue proactive monitoring and escalation of appraisal compliance via ROAG • Improve communication with doctors regarding appraisal and revalidation requirements • Finalise appraiser assurance processes and continue appraiser development programmes • Continue attendance at regional and network meetings • Ensure appropriate representation at relevant forums • Continue development of workforce demographic dashboards
Overall concluding comments (consider setting these out in the context of the organisation’s achievements, challenges and aspirations for the coming year):
The Trust remains compliant with required processes for appraisal, revalidation, and clinical governance, supported by established systems and governance structures. Positive progress has been made in policy development, system collaboration, and monitoring arrangements. Challenges persist in relation to appraiser capacity and timely appraisal delivery, with ongoing actions in place to address these pressures. The Trust will continue to focus on strengthening appraisal capacity, enhancing system collaboration, and improving process efficiency in the coming year.

Section 4 – Statement of Compliance

The Board have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Chief executive

Official name of the designated body:	University Hospitals Dorset NHS Foundation Trust

Name:	Siobhan Harrington
Role:	CEO
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: 4.4.3

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	**Annual Security Report 2025-2026**
Prepared by:	Stuart Willes – Head of Operations & Facilities, Stacey Fuszard – Head of Security and Portering, Dave Bennett – ASMS. Mark Major – Deputy chief Operating Officer
Presented by:	Mark Mould - Chief Operating Officer
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☐
BAF/Corporate Risk Register: (if applicable)	**Security Risks - Key Open Risk (12 +)** **Risk 1873** Behaviour/Aggression towards staff, patients and visitors. Increased number of incidents seen throughout Trust and increased number of LERNs reported. Currently rated as 12 (Moderate) Linked Risk - **Risk 1502** Mental Health Care in a Physical Health environment (12 Moderate)
Purpose of paper:	Assurance
Executive summary:	This Annual Security Report looks at Trust security governance arrangements and incidents for the past year. It also reviews continuing efforts to keep staff and patients safe as well as securing Trust property and assets. **Governance Arrangements** Security governance is provided through the Security Management Group, chaired by the Deputy Chief Operating Officer and reporting quarterly to the Trust Health & Safety Committee. Mark Mould, Chief Operating Officer, is Board lead for Security Management, with Femi Macaulay as the Non-Executive Director providing local oversight. The Trust has two nationally Accredited Security Management Specialists, Dave Bennett and Stacey Fuszard, Head of Security and Portering.

	Further detail on actions taken, assurance and the 2026/27 workplan is set out in the Alert, Assure and Advise sections below, with full analysis provided in the attached Annual Security Briefing Paper. **Violence and Aggression Incident Volume and Severity: Year on Year Comparison** In 2025-26, there was an overall 12.69% (1514) decrease in the number of violence and aggression / security incidents recorded compared to 2024-25 (1734). Of the 1153 incidents where severity has been recorded, 57% are reported as no harm/near miss with minor severity being around 39%. Moderate harm reports averaging at 3.47% of all incidents, an increase from the previous year 2.72%. **Staff Survey** The national staff survey results on security related questions are summarised in the Assure section below, with full detail in the attached annual briefing report; these will inform the 2026/27 workplan. Further detail on actions taken, assurance and the 2026/27 workplan is set out in the Alert, Assure and Advise sections below, with full analysis provided in the attached Annual Security Briefing Paper.
ALERT:	**Data insights (Datix/LERNS)** • 991 violence and aggression incidents were recorded (402 physical, largely unchanged year on year; 571 non-physical, down from 664 but still significant). • Aggression towards staff by patients remains the largest single category at 47% of all incidents, concentrated in Emergency Departments, AMU and a small number of high acuity wards. • Underreporting remains a concern; workload pressures mean not all incidents are captured, which may mask the true scale of risk. • Restraint use is consistent with the previous year at 347 incidents, reflecting ongoing exposure to high-risk patient behaviours. • Staff survey results show continued exposure to violence and abuse from patients and the public, with a small increase in colleague-to-colleague issues. • Key organisational risks are set out in the BAF/Corporate Risk Register above and are reviewed regularly with defined action plans and controls in place.
ASSURE:	**Assuring data insights (Datix/LERN)**

- Overall incidents reduced by 12.69% (1514 from 1734), and verbal and threatening behaviour fell from 664 to 571, indicating improving management of lower-level aggression.
- Strong governance is in place through ASMS leadership, Security Management Group oversight, Violence Prevention and Reduction Group oversight, and Board level accountability with monthly reporting.
- Training compliance remains strong and above the 90% target: Security training 95.36%, Conflict Resolution 93.94%.
- Robust processes support staff: 75 warning letters issued, 30 Critical Patient Information alerts applied, and multi disciplinary review of all incidents.
- Active ward engagement and the new Restraint Rapid Review meetings have strengthened oversight and shared learning.
- VPR standards are embedded and supported by a RAG rated assurance framework, and strong multi agency working with Police and Counter Terrorism partners continues to enhance staff safety and preparedness.

ADVISE:

- **Trust Workplan 26/27**

Area	When
Undertake ward based risk assessments linked to high reporting areas.	Q2
Embed proactive protective security approach across UHD	Q3
Increase communication and visibility of security reporting and response across sites (Pro-security)	Q2
Terrorism (protection of Premises) Act 2025 implications for enhanced tier site ensuring UHD is ready for April 2027	Q4
Finalise the VPR standards ensuring Trust meets requirements monitored through the VPR Group	Q2
Ensure security systems are operational (PAC, CCTV, Deister)	Q4
Reviews of relevant policies ensuring compliance is maintained and any learning considered and introduced	Q3
Continue partnership arrangements with police seeking to increase prosecutions of those who assault staff	Q1
Reflect on the staff survey results including the free text comments and the quarterly Pulse surveys to agree priority areas of focus	Q4
Review of associated security and violence and aggression risks seeking to reduce current risk levels	In progress
Focus on maintaining training compliance across CRT and Security related subjects	Q3

Celebrating Outstanding:	A fully recruited UHD security team deployed across the Trust to support NHS staff when dealing with violence and aggression, or security related incidents. Also providing and consistent, visibly reassuring and welcoming presence to all visitors and staff to site.
RECOMMENDATION:	Trust Board is asked to note the content of this paper and the individual areas of alert, advise and assurance and the workplan for 2026/27.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☐ Operational Performance ☒ People (inc Staff, Patients) ☒ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☐
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
• Security Management Group	17/04/2026	Report to be shared with Health and Safety Group
• Health and Safety Group	22/04/2026	Report shared to include staff Survey results, governance update, work plan updates
• People & Culture Committee	06/07/2026	Noted the contents of the paper.
• Trust Board	15/07/2026	

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 Security Briefing Paper: (Data April 2025 to March 2026)

1. Background

This annual security report looks at security governance arrangements and incidents for the past year. This report also provides details of violence and aggression related incidents (VPR). It also reviews continuing efforts to keep staff and patients safe as well as securing Trust property and assets. The report has been prepared using data collated from the Datix Web reporting system. An annual Security Report is a requirement under Service Condition 24 of the NHS Standard Contract.

The standards require a structure in place for the effective management of the security agenda, to meet this requirement the Trust have in place the following structure:

Security Management Group (SMG) meets Bi-monthly under the Chairmanship of the Deputy Chief Operating Officer and provides reports to the Trust Health & Safety Committee Chaired by the Chief people Officer.

Board lead for Security Management Matters, this post is carried out by Chief Operating Officer. A Non-Executive Director to oversee the local Security arrangements, this post is carried out by Non-Executive Director.

Accredited Security Management Specialist, the Trust currently has two nationally accredited Local Security Management Specialists.

Monthly summary of Trust wide violence and aggression and security related incidents, highlighting trends and themes across the care groups. This is shared across the care groups and senior leadership teams raising awareness including any sanctions issued.

Accredited Security Management Specialists (ASMS) Activity – operational delivery

ASMS have led and supported a wide range of operational activity throughout the year, ensuring security considerations were embedded within both business-as-usual and transformational programmes. This included direct involvement in major service changes such as the department moves and Phase 3 transformation workshops, alongside targeted security reviews across key areas including OPD, COAST, Tringham House and supporting the Care Coordination Hub.

ASMS and security played a role in responding to evolving risks, undertaking specific risk assessments, managing on-going access control (PAC) challenges, reviewing CCTV provision, location and camera masking following CQC feedback. Supporting investigations into incidents such as contractor cable thefts and bike-related crime and responding to Police requests. Operational preparedness was further strengthened through participation in exercises including a nuclear medicine scenario and decontamination testing, as well as planning for industrial action and supporting lockdown reviews in collaboration with UHD EPRR colleague.

In addition to operational delivery, ASMS have maintained a strong strategic and partnership focus, representing the Trust at national, regional and local forums. This included active participation in National Performance Advisory Group (NPAG), ASMS regional meetings and collaboration with Dorset County Hospital (DCH) ASMS to share best practice and align approaches, particularly in preparation for PropCo developments. Engagement with policing partners has taken place, including Action Counters Terrorism (ACT) awareness training, planning in response to animal rights protests (Stericycle) and broader counter-terrorism activity such as Martyn's Law sessions, Self-Initiated Terrorist (SIT) awareness and threat and vulnerability risk assessments.

Further detail regarding Martyn's law is shown at Appendix 3.

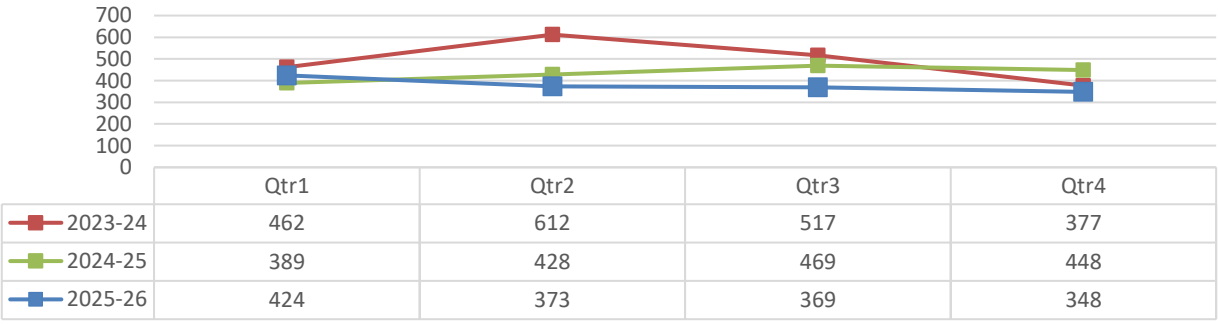
ASMS have also contributed to organisational development through Duty Manager training, Conflict Resolution Training (CRT) scoping with the training department, IOSH linked learning, ETOC support and submission of proposals to the Mandatory Learning Oversight Group (MLOG). This has been complemented by wider engagement with NHSE webinars, communications planning for 2026 and on-going management of information requests, ensuring the service remains aligned to national expectations and continues to strengthen its assurance and governance position.

2. Incident reporting data review

Trend Comparison

Incident reporting remains key to maintenance of a pro-security culture and safe environment for staff and patients. Table 1 below shows the annual comparison trend and compares the overall incidents recorded during 2025-26 (1514) and there was an 12.69% decrease on the previous reporting period (1734 incidents).

Table 1



	Qtr1	Qtr2	Qtr3	Qtr4
2023-24	462	612	517	377
2024-25	389	428	469	448
2025-26	424	373	369	348

Table 2 below shows a monthly comparison in the number of reports received. On review of the data, Bournemouth Hospital recorded 53.24% (806) incidents and Poole Hospital a further 44.39% (672) incidents. The remaining 2.38% (36) incidents were recorded at other site locations including Christchurch Hospital (12 incidents). A review of all categories shows that Inappropriate/Aggressive Behaviour towards Staff by a Patient accounted for 47.23% (715) of the overall total, which was a decrease on the previous year (755).

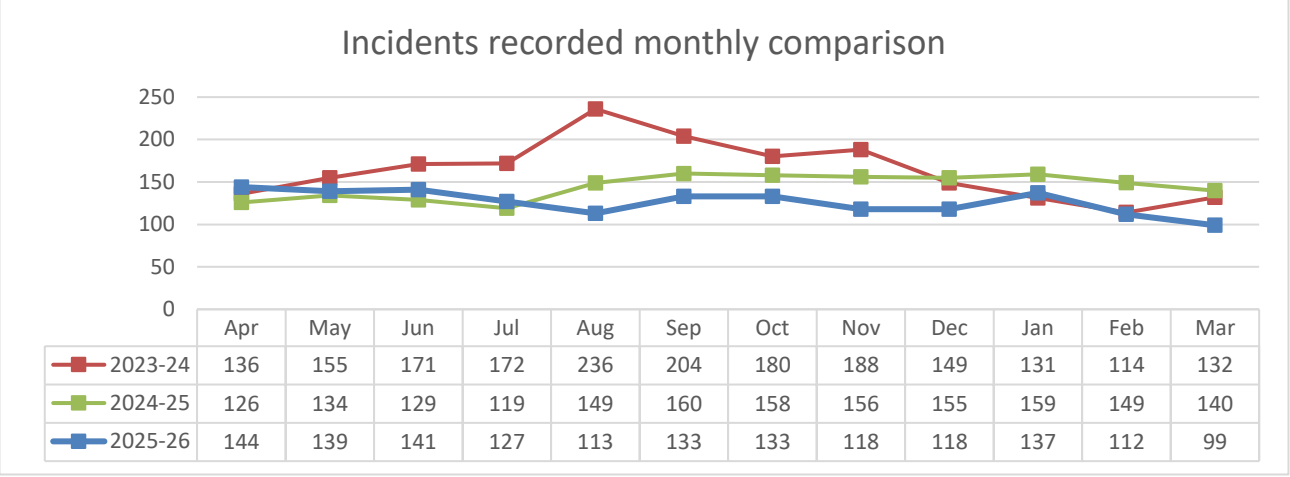
A further review of the 715 incidents shows that;

- 13.15% (94) incidents were reported within Emergency Department (PH)
- 11.89% (85) incidents within Emergency department (RBH).

The following areas were also listed within the top 10 or reporting areas.

- A26L (General Medicine) (47)
- A9L (Ward 5) (39)
- Stroke Unit RBH (32)
- AMU Poole (31)
- AMU (RBH) & C25R (Ward 22) each recorded 22
- A29R (OPS) (16)
- A3 RACE, Durlston, A5 Avonbourne Ward and Kimmeridge Ward each reported 13 incidents.

Table 2



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023-24	136	155	171	172	236	204	180	188	149	131	114	132
2024-25	126	134	129	119	149	160	158	156	155	159	149	140
2025-26	144	139	141	127	113	133	133	118	118	137	112	99

When reviewing the recorded incidents across the care groups, 25.96% (393) were recorded from OPS (Older People's Services) and Acute Care, Emergency and Urgent Care Directorate recorded 20.28% (307) and a further 16.91% (256) were recorded from Specialist Medicine.

A full breakdown by care group is provided at Appendix 1. Further analysis of the 393 incidents recorded within the OPS and Acute Care group showed that 52.67% (207) where reported as "Inappropriate/Aggressive Behaviour towards Staff by a Patient" with "A9L (Ward 5)" recording 39 incidents within this category and "AMU Poole" a further 31 incidents. A breakdown of incidents is seen within Appendix 2.

Action taken
Direct engagement with wards providing advice and support when dealing with the challenging patients or visitors has helped reassure reporting areas. Taking positive action and providing relevant guidance has empowered staff to deal with situations. Where this has not been possible, initial support from the Security and placement of additional agency security officers has helped manage those more challenging patients. Warning and sanction letters are issued to help remind or adjust behaviours of patients and visitors towards NHS staff. Critical Patient Information (CPI) markers can also be placed onto a patient record that provides NHS staff with a warning on presentation.

There is no national audit of reported violence and aggression to allow for direct comparison between Trusts although the NHS staff survey may provide an indication. Reported incidents have once again shown a decrease from the previous year, it is not possible to state if this is due to a reduction in episodes or an acceptance of the violence and aggression and not reporting. VPR Group is undertaking spot audits to establish whether the increase in reported incidents is attributable to enhanced reporting from the publicity campaign, suggesting a more positive reporting culture rather than a material increase in incidents. ASMS are aware through engagement that areas are not reporting every episode and this may, in part, be down to workloads.

Reported Violence and Aggression

Of the reported 1514 incidents reported during this period, 991 were attributed to physical or non-physical violence a reduction on the previous year (1093). Table 3 shows the 973 incidents recorded across the two main hospital sites. Of these 41.32% (402) where recorded as physical contact and 58.68% (571) were verbal, sexual or threatening behaviour. When comparing the previous year, recorded physical attacks remained relatively unchanged from 408 to 402 incidents. Verbal abuse,

sexual or threatening behaviour related incidents reduced from 664 to 571, representing a decrease of 93 incidents.

When reviewing the 402 physical contact incidents, 9.45% (38) were reported from A9L (Ward 5), A26L (General Medicine) recorded 7.71% (31) incidents and Emergency Department (PH) and AMU Poole each recorded a further 5.97% (24) incidents.

A further 8 incidents of physical (2) and non-physical (6) violence were recorded at Christchurch hospital. The remaining 10 incidents of physical and non-physical were recorded at other Trust locations.

Table 3

	RBH	PH	Total
Behaviour	**116**	**82**	**198**
Physical	27	19	46
Physical contact (actual assault)	28	19	47
Physical threat (no contact)	11	6	17
Sexual (including indecent exposure)	2	3	5
Stubborn/uncooperative physical Behaviour	18	14	32
Stubborn/uncooperative verbal Behaviour	7	4	11
Verbal	21	16	37
Verbal with disability content	1		1
Verbal with racial content	1	1	2
Behaviour (Including Violence and Aggression)	**420**	**355**	**775**
Physical contact (actual assault)	173	136	309
Physical threat (no contact)	54	36	90
Sexual (including harassment and indecent exposure)	17	25	42
Verbal Abuse	137	129	266
Verbal abuse with disability content	1	1	2
Verbal abuse with gender content	3	5	8
Verbal abuse with racial content	35	23	58
Grand Total	**536**	**437**	**973**

Heat map summary

When reviewing the incidents and where time has been recorded, the following heat maps illustrate the frequency of recorded incidents against the day of week and time of day. Of all the incidents recorded, there were 232 where no time was recorded. Table 4 below shows this data across all sites and Tuesday and Wednesday's most incidents were recorded.

Table 4

	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00
Mon	7	5	4	8	5	5	4	5	7	7	10	11	11	5	14	9	5	7	12	9	14	10	6	8
Tue	3	5	5	4	4	6	10	7	16	13	15	15	11	10	13	9	12	11	14	11	12	11	13	7
Wed	6	6	8	2	6	4	8	3	8	11	13	15	11	5	10	7	13	16	13	7	4	10	11	4
Thu	4	4	7	2	3	3	1	6	4	9	18	10	10	10	8	8	8	13	12	7	6	3	7	10
Fri	6	8	3	11	5	4	3	3	5	13	6	14	10	8	12	10	12	9	7	9	7	5	5	7
Sat	4	2	5	5	5		7	7	9	7	12	7	3	11	11	7	5	8	8	7	4	14	6	2
Sun	6	2	4	2	1	3	3	2	8	8	5	8	7	10	10	9	6	5	6	14	3	8	6	9

Table 5 below shows the heat map for the Bournemouth hospital site. Here you can see most of the incidents were recorded Wednesday around 1100hrs.

Table 5

	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00
Mon	4	3	3	5	4	5	2		2	3	4	6	4	2	5	5	4	3	7	3	7	7	5	5
Tue	1	5	2	4	3	4	5	3	7	8	9	4	3	6	8	3	5	5	5	8	7	2	8	4
Wed	4	5	5	1	5	2	6		4	3	6	11	7	2	6	6	7	8	8	7	2	6	4	4
Thu	1	2	2	1	3	3		4	4	3	9	3	4	3	6	5	4	5	5	2	3	2	4	9
Fri	2	6	1	8	2	2	2	1	3	7	4	5	3	4	4	6	5	3	5	6	2	3	3	6
Sat	4	2	3	4	4		5	1	3	3	8	6		7	6	3	2	5	3	5	3	6	3	2
Sun	2	1	2	2	1	3	3	1	5	5	3	4	7	9	5	6	4	1	6	2	1	4	2	6

Table 6 below shows the heat map for the Poole hospital site. Here you can see most of the incidents were recorded on Tuesday with increases at 0800, 1100, 1800 and 2100hrs.

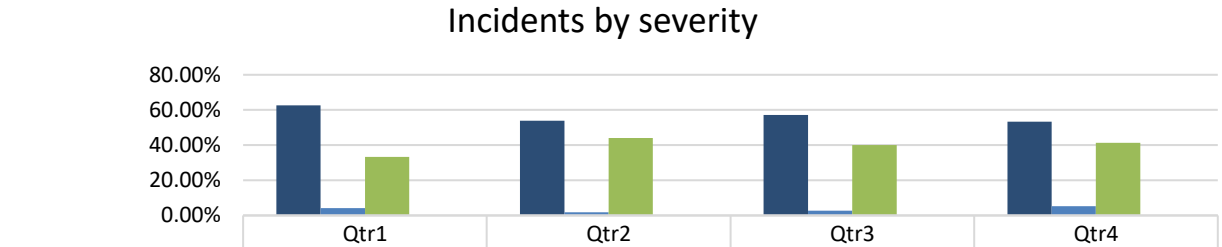
Table 6

	00:00	01:00	02:00	03:00	04:00	05:00	06:00	07:00	08:00	09:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00	22:00	23:00
Mon	3	2	1	3	1		2	5	5	4	5	3	7	3	9	4	1	4	5	6	7	3	1	2
Tue	2		3		1	2	5	4	9	5	6	9	7	4	5	6	5	5	9	3	5	9	5	3
Wed	2	1	3	1	1	2	2	3	4	8	6	4	4	3	4	1	6	8	4		2	4	7	
Thu	3	2	5	1			1	2		5	9	6	4	7	1	3	4	8	6	4	3	1	3	1
Fri	4	2	2	3	3	2	1	2	2	4	1	8	7	3	8	3	6	6	2	3	5	2	2	1
Sat			2	1	1		2	6	6	4	4	1	3	3	5	4	3	3	5	2	1	7	3	
Sun	4	1	2					1	3	3	2	4		1	4	2	2	3		12	2	4	4	3

3. Security Related Incidents (Behavioural) – Severity

Table 7 below shows a comparison by severity of the behaviour incidents recorded during this period. When comparing against the previous reporting period (2024-25) there was an increase in incidents recorded as minor and a decrease in moderate harm incidents. There was 1 incident reported as Death which relates to an unknown female located just off site by NHS staff. No Harm / Near Miss accounted for 56.98% (657) of all incidents reported, Minor 39.46% (455) and Moderate 3.47% (40). 361 incidents had no severity recorded at time of review.

Table 7



	Qtr1	Qtr2	Qtr3	Qtr4
No Harm / Near Miss	62.66%	53.85%	57.19%	53.38%
Moderate	4.11%	1.75%	2.81%	5.26%
Minor	33.23%	44.06%	40.00%	41.35%
Death	0.00%	0.35%	0.00%	0.00%

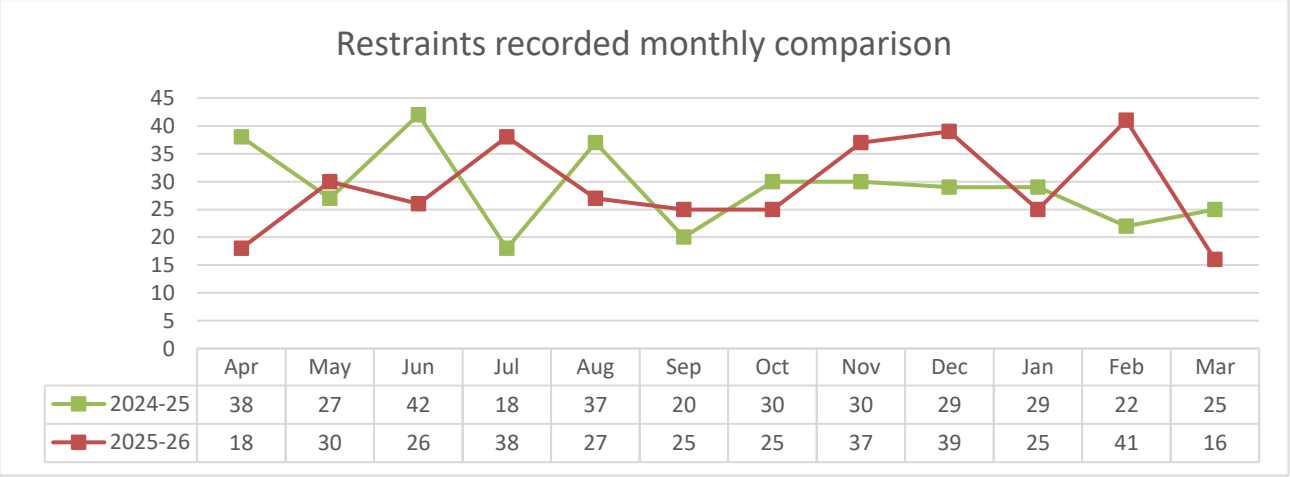
Restraint

There was a total of 347 incidents across UHD where a restraint was recorded as being applied which is the same as the previous year (347). Table 8 below indicates the monthly comparison. When reviewing the restraint data, Emergency Department (PH) recorded 24.21% (84), Emergency Department (BEACH) recorded 16.14% (56), AMU Poole recorded 8.93% (31) and AMU (RBH) recorded a further 3.75% (13) episodes.

The legal framework provides the reason for restraint and the following frameworks were used for the highest recorded areas, MCA (Mental Capacity Act) 49.86% (173), Common Law 22.48% (78) and Common Law, MCA (Mental Capacity Act) 12.68% (44). MHA (Mental Health Act) reported 10.66% (37) episodes.

During this reporting period, fortnightly Restraint Rapid Review meetings were introduced. These meetings review all reported restraints and share key learning outcomes. The meetings are supported by ASMS due to the direct involvement of the security and portering teams in restraint incidents.

Table 8



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024-25	38	27	42	18	37	20	30	30	29	29	22	25
2025-26	18	30	26	38	27	25	25	37	39	25	41	16

4. Warnings Issued & Multi-Disciplinary Team Meetings

75 warning letters were issued by the ASMS over the report period indicated in table 9 below. A total of 4 Acceptable Behaviour Agreement (ABA) letters were issued to patients who were challenging towards staff and subject to multiple incident reports being generated. A total of 30 Critical Patient Information (CPI) flags were added to patient records alerting staff to a potential issue around violence and aggression.

Table 9

Warnings Issus	Q1	Q2	Q3	Q4	Total
First Warning Letter	19	20	20	16	**75**
Acceptable Behaviour Agreement		1	2	1	**4**
Final warning letter					**0**
Critical Patient Information (Warning)	9	8	8	5	**30**

Warnings are issued in line with the Violence Prevention & Reduction Policy (VPR) (formerly Violence & Aggression Policy) which was also reviewed and updated during this period.

The process for issuing warning letters has been reviewed in the last year to strengthen assurance and consistency when addressing incidents of aggression or violence against NHS staff. Oversight of this process now sits with the Accredited Security Management Specialists (ASMS), who maintain a central database of all issued warnings and associated dates. Prior to issuing any warning letter, appropriate checks and verification of details are undertaken.

Issuing warning letters can contribute to a reduction in violence and aggression by clearly reinforcing that such behaviours will not be tolerated within UHD. These letters make individuals aware that inappropriate actions may result in escalation to police action and/or the withdrawal of care, where appropriate.

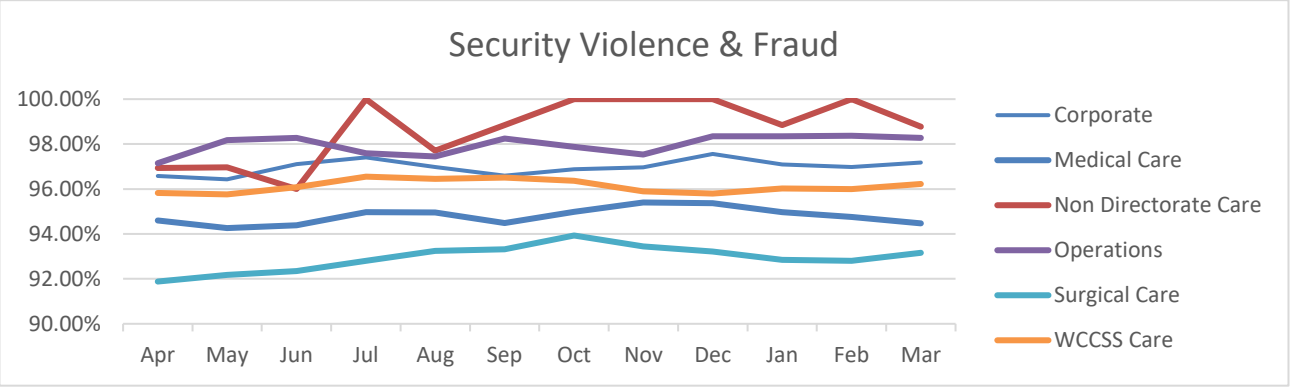
5. Training

Training compliance (Target is 90%)

Security

Trust compliance over the year remained above the target (90%) ending on 95.36% compliance. Table 10 below provides an illustration of the compliance across the Trust groups. All groups are above the required training compliance. Non Directorate Care Group (Research colleagues) also achieved 100% compliance 5 times during this period which is a great achievement

Table 10

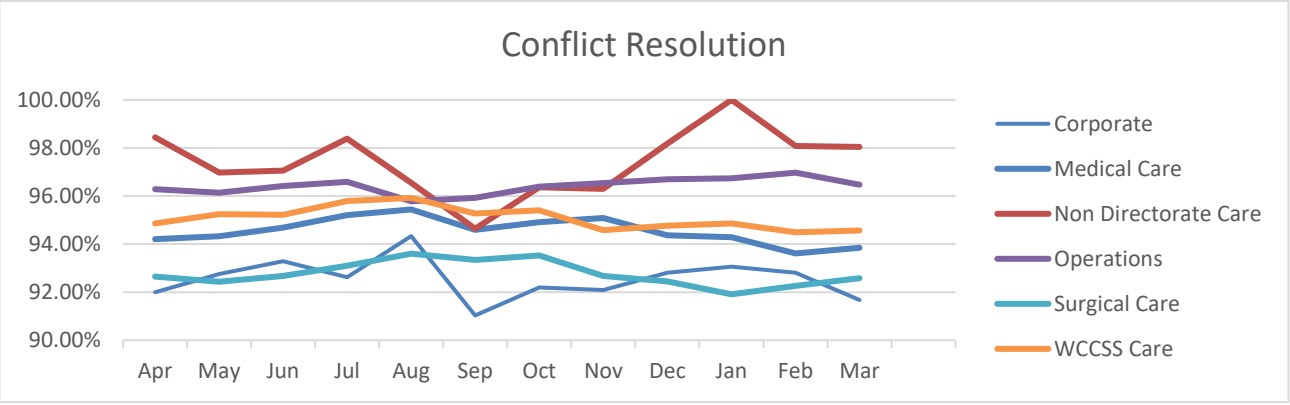


Conflict Resolution

Overall as a Trust, there was good compliance over the year ending on 93.94%. Corporate shows the lowest overall across the reporting period but remined above the required compliance (90%). Corporate also showed a drop in compliance during September but demonstrated a steady improvement towards the end of 2025. Non Directorate Care Group also achieved 100% in January 2026 which is an achievement. Table 11 below provides an illustration across the Trust groups.

The ASMS has attended face-to-face conflict resolution training sessions and will continue to support this training offering examples and direct support to attendees.

Table 11



Preventative Management of Violence & Aggression (PMVA) Training

Security, Portering and Clinical Site teams have continued to undertake both initial and refresher training in PMVA, ensuring compliance with recognised national standards set by the British Institute of Learning Disabilities (BILD) and the Restraint Reduction Network (RRN). This training equips those staff with the skills to respond safely, proportionately and lawfully when managing challenging behaviour, including the use of restraint where clinically justified. A structured and on-going training programme is in place for 2026/27 to maintain compliance, ensuring that all staff required to undertake restraint remain appropriately trained, competent and aligned to best practice.

6. Violence Prevention and Reduction Standards (VPR)

The Trust remains committed to the Social Partnership Forum (SPF) priority of reducing violence and aggression across the NHS, working collaboratively with partner organisations to share learning, solutions and best practice. This commitment aligns with the Violence Prevention and Reduction (VPR) standards, ensuring they are embedded and sustained across the organisation.

Regular VPR meetings provide structured oversight of progress, supporting continuous improvement and offering assurance that actions are being delivered. In the absence of a national audit framework, the Trust continues to rely on robust local governance arrangements, with oversight provided through the Violence Prevention and Reduction Group.

Revised VPR standards introduced in December 2024 set out seven key domains (Leadership and Accountability, Governance and Assurance, Collaboration, Data, Workforce, Interventions, and Evaluation) and are supported by a Red, Amber, Green (RAG) self-assessment framework. Current assessments indicate overall compliance, with several areas rated Green, while recognising opportunities for further improvement. Work to embed and strengthen these standards will continue throughout the coming year, ensuring sustained compliance and on-going monitoring.

7. Security Risks

Security risks are managed in accordance with the Trust Risk and Governance Policy and entered on to the Datix system where they can be regularly reviewed in addition a system generated electronic alert, with actions applied and tracked through this process. This supports thematic analysis and management of associated risks.

Risk 1873 Behaviour/Aggression towards staff, patients and visitors. Increased number of incidents seen throughout Trust and increased number of LERNs reported. Currently rated as 12 (Moderate)

Risk 1801 Violence and Aggression on AMU Increased number of Violence and Aggression seen on AMU affecting staff and patients. 8 (Moderate)

Risk 2040 Increase mental health/violence & aggression issues for trauma patients 8 (Moderate)

Risk 1767 Loss of service delivery from Portering Department. This risk reflects the impact of Porters delivering core business in support of the Trust when responding to a call for security response. Currently rated as 8 (Moderate)

Risk 2257 RBH main building entry/egress door security and access control 6 (Low)

Risk 2311 Non-compliance with NHS agency standards for external agency security staff 6 (Low)

8. High Risk Area assessments

During 2025/26, ward risk assessments were prioritised and completed across the highest reporting areas, focusing on those wards identified through incident reporting, risk trends, and operational concerns. This targeted approach is intended to ensure that areas with the greatest identified risk receive timely review and mitigation. In addition, wards outside of this primary scope have also been asked to complete risk assessments to provide wider assurance, support consistency across services, and identify any emerging risks that may require further action. Progress of these assessments are provided at the Violence Prevention and Reduction group.

9. Staff Survey Results 2025

The Trust's national staff survey report includes results on security related questions that will help inform the work plan for 2026/27. A summary of the key questions is listed below.

Q13a and Q14a specifically highlight issues from patients or visitors towards UHD staff and comparing the previous year there has been small changes in both. UHD is below the national average apart from 2 questions, which should be seen as positive coupled with the reduction in overall reported incidents.

Q13a In the last 12 months how many times have you personally experienced physical violence at work from...? Patients / service users, their relatives or other members of the public.

UHD increased from 13.33% (2024) to 13.42% (average result during 2025 14.65%)

Q13b In the last 12 months how many times have you personally experienced physical violence at work from...? Managers.

UHD decreased from 0.61% (2024) to 0.53% (average result during 2025 was 0.76%)

Q13c In the last 12 months how many times have you personally experienced physical violence at work from...? Other colleagues.

UHD increased from 1.46% (2024) to 1.56% (average result during 2025 was 1.8%)

Q14a In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Patients / service users, their relatives or other members of the public.

UHD decreased from 22.72% (2024) to 22.35% (average result during 2025 was 24.59%)

Q14b In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Managers.

UHD increased from 7.71% (2024) to 7.81% (average result during 2025 was 9.2%)

Q14c In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...? Other colleagues.

UHD decreased from 16.43% (2024) to 16.37% (average result during 2025 was 17.86%)

Q17a In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From patients / service users, their relatives or other members of the public

UHD increased from 9.6% (2024) to 9.7% (average result during 2025 was 8.07%)

Q17b In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From staff / colleagues

UHD increased from 3.62% (2024) to 3.81% (average result during 2025 was 3.39%)

10. Key Security initiatives taken during 2025/26

Workforce Development and Training

Significant progress has been made in strengthening workforce capability through the delivery of targeted Security and Violence & Aggression training across multiple staff groups, including induction cohorts, Enhanced Therapeutic Observation Care (ETOC) teams and new Duty Managers group. This has been complemented by engagement with national NHS forums to ensure alignment with emerging best practice. Training delivery has evolved beyond compliance, focusing on practical application, role-specific risks and improving staff confidence in managing challenging situations. In collaboration with Education and Training department, a review of Conflict Resolution Training (level 1) was undertaken in preparation for the new framework and changes anticipated during 2026.

Counter Terrorism and Protective Security

During the year, there has been a marked shift towards proactive protective security, with direct engagement with Counter Terrorism Policing to enhance understanding of emerging threats such as Self-Initiated Terrorists (SIT) and hostile reconnaissance. This has informed a review of publicly available Trust information and estate visibility. Preparatory work aligned to the Terrorism (Protection of Premises) Act 2025 has commenced, positioning the Trust to meet forthcoming legislative requirements.

Security Infrastructure and Systems

Access control and CCTV systems have remained a key operational focus, with on-going challenges relating to system stability, integration and performance across sites. Targeted work with Estates team and external providers has resulted in incremental improvements, alongside a review of system architecture, including the ongoing consolidation of the access control (PAC) platforms. CQC feedback has further driven improvements in CCTV governance and deployment.

Governance, Assurance and Continuous Improvement

Governance arrangements have strengthened through structured review processes, including attendance and engagement at After Action Reviews and the new Restraint Rapid Review Group.

These forums provide a mechanism for multi-disciplinary learning, ensuring that incidents are fully understood and that improvements are identified and embedded. External scrutiny, including CQC activity, has supported continuous improvement and enhanced assurance.

Communication and Staff Engagement

A more proactive and accessible approach to communication has been established, including the introduction of Security and Violence & Aggression FAQs on the Trust intranet and articles within the Brief and Staff Bulletin. This supports staff to self-manage common issues and improves awareness of available support. A broader communications programme has also been developed to promote key security messages, including awareness around Terrorism (Protection of Premises) Act, lone working and general staff safety awareness.

Operational Learning and Preparedness

Operational readiness has been enhanced through both live incident learning and structured exercises, including major incident and decontamination training. Learning from real incidents and After Action Reviews (AAR) has informed improvements in processes and response. This approach ensures that the organisation remains adaptable and responsive to both routine and high-impact incidents.

Partnership Working and System Collaboration

Collaboration has continued to develop across internal and external partners, including neighbouring Trusts, Estates, Communications, ASMS, Police and Counter Terrorism networks. This has enabled the sharing of best practice, improved coordination in managing high-risk situations and supported a more joined-up approach to security management.

Strategic Development and Policy Alignment

The ASMS has contributed to a number of strategic initiatives, including proposals to the Mandatory Learning Oversight Group (MLOG) to strengthen the focus on Security and Violence training. Engagement with Trust-wide groups, including the Violence Prevention and Reduction Group, Restraint Rapid Review, Mental Health Steering group and staff survey workstreams, has ensured that security priorities are aligned with broader organisational objectives.

Risk Management and Site-Specific Challenges

A number of recurring risks have been actively managed throughout the year, including access control reliability, lone working arrangements and security oversight at standalone sites. Targeted interventions and engagement with wards and departments have improved oversight and accountability. Additional reassurance activity has also been provided during specific Trust events, ensuring a visible and supportive security presence where required.

Proactive Risk Assessments

Several proactive security risk assessments were completed by the ASMS demonstrating a continued commitment to identifying and managing potential security risks at an early stage. These assessments have informed clear recommendations to improve safety, resilience, and compliance. While several mitigations have already been progressed, a small number are dependent on the allocation of additional departmental funding before works can advance.

UHD Security service

The UHD Security Service has maintained a strong and resilient presence throughout the year, now operating at full establishment with a dedicated team of 20 NHS colleagues. This stability has enabled the team to consistently deliver a professional, responsive, and visible service across 3 main sites. Through proactive patrols, effective incident management, and close collaboration with clinical and operational teams, the service continues to play a vital role in promoting a safe, secure, and welcoming environment for patients, staff, and visitors alike.

Security, Violence and Aggression Documentation Review

The following documentation has been reviewed and is available on the UHD intranet policy page under Security.

- Security Management Policy
- Violence Prevention & Reduction Strategy
- Violence Prevention & Reduction Policy
- Lone Worker Policy
- Missing Person Procedure
- CCTV Policy

11. ASMS Workplan 2024/25

The annual workplan outlines agreed work to be undertaken during the year to improve compliance and change for the better. Whilst all areas have been completed, certain aspects will roll over and be ongoing based on need. Focus in the coming year will be supporting assurance when considering the Terrorism (Protection of Premises) Act 2025 which should be legally required around April 2027 following a minimum of 24 month period for implementation.

Area	When	Status
Undertake ward based risk assessments linked to high reporting areas.	Ongoing	Ongoing
Enhance the security coverage across sites. Recruit, develop in-house security team across the Trust.	Q1	Complete
Increase communication and visibility of security reporting and response across sites (Pro-security)	Q2	Complete
Undertake a review Terrorism (protection of Premises) Act 2025 implications for enhanced tier site	Q2	Complete
Review new VPR standards ensuring Trust meets requirements monitored through the VPR Group	Ongoing	Ongoing
Input into the changes needed for the emergency & planned care hospital/ consistent approach	Q2	Complete
Ongoing reviews of relevant policies ensuring compliance is maintained and any learning considered and introduced	Q3	Complete
Strengthen partnership arrangements with police seeking to increase prosecutions of those who assault staff	Ongoing	Ongoing
Reflect on the staff survey results including the free text comments and the quarterly Pulse surveys to agree priority areas of focus	Q4	Complete
Focus on maintaining training compliance	Q4	Complete
Review of associated security and violence and aggression risks seeking to reduce current risk levels	Ongoing	Ongoing

The 2026/27 ASMS workplan with build upon this years plan with additional initiatives agreed via the Security Management Group (SMG).

Stacey Fuszard
Head of Security and Portering

Appendix 1 - Datix reported incidents by Care Group

	Qtr1	Qtr2	Qtr3	Qtr4	Total
Anaesthetics Directorate	7	13	7	7	34
Cancer Care Directorate	7	6	6	11	30
Child Health Directorate	14	14	1	9	38
Clinical Support Directorate	11	7	6	2	26
Emergency and Urgent Care Directorate	78	83	64	82	307
Estates and Capital Development	6	6	3	5	20
External to UHD	5	6	7	5	23
General Area Department level	3	2	1		6
Head and Neck	3		4	4	11
Information Governance and IT	2	2			4
Networked Medicine	37	17	25	23	102
Nursing and Quality Directorate		1	1	2	4
Operations	14	18	4	10	46
OPS and Acute Care	96	88	115	94	393
Pathology Directorate		1	1	2	4
People	12	4	8	7	31
Private Health UHD	1	1			2
Radiology and Pharmacy Directorate	2	5	3	5	15
Specialist Medicine	82	60	68	46	256
Surgery Directorate	18	21	16	11	66
Trauma and Orthopaedics Directorate	13	12	25	18	68
Women's Health Directorate	13	6	4	5	28
Grand Total	**424**	**373**	**369**	**348**	**1514**

Appendix 2 - Top Reported Incidents

The tables below show the top reported incidents by type per quarter.

Behavioural Incidents

	Qtr1	Qtr2	Qtr3	Qtr4	Total
Inappropriate/Aggressive Behaviour by a Contractor	1		2	1	4
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm)	18	13	14	9	54
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	20	11	13	12	56
Inappropriate/Aggressive Behaviour towards a Patient by a Visitor/Other	4	2	1	2	9
Inappropriate/Aggressive Behaviour towards a Patient by Staff	17	6	8	6	37
Inappropriate/Aggressive Behaviour towards a Visitor by a Visitor				1	1
Inappropriate/Aggressive Behaviour towards Staff by a Patient	169	175	185	186	715
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	28	18	10	12	68
Inappropriate/Aggressive Behaviour towards Staff by Staff	8	19	7	3	37
Inappropriate/Aggressive Behaviour towards Visitor by a Patient	2	3	2	2	9
Inappropriate/Aggressive Behaviour towards Visitor by Staff			1		1
Missing Patient (absconded/abducted patient)	31	25	23	17	96
Other	37	28	26	31	122
Patient refusal of diagnostic/therapeutic recommendations/interventions	3	1	3	2	9
Persons Performing Unauthorised Acts	5	5	3		13
Self-harming Behaviour	19	18	16	22	75
Uncooperative/Stubborn patient Behaviour	12	11	9	11	43
Use/Possession of Prohibited/Stolen Goods	6	5	8	4	23
Grand Total	**380**	**340**	**331**	**321**	**1372**

Organisational Incidents

	Qtr1	Qtr2	Qtr3	Qtr4	Total
Break in/Forced Entry (proven, alleged or suspected)	1	2	1	1	5
Confidentiality Breach	3	2	1	1	7
Controlled Crowds/Gatherings		1			1
Corruption or inability to recover electronic data	1			1	2
Missing/Lost Property	19	16	30	14	79
Other	9	3	2	4	18
Privacy Breach	1		1	1	3
Property Theft (proven, alleged or suspected)	2	1	1		4
Theft (proven, alleged or suspected)	1	2		1	4
Trespassing/Intrusion	2	4		2	8
Unconsented or Unauthorised use of Property	1	1			2
Uncontrolled Crowds/Gatherings (spontaneous)	4				4
Use/Possession of Prohibited/Stolen goods		1		1	2
Vandalism (proven, alleged or suspected)			2	1	3
Grand Total	**44**	**33**	**38**	**27**	**142**

Appendix 3 – Terrorism (Protection of Premises) Act 2025 (Martyn's Law)

The Terrorism (Protection of Premises) Act 2025, commonly referred to as *Martyn's Law*, introduces a new legal duty on those responsible for publicly accessible locations to consider and mitigate the risk of terrorist attacks. The legislation is designed to improve protective security and organisational preparedness by ensuring that proportionate measures are in place to reduce harm and save lives. It reflects a national shift from reactive response to proactive risk management, particularly in high-footfall environments such as healthcare settings.

The Act establishes a tiered approach based on the capacity of premises and the nature of activities undertaken. Healthcare sites are likely to fall within both the *Standard Tier* (200-799 people) and *Enhanced Tier* (+800 people), depending on specific locations (e.g. main entrances, Emergency Departments, and large outpatient areas). Core requirements include the completion of terrorism risk assessments, the implementation of proportionate mitigation measures, and the development of clear response plans. Organisations must also ensure staff are appropriately trained in recognising and responding to threats, including applying principles such as *Run, Hide, Tell*, and identifying suspicious activity.

For premises within the Enhanced Tier, additional expectations include more detailed planning, formalised security procedures, and demonstration of how risks are being actively managed and reviewed. There is also a requirement to maintain appropriate documentation and, where necessary, engage with regulatory bodies. The Act places emphasis on senior leadership accountability, ensuring that responsibility for compliance is clearly defined within governance structures.

The legislation is expected to be implemented in a phased manner following Royal Assent, with a transition period anticipated (typically up to 24 months) to allow organisations to achieve compliance. During this period, organisations are expected to assess current arrangements, identify gaps and implement improvements aligned to the new requirements. For the Trust, preparatory work is already underway through existing security risk assessments, engagement with Counter Terrorism Policing, and alignment with Emergency Preparedness, Resilience and Response (EPRR) processes. Continued focus throughout 2026/27 will ensure the Trust is compliant within the required timeframe and able to demonstrate a robust and proportionate protective security posture.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

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 **1 June 2026**, the Group received, and reviewed in detail the following: • Programme Risks • People Ready Update • Build Ready Update • Reconfiguration Ready Update ○ Phase 3 Move Planning • TCT Digital Update • Communications and Engagement Update • Winter plan
ALERT	The Committee wishes to alert that: Complex challenges with the Coast building continue with no defined date for completion. No assurance at this stage can be given on a December move date and confidence is low. Several meetings are arranged in the next few weeks with the contractors and the New Hospital program (who are not proposing any formal intervention at this stage). There is ongoing and active engagement with NHSE. The agenda is moving at a fast pace. Since this meeting TMG has discussed options and recommends a move date in mid April, based on a careful consideration of all the factors. Work with partner organisations is now underway to ensure readiness of the system for the moves, based on April. A fuller update is provided in a separate Board paper.
ADVISE	The Committee wishes to advise: The Committee reviewed a detailed updated Transformation, Communications and Engagement plan. The Committee reviewed a draft of the winter 26/27 capacity assessment and the reconfiguration options, noting the alignment with the phase 3 planning process.

ASSURE	The Committee wishes to assure that: A new BAF risk for transforming care together has been created for 26/27 to ensure effective Board oversight of the overarching configuration.
Review of Risks	A paper detailing all the strategic and transformation program risks was reviewed by the Committee. The overarching portfolio risk has a high score of 20 reflecting high risk of delays in integrating the teams and services and then reconfiguring, to create the planned and emergency hospitals. (critical path management) Emergency department capacity remains a principal ops risk
Celebrating Outstanding	The building works for the AMU/RACE at RBH is ahead of schedule. This provides a new Same Day Emergency Care area, and 52 beds for rapid adult and elderly care assessment, most of which are single rooms.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: **4.5.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Transforming Care Together (TCT) Steering Group Terms of Reference
Prepared by:	Leonora May, Director of Corporate Governance
Presented by:	Judy Gillow, Trust Chair and Chair of the TCT Steering Group
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 purpose of this report is to present the updated terms of reference for the TCT Steering Group as part of the annual review process. At its meeting in April 2026, the group discussed the future of the Steering Group and agreed that it should remain in place for now. The group agreed that the terms of reference should be reviewed and revised. The following changes were made to the terms of reference: - Clarifying the group as a time limited internal Trust forum The terms of reference have also been transferred onto the new corporate template introduced through the 'Organising for Success' corporate project, which aims to streamline and standardise governance arrangements across the Trust.
ALERT:	None
ASSURE:	None
ADVISE:	The following changes were made to the terms of reference: - Clarifying the group as a time limited internal Trust forum
Celebrating Outstanding:	N/A
RECOMMENDATION:	The Board is asked to approve the Steering Group terms of reference.

Implications associated with this item:	Council of Governors	☐
	Environmental Sustainability	☐
	Equality, Equity, Diversity & Inclusion	☐
	Financial	☐
	Health Inequalities	☐
	Operational Performance	☐
	People (inc Staff, Patients)	☐
	Public Consultation	☐
	Quality	☐
	Regulatory	☐
	Strategy/Transformation	☒
	System	☐
	Explain the impact on each selected area; positive outcomes, risks and mitigations, and any oversight needed.	
CQC Assessment Framework:	Safe	☐
	Effective	☐
	Caring	☐
	Responsive	☐
	Well-Led	☒
	Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
TCT Steering Group	08/04/2026	Agreed that the Steering Group should remain in place with some suggested minor amends to the terms of reference.
Reason for submission to the Board (or, as applicable, Council of Governors) in Private Only (where relevant)	Commercial confidentiality ☐ Patient confidentiality ☐ Staff confidentiality ☐ Other exceptional reason ☐	

University Hospitals Dorset
NHS Foundation Trust

TERMS OF REFERENCE

for the

University Hospitals Dorset NHS Foundation Trust

Transforming Care Together Steering Group

DOCUMENT DETAILS

Author:	Richard Renaut
Job Title:	Chief Strategy & Transformation Officer
Signed:	Richard Renaut
Date:	08/05/2026
Version No: (Author Allocated)	4.0
Next Review Date:	03/05/2027

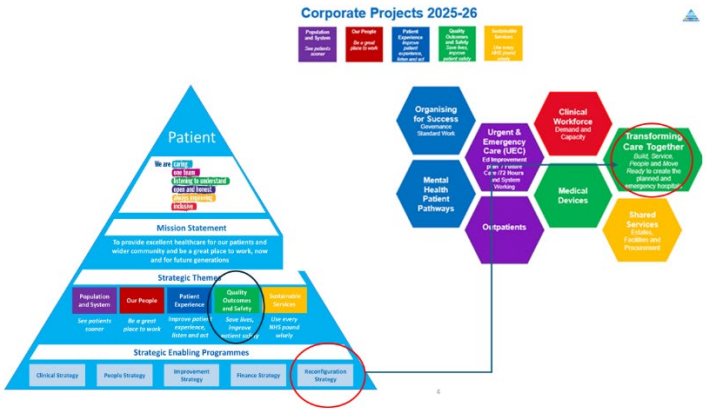
Approving Body/Committee:	Board of Directors
Chair:	Judy Gillow – Chair
Signed:	Insert e-signature of Chair of Approving Committee/Group
Date Approved:	15 July 2026
Target Audience:	Board of Directors

Document History

Date of Issue	Version No:	Next Review Date:	Date Approved:	Person responsible for Change	Nature of Change
December 2023	1			Director Integration	New document
December 2023	2.0			Director Integration	Adopted trust format, added in content from Liverpool, amended for Service Ready Group feedback
December 2023	2.1			CSTO/COO	Feedback from NED discussion
26/02/2024	2.2			CSTO/COO	Version following TCT Inaugural meeting for Board Approval
22/10/2025	3.0			CSTO	Adopted Trust format with full review of contents

08/05/2026	4.0			CSTO	Amended to reflect April 2026 TCT Steering Group discussion, clarifying the Group as a time-limited, internal Trust forum with revised arrangements for external stakeholder engagement.

TERMS OF REFERENCE

COMMITTEE NAME:	Transforming Care Together Steering Group
PURPOSE *(1.2)*:	The purpose of the Transforming Care Together Steering Group is to oversee delivery of the *Transforming Care Together* corporate project, which supports the Trust's *Quality Outcomes and Safety* strategic theme. The programme brings together core workstreams — *Build Ready*, *Service Ready (including Move Ready), People Ready, plus Digital* Governance to ensure the Trust is fully prepared for service moves, workforce transition and the opening of new hospital facilities. This is pictorially set out below:  **The Steering Group operates as a time-limited, internal Trust forum**, providing executive oversight of programme delivery, **critical path, delivery confidence, risks, issues and mitigations**, and acts as a coordinating point for assurance across the programme.

	This is a multi-year, strategic enabling programme of significant scale and complexity, and so the steering group acts as a time limited Board committee. The **objective** of the Transforming Care Together Programme is to deliver safe, high quality and sustainable services by transforming care and establishing our Planned & Emergency Hospitals. This in turn unlocks the benefits, as set out in the Clinical Services Review, and subsequent business cases. The Transforming Care Together Steering Group will do this through: a) Providing input and recommendations direct to the Trust's Board of Directors (Board) and/or relevant Board Committees for the delivery of the Reconfiguration Ready, Build Ready, and People Ready programmes. b) To have oversight of the major capital investments, that includes STP Wave 1 and New Hospitals Programmes. This will include work as part of any Board Gateway Reviews. c) Maintaining oversight of the critical paths across all workstreams (*Build Ready*, *Reconfiguration Ready (including Move Ready), People Ready and allied workstreams including Digital Demand*). Monitoring risks and mitigations relating to the programme. d) Co-ordinating the formal assurance held by Board Committees, (Finance and Performance, People and Culture, Quality and Audit) e) To provide a forum for internal discussion, reflection and shared learning into the programme, taking "go out and see" approach, in line with the Patient First methodology. The Steering Group does not operate as an operational, partnership or stakeholder forum. Engagement with external partners, including Local Authorities and system stakeholders, will be undertaken through separate briefings and established system forums, rather than through attendance at the Steering Group. The Group is a time-limited sub-group of the Board, expected to operate for the duration of the Transforming Care Together programme. It has no executive powers other than those specifically delegated within these Terms of Reference and is not an executive, decision-making or operational oversight group.
RESPONSIBILITIES *(2.1)*:	• **"To provide a focused internal forum for discussion of delivery risks, dependencies and mitigations to support timely escalation and decision-making."** • To receive confirmation from the Board, on an annual basis, of the relevant breakthrough objectives, strategic initiatives and corporate projects within the remit of the Group, for which it is to be held to account. • To obtain assurance that the programme is being delivered effectively through monitoring progress, constructive challenge and escalation to the Board, or relevant Board Committees when required.

- To maintain focus on the “wicked issues” (major challenges) identified by the work streams using the AAA approach, including key system risks, workforce challenges, and patient safety during transition and move phases.

- **Delivery of the Transforming Care Together Programme** To ensure the *Build Ready*, *Reconfiguration (Service) Ready (including Move Ready), People Ready and Digital* programmes, along with associated corporate workstreams, are delivering to plan, on time and to the expected quality standards.

To oversee that the Transforming Care Together Programme delivers safe, high-quality and efficient services through transformation of care and establishment of the Trust’s planned and emergency hospital model.**This includes for these key aspects:**

- Assure the implementation of the future operating model, ensuring there is oversight of the wider project incorporating clinical redesign projects, service reviews and associated actions, integration activities and corporate transformation activities.

- Assure the implementation and oversight of the overarching move plan to ensure the safe and timely move of all services to deliver a Planned and Emergency site.

- Application of the principles of the Quality Strategy to ensure there is a single integrated approach to transformation that delivers safe, effective and caring services from day one and supports staff throughout the transition.

- Work with the Finance and Performance Committee to ensure that future clinical and service models and estate delivers value for money, and the overall programme realises the benefits set out in the business case.

- Meeting the Trusts requirements for effective communication and engagement regarding the Transforming Care Together Programme for staff, partners, patients, the wider public and their representatives, and regulators through agreed Trust communication and engagement routes.

- Preparedness of the workforce for moves including organisational development, staff engagement, workforce capacity and capability, people processes and ways of working, and our statutory compliance in the management of change.

- Working with ICB system groups to ensure the CSR is implemented safely and effectively

- Undertaking any other duties as advised by Non-Execs/Execs.

- Overseeing the delivery of the construction programme, including compliance with the business case approval conditions and scheme of delegation set by the Department of Health and Social Care.

- Oversight of the co-ordination of the construction and handover process to minimise impact on the operational running of existing services.

Risk Management:

- To regularly review the Board Assurance Framework (including through in-depth review of specific risks) and to ensure that it reflects the assurances for which the Group has oversight, with risks highlighted being appropriately reflected on the risk registers. This includes acting in accordance with Board approved risk appetite and risk tolerance levels when reviewing risks.

Being kept appraised of all new and current risks rated 15-25, both clinical and non-clinical, identified on the risk register across the organisation and monitoring progress of action plans identified to mitigate these risks.

- Ensuring the *People Ready* Group enables delivery of the Transforming Care Together Programme on time, supporting effective service integration, consideration of interdependencies, and readiness for safe operation of the new planned and emergency hospital configuration.
- Working with the *Build Ready* Group to ensure staff relocating to a different Trust site are clear on transport and parking arrangements.
- Providing assurance that each service with an agreed move plan (from the *Service Ready* Group) has a *People Ready* Plan in place, covering (but not limited to) staff engagement, rota templates, on-call arrangements, recruitment, training, staff consultation, and workforce system requirements (e.g. e-Rostering, HealthRota).
- Ensuring all services have an organisational change plan in place, and that there is sufficient capability and capacity within operational management, HR, and staffside to deliver to required timelines.
- Ensuring any service required to change its operating model has a clear staff readiness plan and an established “go/no-go” governance process to support safe staffing in the new configuration.
- Ensuring Workforce Standard Operating Procedures, policies and processes are revised so that a single UHD version is in use, unless site-specific documents are required.
- Ensuring robust monitoring is in place to capture and track all activity, including timelines, milestones, and progress updates.
- Ensuring appropriate action is instigated and monitored through the relevant Trust governance forums to maintain compliance with legal, regulatory, contractual, and Trust Board requirements.

	Providing a focused internal forum for collective problem solving and resolution of programme-level risks and dependencies. ”For Digital Readiness: To have oversight of the digital readiness work, and that any critical path issues are being resolved at the operational and project governance levels, as appropriate.

MEMBERS *(3.1):*	The Group shall be composed of the following members: • Chair (who must be a Non-Executive Director) • Chairs of Finance and Performance Committee, Quality Committee, People and Culture Committee, and Audit Committee • Chief Executive • Chief Strategy and Transformation Officer • Chief Operating Officer • Chief Finance Officer • Chief Nursing Officer • Chief People Officer • Chief Digital Officer • Chief Medical Officer		**STANDING ATTENDEES *(3.2):***	In addition, the following will attend the Group to provide information and advice with prior agreement of the Group Chair and/or to present a report to the Group or a Chief Officer is unable to attend: • Medical Director for Transformation • Director of Integration • Director for Transformation	
CHAIR (*3.3*):	The Group will be chaired by the Chair of the Board.	**DEPUTY CHAIR *(3.3)*:**	A Non-Executive Deputy Chair should be nominated. In the absence of the Group Chair and/or any appointed Deputy, the remaining members shall elect one of the Non-Executive Directors present to chair the meeting.	**SECRETARY *(5.5)*:**	The Company Secretary (or their nominee) will maintain a register of members' attendance

MEETING TIMING (FREQUENCY AND DURATION) *(5.1)*:	The Group will normally meet bi-monthly and at such other times as the Group Chair shall require.	**QUORUM *(5.2)***	Meetings of the Group shall be quorate if there at least five members present, which will include the Chair (or a Non-Executive Director deputy), and two Executive Directors or their deputies. For the avoidance of doubt, an Officer in attendance who has been formally appointed by the Board to act up for an Executive Director shall count towards the quorum.
ACCOUNTABLE TO: (the Accountable Group) *(6)*	The Group shall be accountable to the Board. The Group shall make recommendations to the Board in relation to issues that require decision or resolution by the Board.	**REPORTING GROUPS *(6.5)*:**	The Group shall refer to the Audit Committee, Charitable Funds Committee, Finance & Performance Committee, Quality Committee, People & Culture Committee any matters requiring review or decision in such forum(s). For the avoidance of doubt: • the People and Culture Committee will have oversight of the development by the Trust of an effective staff structure and workforce operating model across the organisation; and • • the Quality Committee will have oversight of quality and safety issues including private patient care as part of the quality governance process; and • The Finance and Performance Committee will have oversight of the financial (capital and revenue) plans, and the operational performance; The Group shall receive reports from sub-groups of

			the Trust Management Group (including the Build Ready, Service Ready, People Ready and Digital Demand highlight reports). The Group shall also receive, from time to time, such reports from such sub-groups as it may require to provide it with assurance relating to matters within the scope of the Group's responsibilities.

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 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 The Committee/Group is authorised by the Board to investigate/review any activity within the Terms of Reference.

4.3 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 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 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/**	Transforming Care Together Steering Group											
Present (*include names of members present at the meeting)*	**Meeting Dates**											
Was the meeting quorate? Y / N (*Please refer to Terms of Reference*)												

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

ESCALATION and ASSURANCE REPORT – Alert, Advise, Assure	
Report from:	Charitable Funds Committee – Chair's Report
Presented by:	Femi Macaulay, Chair of the Charitable Funds Committee
Agenda items discussed:	At its meeting held on **18 May 2026**, the Committee received reports on the following: • Investment Update • Fundraising Report – Q4 • Review of Fundraising and Spending Strategy 2026-29 • Finance Report – Q4 • Fundraising Strategy • WCCSS Care Group spend plan • Lottery safeguards and risks • Draft Annual Report Narrative • Risk Register The Committee also ratified the following: • Fundraising Strategy • Fundraising Policies • Its Governance Cycle In addition, the Committee received various proposals and business cases for approval and one business case for recommendation to Board to approve.
ALERT	There is nothing to alert the Board.
ASSURE	The charity's financial performance remains strong. Total income for 2025/26 reached approximately £4 million, exceeding the planned target of £3.6 million. This positive variance was driven by strong legacy income and sustained fundraising activity, including the BEACH appeal and a new Wi-Fi donor engagement pilot. The cost to raise a pound remained stable at approximately 22 pence, reflecting continued efficiency. Total fund balances are approaching £18 million at year end. The investment portfolio has grown from approximately £9.7 million to just under £9.9 million over the quarter. The portfolio is deliberately positioned defensively, with significant allocations to cash and alternative assets, reflecting ongoing geopolitical and macroeconomic uncertainty. The ethical investment framework, including restrictions on sectors such as oil and gas, remains in place and has had only marginal impact on performance. The Committee is content with the current

	investment approach and has agreed to receive detailed presentations from Quilter Cheviot on a twice-yearly basis. The Committee formally ratified the Fundraising Strategy 2026-29 and associated Fundraising Policies and Governance Cycle at this meeting. It also endorsed its own Annual Report, with recommendation to the Board to approve.
ADVISE	The Charitable Funds Committee recommends that the Board approve charitable funding for an Interventional Radiography Day Case Unit. The absence of dedicated recovery space is currently constraining service capacity, and the proposed unit would improve patient flow, reduce delays, and support more efficient use of clinical time as activity volumes continue to grow. A range of options were evaluated; the proposed model was judged the most effective in terms of operational efficiency and long-term value. The Committee also wishes to advise the Board that, while income performance is excellent, there is not yet an equally developed strategy for the deployment of charitable funds. With total fund balances approaching £18 million, the Committee has identified the need to strengthen the strategic approach to expenditure, ensuring charitable investment is clearly linked to agreed Trust objectives and that funds are deployed effectively and in a timely manner. Work to address this will be progressed as a priority. The Committee further advises that the use of charitable funds to support staff posts continues to grow. While the Committee recognises the value of individual proposals, it has emphasised that funded roles must be subject to clear time limits and exit strategies, and that the charity should not inadvertently substitute for core funding responsibilities. Early engagement with commissioners will be important where there is potential for roles to transition into recurrent arrangements. The Committee discussed ethical considerations associated with the expansion of lottery-based fundraising. Concerns were raised at the meeting regarding the potential impact on individuals experiencing financial hardship or vulnerability. The Committee acknowledged that the lottery model has been approved through the Trust's governance framework, including Board consideration, and that robust regulatory safeguards are in place. However, it has agreed that this area warrants ongoing scrutiny given its financial significance and ethical sensitivity, and will maintain rigorous oversight of lottery activity going forward
Review of Risks	Review of the risk register did not identify any major risks. The investment risk remains rated as moderate. Following delivery of the 2025/26 fundraising plan, fund balances have stabilised. The primary area of ongoing focus remains the management of charitable expenditure.

Celebrating Outstanding	The Committee recognises and commends the Charity team for exceeding its annual income target, raising approximately £4 million against a plan of £3.6 million, while maintaining strong cost discipline with a cost-to-raise of 22 pence in the pound. This is a significant achievement and reflects the continued dedication and creativity of the fundraising team and wider charity staff.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: **4.6.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Charitable Funds Committee Annual Review 2025-26
Prepared by:	Klaudia Zwolinska, Deputy Company Secretary
Presented by:	Femi Macaulay, Committee 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:	Assurance
Executive summary:	The report describes how the Committee discharged its responsibilities during the period from 1 April 2025 to 31 March 2026 and provides assurance to the Board that the Committee has met its duties as set out in its Terms of Reference over that period.
ALERT:	N/A
ASSURE:	A review of the Committee's compliance with its Terms of Reference was undertaken in May 2026 by the Corporate Governance Team, in support of the Committee. This review involved scrutiny of the agendas and minutes of the four Committee meetings held between 1 April 2025 and 31 March 2026.
ADVISE:	N/A
Celebrating Outstanding:	N/A
RECOMMENDATION:	The Board is asked to note the report.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☐ Regulatory ☒

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

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Charitable Funds Committee	18/05/2026	The Committee endorsed the report with recommendation to 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 ☐	

University Hospitals Dorset
NHS Foundation Trust

UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST

CHARITABLE FUNDS COMMITTEE ANNUAL REPORT 2025/26

1 PURPOSE OF THE REPORT

1.1 The Charitable Funds Committee (the "Committee") has prepared this report for the Board of Directors. It sets out how the Committee satisfied its terms of reference – which relate to the operation of the University Hospitals Dorset NHS Foundation Trust Charitable Funds (Charity Registration Number 1057366) (the "Charity") - between 1 April 2025 and 31 March 2026. The Committee seeks to provide the Board with evidence that it has met its responsibilities as set out in its terms of reference during the relevant period.

1.2 The Committee exists as a committee of the Trust (in its capacity as Corporate Trustee of the Charity), with the Board of Directors acting as the Board of the Trustee.

2 MEETINGS

2.1 Four formal meetings were held during the year, all of which were quorate:

- Monday, 12 May 2025
- Wednesday, 6 August 2025
- Monday, 10 November 2025
- Monday, 16 February 2026

2.2 Meeting attendance is detailed in **Appendix 1.** All members attended at least 75% of the meetings for which they were eligible.

3 MEMBERSHIP

3.1 Membership of the Committee comprises three Non-Executive Directors, the Chief Finance Officer, the Chief People Officer.

Membership of the Committee in 2025/26 comprised of:

- Claire Whitaker, Non-Executive Director and Committee Chair *(until 2 July 2025)*
- Femi Macaulay, Non-Executive Director *(Committee Chair from 3 July 2025)*
- Helena McKeown, Non-Executive Director
- Michael Marsh, Non-Executive Director *(member from 1 September 2025)*
- Pete Papworth, Chief Finance Officer
- Melanie Whitfield, Chief People Officer *(member from 18 August 2025)*[1]

[1] Irene Mardon, Deputy Chief People Officer, attended the Committee meetings between Tina Rickett's departure from the Trust and Melanie Whitfield joining on 18 August 2025.

4 COMPLIANCE WITH TERMS OF REFERENCE

4.1 A review of the Committee's compliance with its own terms of reference was undertaken (by the Corporate Governance Team to support the Committee) in May 2026 by scrutinising the agendas and minutes of the four Committee meetings which took place between 1 April 2025 and 31 March 2026. This evidences how the Committee has discharged each of its responsibilities:

4.1.1 **To monitor and authorise the application of all charitable funds in accordance with the Charities Acts, external guidance and applicable legislation and to ensure that decisions on the use or investment of such funds are compliant with the explicit conditions or purpose of each donation or bequest.**

Across all four meetings, the Committee repeatedly demonstrated active scrutiny of every charitable fund application. Members challenged proposals to ensure they were enhancements and not core NHS obligations, assessed alignment with donor restrictions, and confirmed that expenditure complied with charitable purpose

In addition, the Committee monitored the application of charitable funds through the quarterly finance report and fundraising reports.

Under the Trust's Standing Financial Instructions (section 16.2):

- The Chief Finance Officer is to arrange for the administration of all charitable funds and ensure that a governance document exists.
- The Chief Finance Officer shall periodically review the funds in existence and shall make recommendations to the Committee regarding the potential for rationalisation with statutory guidelines.

(Please see below in relation to policies).

The Committee received the charity recharges report in August 2025 (which references the charges being the subject of a detailed independent audit).

4.1.2 **To make decisions involving the investment of charitable funds with regards to the existing and subsequent legislation, policy and guidance from the Charity Commission.**

The Committee regularly received and scrutinised investment updates from investment manager Quilter Cheviot. Members questioned asset allocation, performance, benchmarking, volatility risks, and ethical investment constraints. The ethical policy was reviewed and consistently reaffirmed, with evidence presented that the screened portfolio had outperformed an unrestricted equivalent.

In relation to legislation, policy and guidance from the Charity Commission, recommendations of the Chief Finance Officer were taken into account. Under the Trust's Standing Financial Instructions (section 16.5), the Chief Finance Officer is responsible for all aspects of the management of the investment of charitable funds.

4.1.3 **To ensure compliance with the Trust's Standing Financial Instructions and Scheme of Delegation as applicable to charities.**

The Committee reviewed and approved business cases between £25,000 and £250,000 in line with the Scheme of Delegation. Where presented to the Committee, approval of expenditure from charitable funds exceeding £250,000 was recommended to the Board.

4.1.4 **To monitor the performance of the investment portfolio, to include the review of spending plans and balances held within individual charitable funds.**

Performance of the investment portfolio was presented at all four meetings by the investment manager, Quilter Cheviot, and monitored by the Committee (with reports presented for all four meetings of the Committee).

The Investment Policy was reviewed in August 2025.

Balances of individual funds were reviewed through the quarterly finance report.

4.1.5 **To review and recommend approval to the Board of the Annual Report and Accounts of the Charity for submission to the Charity Commission.**

The Committee reviewed the draft Annual Report in May 2025 and draft Annual Accounts in August 2025. At the November 2025 meeting the audited Annual Report and Accounts were received. Members scrutinised the KPMG audit report, verified there were no concerns or findings, and recommended approval to the Board.

The Annual Report and Accounts were approved at the January 2026 Board meeting.

4.1.6 **To receive and review the quarterly charitable funds income and expenditure accounts together with any other supporting information.**

The Committee received and reviewed the quarterly finance report. It also reviewed and approved charity recharges and the financial forecast.

The reserves policy was also considered in November 2025.

4.1.7 **To ensure that expenditure is controlled and utilised on suitable projects.**

The Committee reviewed expenditure and charitable funds applications through the quarterly finance report. It also considered and, if thought suitable, approved applications presented to it between £25,000 and £250,000.

4.1.8 **To establish policies and procedures to ensure the effective day to day management of the charitable funds and to ensure that these procedures are followed.**

The Committee reviewed and approved the fundraising policies in February 2026. It also approved the reserves policy in November 2025.

Assurance of the effective day-to-day management of the charitable funds was provided through the quarterly fundraising and finance reports.

4.1.9 **To review detailed business cases relating to major investment decisions and to recommend investment or otherwise.**

The Committee reviewed and, if suitable, approved business cases between £25,000 and £250,000. Business cases above £250,000 were recommended to the Board for approval.

4.1.10 **To ensure legacies are realised in a timely and complete manner.**

Legacy performance was reported to the Committee through the quarterly fundraising report.

4.1.11 **To safeguard donated money.**

At each meeting of the Committee, the following were received:

- a fundraising report;
- a finance report.
- an investment portfolio update.

and the risk register reviewed and discussed.

4.1.12 **To review annually the overall fundraising strategy and fundraising projects and recommend schemes to the Board for approval.**

The fundraising strategy for 2026/27 was approved by the Committee in February 2026. Business cases were recommended to the Board where the value exceeded the Committee's delegated limit of £250,000.

4.1.13 **To enact the overall strategy, as set by the Board, on the use of the Charitable Fund.**

Progress against the fundraising strategy was regularly monitored through the Committee's quarterly fundraising and finance reports.

4.2 A governance cycle detailing which reports are to be expected at each meeting was formally reviewed and approved in February 2026. The governance cycle attached at **Appendix 2** is the version approved in February 2025 being the version against which this review has been conducted**.**

5 CONCLUSION

5.1 The Committee considers that it has effectively discharged its responsibilities as set out in its terms of reference.

Femi Macaulay
Chair, Charitable Funds Committee
May 2026

Appendix 1 – Attendance at Charitable Funds Committee 2025/26

Charitable Funds Committee		12 May 2025	6 August 2025	10 November 2025	16 February 2026
Present	Claire Whitaker		A		
	Femi Macaulay				
	Michael Marsh				
	Helena McKeown				
	Pete Papworth				
	Melanie Whitfield				
Attendees	Laura Adams				
	Debbie Anderson				
	Nicola Barwell				
	Mike Bayne				
	Clare Bone				
	Juliet Browning				
	Daniel Bundy				
	Jess Channon				
	Sylvia Charasika				
	Abigail Daughters				
	Jennifer Downs				
	Charlotte Freeeman-Laurence				
	David Frost				
	Jemima Greenwood				
	Nichola House				
	Darren Jose				
	Jonny Lee				
	Irene Mardon				
	Laura Northeast				
	Stacey Payne				
	Rachel Plant				
	Nik Ramsay				
	Joanna Samways				
	Truda Scriven				
	Helen Slade				
	Mandy Tanner				
	Lorin Taranis				
	Nicki Walsh				
	Philip Watson				
	Samantha Whittle				
	Stuart Wiles				
	Scott Williams				
	Klaudia Zwolinska				
	Was the meeting quorate?	Y	Y	Y	Y

Key

	Not in Attendance
A	Apologies
D	Delegate Sent
	In attendance
	N/A

University Hospitals Dorset
NHS Foundation Trust

Appendix 2 – Charitable Funds Committee Governance Cycle (version February 2025)

Agenda Item	Feb	May	Aug	Nov	Goes to
Quarterly Reports					
Charitable Funds Committee Minutes	X	X	X	X	N/A
Matters Arising - Action List	X	X	X	X	N/A
Investment Report	X	X	X	X	N/A
Risk Register	X	X	X	X	N/A
Fundraising Quarterly Report	X	X	X	X	N/A
Finance Quarterly Report	X	X	X	X	N/A
Business Cases / Charitable Funds Applications	X	X	X	X	Board Part 2 (if over £250k)
Care Groups Spend Plan	X	X	X	X	N/A
Annual Reports					
Fundraising Strategy	X				N/A
Fundraising Policies	X				N/A
Charitable Funds Committee Governance Cycle	X				N/A
Charitable Funds Committee Terms of Reference		X			Board Part 1
Charitable Funds Committee Annual Report		X			Board Part 1
Draft Annual Report Narrative		X			N/A
Seasonal Staff Benefits		X			N/A
Annual Report & Accounts			X		Board Part 2
Charity Recharges			X		N/A
Financial Forecast and Compliance with Reserves Policy			X		N/A
Review of Investment Policy			X		N/A

Ad hoc
Review the case for becoming an independent Charity - November 2026
(reviewed at November 2024 meeting)

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: **4.7**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Integrated Performance Report (Safety, quality, experience, workforce and operational performance)
Prepared by:	Executive Directors, Leanne Rathbone, Mark Major, Judith May, David Mills, Irene Mardon, Jo Sims, Viv Alividza and Adrian Tron.
Presented by:	UHD Chief Officers
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	BAF Risks 1-7 Trust Integrated Performance report for May 2026 - Appendix A
Purpose of paper:	Assurance
Executive summary:	**Forward Look: Building Momentum** May marks a meaningful step forward in UHD's improvement journey. The NHS Oversight Framework results for Quarter 4 2025/26 provide important external validation of that progress, with UHD rising 17 places nationally from 87th to 70th, and an improved average metric score of 2.34 against 2.51 in Quarter 3. While the Trust remains in segment 3, this is the most significant single-quarter ranking improvement UHD has recorded and reflects the breadth of work now embedded across the organisation on behalf of our patients. The month brought real reasons for confidence across the domains that matter most to patients. The 4-hour standard was met at 70.2%, ahead of trajectory. RTT performance exceeded operational plan at 66.9%, with 65-week waits eliminated and 52-week waits below 1%. Fewer patients experienced moderate or greater harm from falls compared to the same period last year. Maternity continues to perform strongly, with 15 consecutive months of neonatal admission rates below regional and national targets, and 95.2% of black and Asian women on a continuity of care pathway. SDEC is keeping more patients out of hospital who do not need to be there, and theatre utilisation at 82.9% means more patients are receiving planned surgery without delay. The areas requiring continued focus are clear. Patients who are medically ready to leave hospital are waiting too long for community and social care

provision, with NCtR at around 230 against a target of 110. This is a system-level challenge with direct consequences for the patients who remain with us beyond their clinical need, and for those waiting to come in. Cancer performance in Q1 has not met national recovery targets, and while structured recovery plans are in place and improvements are expected from July onwards, we are acutely aware of what these numbers mean for individual patients waiting for a diagnosis or treatment. The financial position requires disciplined delivery throughout the remainder of the year.

The Clinical Vision of Flow programme, launched in May with 130 colleagues, the first meeting of the steering group in June, has taken place, providing a platform through which we will improve the experience of every patient moving through our urgent, emergency and elective pathways. We will report openly to the Board on progress throughout the year ahead.

Population & System (2)
Strategic goal: To meet the national constitutional standards for Planned and Emergency care, supporting reducing inequalities in outcome and access and improving productivity and value.

Alert 1: No Criteria to Reside: The May NCtR position remained relatively static at around 230, 30 more than forecast, and 120 above the 110, the figure required to support the Phase 3 hospital reconfiguration. The deterioration flows directly from two connected system failures: the removal/ decommissioning of P1 community capacity, and the absence of a funded pathway for a cohort of patients who sit outside standard commissioning thresholds.

Alert 2: Cancer standards: Following a challenging start to the Q1 position, recovery actions have been implemented to support improvements which will start to be realised from June 2026 onwards. In April 2026, the Trust did not achieve the 28 Day Faster Diagnosis Standard national recovery target and the Trust's operational plan trajectory (80%), reporting a position of 67.2%. The 62D Standard did not achieve the national recovery target (80%), reporting a position of 65.8%.

Quality Outcomes and Safety (4)
T*o reduce moderate/severe harm patient safety events by 30% through the development of an outstanding learning culture*

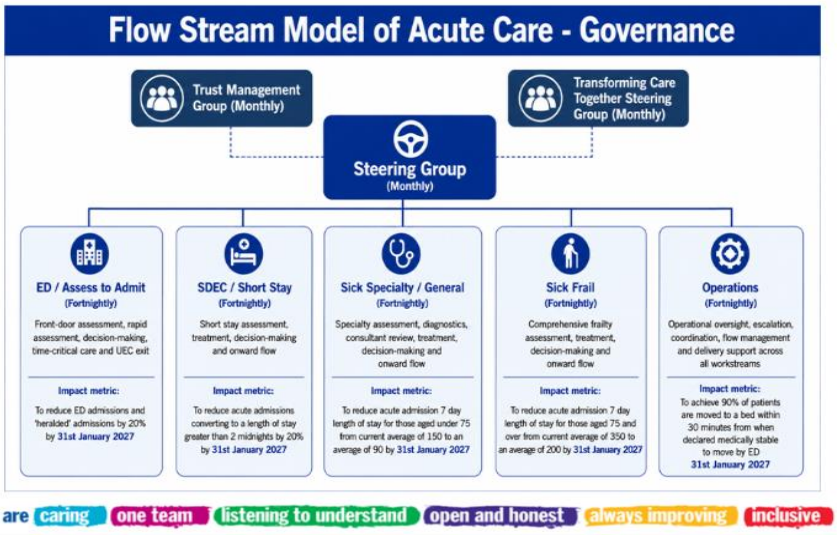
Alert 1: Outbreaks/cohort of infectious disease:
1 case of hospital associated MRSA bacteraemia in May 2026 (HOHA).

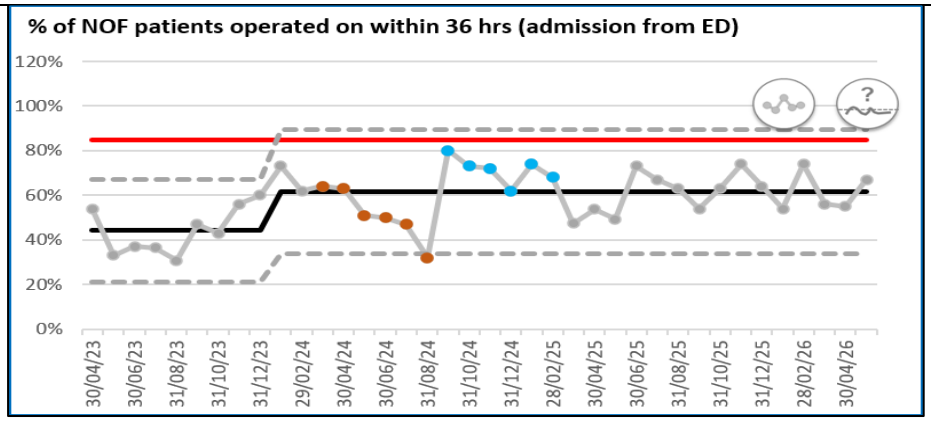
Patient Experience (none)
Every team is empowered to make improvements using patient (or user) feedback, in order that all patients at UHD receive quality care, which results in a positive experience for them, their families and/or carers.

Our People (4)
Strategic goal: To significantly improve staff experience, engagement, and retention.

Alert 1: Bank usage did not achieve a balanced plan with an adverse variance of 33.49 wte against the in-month plan. This reflected the operational pressures experienced during May.

	Alert 2: Off-framework agency usage in M2 doubled to 48 shifts, this was largely driven by enhanced care needs in the Critical Care Unit. A notable month-on-month increase in the use of Registered Mental Health workers, is contributing to off-framework supply utilisation. **Alert 3:** While overall Time to Hire and employment check performance remain within agreed KPIs, there continues to be variation in delivery against some key recruitment service standards, particularly time to shortlist and the time taken to issue conditional offers. **Alert 4:** The number of appraisals completed has not met target compliance. Values based appraisal compliance has failed to achieve the 90% target rate over past 11 months and is at 77.31% for April 2026 Medical and Dental appraisal compliance has failed to achieve the 90% target rate over past 11 months and is at 83.52% for M11 **Sustainable Services – Finance (2)** ***Strategic goal: To return to recurrent financial surplus from 2026/27*** **Alert 1: Revenue Outturn** Whilst the expenditure run rate improved in May, the Trust has delivered a cumulative deficit of £6.249 million being £1.234 million adverse to plan. This includes unplanned Industrial Action costs of £518,000, with the remaining adverse variance relating to efficiency savings being below the phased plan for April and May. NHS England has confirmed that there is no funding for Industrial Action costs which are expected to be mitigated locally. A full outturn forecast is being developed using the Month 2 outturn to identify any additional risks and inform mitigation plans. **Alert 2: Efficiency Improvement Programme** The Trust has delivered £6.2m of savings, being £0.7 million below the phased plan. The trust has identified total savings opportunities of £51.1 million, however when adjusted to reflect the risk of delivery in year, this is reduced to a current forecast of £30.4 million. Whilst this is an increase of £4.8 million from the April report, this is £38.1 million short of the full year savings requirement representing a material financial risk for the Trust.
Population & Systems	Strategic goal: To meet the national constitutional standards for Planned and Emergency care, supporting reducing inequalities in outcome and access and improving productivity and value.
Urgent & Emergency Care **ALERT: 1**	**Alert (1): No Criteria to Reside (NCtR)** The May NCtR position remained relatively static at c.230, 30 more than our forecast, and 120 above the 110 figure we need to support the Phase 3 hospital reconfiguration. The deterioration is directly from two connected system challenges: the removal of P1 community capacity, and the absence of any funded pathway for a cohort of patients who sit outside standard commissioning thresholds. (Appendix A Excessive Hospital Patient Stays) As part of the 5 key priority areas for the wider system, and the commitment to improving UEC pathways alongside an acknowledgement of how internal

	processes and pathways contribute to delay, UHD has enlisted the support of the National UEC Subject Matter Expert, Dr Ian Sturgess and the internal development of a Clinical Vision of Flow programme. The diagnostic work and the baseline data demonstrate improvement potential across all pathways, and for those patients with and without Criteria to Reside. This quality improvement programme launched on 26th May, attended by approximately 130 multidisciplinary UHD colleagues. Beyond launching the initiative, the workshop focused on establishing a shared clinical vision of flow and aligning priority areas around Internal Professional Standards and GIRFT's Clinical Operational Standards. The programme will serve as the vehicle for all UEC improvement activities and act as a critical enabler across the Trust's strategic priorities. The programme is structured into five Executive-sponsored workstreams: and is governed via an oversight group utilising the Patient First improvement methodology. 
Urgent & Emergency Care **ADVISE: 2**	**Advise (1): Ambulance Performance**: Ambulance handover in May saw some improvement to 28 minutes, likely influenced by occupancy in the department and a reduction of mean time LOS within ED. New process in place for corridor care escalation and embedding GIRFT standards to eradicate corridor care and 24hrs waits, which will drive ambulance handover performance.
Urgent & Emergency Care	**Advise (2): Trauma: May performance for time to theatre for fractured neck of femur (#NoF) patients saw 67% of patients operated on within 36 hours of admission.** Performance in May has improved and is above the process mean (common cause variation). The target continues to fall within the process limits, indicating it is achievable. 79% achieved surgery within 36 hours of being fit for surgery.



Key actions:

- Day to day review of trauma position and timely response to provide additional Theatre & Fracture clinic capacity in response to higher level 2 and when in level 3 escalation
- Ongoing recruitment to TAC team and ACP to fill vacancies which contributes to the robustness of the TAC team and provision of Ward rounds and Trauma Hand Hub
- Supporting workforce gaps for TOACU impacting volume of cases which can be carried out in TOACU instead of Theatres
- Developing SipTilSend policy for all Hip Fractures
- Aligning all Trauma theatre activity to all day lists and aligning Surgeon and Anaesthetic job planning to all day sessions
- Ensuring a focus on patient flow through trauma wards and appropriate operational escalation processes are followed for early identification of issues.

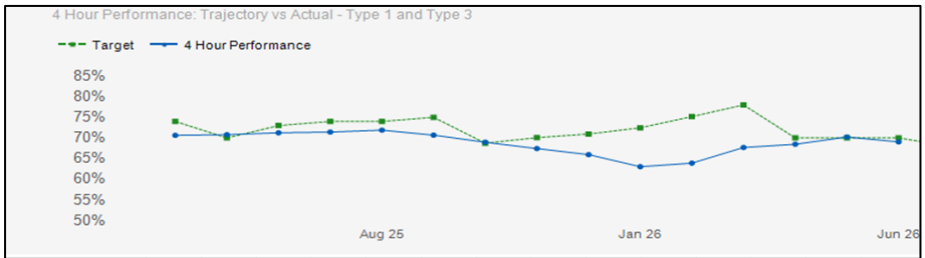
Urgent & Emergency Care

ASSURE (2)

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

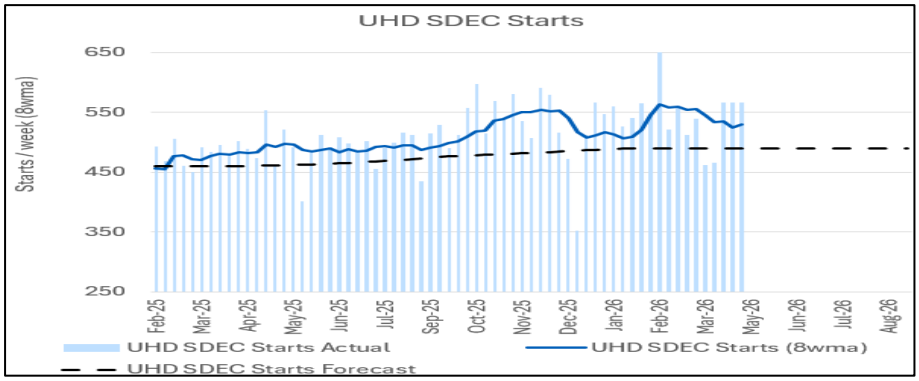
The Trust's performance against the standard was finalized at 70.2%, successfully meeting the 70% trajectory. However, admitted performance remains relatively static at circa 25%.

The *Clinical Vision of Flow* programme, detailed above, is designed to unlock the barriers and constraints currently impeding admitted performance due to sub-optimal patient flow. Additionally, by improving downstream out-flow, the programme will mitigate pressure and reduce congestion within the Emergency Department.



	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26
Target	74.0%	70.0%	73.0%	74.0%	74.0%	75.0%	68.7%	70.1%	71.0%	72.5%	75.2%	78.0%	70.0%	70.0%
4 Hour Performance	70.6%	70.8%	71.2%	71.4%	71.9%	70.7%	69.0%	67.4%	66.0%	63.0%	63.9%	67.7%	68.5%	70.2%

Assure (2): Alternatives to Admission:

	Avoided admissions through SDECs has continued to outperform the forecast and trajectory. Ongoing improvement work to further exploit opportunities and to extend the service, will be driven through the Clinical Vision of Flow Programme. 
Population & Systems: Planned Care including Cancer standards	**Strategic goal: To meet the national constitutional standards for Planned and Emergency care, supporting reducing inequalities in outcome and access and improving productivity and value.**
ALERT: 1	**Alert (1) Cancer Waiting Times** **Following a challenging start to the Q1 position, recovery actions have been implemented to support improvements which will start to be realised from June 2026 onwards.** In April 2026, the Trust did not achieve the 28 Day Faster Diagnosis Standard national recovery target and the Trust's operational plan trajectory (80%), reporting a position of 67.2%. The 62D Standard did not achieve the national recovery target (80%), reporting a position of 65.8%. There are several factors that have continued to impact performance: • 50% reduction in staffing in the Colorectal service due to sickness alongside pre-planned leave. • 5.5% increase in treatment demand compared to 24/25 • A loss of medical capacity and insourcing capacity due to staff being impacted by the conflict in the Middle East. • Insourcing provider supporting skin failed to deliver against planned activity. There are a set of agreed recovery actions in progress for Q1 of 26/27: • A staffing business case for Colorectal has been submitted for approval following recommendations from a service deep dive review supported by the Wessex Cancer Alliance and has been supported in principle at SSG. • Establishment of a weekly Cancer Improvement Group to improve patient pathways and performance, including a refreshed Cancer

	Improvement Programme underpinned by improvement plans and trajectory per site. • Contract discussions with 18 Weeks support to confirm their commitment to delivering activity for the remainder of 26/27. • Recovery plans and trajectories for all tumour sites to recover the Trust position in Q1, whilst aspiring to meet all the 26/27 targets by March 27. • Executive level escalation and support with all services. • Funding confirmed through the Wessex Cancer Alliance to support additional WLI and insourcing capacity across the major tumour sites.
ADVISE: 1	**Advise (1) The % of patient waiting >52 weeks for Community Health (neurodevelopmental) services remains high.** In May the Trust continued to transfer the longest waiting children on a neurodevelopmental pathway to local Right to Choose providers for assessment. The impact of these transfers, however, was not sufficient to fully mitigate an ongoing increase in patients exceeding 52 weeks on the waiting list. The result is an increase in the % of patient waiting > 52 weeks as a proportion of the total waiting list. Key actions: 1. Continue the transfer of the longest waiting children on a neurodevelopmental pathway to Right to Choose providers (total 622 by end of July). 2.Confirm a plan for children 'ageing out' of the waiting list to ensure equitable access to an adult waiting list. 3.Validation of children on the waiting list to ensure they continue to need assessment. 4. Engagement with DHC regarding use of the Neurodiversity Exploration and Strengths Tool (NEST) in Dorset. 5. Workforce planning for Nurse Medical Prescriber roles to increase long term capacity.
ASSURE: 2	**Assure (1) RTT Performance is exceeding the operational plan target in May** The Trust's operational plan (66.8%) was exceeded in May 2026 (66.9%). This was supported by an increase in the proportion of patients receiving first contact (OPA or diagnostic) within 18 weeks of referral (76.4% of patients seen under 18 weeks), which also exceeded the plan. **Assure (2) The percentage of >52 week waits as a proportion of the waiting list remained below the national target of 1% at 0.99%** Whilst the total number of patients breaching 52 weeks were marginally above trajectory (672 versus 619 plan), the percentage of patients waiting >52 weeks, met the national target again this month. There was an unexpected loss of capacity in Gynaecology due to clinician availability in May that contributed to the position. Steps are being taken to re-provide this capacity in June.

Planning requirement	Apr 26	May 2026	
Referral to treatment 18-week performance	66.5%	66.9%	National standard 92% Trajectory 66.8% May 2026
Eliminate >65 week waits	0	0	Plan trajectory 0
Reduce >52+ weeks	619 (0.91%)	672 (0.996%)	Plan Trajectory, 602 by May 2026 (0.91%)
Reduce Waiting List size	67,800	67,497	Plan Trajectory 66,447 May 2026
Waits for first activity <18 weeks	76.3%	76.4%	Plan trajectory 73.3% May 2026

Celebrating Outstanding:

The Trust is showing sustained improvement in RTT performance to eliminate 65 week waits consistently.

Population & Systems

Health Inequalities and Primary Prevention

ADVISE: 1

Advise (1) The DM01 (Diagnostic) standard performance was 13.7% in May, which means that the operational plan trajectory (7.5%) was not met.

National standard: No more than 1% of patients should wait more than 6 weeks for a diagnostic test.

May 2026	Total Waiting List	<6 weeks	>6 weeks	Performance
UHD	12,709	10,974	1735	**13.7%**

The Trust remains a strong performer on DM01 (Diagnostics) performance in the Southwest Region. Performance in May was mainly impacted by Endoscopy and Echocardiology.

In Endoscopy the key drivers are administrative booking constraints, reduced clinical capacity, and higher complexity colonoscopy procedures and in Echocardiology, the drivers are capacity and a high influx of referrals in March and April. Both services have a phased recovery plan in place focused on restoring utilisation, strengthening the booking function (endoscopy), stabilising clinical capacity, and deploying targeted additional activity. The new Endoscopy build is on schedule to become operational in Quarter 2.

Celebrating Outstanding:

Imaging and physiological measurement both achieved below 2% performance.

Population & Systems

Operational Productivity

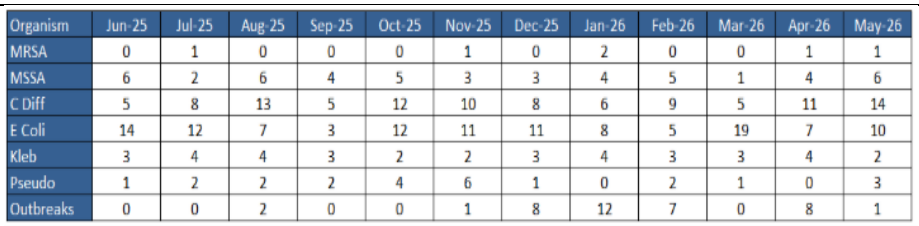
ASSURE 2

Assure (1) Capped theatre utilisation in May was 82.9%, improving above the process mean, but remaining below the national target of 85%.

The Trust has sustained performance above 82% for a second consecutive month. This is a significant achievement and an important marker of the impact of the Theatre Improvement Programme.

	Assure (2) The British Association of Day Surgery (BADS) day surgery rate target (85%) has been exceeded in the latest reported data (Jan 2025) at 85.7%. This performance continues the improvement seen at the end of 2025. Key improvement actions in Q1 26/27 • Both theatre and day case improvement programmes have been relaunched in March 2026 with a focus on using Patient First methodology to deliver optimal theatre and day case utilisation, productivity and patient experience. Programme teams are meeting fortnightly to progress workstreams spanning programme delivery, flow and capacity, data coding and reporting, estates and equipment, and workforce optimisation. • A focused deep dive on the reasons for on the day cancellations. • St Mary's OAC Procedural suite is supporting key specialties to move procedures from Theatres to Outpatients including T&O, Urology and Dermatology, which commenced in April 2026. • A review of opportunities for High Volume Low Complexity List planning is underway within Care Groups. Both improvement programmes are overseen by the Planned Care Improvement Group.
Maternity **ADVISE: 1**	**Maternity** Progress in achievement of maternity improvement plan: Most recent CQC inspection took place in September, with the final report received in March 2026, rated the service as “requires improvement”. Initial recommendations and action plan in place for baby abduction/security and safe staffing rosters.  Staff survey: Initial results show staff feel confident that the Trust prioritises patient care. Areas to focus – improving staff health and well-being, reducing exhaustion and increasing opportunities for teams to meet and discuss effectiveness. Culture improvement plan – Focus on behaviour charter work underway with perinatal leadership team in updating plan for 2026. **Key Areas of Focus** • Bookings completed before 10 weeks 78.4with target set at 65% • Avoidable term admissions to Neonatal unit ATAIN – 15 months of admission rates below the regional and national target. • Percentage of black and Asian women on continuity of care pathway by 28 weeks, 95.2%

	• Percentage of women smoking at delivery 4% national target <6%
Celebrating Outstanding:	Areas to note improvement: Bookings completed,10 weeks 71% with target set at 65% Avoidable term admissions to Neonatal Unit ATAIN – 14 months of admission rates below the regional and national target. Rate per 1000 of women with 3rd and 4th degree tears – fluctuations seen in rates but well below the national target since October 2023. Refresh training planned for June 2026
Infection Prevention and Control:	**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	**Alert (1) Methicillin Resistant *Staphylococcus aureus (*MRSA) bacteraemia:** 1 case of hospital associated MRSA bacteraemia in May 2026 (HOHA). Medical Care Group, OPS speciality. LERN submitted and reviewed at Rapid Review 02/06/26 and AAR to be completed within 20 days.
ADVISE: 5	**Advise (1) *E.coli* bacteraemia:** 910 cases of *E.coli* bacteraemia were identified in May 2026, with 7 being HOHA cases. All cases are being investigated via the PSIRF process to ensure any links or themes are identified for learning with ongoing work through the Fundamentals of Care Bladder and Bowel Group for catheter care an and pathways. **Advise (2) *Klebsiella* bacteraemia**: 2 HOHA cases reported in May 2026, a reduction of 1 compared to April 2026. **Advise (3) *Pseudomonas* bacteraemia:** 3 cases reported in May 2026, an increase of 3 compared to April 2026. No cases were linked or within areas of increased water counts. **Advise (4) Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia:** 7 cases identified in May 2026, an increase of 3 compared to April 2026.Ongoing PSIRF reviews for all cases, noting cannula sites as source of infection have been listed. Cannulation policy reviewed and revised policy in final draft form, for launch next quarter with supportive education. **Advise (5) *Clostridioides difficile* cases**: 14 cases of hospital associated *C.difficile* cases were reported and investigated in May 2026, increasing trajectory in Q1. Cases investigations ongoing, no areas have active outbreaks confirmed and no direct links between cases have been observed to date.

Organism	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
MRSA	0	1	0	0	0	1	0	2	0	0	1	1
MSSA	6	2	6	4	5	3	3	4	5	1	4	6
C Diff	5	8	13	5	12	10	8	6	9	5	11	14
E Coli	14	12	7	3	12	11	11	8	5	19	7	10
Kleb	3	4	4	3	2	2	3	4	3	3	4	2
Pseudo	1	2	2	2	4	6	1	0	2	1	0	3
Outbreaks	0	0	2	0	0	1	8	12	7	0	8	1

Clinical Practice Team **ALERT: 0**	**Falls prevention & management**:
ADVISE: 2	**Advise (1)**: Falls remain within the expected range on the SPC chart; May 2026 falls are comparable to May 2025; however, fewer resulted in moderate or greater harm. May 2026 rate: 7.3 per 1,000 bed days. Three inpatient falls resulted in moderate or greater physical harm, equating to 0.1 per 1,000 bed days. **Advise (2)**: Monthly Falls Steering Group meetings continue and are chaired by the WCCSS Group Director of Nursing (GDON).
ASSURE: 1	**Assure (1)**: eObs functionality for lying and standing BP recording has passed clinical acceptance testing (CAT) phase and is being presented for final sign-off by digital/EHR team.
Patient Experience	**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.**
ALERT: 0	There are no alerts
ADVISE: 2	**Advise (1) - Average complaint response timescale** Average Complaint response time = 51.96 days (increase from April = 39.76 days) **Advise (2) – Contributors to the final response letter will be asked to include the learning from the complaint in the response.** This is helping ensure that learning is captured and will enable the contributors to focus on what can be done to make improvements. It is also reducing the work needed by the complaints team to compose the final response.
ASSURE: 2	**Assure (1) – Complaints are kept up to date.** All complainants are kept up to date regarding any delays in the complaint investigation and response. **Assure (2) - new process for contributors to provide input started 09 March 2026.** Contributors are being asked to add the requested input directly into a final response template letter. This is showing that contributors focus on the questions being asked and the learning from the complaint.
Nurse Staffing:	No areas to alert

ALERT: 0	
ADVISE: 2	**Care Hours per Patient Day (CHPPD):** **Advise (1)** CHPPD for Registered Nurses/Midwives combined for May 2026 is 4.8 which is a slight increase of 0.1 from April 2026, the overall CHPPD for a Registered and non- registered care staff combined is 7.8, which again is a slight increase of 0.1 from April 2026 The Registered Nurse/Midwives fill rate for the trust is 90.4% and an overall percentage rota fill rate against planned staffing (day and night all nursing/care staff) for May 2026 was 91.5%. This is a slight decrease from April 2026. A HealthCare Support Worker (HCSW) trust wide recruitment event is taking place WB 15th June 2026 and a further HCSW open day planned 11th July 2026. **Red Flag Reporting:** **Advise (2)** There has been a decrease in the occurrence of Red Flags in May. 30 Red Flags occurred on adult inpatient wards overall in the trust for May 2026. 55% (11) are due to Patient at Risk as unable to provide Enhanced Care, 30% (6) due to Omission of fundamental care and 15% (3) due to RN shortfall of more than 8 hours or 25% versus shift demand.
ASSURE: 1	**Workforce Controls:** **Assure (1)** Red flags are reviewed by Matrons and data is triangulated with other quality and safety information in preparation for unannounced assurance visits to in-patient wards. Monthly review of Open Red flags by Senior Nursing staff within the Workforce Assurance group.
Workforce Performance:	**Strategic goal: To significantly improve staff experience, engagement, and retention.**
ALERT:2	**Alert (1):** UHD Bank usage did not achieve a balanced plan with an adverse variance of 33.5 wte against in-month plan. **Alert (2):** Off-framework agency usage in M2 doubled to 48 shifts largely driven by enhanced care needs in Critical Care Unit. A notable month-on-month increase in the use of Registered Mental Health workers, is contributing to off-framework supply utilisation.
ADVISE:3	**Advise (1):** Patient First A3s have now been drafted for the three elements of temporary staffing within the Workforce Operational Efficiency and Reduction Plan (WOERP) - 15% bank usage reduction, 30% agency usage reduction, removal of off-framework usage. **Advise (2):** In support of the workforce redesign strand of WOERP the following progress has been made: • Initial session has been held with an overview of the model hospital data to compare workforce metrics as a benchmark against UHD activity

	• Business case workforce growth tracker is being shared from finance and monitored on a monthly basis. **Advise (3):** Agency usage increased this month by 9% compared to last month, however it remains in a favourable position below plan.
ASSURE:3	**Assure (1):** Whilst bank usage increased in M2, Substantive and Agency continued to show favourable positions in the second month of the financial year. • Substantive workforce actual was favourable by 82.1wte against in month plan. • Actual usage for Agency workforce was favourable by 18.13wte against in month plan. **Assure (2):** The 15% reduction in bank spend and the 30% agency spend has been factored into the WTE planned figures for the 26/27 financial year and is being monitored at Trust, Care group and /directorate level by the HRBPs and workforce team. **Assure (3):** Break glass' protocol is in use to mitigate off framework. Additionally, there is a revised sign-off process of off framework authorisation to include Security requests and is expected to relaunch week commencing 22nd June 2026.
Celebrating Outstanding:	Total workforce progressed to a favourable variance of 66.7 whole time equivalents (WTE) against M2 plan. This was underscored by a favourable position in Substantive and Agency WTE in M2 2026-27.
Resourcing:	
ALERT: 1	**Alert (1):** While overall Time to Hire and employment check performance remain within agreed KPIs, there continues to be variation in delivery against some key recruitment service standards, particularly time to shortlist and the time taken to issue conditional offers. This inconsistency creates a risk to sustained improvement, candidate experience and manager confidence, and reinforces the need for continued process streamlining, automation and escalation through agreed governance routes. In addition, the review of vacancy control arrangements identified that the previous VRP model had not consistently provided effective workforce control, with routine requests often progressing with limited visible challenge.
ADVISE:1	**Advise (1):** Implementation of the Trust's Recruitment Service Level Agreements (SLAs) and associated KPIs has continued during May, with the framework now supporting clearer expectations, defined responsibilities and routine monitoring through existing workforce governance. This has been supported by associated reporting development and intranet publication activity, alongside continued socialisation with stakeholders. In parallel, Resourcing has also been supporting live system and corporate recruitment priorities, including ongoing Healthset Resourcing Workstream - Oversight Group activity and tranche-based recruitment planning.
ASSURE: 1	**Assure (1):** Work to improve recruitment performance and strengthen workforce control is continuing through a coordinated programme of action. This includes monthly monitoring of SLA and KPI performance,

<table>
<tr><td></td><td>escalation through the Trust Vacancy Review Panel, further refinement of vacancy review arrangements, and continued focus on reducing Time to Hire. May reporting indicates that, since September 2025, 22 working days (four+ weeks) have been removed from Time to Hire, with employment checks averaging 19.3 days against a KPI of 22 days. The revised governance framework is intended to provide stronger assurance over vacancy decisions, alignment to workforce plans and more consistent recruitment practice.</td></tr>
<tr><td>Organisational Development:</td><td></td></tr>
<tr><td>ALERT: 1</td><td>Alert (1) Appraisals: Number of appraisals completed has not met target compliance
Values based appraisal compliance has failed to achieve the 90% target rate over past 11 months and is at 77.31% for April 2026
Medical and Dental appraisal compliance has failed to achieve the 90% target rate over past 11 months and is at 83.52% for M11</td></tr>
<tr><td>ADVISE:1</td><td>Advise (1) Building readiness for change – a total of 36 team leaders have taken part since launching in January. To increase uptake, new shorter, targeted modules have been advertised, and an increase in uptake is noted with an additional 95 bookings made across the modules in April.</td></tr>
<tr><td>ASSURE: 0</td><td></td></tr>
<tr><td>HR Operations:
ALERT: 0
ADVISE: 1</td><td>Resident Doctors were due to commence a period of industrial action between 7 am on Monday 15 June to 7 am on Friday 19 June 2026, however it was announced on Saturday 13th June that this had been stood down following a revised offer.</td></tr>
<tr><td>ASSURE: 1</td><td>All Trusts must demonstrate progress to achieve 4.10% sickness absence rate by March 2027. Trajectory in place from March 2026. As of May 2026, the Trust’s sickness absence rate is 4.6% which is favourably below the May 2026 trajectory of 4.7%. A range of targeted actions continue to support improvement, including enhanced focus on the areas with the highest absence levels, strengthened management oversight and line manager training, together with earlier actions through HR, Psychological/Occupational health and musculoskeletal interventions.

<table>
<tr><th></th><th>Forecast outturn year ending 31/03/2026</th><th colspan="12">2026/27 Plan</th></tr>
<tr><th></th><th></th><th>M01</th><th>M02</th><th>M03</th><th>M04</th><th>M05</th><th>M06</th><th>M07</th><th>M08</th><th>M09</th><th>M10</th><th>M11</th><th>M12</th></tr>
<tr><td>Sickness Absence rate % (total substantive workforce)</td><td>4.70%</td><td>4.70%</td><td>4.70%</td><td>4.60%</td><td>4.60%</td><td>4.50%</td><td>4.40%</td><td>4.30%</td><td>4.30%</td><td>4.30%</td><td>4.20%</td><td>4.20%</td><td>4.10%</td></tr>
</table></td></tr>
<tr><td>Trust Finance Position</td><td>Strategic goal: To return to recurrent financial surplus from 2028/29</td></tr>
<tr><td>ALERT: 2</td><td>Alert 1: Revenue Outturn
Whilst the expenditure run rate improved in May, the Trust has delivered a cumulative deficit of £6.249 million being £1.234 million adverse to plan.</td></tr>
</table>

	This includes unplanned Industrial Action costs of £518,000, with the remaining adverse variance relating to efficiency savings being below the phased plan for April and May. NHS England has confirmed that there is no funding for Industrial Action costs which are expected to be mitigated locally. A full outturn forecast is being developed using the Month 2 outturn to identify any additional risks and inform mitigation plans. **Alert 2: Efficiency Improvement Programme** The Trust has delivered £6.2m of savings, being £0.7 million below the phased plan. The trust has identified total savings opportunities of £51.1 million, however when adjusted to reflect the risk of delivery in year, this is reduced to a current forecast of £30.4 million. Whilst this is an increase of £4.8 million from the April report, this is £38.1 million short of the full year savings requirement representing a material financial risk for the Trust.
ADVISE: 1	**Advise (1): Capital Outturn** The Trust reported capital expenditure of £13.5 million during April and May, in line with the planned spend. The capital programme has been refreshed to account for the final impact of the 2025/26 programme outturn. The updated programme has enabled additional prioritisation of the high-risk estates backlog, off set by a reduced medical equipment requirement.
ASSURE: 2	**Assure 1: Cash** As at the end of May 2026, the Trust is holding a consolidated cash balance of £98.4 million. After adjusting the £29.1 million of capital payables, this represents 28 days of operating expenditure and an underlying cash balance of £69.2 million. **Assure 2: Public Sector Payment Policy** In relation to the timely payment of invoices, the Trust has exceeded the national standard of 95% with a cumulative performance of 96.6%.
Sustainable Services	**Digital**
ADVISE: 1	**Advise (1) The rate of Advice and guidance requests per 100 first attendances demonstrate significant improvement however the target sits outside the current process control limits** All specialties are now live with Consultant Connect for Advice & Guidance.
ASSURE: 2	**Assure (1) Did not attend or missed appointment rates are demonstrating an improving trajectory at 5.2% (5% target)** The DNA rate (5.2%) is demonstrating normal variation falling below the process mean in May for the second consecutive month (improvement). The Trust continues to expand its use of DrDoctor to support patient self-management of appointments. **Assure (2) ICE for Ordering vs paper - target set for August 2026**

	The Task and Finish group has confirmed that the new carts and equipment will be fully rolled out by the end of June. The roll out of printers into outpatient areas will then continue until August. The plan for the cessation of paper requests to Pathology is being scheduled to support paperless requesting by August, which should result in an increase in ICE filing with improved accuracy.
RECOMMENDATION:	Members are asked to note the content of the report.
Implications associated with this item:	Council of Governors ☐ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☒ Financial ☒ Health Inequalities ☒ Operational Performance ☒ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☒ Regulatory ☒ Strategy/Transformation ☒ System ☒ Explain the impact on each selected area; positive outcomes, risks and mitigations, and any oversight needed.
CQC Assessment Framework:	Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well-Led ☒ Use of Resources ☒

Report History: Committees/Meetings at which the item has been considered:	**Date**	**Outcome**
Finance & Performance Committee (Operational / Finance Performance)	06/07/2026	Pending
Trust Management Group	25/07/2026	Pending
Quality Committee	07/07/2026	Pending

Appendix A SBAR
Excessive Hospital Patient Stays

S SITUATION	**UHD currently has around 230 patients with no criteria to reside (NCTR)**, against a Phase 3 requirement of 110. The position has been broadly static month on month but the underlying trajectory is

deteriorating, leaving NCTR around 120 off target. The trajectories for NCTR and Occupied Bed Days (OBD) shown below are being updated to reflect the revised hospital consolidation date of April 2027.

Figure 1: NCTR Trajectory

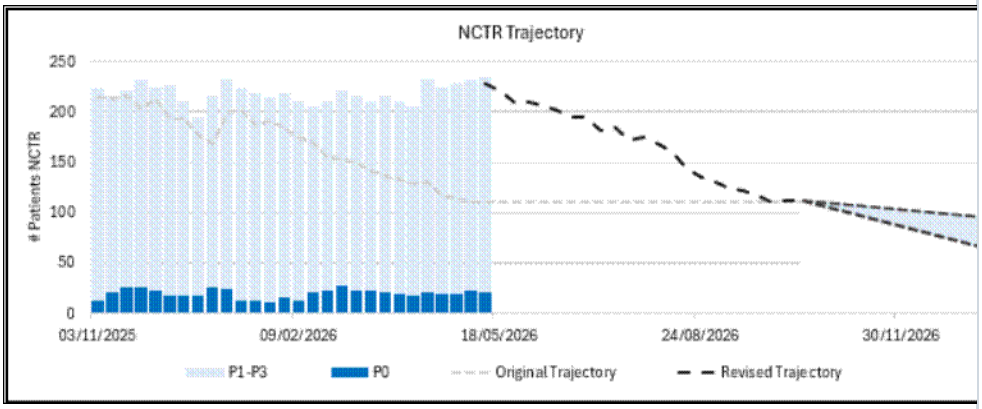
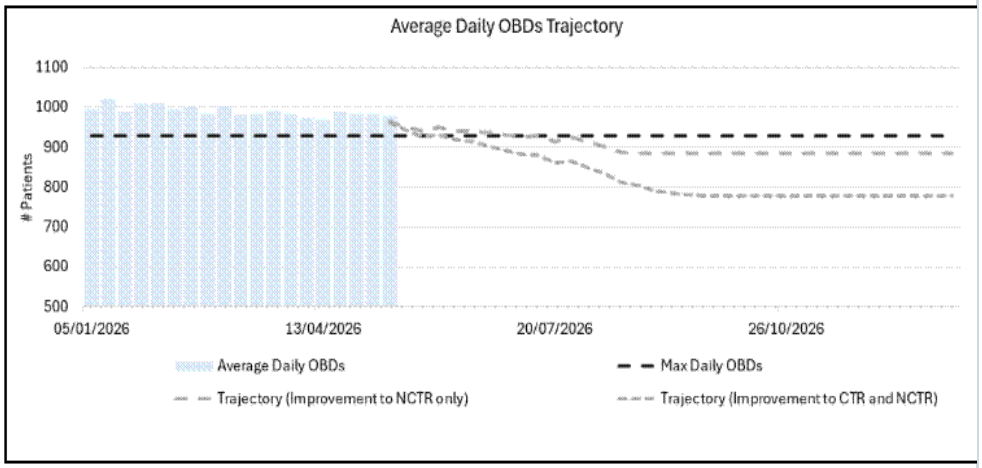


Figure 2: OBD Trajectory



Both trajectories are being revised to align to April 2027 as the planning date for hospital site consolidation. The solid, dashed and dotted lines continue to model three scenarios: NCTR delivery only; combined NCTR and CTR delivery; and current trajectory. The gap between scenarios provides deliberate planning headroom.

Scope: Progress is reported against three requirements: sustaining Horizon 1 ways of working through the Clinical Vision of Flow; delivering the in-gift admitted flow programme; and system re-design and re-commissioning.

B
BACKGROUND

Why has the position not improved?

- **Demand:** Emergency attendance is up 6% and admitted patient acuity exceeds the assumptions on which the bed model was built.
- **System capacity lost:** 610 P1 hours were removed over six weeks (March to April 2026), directly correlating with NCTR rising from 212 to around 230. The Trusted Assessors Service is discontinuing on 30 June 2026, removing a further discharge enabler.

- **Commissioning gaps:** CHC and joint funding routes have been reduced or withdrawn. End-of-life pathway capacity has diminished. These changes removed platforms the original trajectory assumed would remain available.

The challenge differs by cohort. CTR is within the Trust's operational control. A portion of NCTR is in our gift through earlier TOC referrals and internal handoff improvements. The larger NCTR portion requires system commissioning decisions and is not within the Trust's unilateral control.

Figure 3: CTR / NCTR In-Gift Framework

CTR — Criteria to Reside	NCTR — No Criteria to Reside
In our gift — addressed through the Admitted Flow Programme / CVF	Mixed — in-gift portion via CVF; larger portion requires system action
✓ **All CTR length of stay**	✓ TOC referral timeliness (in gift)
✓ TOC referral timeliness	⚠ Commissioning gaps (system)
✓ Internal delays	⚠ Discharge-to-Assess model (system)
	⚠ Social work response times (system)

A
ASSESSMENT

Requirement 1: Hold Horizon 1 Ways of Working (now within CVF)

The ways of working established through Horizon 1, including board rounds, wrap-ups, TOC referral discipline, and SDEC streaming, are now embedded within the Clinical Vision of Flow (CVF) programme. Reporting is being strengthened to provide consistency from ward through to Care Group, with sustainability embedded via the Patient First mechanism. Two health-checks will be undertaken over the coming months to examine sustainability and make recommendations.

- **SDEC** remains a key admission-avoidance lever and is performing above expectation.
- **Home-based intermediate care** length of stay reduction is being sustained.
- **TOC Hub** continues to coordinate complex discharge, operating under severe demand, supported by an enhanced digital discharge platform improving ward tracking.

Requirement 2: Admitted Flow Programme (Clinical Vision of Flow)

The Clinical Vision of Flow is an executive-sponsored programme governed via a steering group, built on Patient First methodology. It delivers improvement through four workstreams, with the inaugural steering group meeting held 29 June 2026.

Clinical Vision of Flow	Emergency Department & Assessment	Same Day Emergency Care & Short Stay	Sick Speciality	Sick Frail
Focus	**Front door flow** Streaming, 12hr waits, ambulance handover	**Avoid admissions** SDEC pathways, under-72hr stays	**Admitted specialty** Review, decisions, LOS management	**Frail cohort** Frailty assessment, deconditioning

Outcome	**Reduce 12hr waits** and corridor care	**Reduce patients** admitted > 2 midnights	**Reduce <75 admitted** > 7 days LOS	**Reduce >75 admitted** > 7 days LOS
Governance	**Executive Sponsor** Clinical Lead SRO	**Executive Sponsor** Clinical Lead SRO	**Executive Sponsor** Clinical Lead SRO	**Executive Sponsor** Clinical Lead SRO

Progress to date:

- Around 1,000 patient reviews completed via ward-based discovery interviews and NEWS2 audit across all UHD wards.
- Full diagnostic completed using a range of UEC and quality indicators.
- Clinical Vision of Flow Workshop attended by approximately 130 multidisciplinary staff across all areas.
- Writing Committee has produced vision statements and improvement plans aligned to GIRFT Clinical Operating Standards and internal professional standards.
- Governance structure in place: Executive Sponsors, Clinical Leads, Senior Responsible Officers, and workstream MDT membership confirmed.
- Length-of-stay and discharge performance targets in development at ward, directorate, and care group level, with corresponding targets for the TOC Hub and joint system performance reporting.

Requirement 3: System Re-Design and Re-Commissioning

Around 50 acute beds at UHD are occupied by patients outside CHC eligibility whose needs exceed Local Authority commissioning thresholds, costing UHD approximately £3.4m per year. This system commissioning gap is being absorbed through acute occupancy. Four conditions must be met to reach 110 NCTR; none has yet been fully delivered.

Condition	Lead	Position
1. Close commissioning gaps (ring-fenced placement budget, delirium in-reach, enhanced P1 offer)	ICB	Business case supported by ICB; progressing to investment panel July 2026.
2. Discharge-to-Assess operationalisation	ICB and system partners	Service standards approved 14 May 2026. Dependent on Condition 1 to deliver capacity.
3. Right-size community P1 and P2 commissioning	Dorset ICS	Case for P1 re-provisioning presented. 300 additional hours agreed for 4 weeks in response to immediate demand. No long-term decision yet.
4. Optimise BCP Adult Social Care response times	BCP Council	Allocation: 5 days vs 2 to 3 day target. CAA completion: 25 to 26 days vs 7 to 21 day target. In-hospital CAA: averaging 37 days. Direct engagement with BCP leadership ongoing.

R

RECOMMENDATION

The Committee is asked to:

- Note progress against the Clinical Vision of Flow programme, including the governance structure now in place
- Note the risk that the current NCTR position of approximately 230 against a target of 110 presents to both the operational health of urgent and emergency care pathways and the April 2027 hospital consolidation programme.
- Note that both the NCTR and OBD trajectories are being updated to align to April 2027 as the planning date for hospital consolidation.
- Note that all four system conditions required to reach 110 NCTR remain undelivered and outside the Trust's direct control, and that the Trust continues to escalate each to the ICB and system partners.
- Note that the business case for the specialist placements budget has ICB support and is progressing to the investment panel in July 2026.

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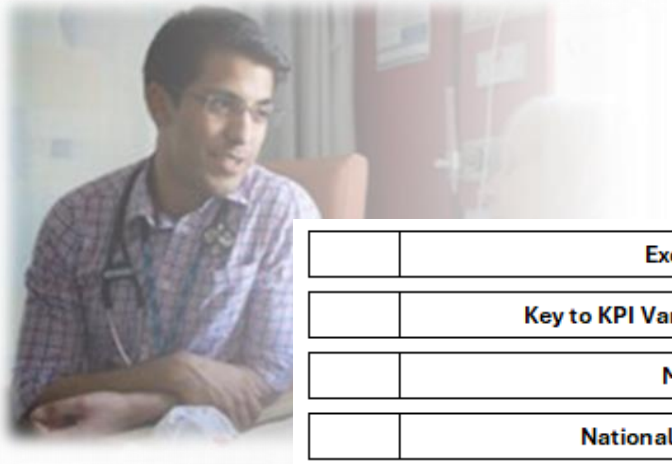
Integrated Performance Report

Reporting month: May 2026

Meeting Months : June / July 2026



Contents

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Executive Summary

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Forward Look: Maintaining Momentum
May marks a meaningful step forward in UHD's improvement journey. The NHS Oversight Framework results for Quarter 4 2025/26 provide important external validation of that progress, with UHD rising 17 places nationally from 87th to 70th, and an improved average metric score of 2.34 against 2.51 in Quarter 3. While the Trust remains in segment 3, this is the most significant single-quarter ranking improvement UHD has recorded and reflects the breadth of work now embedded across the organisation on behalf of our patients.

The month brought real reasons for confidence across the domains that matter most to patients. The 4-hour standard was met at 70.2%, ahead of trajectory. RTT performance exceeded operational plan at 66.9%, with 65-week waits eliminated and 52-week waits below 1%. Fewer patients experienced moderate or greater harm from falls compared to the same period last year. Maternity continues to perform strongly, with 15 consecutive months of neonatal admission rates below regional and national targets, and 95.2% of black and Asian women on a continuity of care pathway. SDEC is keeping more patients out of hospital who do not need to be there, and theatre utilisation at 82.9% means more patients are receiving planned surgery without delay.
The areas requiring continued focus are clear. Patients who are medically ready to leave hospital are waiting too long for community and social care provision, with NCtR at around 230 against a target of 110. This is a system-level challenge with direct consequences for the patients who remain with us beyond their clinical need, and for those waiting to come in. Cancer performance in Q1 has not met national recovery targets, and while structured recovery plans are in place and improvements are expected from June onwards, we are acutely aware of what these numbers mean for individual patients waiting for a diagnosis or treatment. The financial position requires disciplined delivery throughout the remainder of the year.

The Clinical Vision of Flow programme, launched in May with 130 colleagues, provides a platform through which we will improve the experience of every patient moving through our urgent, emergency and elective pathways. We will report openly to the Board on progress throughout the year ahead.

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

Key to KPI Variation and Assurance Icons

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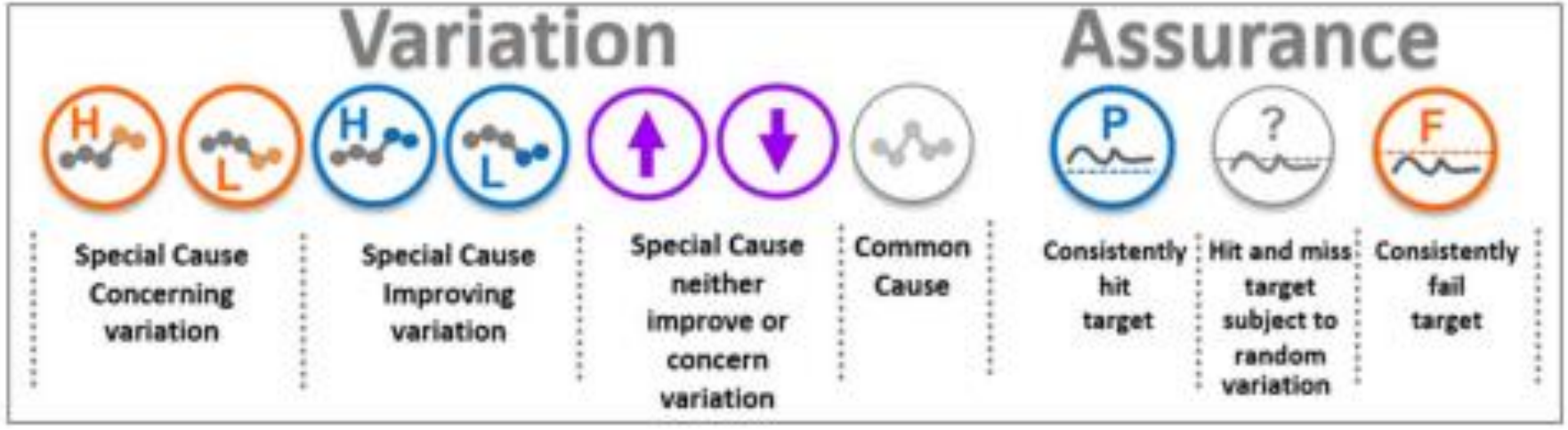

Special Cause Concern - this indicates that special cause variation is occurring in a metric, with the variation being in an adverse direction. Low (L) special cause concern indicates that variation is downward in a KPI where performance is ideally above a target or threshold e.g. ED or RTT Performance.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

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

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

Matrix Summary

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2026/27 IPR Matrix

VARIATION	ASSURANCE: Pass - the target/trajectory within the process limits and will be achieved if no change (P)	"Flip Flop" - the target may or may not be achieved (?)	Fail - the target/trajectory outside the process limits and will not be achieved without change (F)	No Target
special cause variation, IMPROVEMENT (H / L)				**SHMI – Summary Hospital Level Mortality Indicator ***
common cause or normal variation no significant change observed (same)		**RTT Performance against trajectory for 18 week standard (92%)*** **% Patients waiting >52 weeks (1% std) against trajectory *** Faster Diagnosis Standard (FDS) 28 days **% Patients waiting <18 weeks for 1st attendance** **4 hour safety standard ***	**62 day cancer standard *** DM01 - % waiting over 6 weeks Theatre utilisation (capped) HSMR In Month - UHD (Source: HED) **In Month Sickness Absence ***	Ambulance handovers - average handover time UHD **Patients >12hrs in dept *** **Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays *** **hospital associated infections - MRSA** **hospital associated infections - CDiff** **hospital associated infections - E Coli** Mortality Reviews % of total complaints closed within 35 days Number of Early Resolutions Number of Complaints Received
special cause variation, DETERIORATION (H / L)		RTT total PTL 31 day cancer standard Vacancy Rate at end of each month		Under 18's RTT pathways **Community Health Services SITREP % over 52 weeks**

**scored in NOF*

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

National Oversight Framework

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UHD has been placed into **segment 3** of the NHS Oversight Framework (NOF) in **Quarter 4, 2025/26** (published June 2026), with with a rank of #70/134 acute and specialist providers (an improved position) and an average metric score of 2.34 (previous quarter 2.51).

Scores and ranks are refreshed quarterly (Segment 1 is best)

Domain	Domain Score (March 2026)	Segment	Direction of Travel since last segmentation	Prevoius score (Dec 2025)
Access to Services	2.57	3	↑	Domain score 2.91 / Segment 4
Effectiveness and Experience of Care	2.49	3	↑	Domain score 2.56 / Segment 4
Patient Safety	1.78	1	↑	Domain score 2.13 / Segment 2
People and Workforce	2.17	2	↔	Domain score 2.19 / Segment 2
Finance and Productivity	1.95	2	↓	Domain score 1.54 / Segment 1

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Population & System

Mark Mould
Chief Operating Officer

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

Committees:
Finance and Performance Committee

Performance at a Glance

Population & System

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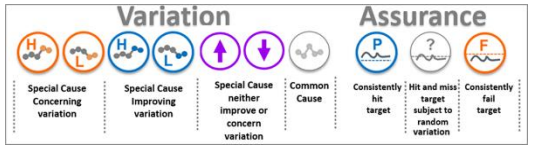

UHD Elective Care

KPI	Latest month	Measure	Target	Variation	Assurance
RTT Total Waiting List Size	May 26	67497	66447		
RTT Performance against trajectory for 18 week standard (92%)	**May 26**	**66.9%**	**66.8%**		
Patients waiting >52 weeks	May 26	672	602		
% Patients waiting >52 weeks (1% std) against trajectory	**May 26**	0.996%	**0.91%**		
Patients waiting >65 weeks	May 26	0	0		
% Patients waiting <18 weeks for 1st attendance	May 26	76.4%	73.3%		
Under 18's RTT pathways	**May 26**	**5394**	-		
UHD - Total Diagnostic Waiting List	May 26	12709	12587		
UHD - % waiting over 6 weeks (1% std)	**May 26**	**13.7%**	**7.4%**		
UHD - % waiting over 13 weeks	May 26	1.3%			
Community Health Services SITREP % over 52 weeks	**May 26**	**77.0%**	-		
Faster Diagnosis Standard (FDS) 28 days (75% std)	**Apr 26**	**67.2%**	**79.25%**		
31 day standard (96% std)	Apr 26	91.0%	96.0%		
62 day standard (85% std)	**Apr 26**	**65.8%**	**73.6%**		
Trauma Admissions	May 26	399	-		
% of NOF patients operated on within 36 hrs (admission from ED)	May 26	67.0%	85.0%		
% Outpatient appointments with procedures	May 26	26.3%			
UHD - Total Outpatient - Virtual (%)	May 26	16.8%	25.0%		
UHD Outpatient DNA rate	May 26	5.2%	5.0%		
Theatre utilisation (capped)	May 26	82.9%	85.0%		
UHD Theatre case opportunity	May 26	6.2%	15.0%		

UHD Urgent and Emergency Care

KPI	Latest month	Measure	Target	Variation	Assurance
Arrival time to initial assessment	May 26	16	15		
Clinician seen <60 mins %	May 26	29%	-		
Patients >12hrs from DTA to admission	May 26	447	0		
Patients >12hrs in dept	**May 26**	**1542**	-		
4 hour safety standard	**May 26**	**70.2%**	**70.0%**		
Ambulance handovers - average handover time UHD	May 26	32.7	-		
Ambulance handovers - average handover time RBH	May 26	33.6	-		
Ambulance handovers - average handover time Poole	May 26	31.6	-		
Ambulance handover >60mins breaches	May 26	302			
Ambulance handovers	May 26	4352	-		
Bed Occupancy (capacity incl escalation)	May 26	93%	85%		
Stranded patients: Length of stay 7 days	May 26	499	-		
Stranded patients: Length of stay 14 days	May 26	317	-		
Stranded patients: Length of stay 21 days	May 26	224	108		
Non-elective admissions	May 26	6624	-		
> 1 day non-elective admissions	May 26	3935	-		
Same Day Emergency Care (SDEC)	May 26	2689	-		
Conversion rate (admitted from ED)	May 26	26.4%	30.0%		
Temporary Escalation Spaces use in ED (average daily - over 45mins)	May 26	21.41	-		

Elective Access - RTT

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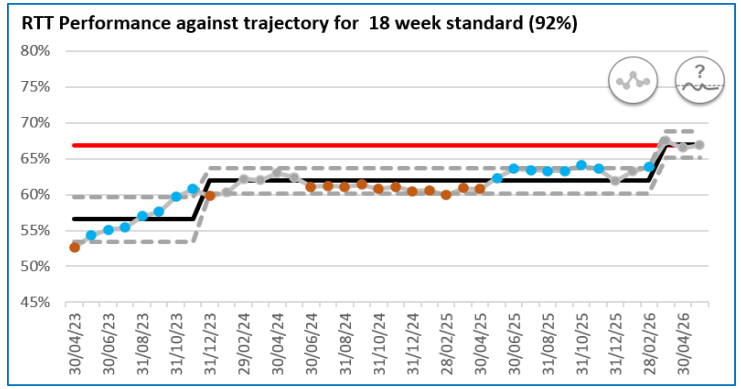
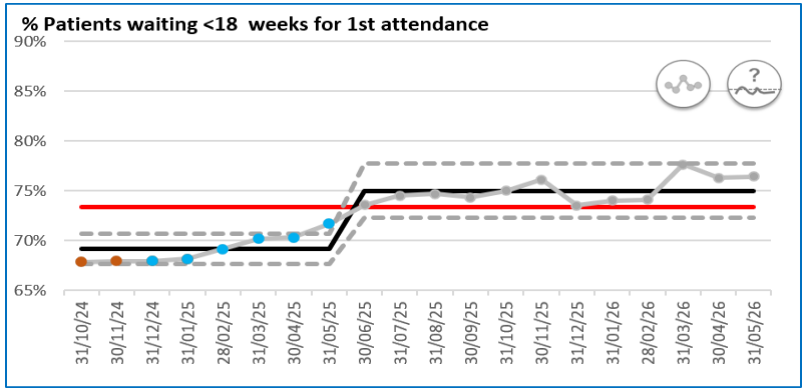
May 26
66.9%
Variance/Assurance
Targeting (Internal)
66.8%
Business Rule
Full CMS



May 26
76.4%
Variance/Assurance
Targeting (Internal)
73.3%
Business Rule
Note performance



May 26
0.996%
Variance/Assurance
Targeting (Internal)
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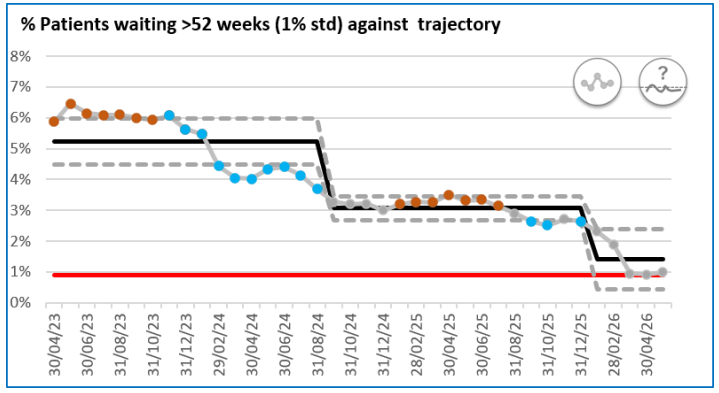
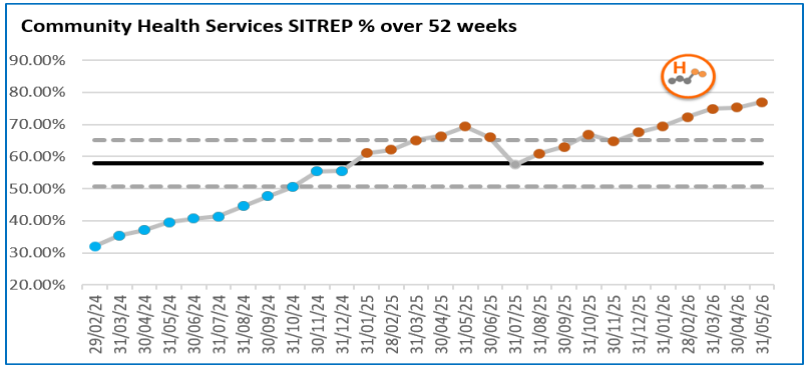
Business Rule
Full CMS



May 26
77.0%
Variance/Assurance
Targeting (Internal)
Business Rule
Note performance



Summary

The RTT 18 week performance trajectory for May was met.

- **RTT Waiting list –** Whilst the total waiting list remains above plan the variance to plan reduced to 1.6%.
- **Waits for first attendance (OPA or diagnostic test) within 18 weeks of referral** continue to exceed the planned trajectory; supporting early identification of treatment pathways.
- **% of RTT waits over 52 weeks** were maintained below 1%, achieving the national target. The total number of 52ww however were 70 above plan, due to a reduction in Gynecology capacity in month.

>52 weeks for Community Health (neurodevelopmental) services are above the upper process control limit. The rate of increase in patients exceeding >52weeks is higher than the rate of transfers to Right to Choose providers,.

Actions

Maximise the opportunity to deliver elective activity in Q1.

- Increase treatments by implementing activity plans with trusted in/outsourcing providers and improving internal productivity.
- Continue targeted validation of the waiting list to ensure patients who no longer need to be seen are discharged.
- Continue the expansion of the activity delivered via St Mary's Outpatient Procedural Unit in Q1 26/27, including one stop pathways.
- Community Paediatrics: 1. Continue the transfer of the longest waiting children on a neurodevelopmental pathway to Right to Choose providers (total 622 by end of July). 2.Confirm plan for children 'ageing out' of waiting list to ensure equitable access to adult waiting list. 3.Validation of waiting list. 4. Engagement with DHC regarding profiling tool. 5. Workforce planning for Nurse Medical Prescriber roles to increase long term capacity.

Assurance & Timescale for Improvement

Planned Care Improvement Group providing oversight and weekly performance huddle in place.

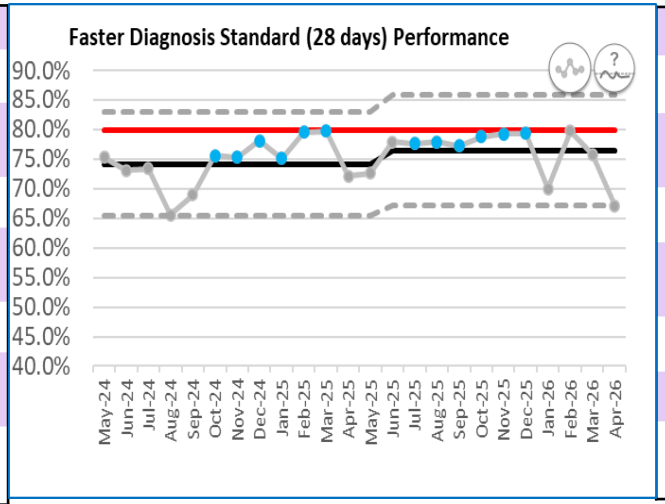
Timescales:

- Aim to meet the >52 week waits trajectory by end of Quarter 1 26/27.
- Maintain RTT performance on plan – Q1.
- Reduction in longest waits for patients waiting neuro-developmental assessment in Q1. Improved triage tool implemented. Oversight to be delivered by the School Health Neurodevelopmental Steering Group.

Elective Access - Cancer

University Hospitals Dorset
NHS Foundation Trust

Apr 26
67.2%
Variance/ Assurance
Targeting (Internal)
80.0%
Business Rule
Note performance



Apr 26
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Variance/ Assurance
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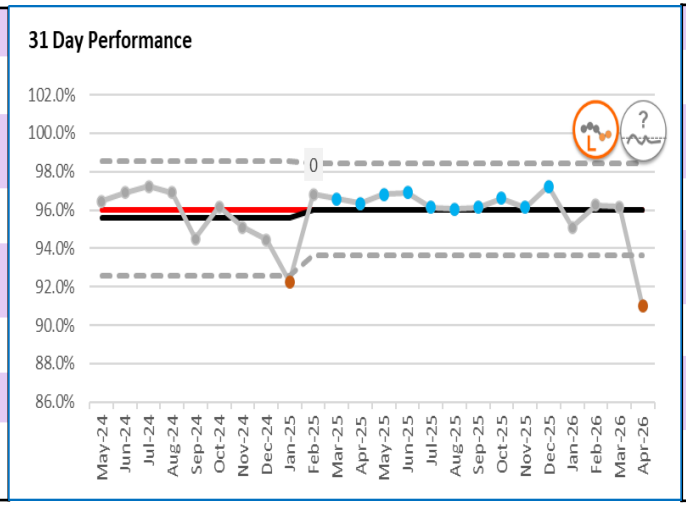
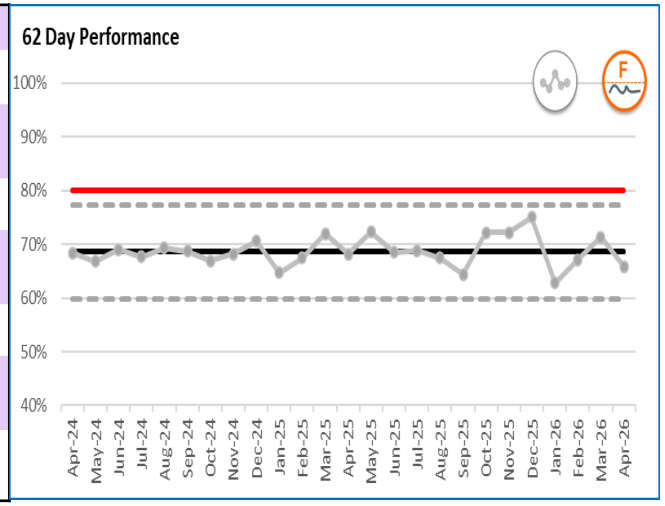


Apr 26
65.8%
Variance/ Assurance
Targeting (Internal)
80.0%
Business Rule
Full CMS



Summary

The Trust failed to deliver against all three of the National Cancer standards in April 2026:

FDS 28D Apr-26 performance of 67.2% falling short of the national recovery target and the Trust's operational plan (80%). Performance remains within common cause variation despite not being at this level since Aug-24.

31 Day Apr-26 performance of 91% failed to achieve the 96% national standard. This is the lowest monthly performance the trust has recorded since the combined Cancer Waiting Time Standards were introduced in Oct-23, reflecting the combined challenges of surgical, IR and Chemotherapy capacity affecting Cancer Pathways in-month.

62 Day Apr-26 performance of 65.8%, did not achieve the Trust's operational plan or the national recovery target (80%). Recovery actions continue to support the May-26 position and bring about process changes which will ensure the target is achievable.

The **over 62 Day PTL** remained below 220 patients with the end of April position reporting 201 patients with marginal improvement in May 26 at 198.

Actions

- **Colorectal** – Rapid improvement plan and Business Case in progress in conjunction with the Wessex Cancer Alliance, alongside additional WLI sessions, insourcing and 'Super Saturdays'. Additional insourcing has been delivered but ongoing staff sickness has impacted the pace of recovery.
- **Urology** – Action plan in development with the Wessex Cancer Alliance to improve MRI capacity and subsequently the performance against the 62D standard.
- **Skin** – 18 weeks contracted for 26/27 to support capacity whilst the ICB confirm their commissioning intentions.
- **Gynecology** – additional clinics in Q1&2 and new Consultant starting in June and 2nd in Sept to support FDS. Introduction of Penthrox in clinic from June 26 to improve access to treatments.
- **Breast** –. A new Breast Pain service will launch at the start of Q2 of 26/27.
- **All sites** – review of PTL management with enhanced weekly Exec level support and improvement plans and trajectories in place.

Assurance & Timescale for Improvement

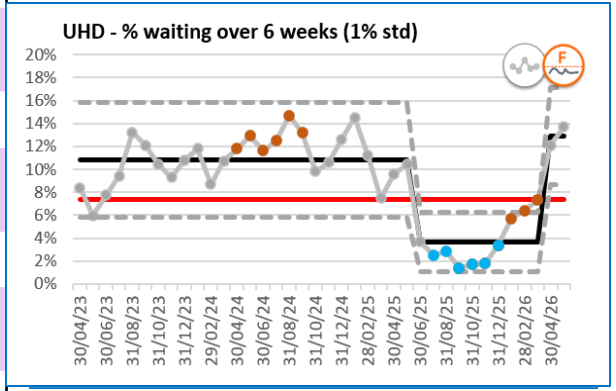
- Cancer governance and reporting arrangements have been updated with a weekly Cancer Improvement Group now in place and a new Cancer Board being implemented in June 26.
- Expecting a challenged but improved position for the 31 day, FDS and 62 Day standards in May.
- Overall performance for Q1 of 26/27 is expected to be challenging following industrial action and holiday periods.
- Bi-weekly tumour site level communications on key actions are being circulated to services, as well as daily escalation of individual cases.
- Gynaecology recovery action for the FDS standard to be realised in Q2
- Impact of Colorectal improvement plan on track for Q4 26/27 following approval in principle of Business Case in June 26.
- Wessex Cancer Alliance (WCA) will be supporting the urology recovery plan through various improvement activities and pathway work

Health Inequalities and Primary Prevention

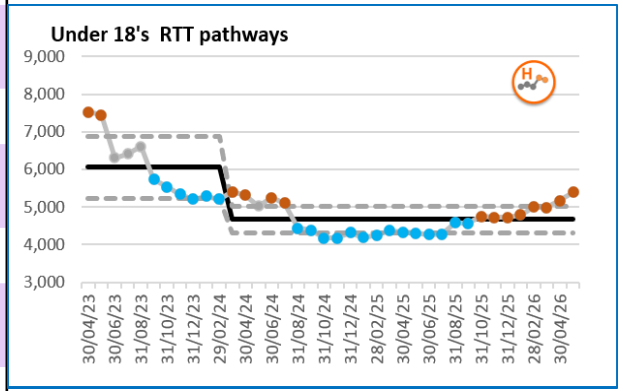
Diagnostic Access , RTT Under 18's waiting and Smoking Referrals

University Hospitals Dorset
NHS Foundation Trust

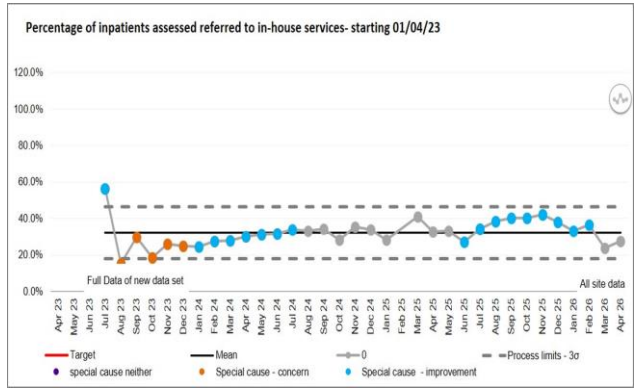
May 26
13.7%
Variance/ Assurance
Targeting (Internal)
7.5%
Business Rule
Note Performance



May 26
5,165
Variance/ Assurance
Targeting (Internal)
Business Rule
Full CMS



Apr 26
27.38%
Variance/ Assurance
Targeting (Internal)
Business Rule
Note Performance



Summary	Actions	Assurance & Timescale for Improvement
DM01 (Diagnostics) performance showed further deterioration against the target at 6.2% above plan. Performance in May was impacted by a spike in cardiology referrals in March/April with ongoing reduced outsourcing capacity for echocardiology. Capacity was also challenged in neurophysiology and endoscopy along with a depleted bookings admission team and higher complexity colonoscopy procedures restricting improvement in endoscopy. Imaging (1.6%) and physiological measurement (1.7%) both exceeded the internal target. The RTT waiting list size for patients <18 yrs demonstrates >7 points of special cause variation at the upper process control limit. RTT performance however at 69.2%, is higher than all age groups. The average weeks waiting at the point of treatment for people in IMD 1-2 (most deprived) shows no variation compared to people from IMD 3-10 in Quarter 1 to date 2026/27. Children within the 20% most deprived groups, on average have 1 weeks less to wait compared to those in IMD 3-10. When analysing by ethnicity for all age groups, patients from community minority groups on average wait 1 week less than white British groups. Children from community minority groups are waiting an average of 4 weeks less. UHD Tobacco Service – The latest data is May 2026 - referrals 283 with 81% (229/283) of patients seen Following referral. 28 Day Quit Outcomes – Apr 2026 – 12.3%	Diagnostics actions: Endoscopy: • New Endoscopy Unit is on schedule to open in Quarter 2. • Training and of additional staff to undertake booking processes • Continuation of insourcing and use of Wimborne Hospital to maximise capacity for lists. In Echocardiology, new staff have been recruited alongside additional insourcing planned for Quarter 2. Both services have a phased recovery plan in place focused on restoring utilisation, strengthening the booking function (endoscopy), stabilising clinical capacity, and deploying targeted additional activity. Analysis completed to understand the RTT waiting list trends for Under18yrs olds. Specialties requiring deep dive include ENT, Orthopaedics, Paed Surgery and Paed Gastroenterology. Review underway. Orthopaedics has been impacted by short term loss of capacity within the consultant and therapy workforce. Recruitment is underway and additional sessions scheduled.	DM01: Recovery plans are in place for cardiology, neurophysiology and endoscopy with oversight managed through the Planned Care Improvement Group. Orthopaedic paed waits – improvement expected Q2.

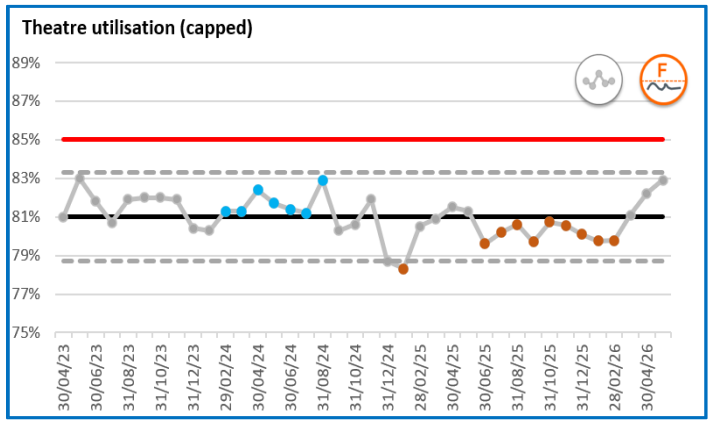
Operational Productivity

University Hospitals Dorset
NHS Foundation Trust

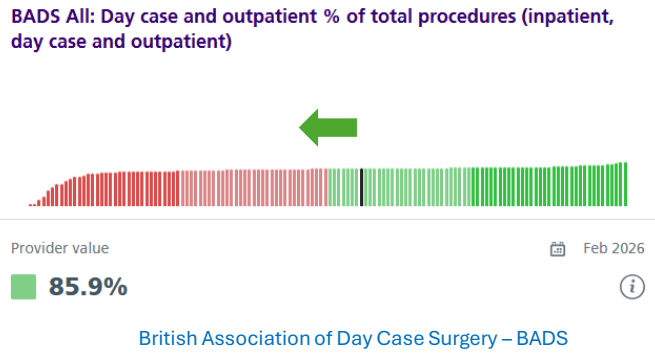
Month 1 freeze activity vs annual plan.

Activity POD	M1 Plan	M1 Actual	% Variance
1st outpatients	20,747	19,823	96%
Follow-up outpatients	25,064	23,857	95%
Elective day cases	7,427	7,515	101%
Elective inpatients	1,175	875	74%

May 26
82.9%
Variance/ Assurance
Targeting (Internal)
85%
Business Rule
Verbal CMS



Feb 26
85.9%
Variance/ Assurance
Targeting (Internal)
85%
Business Rule
Note Performance



Summary

- **Capped theatre utilisation** improved to 82.9% moving above the process mean for a second month. The case opportunity is also well below the 15% target at 6.2%. A structured theatre improvement programme is supporting this performance improvement.
- **BADS Daycase rate** (Feb 2026) is 85.9%, maintaining performance above the national target (85%). Within this, Day cases were above National average (63% vs 45.8%) and outpatient procedures below (22.9% vs 36.8%).
- **Implied productivity growth:** The month 10, 25/26 implied productivity growth (latest nationally reported data) compared to month 10 2024/25 is 2.1%, returning the Trust's performance above the national >2% growth target. Costed Weighted activity has increased by 2.9% conversely expenditure growth increase of 0.8%
- **Elective activity** in April (post freeze date) was below plan for Outpatient First and follow up appointments and for elective inpatients. Day cases exceeded plan. Industrial action adjacent to Easter impacted the type and volume of activity able to be scheduled.

Actions

Theatre improvement programme – key areas of focus:
- Data validation completed daily to ensure accurate recording of elective vs emergency patients within theatre lists.
- Review of shadow patients process to ensure patients are identified prior to operating date.
- Deep dive into reasons behind patients not being fit on day of surgery.
- Review of SSD and theatre process, with the aim to have equipment on site >36hrs before surgery to eliminate short notice issues
- Patient optimisation 'waiting well' during pre-operative period.

Day case improvement programme - key areas of focus:
- Implement day case as default across surgery
- Reduce clinical variation and increase pathway alignment across surgery
- Reconfigure pathways in day surgery to improve efficiency and clinical outcomes
- Expansion of outpatient procedural pathways at St Mary's hospital, increasing one stop pathways.

Assurance & Timescale for Improvement

The Planned Care Improvement programme provides oversight to elective activity, and Theatre Improvement and Daycase programmes.

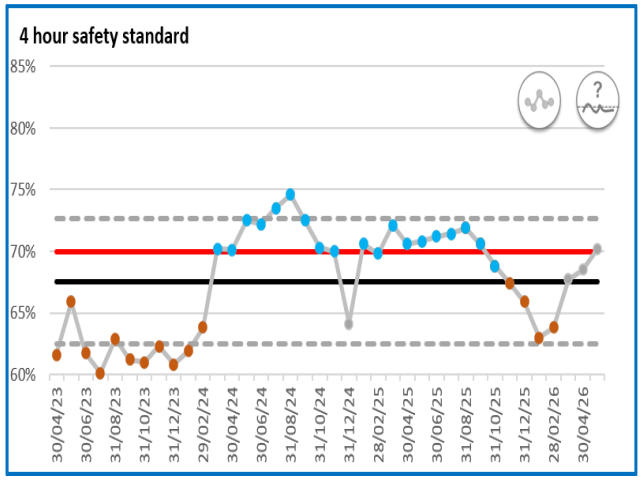
The Theatre improvement programme is delivering oversight of the improvement plans for specialties. 2026/27 trajectories have been reset. Aim to deliver >85% standard consistently from December 2026. Five workstreams:
- Peri- Operative Medicine
- List Planning and Scheduling
- Workforce Optimisation
- Data and Governance
- Estates and Equipment

Maintain BADS day case rate – current performance delivered above >85% national target.

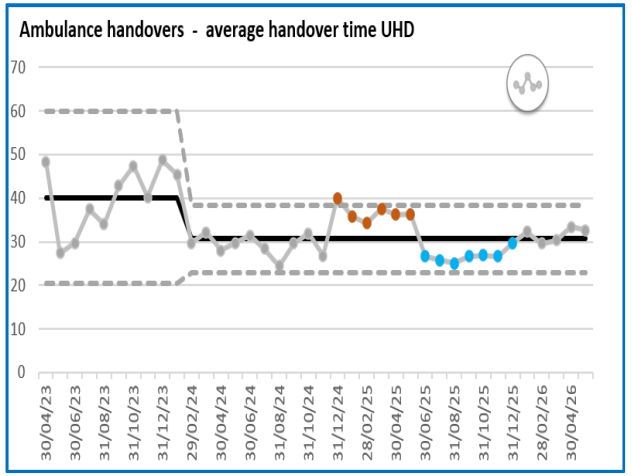
Urgent and Emergency Care

University Hospitals Dorset NHS Foundation Trust

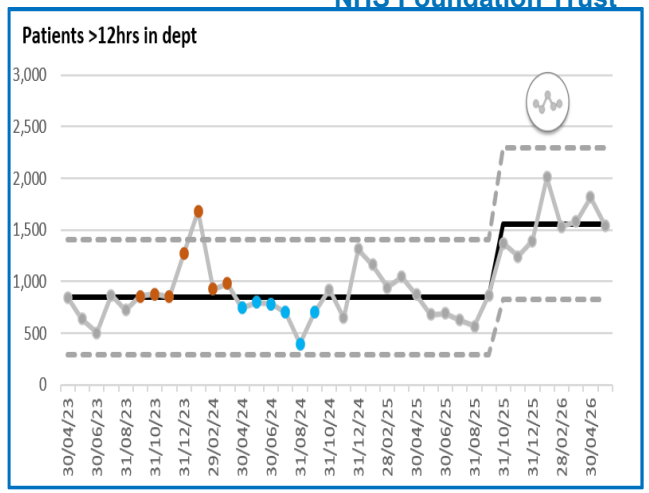
May 26
70.2%
Variance/ Assurance
Targeting (Internal)
70.0%
Business Rule
Verbal CMS



May 26
32.7 minutes
Variance/ Assurance
Targeting (Internal)
Business Rule
Note performance



May 26
1542
Variance/ Assurance
Targeting (Internal)
Business Rule
Full CMS



Summary

- The Trust delivered 70.2% in May against a target of 70%.
- There was a slight drop off in attendances, 596 a day vs 624 in April.
- There was also a small increase in Type 3 activity of circa 700 attendances driven by predominantly by UTC but MIUs also saw a small increase.
- Whilst decision to admit time remained relatively static, time to triage dropped from 22.4 minutes to 16.2- the lowest since August 2025. As well as mean time in the department dropping at both sites by 20 minutes.
- Number of patients waiting over 12 hours within the department also dropped from 9% to 7.3%.
- There was some improvement in admitted performance increasing to 25%.
- Non admitted performance also increased to 81.1% from 80.4% showing ongoing improvement.
- Ambulance handover times continues to see marginal improvment at 28minutes.
- The number of NCTR averaged 223 in May, significantly off trajectory. The benefit of an improved P0 position has been more than offset by the increase in P1 patients, delayed through a reduction in capacity. BCP have written to UHD informing of their intention to withdraw the Trusted Assessor service which alongside a lack of D2A beds / service and CHC no longer assessing in the hospital, creates a challenging space for patients with the most complex needs, to be discharged to a more and supportive care setting.

Actions

- Pilot has gone live with the 111 Service to enable the clinical triage of activity to either a virtual contact or to stream away from ED to better utilise capacity.
- Review of medical workforce to expedite reconfiguration proposal to meet increased demand and senior decision making at RBH site.
- Business case being presented to the system UEC delivery group for decision around i) short term funding to support complex discharges and ii) assessment out of hospital (D2A). This will establish a funding route out of hospital for patients with complex needs who remain within an acute bed. In addition the case advocates for an increase in P1 capacity to mitigate in part the withdrawal of hours and the apparent impact on NCtR number.
- Ongoing focus on NCtR recovery actions including review of trajectory, with four priority areas requiring coordinated effort and agreement from system partners.
- Board paper drafted with actions attributed to reducing NCTR, risk register updated to align.
- Clinical Vision of flow event has launched, with a 130 attendees. Follow ups with a writing committee and the associated trust governance are underway to establish the trust program aligning with patient flow.
- A site flow PDSA has begun focusing on quality and outcomes to create capacity through greater ownership to optimise discharge potential to create flow through the organisation. This is being followed up with some patient process mapping.
- Improvement cycles in place across Specialist Medical wards and about to roll out to Older People's wards. This will create a blue-print forward processes including Board / Ward rounds and discharge planning and will standardise the approach across the Trust. Focus for the next reporting period will be to continue to roll out to the wider Trust.
- GIRFT standards and processes being embedded in relation to Corridor care and greater than 24 hrs wait, with a structured judgement review underway. Governance for reporting themes has been set underway, working through how this aligns and informs.

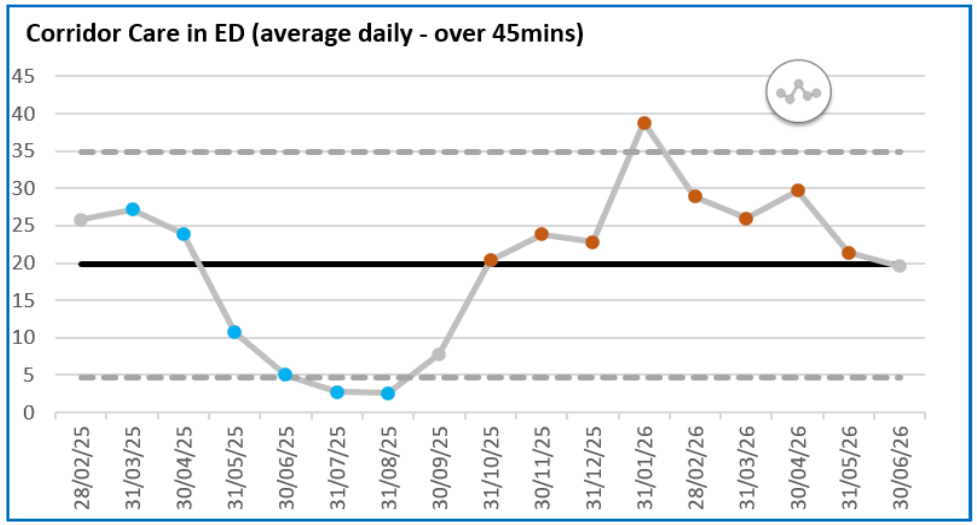
Assurance & Timescale for Improvement

- Front Door: Same-Day Emergency Care (SDEC) now supports 20% more patients attending hospital, without needing to admit them. Despite hospital attendances increasing by 6% compared to last year, admissions have decreased by 1%. This has been supported by improvements in SDEC.
- Transfers of Care Hub continues to develop and mature in line with the ward rollout program to wrap around the broader systems and processes.
- 30% reduction in P2 referrals following the establishment of a triage process converting to pathway 1.
- Case for interim care budget to support complex pathways being presented to UEC Group 10th June.
- Executive escalation process in place enhancing the visibility of the commissioning gaps and approach to discharge across Dorset.
- Clinical Vision of Flow programme commenced in May 26. This programme will deliver benefit across all pathways with focus on Criteria to Reside will positively impact NCtR.

Corridor Care

University Hospitals Dorset
NHS Foundation Trust

May 26
21 per day 664 total
Variance/ Assurance
Targeting (Internal)
Business Rule
Note performance



June 26
20 per day 587 total
Variance/ Assurance
Targeting (Internal)
Business Rule
Note performance

Summary	Actions	Assurance & Timescale for Improvement
Corridor care, (previously temporary escalation space care) has been published nationally for the first time by NHSE (May postion). Statistics » Corridor Care – Urgent and Emergency Care Daily Situation Reports NHSE recognise that this metric is immature and have therefore classified the data in this report as "experimental." The data is collected as part of the UEC Daily SitRep, Guidance for the collection was refined after it was first issued in March. Nationally, data quality and completeness work is ongoing. The national ambition is to end corridor care Within the South West Region , UHD ranked 7 out of 13 trusts in May 2026. Daily rates in the SW Region ranged from 4 –32 per day. The SPC chart show that the volume of corridor care periods has dropped below the mean and moved from special cause variation (concern) to common cause variation indicating some improvement on previous months.	Within slide 13	Within slide 13

University Hospitals Dorset
NHS Foundation Trust

Our People

Operational Leads:
Irene Mardon- Deputy Chief People Officer

Committees:
People and Culture Committee

Performance at a Glance
Our People

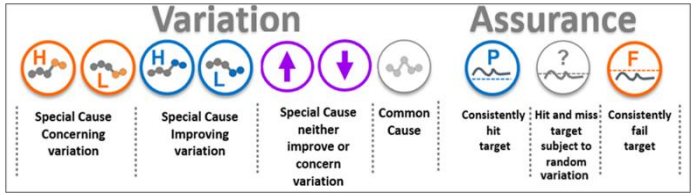
University Hospitals Dorset
NHS Foundation Trust

UHD Workforce

KPI	Latest month	Actual	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Vacancy Rate at end of each month	Apr 26	10.7%	7.5%	H	?	7.4%	5.2%	9.6%
In Month Sickness Absence	May 26	4.6%	4.0%		F	4.7%	4.1%	5.3%
Mandatory Training Compliance at end of each month	May 26	86.0%	90.0%	L	?	89.1%	87.9%	90.2%
Agency Pay as Proportion of Total Pay	May 26	0.7%	3.2%	L	P	2.5%	1.8%	3.2%

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



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

Workforce monitoring - Actual vs plan

University Hospitals Dorset
NHS Foundation Trust

Operational Plan Monitoring

Staff Type	Plan/Actual	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Substantive	Actual	9147.1	9170.1										
	Plan	9229.8	9252.2	9317.1	9322.8	9305.2	9288.6	9280.5	9272.4	9264.3	9251.2	9239.2	9226.1
Bank	Actual	664.6	590.7										
	Plan	579.8	557.2	540.4	537.3	540.4	546.6	552.9	559.2	565.5	568.5	559.2	534.1
Agency	Actual	55.2	60.0										
	Plan	83.8	78.1	72.2	70.2	69.6	68.2	67.7	70.0	75.0	73.9	68.0	63.5

Staff Type	Plan/Actual	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Total Staff	Actual	9866.8	9820.8										
	Plan	9893.4	9887.5	9929.6	9930.2	9915.2	9903.4	9901.0	9901.6	9904.8	9893.7	9866.3	9823.6

Summary

- In M2, UHD total workforce was 9820.8 whole time equivalent (wte), a favourable variance of 66.8 against in-month plan.
- M2 substantive workforce had a favourable variance of 82.1wte to in-month plan.
- Bank usage returned an adverse variance of 33.5wte against planned usage.
- Agency usage had a favorable variance of 18.1wte against an in-month plan of 78.1wte.

Actions

The '*Workforce Operational Efficiency and Reduction plan*' (WOERP) has been updated to increase specificity in the targets for the Clinical Workforce Transformation i.e. reducing medical spend by 8%.

The 15% reduction in bank spend and the 30% agency spend has been factored into the WTE planned figures for the 26/27 financial year and is being monitored at Trust, Care Group and Directorate level by the HR Business Partners and the workforce team.

Assurance & Timescale for Improvement

Strategic A3s have been drafted for the three elements of temporary staffing within WOERP (15% bank usage reduction, 30% agency usage reduction and the removal of off-framework usage). Additionally, there is a planned rework of the sign-off process of off framework authorisation through Heads of Nursing. The re-launch of revised process has been tentatively agreed with a timeline set for the week commencing 22nd June.

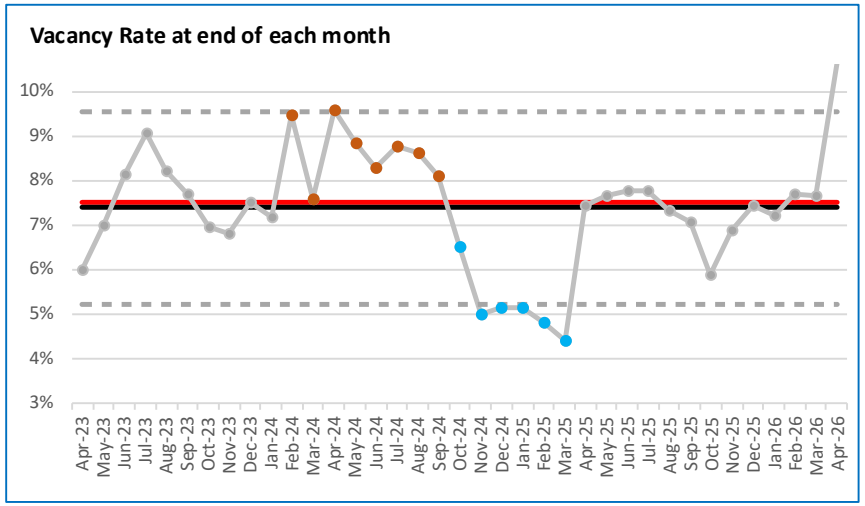
In support of the workforce redesign strand of WOERP the following progress has been made:

- Initial session has been held with an overview of the model hospital data to compare national workforce metrics as a benchmark against UHD activity.
- Business case workforce growth tracker is being shared from finance and monitored on a monthly basis.

Workforce monitoring - Vacancy Rate

University Hospitals Dorset
NHS Foundation Trust

April 26
10.7%
Variance/ Assurance
Targeting (Internal)
7.5%
Business Rule
Verbal CMS



Summary

Vacancy Position – April 2026

Reporting against Establishment (Cosmos / ESR) shows a vacancy rate of 10.66% (1,070.48 WTE), representing a major increase from the previous month.

There are 743.92 WTE live vacancies active on the Recruitment system across the Trust, representing posts approved for recruitment and in progress.

Not reported in this figure are 40 WTE vacancies aligned to the Healthset programme – where internal recruitment is currently being prioritised. Not all these posts will be fulfilled with UHD employees, with successful candidates remaining employed by their existing Trust.

Actions

- Continue to strengthen workforce and recruitment oversight through the Vacancy Review Panel (VRP), supporting prioritisation and alignment to Trust-wide workforce plans.
- Continue embedding of Recruitment Service Level Agreements (SLAs) and KPIs, strengthening accountability and consistency across the end-to-end recruitment process.
- Maintain focus on Time to Hire improvement, supporting timely conversion of the increased volume of live vacancies, with performance monitored through routine reporting.
- Healthset EHR recruitment is now live, with a phased internal and system-wide approach underway to support programme delivery.

Assurance & Timescale for Improvement

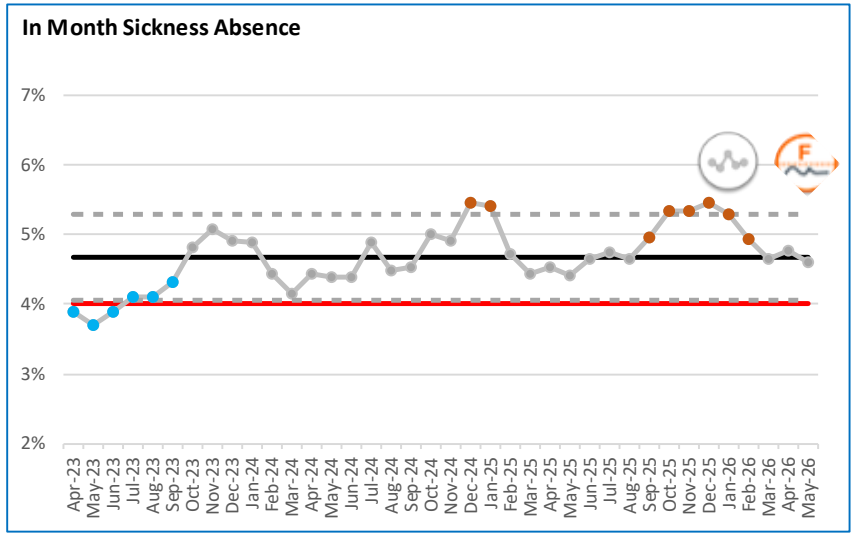
- Revised Vacancy Review Panel (VRP) arrangements remain in final design, and will further strengthen vacancy control, prioritisation and consistency of decision-making once implemented.
- Recruitment performance improvements are supporting delivery of vacancies, providing confidence in the Trust's ability to respond to increased establishment over time.

Sickness Absence Rate / Turnover

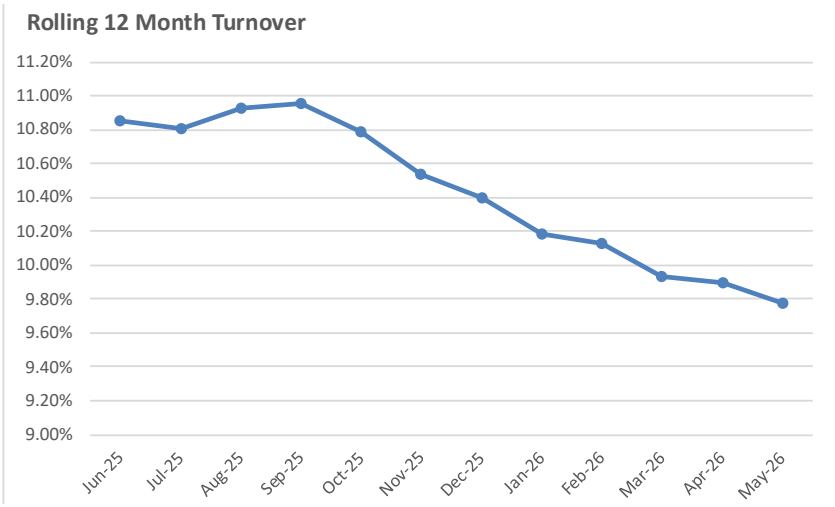
University Hospitals Dorset
NHS Foundation Trust

May 26
4.6%
Variance/ Assurance

Targeting (Internal)
4.0%
Business Rule
Verbal CMS



May 26
9.8%
Variance/ Assurance
N/A
Targeting (Internal)
10%
Business Rule
Verbal CMS



Summary

- In month sickness absence for M2, slightly decreased from last month by 0.16%, decreasing to 4.60%. This consisted of 2.69% short term sickness absence and 1.91% long term sickness absence.
- Across care groups and functions: Operations – 6.54%, Surgical – 4.64%, Medical – 4.92%, WCCSS – 3.92% and Corporate – 3.87%.
- The top 3 reasons for sickness were 1) anxiety/ stress/ depression/ other psychiatric illnesses (1.2%), 2) MSK (0.5%) and 3) cold/ cough/ flu (0.4%) plus other (not classified elsewhere) (0.4%).
- Turnover slightly decreased M2 to 9.8%.

Actions

Sickness absence management continues to be a focus across the organisation. The Managing Attendance Policy and Procedure is currently under review, with a target completion date of 30 September 2026. HR continues to support managers in managing absence within their teams. delivering bite-sized training sessions and providing data. This supports managers to identify employees with high levels of absence and ensure that both short and long term absence cases are managed appropriately and in accordance with the policy and procedure.

Turnover remains stable, again noting a slight month 2 reduction. The focus remains in areas with the highest rates, however, it is worth noting that in recent months, the number of leavers has significantly declined, i.e. within Outpatients. Targeted actions in the Discharge Team to improve retention, along with staff survey reviews for wider services continuing.

Assurance & Timescale for Improvement

All Trusts must demonstrate progress to reduce sickness absence rates to 4.1% by March 2027.

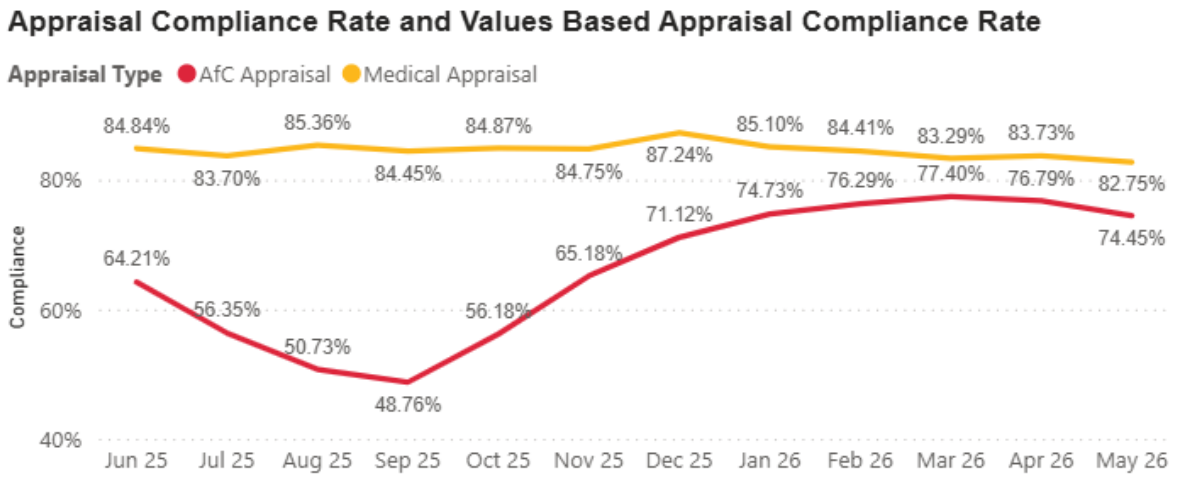
March 2026 – March 2027 trajectory in place to achieve 4.1% by March 2027. Monitored through NHSE.

Performance on track with favourable M2 position against the agreed trajectory to achieve a sickness absence target of 4.7% in M2.

Appraisal Rates

University Hospitals Dorset
NHS Foundation Trust

AFC Appraisal May 26
74.45%
Variance/ Assurance
N/A
Targeting (Internal)
90%
Business Rule
Full CMS



Medical Appraisal May 26
82.75%
Variance/ Assurance
N/A
Targeting (Internal)
90%
Business Rule
Full CMS

Summary

•The rate of AFC appraisal compliance for Month 2 has decreased from 77.31% to 74.45%. Additionally, Medical appraisal has decreased from 83.73% to 82.75%.

•AfC Compliance is lowest in the medical care group at 65.8% and highest within WCCSS at 80.8%.

•Compliance is highest amongst our Healthcare Scientist staff group and lowest amongst Admin and Clerical staff.

•Monthly Appraisal Essentials briefings continues. 21 appraisers attended this month with 25% of attendees completing the more comprehensive formal appraisal skills training.

Actions

•The procurement of a a new UHD learning management system during 2026, will incorporate an appraisals module, anticipated implementation is Q4.

•Further to the development of the A3 focused on appraisal improvement, a task and finish group has been set up to scope actions.

•HR Business Partners remain aligned to support continued work to improve compliance within care groups and corporate functions.

•A targeted approach for appraisal training is taking place for areas with low compliance.

Assurance & Timescale for Improvement

- Appraisal rates continue to be monitored for compliance to 90% with additional improvement actions to increase compliance.

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	May 26	43.60	-			38.01	31.80	44.22
Patient Safety Incidents (Moderate +) per 1,000 beddays - Closed only	May 26	0.20	-			0.47	0.11	0.83
Medication Incidents (All) per 1,000 beddays	May 26	4.80	-			5.06	3.19	6.92
Associated Pressure Ulcers (Cat 3 & 4) per 1,000 beddays	**May 26**	**0.50**	-			**0.40**	**0.13**	**0.66**
Inpatient Falls (Moderate +) per 1,000 beddays	May 26	0.20	-			0.18	-0.06	0.42
Hospital Associated Infections - MRSA	**May 26**	**1**	-			**1**	**-2**	**3**
Hospital Associated Infections - MSSA	May 26	6	-			5	-1	10
Hospital Associated Infections - C Diff	**May 26**	**14**	-			**9**	**-1**	**19**
Hospital Associated Infections - E Coli	**May 26**	**10**	-			**11**	**1**	**22**
Hospital Associated Infections - Kleb	May 26	2	-			5	-2	11
Hospital Associated Infections - Pseudo	May 26	3	-			2	-2	6
Hand Hygiene Compliance	May 26	0.0%	-			90.5%	81.9%	99.1%
Infection Control Mandatory Training Compliance	May 26	0.0%	-			79.4%	64.9%	93.8%

NHS Staff Survey Results will be reported annually

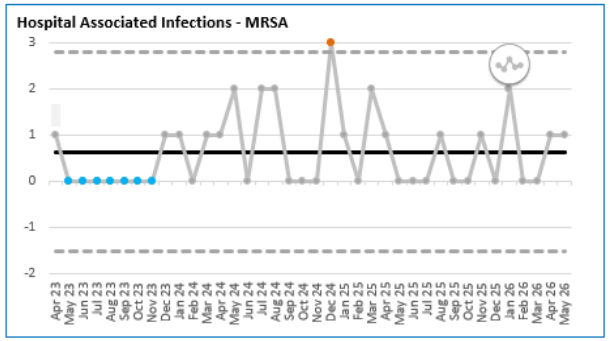
- Improved NHS Staff Survey culture questions by 5% - raising concerns sub-score

Hospital Associated Infections

University Hospitals Dorset
NHS Foundation Trust

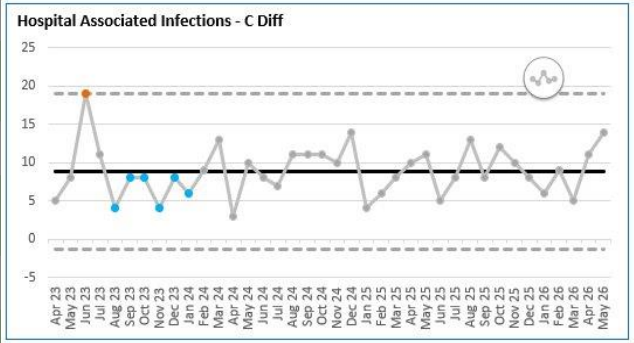
May 26
1
Variance/ Assurance

Targeting (Internal)
-
Business Rule
N/A



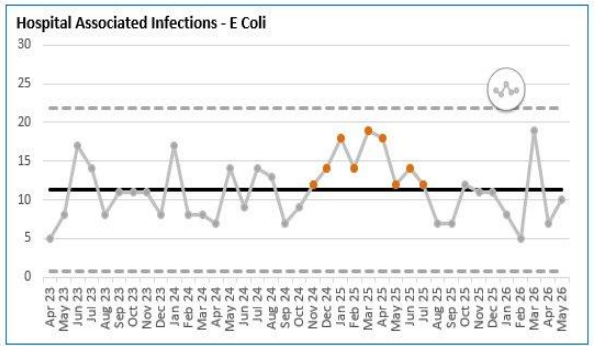
May 26
14
Variance /Assurance

Targeting (Internal)
-
Business Rule
N/A



May 26
10
Variance /Assurance

Targeting (Internal)
-
Business Rule
N/A



Summary

May 2026:
Hospital associated MRSA bacteraemia – 1 x HOHA
Hospital associated MSSA bacteraemia – 7 (4 x COHA, 2 x HOHA)
Clostridiodes difficile hospital associated cases – 14 (0 x HOHA)
Escherichia coli bacteraemia cases – 9 (2 x COHA, 7 x HOHA)
Klebsiella cases – 2 (2 x HOHA)
Pseudomonas cases – 3 (2x COHA, 1 x HOHA)

Outbreaks – 1

Actions

Ongoing ward Hand Hygiene audits, now managed via AMaT. Feedback on day to ward staff and full visibility for areas on AMaT dashboard.

Ongoing work with Teams and departments to strengthen Trust adherence to requirement for AARs for HCAI response.

Revision of IPC care group meeting agendas and function to ensure AA reporting and adherence to Governance structure

Assurance & Timescale for Improvement

Learning shared at the monthly care group IPC meetings and Care Group Governance

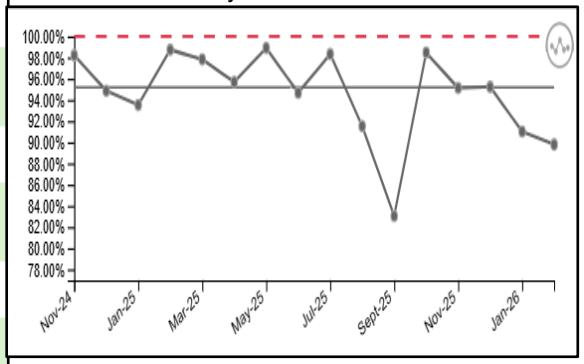
Hand Hygiene Trust wide project revision to improve compliance

eMortality Consultant Review Compliance
HSMR < 100

University Hospitals Dorset
NHS Foundation Trust

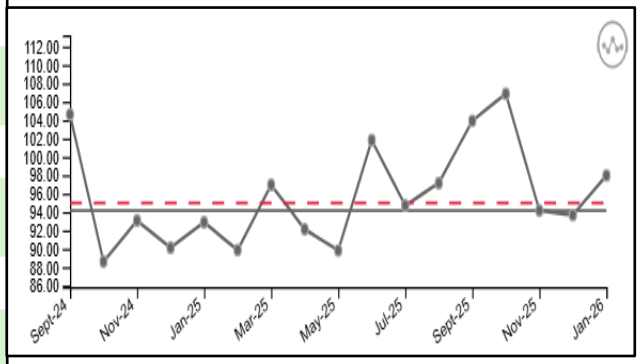
February 26
89.8%
Variance/ Assurance
Targeting (Internal)
100%
Business Rule
Verbal CMS

Consultant Mortality Reviews



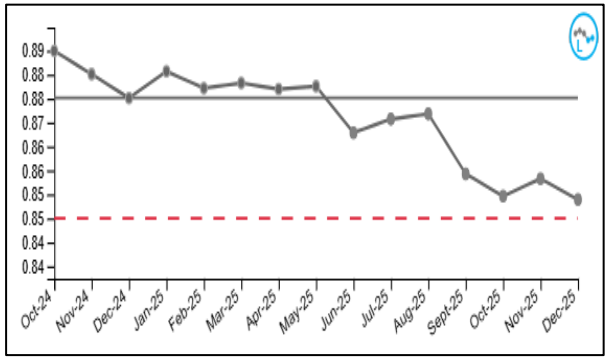
January 26
98.0
Variance /Assurance
Targeting (Internal)
96.0
Business Rule
Verbal CMS

HSMR in month



December 25
0.85
Variance /Assurance
Targeting (Internal)
0.85
Business Rule
Verbal CMS

SHMI – Summary Hospital Level Mortality Indicator



Summary

E-Mortality review compliance remains below target at 89.8%. This is reported 3 months in arrears.

HSMR in month remains within range. Regularly below target of 100 since October 2024 with expected variation.
In month HSMR for January 2026 has remained within expected variation at 98.0.
SHMI remains below national average at 0.8539, however slightly higher than internal target of 0.85.

Actions

Continued education and engagement of consultants
Working to ensure that the reviews are completed by the most appropriate team for learning e.g. ITU
Ongoing issues around identifying the correct consultant delay reviews.
Audit in progress to ensure pathways are correctly followed to identify patients for eLFD review to ensure 30% of all cases are consistently reviewed as per policy.

External audit of mortality coding in progress to review codes and accuracy. Risk (2302) agreed around coding accuracy and potential impact on HSMR
Flow chart to use to address HED alerts presented March MSG for review.

Assurance & Timescale for Improvement

Significant improvement noted, particularly in medicine. Plan for pathway for specific group of ITU patients to be reviewed directly by ITU and further links from ITU M&M to support teams with eLFD forms planned. The aim is for these pathways to be finalised and introduced by April.
Updates to HoW will support clinicians to change owning consultant in real time to improve accuracy of ECamis.

UHD is in the top 10 trusts of the 119 trusts included in the SHMI reporting.

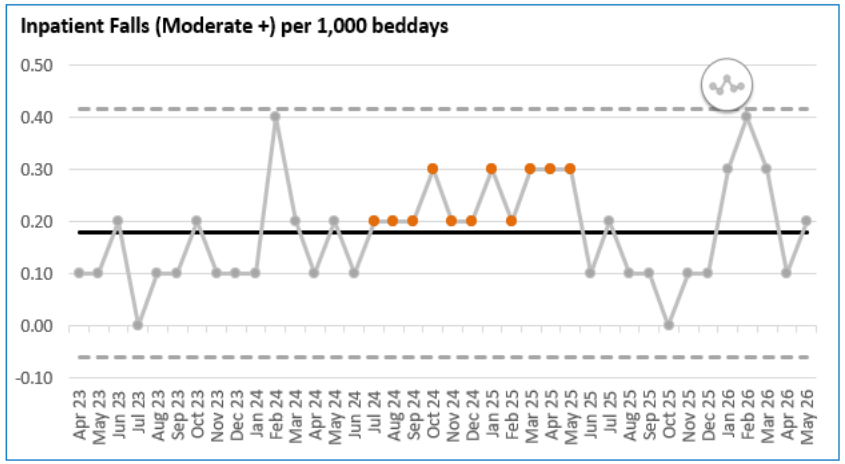
New flowchart will ensure that all alerts are assessed for accuracy and to identify concerns within that patient cohort.

Patient Safety – Falls

University Hospitals Dorset
NHS Foundation Trust

May 2026
0.2
Variance/ Assurance

Targeting (Interna)
-
Business Rule
N/A



Summary

- May 2026 falls are comparable to May 2025; however, significantly fewer resulted in moderate or greater harm this year.
- Overall inpatient fall rate in May 2026: 7.3 per 1000 bed days.
- Three inpatient falls resulted in moderate or greater physical harm, equating to 0.1 per 1,000 bed days. No fatalities reported.
- 94% of falls were recorded as low or no harm.
- 4% of LERNs submitted on incorrect forms or without recorded harm level.
- The activity at the time of the fall was primarily related to toileting or the patient mobilising independently, with staff unable to intervene due to other patient care tasks.

Actions

PSIRF Learning: Four incidents triggered SWARM learning response; All but one is complete, due to delayed identification of the injury.

- **Key themes identified** include ward pressures and competing demands, which limit staff ability to intervene, as well as late bed moves as a contributory factor.
- **Learning highlights include** increasing awareness of appropriate bed rail use and optimal bed height positioning. A trust-wide bed rail audit is planned for Quarter 2, alongside sharing the updated bed rail matrix and rail use guidance with staff.

Falls Steering Group: Regular meetings continue and chaired by the WCCSS GDON: June 2026 meeting focus on approving the updated draft Falls Policy ahead of circulation to care groups and submission to the Policies and Procedures Group.

Assurance & Timescale for Improvement

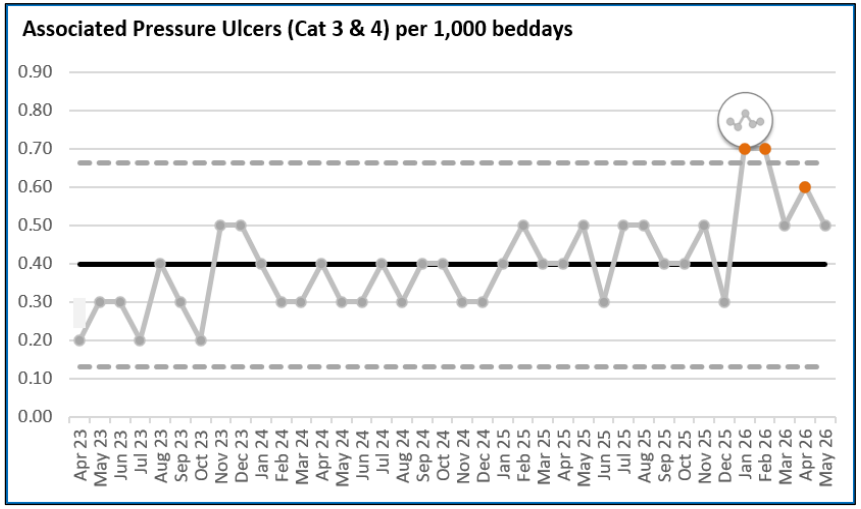
- **PSIRF Learning:** the Falls Steering Group will provide trust-wide oversight of falls incidents and assurance of completion of identified learning, actions and Duty of Candour requirements.
- **Falls Thematic Review 2025** actions: the Falls Steering Group will provide trust-wide oversight of the completion of identified actions.
- **Digital Integration:** eObs functionality for lying/standing BP recording has passed clinical acceptance testing (CAT) phase and is being presented for final sign-off by digital/EHR team.

Patient Safety – Pressures Ulcers

University Hospitals Dorset
NHS Foundation Trust

May 2026
0.4
Variance/ Assurance

Targeting (Internal)
-
Business Rule
N/A



Summary

There were 19 acquired full thickness pressure ulcer in April 2026

- 17 patients acquired pressure damage of Category 3 (one patient developed pressure damage to both sacrum and heels)
- There has been one Category 4 pressure ulcer

- The rate per 1,000 bed days 0.6 /1000 bed days. This represents a shift with 4 consecutive data points above the mean

NB: Pressure ulcer data reported 4-8 weeks in arrears

Actions

- Pressure ulcer event reviews completed for 17 of the 19 incidents identifying themes and learning
- In two cases instance notes not yet available
- One incident escalated for After Action Review
- One incident escalated for agreed learning response
- One incident as nominated enquired (Safeguarding)

Assurance & Timescale for Improvement

- Pressure ulcer steering group now set up and will meet monthly
- Clusters incidents or significant harm- clinical leads will attend Pressure ulcer Panel to report on learning and improvement plans
- After Action Review requested for Category 4 damage

- PSII ongoing (Previous category 4)

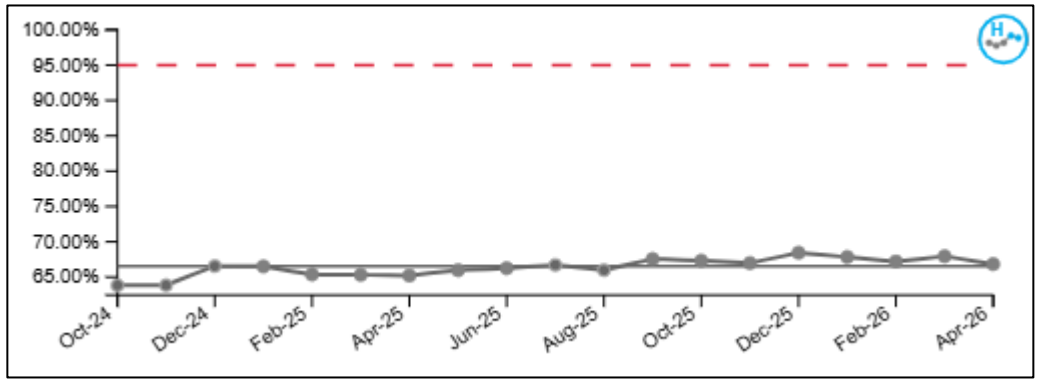
Patient Safety – VTE Prophylaxis

University Hospitals Dorset
NHS Foundation Trust

April 2026
67.6%
Variance/ Assurance

Targeting (Internal)
95%
Business Rule
Full CMS

VTE Prophylaxis Prescribing Compliance



Summary

- VTE risk assessment is mandated in EPMA and Trust achieves national mandated target of 95% however there is no electronic mandation to prescribe using current EPMA
- EPMA does not allow visualisation of what is not prescribed
- Not all patients are on EPMA.
- Trust and NICE Guidelines require VTE prescription within 14 hours which is not always possible due to clinical conditions for example awaiting surgery/procedures or awaiting investigation results i.e CT Head.
- New Trust target set to achieve 95% prescribing compliance
- This metric is now reported 1 month in arrears to take into account coding timescales

Actions

- Issues raised with EPMA
- Creation of Dummy Drugs to allow identification of clinical decision that patient does not require VTE prophylaxis
- Twice daily EPMA reports highlighting patients without prophylaxis issued to all wards and clinical depts
- Improved engagement in Thrombosis Group
- New COSMOS report including VTE risk assessment and prophylaxis prescribing timings
- Updated Patient Information
- Developing Patient Information Videos
- Training update Videos for staff
- Raised on RISK register
- VTE on SDR reporting with actions for improvement.
- TG attend Specialty Governance groups

Assurance & Timescale for Improvement

- RCA reporting of all hospital acquired thrombosis
- Reporting into thrombosis group
- PSIRF
- VTE Thematic review to begin

University Hospitals Dorset
NHS Foundation Trust

Perinatal Quality Surveillance

Maternity and Neonatal Dashboard

			Provider	UHD			
Group	Metric Id	MetricName	Latest Date	Value	Target	Variation	Assurance
Birth	1	No. of women delivered (all births)	May 26	300			
	2	No. women delivered (unregistrable baby/babies only)	May 26	4			
	3	Number of women delivered (multiple births where at least one unregistrable and one registrable)	May 26	0			
	6	Number of babies born	May 26	301			
	7	No. of registrable babies born	May 26	297			
Booking	15	Total number of bookings	May 26	324			
	16	% bookings completed <10 weeks gestation	May 26	78.4%			
Continuity of Carer	17	% of women on continuity of carer pathway by 29 weeks' gestation	May 26	5.50%			
	18	% of Black and Asian women on continuity of carer pathway by 28 weeks' gestation	May 26	95.2%			
	19	% of women (IMD-1) placed on a continuity of carer pathway	May 26	0.262%			
Infant Feeding	35	% of babies receiving breast milk at first feed	May 26	79.2%			
	36	% babies receiving breast milk at discharge from midwifery care to HV/GP (10 - 28 days PN)	May 26	70.8%			
Maternal Morbidity & Mortality	13	Rate per 1,000 Women with >= PPH 1500ml(previous 3 months aggregated)	May 26	34.8			
	14	Rate per 1,000 women with 3rd/4th degree tears (current three months aggregated)	May 26	17.5			

Data and Target

The national PQS Diis Scorecard is rated based on SPC methods and comparison to national targets.

Performance

Areas to note improvement :

- **Bookings** completed before 10 weeks 78.4with target set at 65%
- Avoidable term admissions to Neonatal unit **ATAIN** – 15 months of admission rates below the regional and national target.
- % of black and Asian women on **continuity of care pathway** by 28 weeks 95.2%
- % of women **smoking at delivery** 4% national target <6%

Key Areas of Focus

- **Postpartum Haemorrhage > 1500mls** – 34.8 aggregated 3 months (national target of 30) – Note: we include all PPH cases not just singleton term cases – Monthly SIM training this month focussed on PPH management.
- **Apgar score less than 7 at 5 minutes** –. Deep dive review in April 2026, and quality improvement commenced with positive initial improvements seen in May.
- **Training** compliance for **PROMPT <90 %** for anaesthetic team. Immediate action taken to address and plan t be put in place for the training .

University Hospitals Dorset
NHS Foundation Trust

Perinatal Quality Surveillance

Maternity and Neonatal Dashboard

			Provider	UHD			
Group	Metric Id	MetricName	Latest Date	Value	Target	Variation	Assurance
Maternal Morbidity & Mortality	26	Maternal death - number of deaths of women during or up to 1 year following the end of pregnancy (irrespective of place/circumstances of death)	May 26	0			
	27	Number of women admitted to ITU associated with birth up to 28 days post-natal (any birth, not including any other trust birth)	May 26	0			
Perinatal Morbidity	8	% of term babies admitted to NNU	May 26	3.18%			
	22	% of babies <3rd birthweight centile, born >37+6 weeks	May 26	50%			
	62	Rate per 1,000 babies born at term with an Apgar score <7 at 5 minutes (CQIMApgar)	May 26	12.4			
Perinatal Mortality	11	No. of still births per month	May 26	2			
	12	No. of neonatal deaths < 28 Days	May 26	2			
	20	Annual rate of stillbirths per 1,000 births - rolling 12mths	May 26	2.37			
	41	Rate per 1,000 of live birth babies who died within 28 days of birth - rolling 12mths	May 26	3.43			
Preterm Birth Data	23	No. of singleton babies born <27 weeks' or multiples born <28 weeks' gestation or birthweight <800g	May 26	2			
	33	Rate per 1,000 births which are preterm (< 37 week's gestation)	May 26	47.1			
Treating Tobacco Dependency	9	% of women smoking at booking	May 26	6.79%			
	10	% of women smoking at delivery (previous month)	May 26	4.01%			
	37	% of women with a CO measurement at time of booking	May 26	94.4%			
	38	% of women with a CO measurement at time of 36 weeks' gestation	May 26	85.8%			

Maternity and Neonatal Care

	Overall	Safe	Effective	Caring	Responsive	Well-led
CQC Maternity Ratings UHD Assessment Sept 2025	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement

University Hospitals Dorset
NHS Foundation Trust

National position & overview

- **The Perinatal Quality Surveillance Dashboard describes a standard data set for Trust Board overview**
- **The dashboard implementation using the Perinatal Quality Surveillance Tool forms part of our 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 2 reportable case to MBRRACE in May 2026 –

Stillbirth at 34+1, Known intrauterine growth restriction
Stillbirth at 37+5, Born before arrival (BBA), social input -. Non engagement with maternity services.

No immediate care issues identified, and both cases will be assessed through PMRT.

There were X 2 Neonatal deaths following Medical termination of pregnancy (MTOP) <22/40 born with signs of life. These do not meet PMRT criteria but have been reported to MBRRACE.

MNSI

There were one case reported to MNSI in May 2026.

#1 Stillbirth at 37+5, Born before arrival (BBA), social input -. Non engagement with maternity services.

Matters for Board information and awareness

Patient Safety Incident Response Framework (PSIRF)
has been implemented in maternity.
There were no Mat Neo incidents which required escalation for discussion at care group PSIRF Rapid review meetings in May.

Ongoing PSII:
1. #2 - Major Obstetric Hemorrhage (MOH) 6.2Lfollowing a Cat 2 EMCS (Emergency caesarean section) and
Hysterectomy in theatre followed by a transfer to Intensive care unit .
After Action Review (AAR) carried out by the Patient safety team in October. PSII investigation commenced in December
by one of the Patient Safety Investigators following a TOR meeting – Investigator currently sick and replacement now in
place. Currently graded as 'Moderate physical harm' pending review and PSII commenced
2. #3 - Major Obstetric Hemorrhage (MOH) 5.5L ITU admission. Action Planning Meeting in May 26, and
led by patient safety team.

Top incidences LFPSE (April 2026):

- Post partum hemorrhage >1500mls = 16
- Term admission to neonatal unit = 11
- Readmission of baby
- Shoulder dystocia

Safety champions reviews and assurance this month:
MIS year 8 assurance structure
Apgar score less than 7 at 5 minutes – QI project work

Progress in achievement of maternity improvement plan

CQC action plan -
Recent inspection in September – final report in March 2026 – rated as requires improvement. Initial recommendations and action plan in place for baby abduction/security and safe staffing rosters.

Maternity incentive scheme year 8 -
Release of year 8 awaited in April. New format introduced this year
to include wider MDT involvement and accountability.

CQC Maternity Survey 2025 results published, The results show continuing improvement since 2022. 2025 survey showed a stable position.

Staff survey: Initial results show staff feel confident that the Trust prioritises patient care. Areas to focus – improving staff health and well-being, reducing exhaustion and increase opportunities for teams to meet and discuss effectiveness. Local heat maps disseminated and the team have commenced work in all areas

Culture improvement plan – Release of year 8 awaited in April. New format introduced this year to include wider MDT involvement and accountability

University Hospitals Dorset
NHS Foundation Trust

Patient Experience

Sarah Herbert
Chief Nursing Officer

Operational Leads:
Vivian Alividza – Deputy Chief Nursing Officer

Jo Sims – Associate Director Quality, Governance and Risk
Lorraine Tonge – Director of Midwifery
James Balmforth – Clinical Director
Darren Jose – Interim Care Group Director of Operations, Women's, Children, Cancer and Support Services

Committees:
Quality Committee

Performance at a Glance
Patient Experience

University Hospitals Dorset
NHS Foundation Trust

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Friends & Family Test	May 26	91.6%	-			93.7%	92.0%	95.4%
Complaints Received	May 26	76	-			82	-14	178
Complaint Response Rate (Grade Based Target)	May 26	40%	100%			46%	16%	77%
Mixed Sex Accommodation Breaches	May 26	3	-			7	-5	19

Survey Results will be reported annually

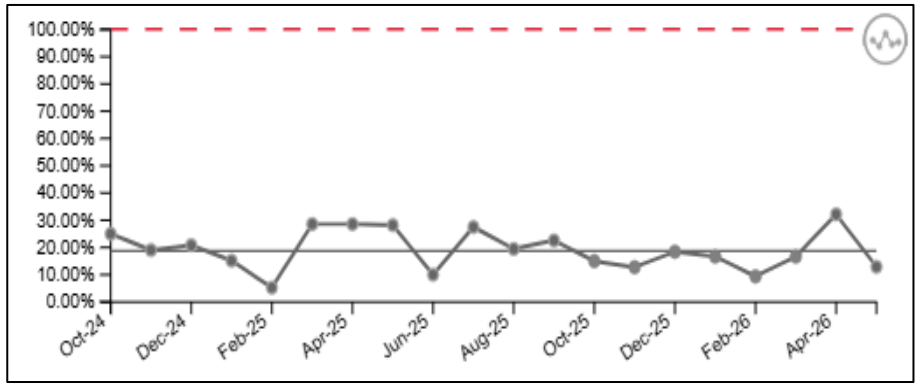
- To increase Have Your Say Survey feedback rates by 30%
- 5% improvement in employees who see patient care as a top priority for UHD

Patient Experience

University Hospitals Dorset
NHS Foundation Trust

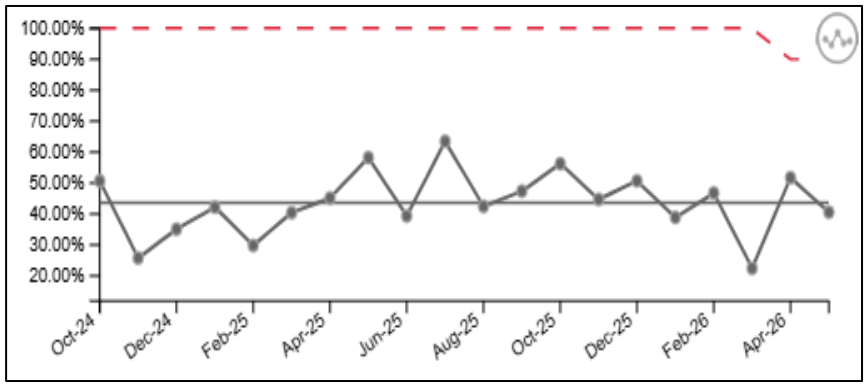
May 26
12.9%
Variance/ Assurance
Targeting (Internal)
100%
Business Rule
Verbal CMS

% of Early Resolutions closed within 10 days



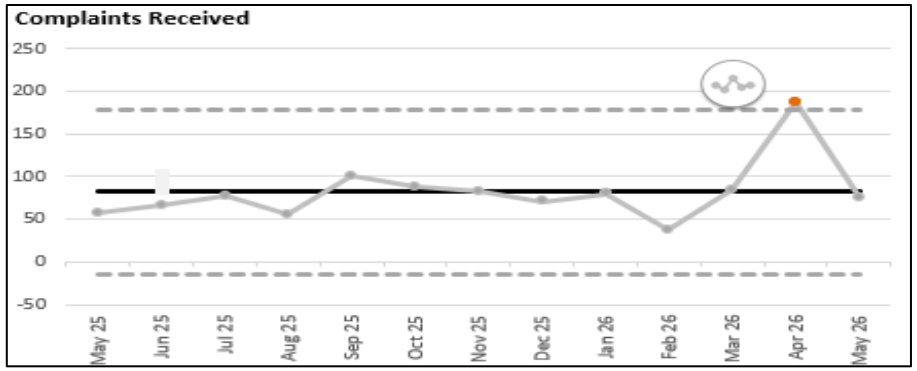
May 26
40.6%
Variance/ Assurance
Targeting (Internal)
90%
Business Rule
Full CMS

% of total complaints closed within 35 days

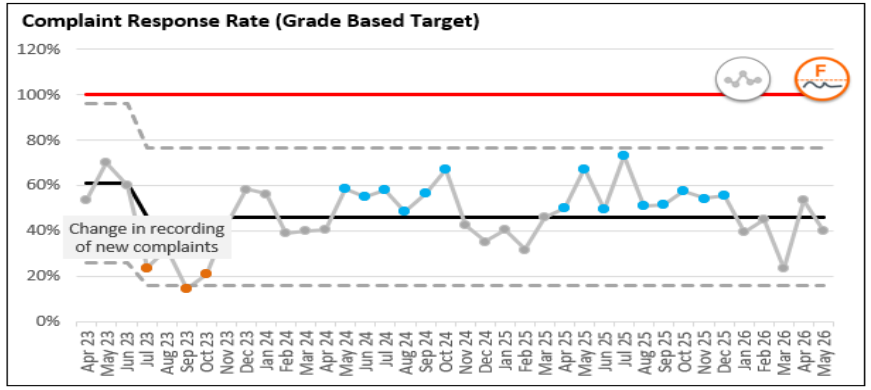


May 26
76
Variance/ Assurance
Targeting (Internal)
-
Business Rule
Note Performance

Number of complaints received



May 26
39.7%
Variance/ Assurance
Targeting (Internal)
-
Business Rule
Verbal CMS



Summary

Formal complaints logged = 34 (April =86)
Early Resolution Complaints = 42 (April = 102). Early staff involvement and local resolution is dependent on competing clinical pressures which lead to delays in closing in 10 days. ERC still require a formal letter as a summary to the patient, where further delays are being seen.
Average Complaint response time = 51.96 days (increase from April = 39.76 days)
PALS contacts = 624 (April = 554)

Actions

PALS enquiries continue to remain high with work ongoing to improve direct communication access to services for patients.
Signposting enquiries from PALS causes duplication of staff involvement and a poorer patent experience.
Complaints process changed alongside trialing the use of AI in the team.
Focus on Early resolution as the preferred method of complaint handling.

Assurance & Timescale for Improvement

Complaints and PALS performance monitored through the Patient Experience Group.
Complaints response time remains a significant concern and the top priority to address, multiple small but significant changes to the process have been made with their impact being continuously monitored and adjusted further in response.

University Hospitals Dorset
NHS Foundation Trust

Sustainable Services

Finance

Pete Papworth
Chief Finance Officer

Operational Lead:
Adrian Tron, Deputy Chief Finance Officer

Committees:
Finance and Performance Committee

Performance at a Glance

University Hospitals Dorset
NHS Foundation Trust

Sustainable Services

Finance

All values £'000 Driver Metric	Latest Month	In Month Plan	In Month Actual	In Month Variance	Year To Date Plan	Year To Date Actual	Year To Date Variance
Revenue Control Total	May-26	(2,374)	(2,626)	(253)	(5,015)	(6,249)	(1,234)
Capital Control Total	May-26	9,255	12,754	(3,499)	13,482	13,497	(15)
Efficiency Programme	May-26	3,536	3,157	(378)	6,976	6,231	(744)
Cash Balance	May-26	56,659	98,394	41,735	56,659	98,394	41,735
Better Payment Practice Code	May-26	95.0%	97.1%	2.1%	95.0%	96.6%	1.6%

Financial Management – YTD Variance to budget

University Hospitals Dorset
NHS Foundation Trust

May 26
£0
Variance/ Assurance

Targeting (Internal)
£0
Business Rule
Verbal Update

Summary I&E	Year to date			Forecast		
	Budget	Actual	Variance	Budget	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Patient Care Income	144,874	143,655	(1,219)	869,410		
Other Operating Income	10,177	10,478	301	50,812		
Charitable Income	599	587	(13)	2,722		
Total Income	**155,650**	**154,719**	**(931)**	**922,943**		
Employee expenses	(105,381)	(106,696)	(1,316)	(618,920)		
Clinical supplies expenses	(12,541)	(12,437)	104	(76,622)		
Drugs expenses	(15,591)	(15,097)	494	(91,646)		
Purchase of healthcare and social care	(2,960)	(3,958)	(998)	(16,243)		
Depreciation and amortisation expense	(7,082)	(6,540)	542	(41,434)		
Clinical negligence expense	(3,385)	(3,211)	174	(20,310)		
Premises & fixed plant	(5,635)	(5,683)	(48)	(33,810)		
Other operating expenses	(5,995)	(5,979)	16	(55,864)		
Operating Expenses	**(158,569)**	**(159,601)**	**(1,032)**	**(954,849)**		
Net finance costs	(2,348)	(1,710)	638	(14,085)		
Other adj to control total basis	252	342	91	45,991		
Control Total Surplus/ (Deficit)	**(5,015)**	**(6,249)**	**(1,234)**	**0**		

May 26
£83,231
Variance/ Assurance

Targeting (Internal)
£83,231
Business Rule
Verbal Update

Capital	Year to date			Forecast		
	Budget	Actual	Variance	Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Estate Schemes	266	576	(310)	10,907		
IT Schemes	5,129	5,158	(29)	13,466		
Medical Equipment	692	145	547	3,994		
Total Operational CDEL	**6,087**	**5,879**	**208**	**28,367**		
Total Donated Assets	**108**	**102**	**6**	**2,657**		
CDC - Outpatient Assessment Centre	1,250	9	1,241	13,700		
CIR - Critical Infrastructure Funding	500	(11)	511	1,000		
NHP - New Hospitals Prog - FBCA & Enabling	1,988	5,175	(3,187)	8,001		
NHP - New Hospitals Programme - FBCB	3,549	2,343	1,206	29,156		
MHLDA - MH, Learning Disability & Autism	0	0	0	350		
Total Central PDC	**7,287**	**7,516**	**(229)**	**52,207**		
UHD Capital Total	**13,482**	**13,497**	**(15)**	**83,231**		

Summary

I&E: The Trust delivered a deficit of £6,249 million as at the end of May, being £1,234 million adverse to plan. This included unplanned Industrial Action costs of £518,000, together with lower than planned efficiency savings.

Capital: The Trust reported capital expenditure of £13.5 million during the first two months of the year, consistent with the phased capital programme.

Actions

I&E: The Trust continues to focus on the identification of efficiency schemes. In addition, a full outturn forecast is being developed using the Month 2 outturn, to identify any additional risks and inform additional mitigation plans. NHS England has confirmed that there is no funding for Industrial Action costs which are expected to be mitigated locally.

Capital: The capital programme has been refreshed to account for the final impact of the 2025/26 programme outturn. The updated programme has enabled additional prioritisation of the high-risk estates backlog, off-set by a reduced medical equipment requirement.

Assurance & Timescale for Improvement

I&E: Assurance over the financial performance of the Trust will continue through the Trust Management Group, supported by the Sustainable Service Group and Care Group SDR meetings.

Capital: Assurance over the delivery of the capital programme will continue through the Trust Management Group, supported by the Sustainable Service Group and Capital Management Group.

Efficiency Improvement Programme

University Hospitals Dorset
NHS Foundation Trust

May 26
44%
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	(1,841)	1,407	(434)	(11,534)	6,524	(5,010)	57%	9,835	85%	1,209	469	(9,856)	15%
Medical	(2,324)	1,113	(1,210)	(13,942)	3,374	(10,568)	24%	7,921	57%	1,651	197	(12,093)	13%
WCCSS	(1,969)	1,062	(907)	(11,644)	5,761	(5,883)	49%	6,371	55%	4,536	173	(6,935)	40%
Operations	(392)	411	19	(2,382)	1,374	(1,009)	58%	2,996	126%	437	7	(1,939)	19%
Corporate	(450)	915	464	(2,702)	3,068	365	114%	3,535	131%	1,336	0	(1,366)	49%
Trust Wide	0	1,323	1,323	(26,295)	10,281	(16,014)	39%	15,817	60%	4,765	201	(21,329)	19%
UHD	**(6,976)**	**6,231**	**(744)**	**(68,500)**	**30,380**	**(38,118)**	**44%**	**46,475**	**68%**	**13,934**	**1,047**	**(53,518)**	**22%**

Summary

Up to the end of May the Trust delivered £6.2m of savings, being £0.7 million below the phased plan. The trust has identified savings opportunities of £51.1 million, however when adjusted to reflect the risk of delivery in year, this is reduced to £30.4 million (an increase of £4.8 million from M1). This remains £38.1 million short of the full year savings requirement.

Actions

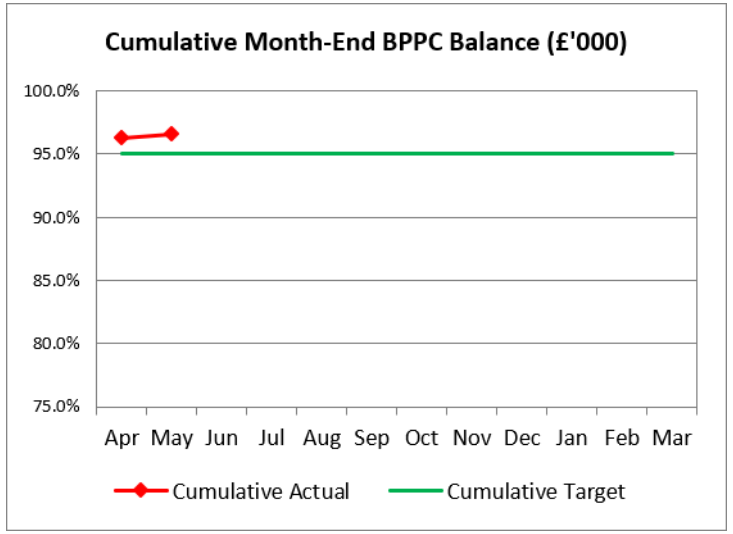
The Trust has strong governance in place in relation to its Efficiency Improvement Programme and has received external assurance over this. The current focus is to identify additional schemes to deliver the 2026/27 savings requirement in full, whilst simultaneously progressing the identified schemes through the gateway process to reduce the risk adjustment.

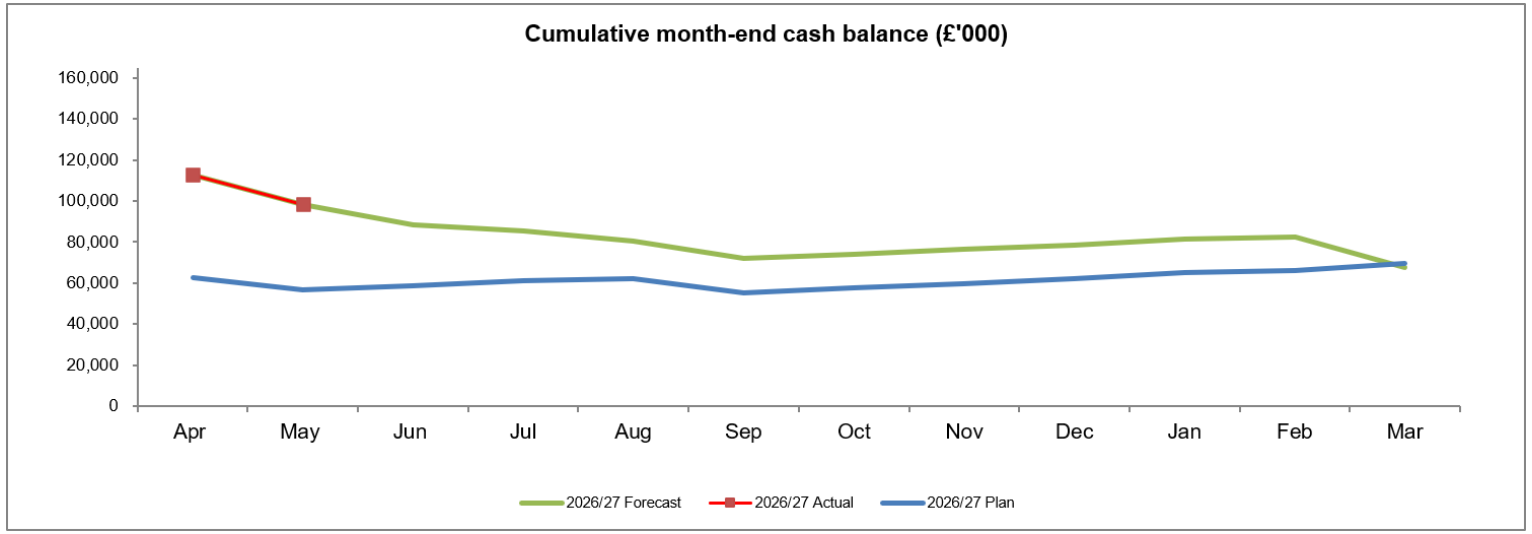
Assurance & Timescale for Improvement

Monitoring of improvements in the identification and delivery of efficiency schemes will continue weekly through the executive team meeting and monthly through Care Group SDR meetings, the Sustainable Services Group and Trust Management Group. The Finance and Performance Committee continue to challenge and closely monitor the Trusts progress in tis area.

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 delivered performance of 96.6%, above the national standard of 95%.	**Public Sector Payment Policy:** This remains a key focus for the Trust, with training and support being offered to budget holders where appropriate.	**Public Sector Payment Policy:** Performance will continue to be monitored and assured through the Sustainable Services Group.
Cash: At the end of April, the Trust is holding a consolidated cash balance of £98.4 million. After adjusting for the £29.1 million of capital payables, this represents 28 days of operating expenditure and an underlying cash balance of £69.2 million. This is significantly above the planned level due to additional funding, increased capital creditors and improvements in the Trusts payment processes.	**Cash:** The cash forecast is currently being refreshed to reflect the additional income and the expected timing of payments.	**Cash:** An updated cash forecast will be in place from Month 3 reporting.

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%	46357		This is to monitor move of A&G to Consultant Connect			
ICE for Ordering vs paper		95%	Aug 26		This is move of ICE to paperless requesting			
ICE results acknowledgement	57%	90%	Aug 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

University Hospitals Dorset
NHS Foundation Trust

Summary	Actions	Assurance & Timescale for Improvement
DNA rate (5.2%) is showing special cause improvement, having fallen below the process mean for the 5th consecutive month. The target (5%) is within the process control limits indicating that it is achievable.	Ongoing roll out of Dr Doctor functionalities to support scheduling is taking place. Integration between the Cardiology booking system (Tomcat) and Dr Doctor was achieved this month to further extend the reach of digital appointment reminders.	DNA and A&G rates are part of a suite of metrics monitored at the Programme Board of the Outpatient Improvement (Corporate) Programme.
Digital Letters Vs Paper – initial scoping has identified opportunities to increase the availability of patient letters digitally. Admin workflow mapping is underway and an analysis of postage and printing spend.	Ongoing review of the use of Synertec / Dr Doctor for the progress of electronic letters. Some elements will need letters to be redesigned / updated as part of the programme. Meeting going in to review the current status of this programme.	This is a project under Transforming and Valuing Administration.
Advice & Guidance is the adoption of Consultant Connect as the new process for A&G and referral management through ERS. All appropriate specialties are now live with consultant connect for A&G and 2 are live with advice and refer ahead of the transition to 10 services having single points of access (SPOA) in place by October 2026.	All specialties are now live on Consultant Connect for Advice & Guidance.	All specialties are now live and therefore this programme will be closed as complete and moved to Business as Usual.
ICE Ordering and Results Acknowledgement – Task & Finish group is now agreeing the Trust wide roll out of electronic requesting on ICE to further support increased adoption of results sign off with accuracy of requesting.	Equipment roll out for ICE requesting is proceeding at pace with the last delivery received. All areas will have their equipment, and we will mandate electronic requesting by August 2026. We should then see the improvement in filing. SDR Patient First metric will be in place in July 2026 once approved by the Patient First Group.	Task & Finish Group for ICE Paperless Reporting and Reporting to Monitor and Track this. Overall target for paperless reporting & requesting is approximately August 2026 based on the roll out of the equipment.
No of Attendances Streamed away via NHS S&R Tool – need to clarify the metrics we intend to monitor for this change.	No further actions other than the tracking on metrics when this data is available	Awaiting the BI Dashboard for the metric monitoring.

University Hospitals Dorset
NHS Foundation Trust

BOARD OF DIRECTORS - PART 1 MEETING

Meeting Date: 15 July 2026

Agenda item: **5.1**

COVER SHEET – ALERT, ASSURE, ADVISE	
TITLE:	Trust Constitution update
Prepared by:	Leonora May, Director of Corporate Governance
Presented by:	Leonora May, Director of Corporate Governance
Strategic themes that this item supports/impacts:	Population & System ☒ Our People ☒ Patient Experience ☒ Quality Outcomes & Safety ☒ Sustainable Services ☒
BAF/Corporate Risk Register: (if applicable)	N/A
Purpose of paper:	Decision/Approval
Executive summary:	During October and November 2025, both the Board of Directors and Council of Governors approved an amendment to S21 and Annex 7 of the Trust's Constitution to reinstate the casting vote for the Trust Chair to ensure that the Board can continue to make timely decisions, given that from May 2025, the Trust has an equal amount of executive and non-executive directors in post (including the Trust Chair), as one of the non-executive directors is currently in the interim Chair role. There is a clause remaining in S21 of the Trust's Constitution and S3.1 of Annex 7 which states that 'provided that at least half of the Board of Directors, excluding the Chair, shall at all times comprise Non-Executive Directors'. It is proposed that this clause is removed as it is conflicting with the previous amendments made to the Constitution and the current position.
ALERT:	None
ASSURE:	The model Constitution for NHS foundation trusts provides that 'in accordance with the principles of good governance, it is recommended that the Constitution provide that at least half the Boad of Directors, excluding the Chairman, should be non-executive directors. Alternatively, in the event that the Constitution provides for parity on the Board of Directors between executive and non-executive directors, the Chairman should have a casting vote.'
ADVISE:	Provision B.2.7 of the Code of governance for NHS foundation trusts requires that at least half of the Board, excluding the Chair, should be Non-executive directors. Trusts are required to

	explain any departures from the Code in the Annual report. The following explanation for the departure has been provided: During 2025/26 and to date, the Trust has eight executive directors and seven Non-executive directors (excluding the Chair) in post. This is because from May 2025, one of the Non-executive directors took up the role of interim Chair and that role was not backfilled. The postholder's substantive role is as a Non-executive director. This position was supported by the Board, Council of Governors and NHSE regional team to provide continuity and stability to the Board during a period of significant transformation and change. During the period, the Trust's Constitution was updated to include a casting vote for the Chair. Changes to the Trust's Constitution also require approval from the Council of Governors. This report will be presented to the Council of Governors at its meeting on 16 July 2025. 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).
Celebrating Outstanding:	NA
RECOMMENDATION:	The Board is asked to approve the recommended change to the Trust's Constitution as set out below. Removal of the following clause from S21 and S3.1 of Annex 7 of the Trust's Constitution: 'provided that at least half of the Board of Directors, excluding the Chair, shall at all times comprise Non-Executive Directors'
Implications associated with this item:	Council of Governors ☒ Environmental Sustainability ☐ Equality, Equity, Diversity & Inclusion ☐ Financial ☐ Health Inequalities ☐ Operational Performance ☐ People (inc Staff, Patients) ☐ Public Consultation ☐ Quality ☐ Regulatory ☒ Strategy/Transformation ☐ System ☐ Explain the impact on each selected area; positive outcomes, risks and mitigations, and any oversight needed.
CQC Assessment Framework:	Safe ☐ Effective ☐ Caring ☐ Responsive ☐

	Well-Led	☒
	Use of Resources	☐

Report History: Committees/Meetings at which the item has been considered:	Date	Outcome
Board of Directors	November 2025	Approval to change to Constitution to reinstate the casting vote for the Trust Chair
Council of Governors	October 2025	Approval to change to Constitution to reinstate the casting vote for the Trust Chair
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 - Attendance at Part 1 Board Meetings

Part 1		May 2026
Members Present	Beverley Bryant	
	Judy Gillow	
	Siobhan Harrington	
	Sarah Herbert	
	Tracie Langley	
	Femi Macaulay	
	Alastair Matthews	
	Michael Marsh	
	Helena McKeown	
	Mark Mould	
	Pete Papworth	
	Sharath Ranjan	
	Richard Renaut	
	Claire Whitaker	
	Melanie Whitfield	
	Peter Wilson	
In attendance	Andrew Doe	
	Alison Honour	
	Klaudia Zwolinska	
Was the meeting quorate?		Y

Key

	Present
	Not in Attendance
A	Apologies
D	Delegate Sent